Coping with the Process of Forced Resettlement: A Qualitative Approach with Somali Refugee Young People and Front-Line Services

By

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(Clinical Psychology)

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<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgements</td>
<td>3</td>
</tr>
<tr>
<td><strong>ACADEMIC DOSSIER</strong></td>
<td>4</td>
</tr>
<tr>
<td>Literature Review</td>
<td>5</td>
</tr>
<tr>
<td>Professional Issues Essay</td>
<td>31</td>
</tr>
<tr>
<td>Problem Based Learning Account One</td>
<td>56</td>
</tr>
<tr>
<td>Problem Based Learning Account Two</td>
<td>67</td>
</tr>
<tr>
<td>Summary of Personal and Professional Learning</td>
<td></td>
</tr>
<tr>
<td>Discussion Group Process Account One</td>
<td>80</td>
</tr>
<tr>
<td>Summary of Personal and Professional Learning</td>
<td></td>
</tr>
<tr>
<td>Discussion Group Process Account Two</td>
<td>82</td>
</tr>
<tr>
<td><strong>CLINICAL DOSSIER</strong></td>
<td>84</td>
</tr>
<tr>
<td>Overview of Three Years Clinical Experience</td>
<td>85</td>
</tr>
<tr>
<td>Case Report Summary One</td>
<td>89</td>
</tr>
<tr>
<td>Case Report Summary Two</td>
<td>91</td>
</tr>
<tr>
<td>Case Report Summary Three</td>
<td>93</td>
</tr>
<tr>
<td>Case Report Summary Four</td>
<td>95</td>
</tr>
<tr>
<td>Oral Presentation Summary</td>
<td>38</td>
</tr>
<tr>
<td><strong>RESEARCH DOSSIER</strong></td>
<td>97</td>
</tr>
<tr>
<td>Service Related Research Project</td>
<td>98</td>
</tr>
<tr>
<td>Qualitative Research Project Abstract</td>
<td>129</td>
</tr>
<tr>
<td>Major Research Project</td>
<td>131</td>
</tr>
<tr>
<td>Research Log</td>
<td>302</td>
</tr>
<tr>
<td>Appendices to the Research Dossier</td>
<td>304</td>
</tr>
</tbody>
</table>
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ACADEMIC DOSSIER

- Literature Review
- Professional Issues Essay
- Problem Based Learning Account 1
- Problem Based Learning Account 2
- Summary of Personal and Professional Learning
  Discussion Group Process Account 1
- Summary of Personal and Professional Learning
  Discussion Group Process Account 2
To what extent can Attachment Theory and the concept of Mentalization inform our understanding and treatment of Borderline Personality Disorder?

Literature Review
January 2010

Year 1
ABSTRACT
Clinical theorists have suggested that attachment theory and the concept of mentalization are central to understanding Borderline Personality Disorder (BPD) psychopathology. This paper reviews a selection of empirical studies that examine the attachment styles of BPD. Insecure attachment was found to be the most characteristic of BPD; however comparison between studies was restricted due to the variety of measures and methodologies employed. The Mentalization Model is evaluated in light of recent research, and Mentalization-based Treatment reviewed for its theoretical roots and empirical research. This review concludes that attachment theory and mentalization can help inform understanding and treatment of BPD. However mentalization is likely not to be the only mechanism by which BPD psychopathology develops and can be treated, and that the Mentalization Model should be applied tentatively. Clinical implications are discussed.

DECLARATION OF POSITION
I found attachment theory integral in informing my previous clinical work with neglected and abused children, who often presented with complex interpersonal difficulties and challenging behaviours. I became aware of inherent transference issues in the therapeutic relationship, and of the need to relate in a marked and congruent way to help facilitate the development of more coherent and positive representations of themselves and other people. This experience has led me to want to explore whether attachment theory may similarly inform my work with adults with borderline personality disorder (BPD), a population that also experiences interpersonal difficulties and frequently a history of childhood trauma and neglect, in the research vein of developmental psychopathology.
INTRODUCTION

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association [APA], 1994) describes BPD as characterised by instability in interpersonal relationships, self-image and affects (see Table 1). The National Institute of Excellence (NICE) Guidelines for BPD (2009) currently recommends a structured care plan approach which includes psychotherapeutic interventions over medication to treat BPD. Clinical psychology therefore should be at the forefront in developing and evaluating models of the diverse presentations and treatments for BPD.

Table 1: DSM-IV criteria for BPD (APA, 1994)

<table>
<thead>
<tr>
<th>A pervasive pattern of instability of interpersonal relationships, self-image and affects, as well as marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-injuring behaviour covered in Criterion 5.</td>
</tr>
<tr>
<td>2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.</td>
</tr>
<tr>
<td>3. Identity disturbance: markedly and persistently unstable self-image or sense of self.</td>
</tr>
<tr>
<td>4. Impulsivity in at least two areas that are potentially self-damaging (e.g. promiscuous sex, eating disorders, binge eating, substance abuse). Note: Do not include suicidal or self-mutilating behaviour covered in Criterion 5.</td>
</tr>
<tr>
<td>5. Recurrent suicidal behaviour, gestures, or threats, or self-injuring behaviour such as cutting, interfering with the healing of scars (excoriation) or picking oneself.</td>
</tr>
<tr>
<td>6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).</td>
</tr>
<tr>
<td>7. Chronic feelings of emptiness.</td>
</tr>
<tr>
<td>8. Inappropriate anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).</td>
</tr>
<tr>
<td>9. Transient, stress-related paranoid ideation, delusions or severe dissociative symptoms.</td>
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</table>

The aetiology of BPD is still unclear, however disturbed attachments are proposed to be a contributing factor, with development of socio-cognitive
capacities undermined in early relationships, leading to impairments in emotion regulation (NICE, 2009). Attachment theory may help to explain the patterns of intense and unstable interpersonal relationships, fear of being alone, unstable sense of self, and feelings of emptiness (Fonagy et al., 1996; Gunderson et al., 1996). As a result, impulsive, emotionally labile and self-damaging behaviours may occur within interpersonal contexts, as a reaction to real or perceived threats of abandonment.

Attachment difficulties can therefore also play out in therapeutic contexts. People with BPD are often perceived as difficult to treat within the mental health services, as being ‘attention-seeking’, leading to negative and inconsistent responses amongst mental health professionals. It is possible that clients’ frequent disengagement from services may be attributed to the services’ current lack of understanding of possible mechanisms that underlie BPD, with services not offering appropriate attentive support or tailored interventions.

In this paper I will evaluate whether attachment theory and the associated capacity of mentalization can inform our understanding and treatment of people with BPD, to the extent effective psychological interventions can be developed. Mentalization-based treatment (MBT) is a relatively new psychological therapy programme developed for BPD, which is rooted in attachment theory (Bateman & Fonagy, 2003). I therefore believe a literature review of the theory base the programme is developed from, and of the treatment itself is both topical and useful.

**Definition of Key Constructs**

Attachment = an emotional bond (between child and caregiver).

Mentalization = ‘...the capacity to make sense of each other and ourselves...in terms of subjective states and mental processes...[which]
biologically originates in the context of the attachment relationship.' (Fonagy & Bateman, 2008, pp.5)

METHOD
The search terminology 'attachment', 'attachment theory', and 'borderline personality disorder' were initially used in PsycINFO to identify papers relevant for the literature review. Identified articles were retained if they referred to the specific relationship between attachment and BPD, mentalization and BPD, attachment-related interventions of BPD, and an adult population. Further relevant terminology ('mentalization') and papers cited in the literature were sourced. The literature was reviewed to identify links between attachment theory or mentalization and BPD, and these links are discussed below.

I acknowledge that I am not reviewing the full breadth of psychological theories of BPD, the contribution of genetics and neuroscience, nor the range of psychological treatments and their relative efficacy. Whilst I recognize their contribution to understanding and approaching the complex nature of BPD, I have chosen to focus on one strand of theory and research in line with the Declaration of Position.

ATTACHMENT THEORY AND BPD

Roots of Attachment Theory
Bowlby (1977) proposed that a child develops a functional emotional bond with their caregiver which provides protection and comfort in times of distress, a safe context to experience and explore the world, and to develop an understanding of self and others. Bowlby (1977) suggested that the child develops socio-cognitive “internal working models” of self, others and interpersonal relationships through interactions with the caregiver, which are ‘...hypothesized to subsequently act as heuristics in relationships,
organising personality development and the regulation of affect' (Levy, 2005, pp.961). Therefore early attachment is proposed to have a strong influence on normal or pathological development of personality and emotion regulation (Bowlby, 1977; Cassidy, 1994).

Ainsworth et al. (1978) went on to define three attachment patterns (secure, avoidant and anxious) from observing infant-mother interactions within the Strange Situation experiment. An additional disorganized attachment strategy was added by Main and Solomon (as cited in Agrawal et al., 2004), considered as result of parental risk factors such as child maltreatment. See Table 2.

Bowlby's (1977) theory predicts that attachment patterns remain stable across a persons' life time, but are also open to change in light of experiences. Waters et al.'s (2000) longitudinal study supports this hypothesis, finding that 72% of 50 participants originally assessed as infants in the Strange Situation received the same attachment classification 20 years later, and significant life events (reduction in availability/responsiveness of caregiver) as an important factor for participants who changed classification.

Fonagy et al. (1996) and Fonagy (2000) theorised that the BPD criteria of affective and relationship instability, fears of abandonment and self-harm are all symptoms experienced in an interpersonal context, and therefore related to impairments in the underlying attachment organisation. For example, Gunderson et al. (1996) draw comparisons between Ainsworth et al.'s (1978) anxious pattern with the clingy and proximity seeking behaviours common in BPD. The relationship between BPD and attachment, and the mechanism underlying stability and change in attachment organisation therefore needs to be examined.
Attachment Research

I will now discuss a sample of research papers that seek to delineate a specific link between attachment and BPD, on the assumption there is relative stability in attachment styles across lifetimes. Reviewing the literature, it appears the studies can be split into using either self-report or interview methods.

Self-Report

Aaronson et al. (2006) compared the attachment style of 50 participants with BPD, with 40 participants with Obsessive Compulsive Personality Disorder (OCPD) using the reciprocal attachment questionnaire (RAQ). Attachment patterns were analysed along dimensions rather than categories. They found that insecure attachment dimensions were distinctive in the BPD group compared to OCPD, with significantly higher means on anxious-ambivalent attachment style (p=0.05) and higher levels on feared loss and separation protest with an attachment figure. However, secure attachment styles were not examined, therefore it is unclear how BPD and OCPD compare to normative groups.

Nickell et al. (2002) used the Three Category Measure of Attachment (TCM-R) and Parental Bonding Inventory (PBI) with 393 nonclinical participants with borderline features, controlled for co-morbid psychopathology. Using a regression model they found a unique relationship between borderline features and anxious-ambivalent attachment styles, and a relationship with conflicting and contradictory perceptions of care from their mothers. Most importantly, they found that parental bonding and attachment styles were not highly related with childhood adversity. However, when co-morbid symptoms were not controlled for, they found that childhood sexual abuse and avoidant attachments were additional predictors for BPD features. This study therefore suggests that trauma may be a general vulnerability factor, with attachment and parenting styles more salient to BPD. However, the extent these findings are generalisable to a clinical BPD population is uncertain.
Table 2: Attachment Styles

<table>
<thead>
<tr>
<th>Attachment Style (Equivalent term for adults from AAI in brackets)</th>
<th>Childhood (Ainsworth et al., 1978)</th>
<th>Adulthood (Taken from AAI; George et al., as cited in Agrawal et al., 2004)</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure (autonomous)</td>
<td>Open communication of distress and acceptance of comfort from caregiver.</td>
<td>Coherent, believable and consistent account.</td>
<td>Adult Attachment Interview (AAI)</td>
</tr>
<tr>
<td>Avoidant (dismissing)</td>
<td>Little communication of distress and distance on caregiver’s return.</td>
<td>Minimising importance of attachment; normalizing of painful experiences.</td>
<td>AAI</td>
</tr>
<tr>
<td>Anxious (preoccupied)</td>
<td>Communication of significant distress and lack of response to soothing attempts.</td>
<td>Verbose, confusing account suggestive of continued entanglement.</td>
<td>AAI</td>
</tr>
<tr>
<td>Disorganized (unresolved)</td>
<td>Contradictory behavioural responses.*</td>
<td>Lapses in reasoning or discourse when discussing loss or trauma (e.g. confusion of past/present, long silences, etc.)</td>
<td>AAI</td>
</tr>
<tr>
<td>Anxious-Ambivalent</td>
<td></td>
<td>Anxiety, fear, and loneliness in romantic relationships; craving intimacy and fearing dependency.*</td>
<td>Three Category Measure of Attachment Reciprocal Attachment Questionnaire</td>
</tr>
</tbody>
</table>

*Main & Solomon (as cited in Agrawal et al., 2004), *Hazan & Shaver (1987)
**Interview**

The Adult Attachment Interview (AAI; George *et al.* 1985, as cited in Barone, 2003) is a semi-structured interview which elicits narratives of participants' early parenting and childhood experiences, which are coded for current attachment organisation; autonomous, dismissing, preoccupied (which map onto the childhood secure, avoidant and anxious categories), and cannot classify (CC, allocated when a respondent does not fit into the above categories and uses multiple attachment strategies). An additional unresolved classification is superimposed over the classifications to represent disorganization when recounting attachment-related trauma. See Table 2.

Patrick *et al.*'s (1994) study used a small sample size (12 participants with BPD, 12 with dysthymia), and found that a greater proportion of people with BPD obtained the preoccupied and unresolved classifications, compared to the comparison group. They concluded that these findings demonstrate a significant relationship between mental representations of early relationships and later dysfunctional attachment style in BPD. However, the nature of this relationship is not established.

Fonagy *et al.* (1996) used a sample of 82 non-psychotic inpatients (36 of which with diagnosis of BPD) and 85 case-matched controls, additionally using the self-devised Reflective Function (RF) Scale. They found 75% of participants with BPD were classified as preoccupied/fearfully preoccupied and 89% classified as unresolved, compared to 65% in non-BPD participants. They also found lower ratings on the RF Scale. From using a multivariate analysis, they concluded that there was a significant relationship between experiences of abuse and neglect, and low RF.

Barone (2003) compared 40 participants with BPD with 40 nonclinical participants and found that the BPD sample were classified as 20% as dismissing, 23% as preoccupied, and 50% unresolved, compared to the nonclinical group who obtained low percentages of preoccupied and unresolved classifications, 62% secure, but similar percentage of dismissing.
This last result suggests caution needs to be taken when drawing conclusions from research findings, with variance in attachment patterns found in general populations as well as clinical.

Conclusions
The studies described indicate very small percentages of secure attachment in BPD, with anxious-ambivalent patterns found in self-report studies, and preoccupied and unresolved patterns found in interview studies. These findings support the theory that disturbed attachment relationships in early childhood may underlie unstable interpersonal functioning, a core deficit in BPD psychopathology, with the above insecure attachment types indicating key markers of BPD such as fear of abandonment or dependency, and disturbed relationships. Barone (2003) and Fonagy et al. (1996) used their findings to propose that these underlying insecure attachments are disorganized, and that mentalization is inhibited as a defensive response to cope with traumatic experiences. Therefore mentalization is proposed as a mechanism by which BPD psychopathology develops due to trauma remaining unresolved.

However, the studies use a cross-sectional and retrospective design, which means a direct relationship between early attachment and BPD, and trauma and mentalization, cannot be established. It is possible that mentalization in adult life can precede, coincide, or be behind development of more secure attachment state (Diamond et al., 2003). It is also possible that not all people with BPD have experienced trauma, and that trauma may be a general vulnerability factor independent from attachment (Nickell et al., 2002). The studies demonstrate the different views on the extent attachment status and BPD are influenced by trauma, with genetics, traits and neurophysiology being additional factors not discussed in this review.

Other insecure attachment patterns were also found, e.g. 20% participants were classified as dismissing in Barone’s (2003) study, and the CC classification was not used so it is unknown how many participants may
have fallen into this category. People with BPD therefore may vary in their attachment organisation.

Comparing findings between studies becomes complicated due to the diverse methodologies and measures used; with comparison groups varying in extent they matched (e.g. nonclinical, dythymia, OCPD), participant populations varying in representativeness of BPD (e.g. nonclinical with BPD features, co-morbidity), and sample numbers possibly affecting the power of findings (e.g. 24 to 393). Self-report data is dependent on the accuracy of self-observation and is vulnerable to self-presentation effects. The AAI may be deemed more reliable due to assessing underlying attachment representations, but may not be representative of participants' typical behaviour.

Also, the extent that different measures attachment categories conceptually overlap is uncertain, with different measures possibly measuring different phenomenon or domains of attachment, making it difficult to compare results. For example, Levy et al.'s (2005) study of 91 participants (with well-characterised BPD) found disparities between participants' self-report measures attachment classifications, and their own cluster analysis classifications of the same sample. Self-report techniques may therefore not accurately represent BPD experience, with a greater split found between insecure attachment categories. It is also possible that looking at both attachment patterns and dimensions may better capture the complex picture of attachment organization than discrete categories (Aaronson et al., 2006).

Future research would benefit from greater communication between researchers for consistency in methods and measures to establish more reliable attachment categories, and therefore help better inform theory and subsequent therapy development. However, a cautious theme of unresolved and anxious attachment styles in BPD has emerged from the research, yielding mentalization as one proposed mechanism by with attachment and BPD is mediated.
MENTALIZATION

The focus of research into attachment and BPD has recently moved from a descriptive theoretical stance, to a more applied focus, where evaluation and support for treatment approaches is of higher importance (Bateman & Fonagy, 2003). MBT is a new therapeutic treatment programme developed for BPD, recommended in the NICE Guidelines for BPD (2009) alongside Dialectical Behaviour Therapy (DBT). I will therefore review the theoretical basis of MBT and its use for BPD.

The Mentalization Model

Fonagy (2000) integrated attachment theory (e.g. insecure behaviour patterns), psychoanalytic (representations of self) and cognitive (theory of mind) concepts to develop a mentalization model of BPD. Bateman and Fonagy (2003) and Fonagy (2000) propose that mentalization and its attachment context are vital for the development of stable self organization, affective and cognitive skills necessary for social functioning. Choi-Kain and Gunderson (2008) describe Bateman & Fonagy’s (as cited in Choi-Kain and Gunderson, 2008) three dimensions of mentalization as; ‘two modes of functioning (i.e., implicit and explicit) ...two objects (i.e., self and other), and ...two aspects (i.e., cognitive and affective) of both the content and process of mentalizing’ (pp.1128).

Bateman and Fonagy (2003) suggest that a secure attachment relationship with a caregiver creates a safe environment for an infant to learn about their own and others minds, and gain awareness of their own subjective view of the world being different from others (Fonagy & Target, 1997). Bateman and Fonagy (2003) theorise that the infant will internalize a representation of self-agency through the caregiver reflecting the infant’s emotions in a marked (clear indication that expressing the infant’s feelings rather than his/her own) and contingent (accurately matching the infant’s internal state) way. The caregiver therefore helps the infant to understand and tolerate life
stressors and subsequent negative affects by encouraging the development of mentalization in a safe, attuned environment.

**Mentalization in the context of BPD**

Bateman and Fonagy (2003) and Fonagy (2000) hypothesized that people with BPD either have a deficit in mentalization due to inadequate development within insecure early attachments (due to lack of sensitive marked and contingent mirroring of affect by the caregiver), or by being defensively inhibited in response to neglectful and abusive care-giving (to avoid thinking about the caregiver’s negative and inconsistent representations of the child). The authors propose that the child will still seek comfort and proximity due to trauma arousing their attachment system, but that they will avoid inter-subjective interaction, developing preoccupied and unresolved attachment styles (Bateman & Fonagy, 2003).

The distinction between self and others mental states is therefore inadequately developed, resulting in the individual developing a fragile self-image, continuing to rely on teleological reasoning (visible outcomes), to experience thoughts and feelings as not contextualised with reality (pretend mode), and of their own subjective view as the “truth” (psychic equivalence) into adulthood. Thus preventing genuine interpersonal interactions, and cognitive and affective interpretations which could help stabilise emotions and self (Bateman & Fonagy, 2003).

The lack of mentalization within interpersonal contexts and the drive to protect a fragile self-image is proposed to be the core of BPD interpersonal pathology, with teleological reasoning accounting for verbal and behavioural impulsivity and emotional lability (due to the inability to understand or predict intentions behind another’s actions) and mental isolation accounting for the sense of emptiness (Fonagy, 2000).

Bateman and Fonagy (2003) additionally suggest that the child might internalize a negative ‘alien-self’ from their caregiver that does not match
their constitutional internal states, which they are later compelled to project onto another to create a sense of control and security. Therefore BPD criteria of frantic avoidance of abandonment could be linked to this need to have another person close to externalize the alien-self, and that suicidal behaviour is an attempt to halt the risk of abandonment, or to destroy the alien-self which they have had to re-internalize.

**MBT Theoretical Roots**

The goal of MBT is for the individual to develop a more stable and coherent self representation, and the capacity to maintain secure interpersonal relationships, which in turn will improve associated symptoms of BPD (Bateman & Fonagy, 2003). The focus is on enhancing mentalization capacities in individual and group therapy contexts, to shift a person from a disorganised attachment style (with emotional lability) to a secure attachment style (emotions more regulated).

*Mentalization-based treatment by partial hospitalization consists of 18-month individual and group psychotherapy in a partial hospital setting offered within a structured and integrated program provided by a supervised team. Expressive therapy using art and writing groups is included. Crises are managed within the team... The understanding of behaviour in terms of underlying mental states forms a common thread running across all aspects of treatment. (Bateman & Fonagy, 2008, pp.632)*

MBT is composed of the following treatment strategies; a) the therapist adopting an explicit mentalizing stance, b) focus on thoughts and feelings in the 'here and now', c) a titrated approach in interpreting transference and therapist acceptance of becoming the 'alien-self', d) marked and contingent mirroring of client’s emotions (mental closeness), and e) identification of emotions.

It appears that a) and d) directly link to the Mentalization Model in that the therapist encourages client’s awareness of their own thoughts and feelings.
as being discrepant from others (as a sensitive caregiver would have in early childhood through marked mirroring) by explicitly verbalising their own internal state and asking the client for theirs. It appears a) works along the implicit/explicit dimension described by Choi-Kain and Gunderson (2008), with the aim of developing more natural implicit mentalization.

B) links to the theory that people with BPD have not developed symbolic representations of themselves or others in an attachment context because of the inhibition/deficit in mentalization (Fonagy, 2000). The strategy therefore appears to aim to develop mentalization by repeatedly discriminating self and other perspectives across contexts (individual and group).

B) and c) encourages therapist awareness of transference dynamics, and how the past is influencing ‘here and now’ relationships. Bateman & Fonagy (2003) theorised very gradual interpretation of these latent beliefs, adapting a staid psychodynamic approach of direct interpretation, which could destabilise a BPD client and perhaps evoke the “pretend mode”, putting a block in therapy. Fonagy’s (2000) concept of the projected ‘alien-self is also incorporated in c), as a proposed stabilising method of a fragile self image. However, Bateman and Fonagy (2003) do not explain how this is utilised within MBT.

Finally e) aims to stabilise affect dysregulation by helping the naming and expression of emotions appropriately in interpersonal contexts, and to understand precipitants of emotions in the ‘here and now’. This strategy appears to link into Fonagy's (2000) theory that emotional instability is due to inhibited mentalization and unstable self when aroused in an attachment context, meaning interpretation of own and others emotions and intentions are disrupted. The strategy therefore appears to try to reduce reliance on psychic equivalence thinking by explicitly understanding emotions, an ability normally developed within early secure attachments (Cassidy, 1994).
Critique of MBT

Overall, the majority of strategies in MBT appear rooted in the Mentalization Model of BPD (Bateman & Fonagy, 2003; Fonagy, 2000), directly focusing on the 3 dimensions of mentalization, therefore integrating attachment and cognitive concepts. These strategies focus on establishing a secure attachment relationship (providing a safe context for understanding of self and others which Bowlby [1977] proposed as central to personality development), on developing mentalized representations or internal working models (Bowlby, 1977) of themselves and others within this attachment context by facilitating inter-subjective interaction that may have previously been shut down, and subsequently developing a sense of themselves as intentional, independent beings able to interpret others mental states (Fonagy, 2000). However, explicit links between specific MBT treatment strategies and the Mentalization Model were unclear in Bateman & Fonagy’s (2003) introduction to MBT. For example, the concept of the “alien-self” is also not clearly evidenced, and its use in MBT unexplained.

Bateman and Fonagy (1999, 2001, 2008) conducted a series of Randomised Control Trials (RCTs) to assess long-term effectiveness of MBT at end of the 18-month programme, 18-month and 8 years follow-up. Using self-report and semi-structured interview measures they found the MBT group (n=~20) had significant and sustained improvements in interpersonal functioning, mood, and reduced service utilization, with continued improvement in symptom distress and rates of self-harm compared to the control group (treatment as usual, n=~20). However, some deficits in global functioning remained. These findings suggest the MBT’s long-term phased approach helped clients to develop psychological capacities to manage their difficulties past therapy, and relationship focus and subsequent symptom improvement suggestive that interpersonal relationships are the crux of many BPD symptoms. The studies provide support in the enduring effectiveness of MBT, with a representative BPD group, long-term control group to account for spontaneous recovery effects and low drop-out rate.
However, whilst these preliminary findings are positive, the small participant number makes them difficult to generalise, and it is unclear which of the many components of MBT elicited positive change. Future research would benefit from larger trials and isolating the different components to determine this. The effectiveness of MBT may be attributable to clients being in a structured, integrated and thoughtful interpersonal programme rather than any particular component, although the common mentalization stance is proposed as key (Bateman & Fonagy, 2003). Gathering client perspectives would provide richer detail on the experience of MBT, which is lost by relying on group means in RCTs.

The Mentalization Model has also recently been updated (see below), and the extent MBT has been adapted to this is uncertain.

**Critique of the Mentalization Model**

The Mentalization Model is a recently developed therapy, and that the theoretical papers, evidence base and research for mentalization is dominated by the same authors has meant I found little literature that directly critique the approach.

The Mentalization Model is a structured psychodynamic approach which has drawn from the empirical sciences to advance a theory that is based on more than psychoanalytic ‘intuition’ (Lansky, 2003). Mentalization as one putative mechanism of change in therapy is supported by Bateman and Fonagy’s (1999, 2001, 2008) RCT studies, and in Transference-Focused Psychotherapy (TFP) research and theory (e.g. Levy, Clarkin et al., 2006; Levy, Meehan et al., 2006). There are some theoretical and conceptual overlaps with DBT (e.g. invalidating family environments and mindfulness; Lynch et al., 2006) and TFP (e.g. integrating representations of self and other; Levy, Clarkin et al., 2006). However, Fonagy and Bateman (2006) claim MBT differs in structure of treatment and therapist training, focusing on mind states within an attachment context, and without directly interpreting relationships.
The model is rooted in attachment theory (e.g. a safe context to learn about self and others, and seek comfort when in distress; Bowlby, 1977). The proposition of a relationship between trauma, insecure attachment and reduced mentalization is supported by studies like Fonagy et al. (1996) and Barone (2003). However, Fonagy and Bateman (2006, 2008) recently describe a more complex relationship, with trauma’s role not so central and genetic and constitutional factors also having a role beside inaccurate mirroring. The exact relationship therefore remains unclear, with research (e.g. Nickell et al., 2002) suggesting there can be interactions, but not always relationships between trauma, attachment style or mentalization.

Fonagy and Bateman (2006) also proposed an additional neurobiological mechanism by which the mentalization deficit is a secondary phenomenon, a separate neural system which is ‘loosely coupled’ with and inhibited by a hypersensitive attachment system. This accounts for recent neuroscientific findings, however leads to multiple hypotheses by which mentalization is developed, and requiring a complex argument of how genetic, constitutional and environmental factors interact for the development of a dysfunctional attachment system. I tentatively suggest that the Mentalization Model appears to be becoming more complex and perhaps contradictory, drawing from diverse scientific disciplines’ research and theories to create support for pre-made conclusions and to incorporate forced additions to the model.

For example, invalidating family contexts have been tentatively included as another factor that impairs the development of mentalization following family environment research findings (e.g. Bradley et al., 2005).

However, the Model does not generally address subsequent attachment influences past the early child-caregiver dyad (as originally proposed by Bowlby, 1977), or the potential ameliorative aspects of later family interactions (Lansky, 2003). I therefore agree with Lansky’s (2003) view that there may be author bias in including evidence for the model, drawing
from an extensive number of studies and dense mentalization literature to create links between research and theory, which are difficult to clearly evaluate.

**CONCLUSIONS AND IMPLICATIONS**

Whilst the aetiology of BPD is still not fully understood, attachment theory and the concept of mentalization provide one applied route of understanding BPD. The attachment literature reviewed repeatedly indicate that insecure attachment styles are the dominant pattern found in people with BPD compared to other clinical and general populations, despite the differences in research methods and measures. Dysfunctional attachment systems therefore appear common in people with BPD, and provide a context for the development of unstable interpersonal functioning central to BPD psychopathology.

The Mentalization Model has offered a potential mechanism in understanding how BPD develops in an attachment context, and preliminary MBT research findings demonstrate an effective psychological treatment with mentalization at its focus. However, the nature of the relationship between mentalization, attachment and trauma proposed by Bateman and Fonagy (2003) still remains under debate (e.g. Nickell et al., 2002). The Mentalization Model’s reliance on associations between the above factors, and the increasing number of potential mechanisms for mentalization, means direct relationships between BPD psychopathology and mentalization cannot be established. This, combined with potential author bias in the literature, suggests that as clinical psychologists, we should maintain a scientist-practitioner approach in evaluating and applying the mentalization approach in our practice with people with BPD.

Considering the heterogeneity of BPD, it is likely that there are a number of different interactions, attachment styles, and mechanisms of change. The Mentalization Model and MBT offer one integrative and manualised way of
understanding and treating BPD psychopathology. Preliminary studies of MBT have found it effective in reducing distressing symptoms and self-harm. However helping to improve quality life is also part of our role as clinical psychologists, and needing to focus on enhancing social functioning as well as symptom reduction is acknowledged by Fonagy and Bateman (2008), to create a truly recovery-focused approach.

Nevertheless, MBT offers an alternative treatment to DBT, therefore more choice for clients as recommended by the NICE Guidelines for BPD (2009). Future research on psychological treatments for BPD would benefit from gathering qualitative feedback from clients to gauge perspectives on the helpfulness of different components of therapy.

On a cautionary note, the *DSM-IV* describes personality disorder as; ‘...an enduring pattern of inner experience and behavior deviating markedly from the expectations of the individual’s culture’ (APA, 1994). The Mentalization Model and MBT are dominated by Western theory and research, therefore the universality of this approach cannot be assumed.

**Implications**

Reviewing the literature on attachment theory and mentalization has helped me to develop a greater appreciation and understanding of the interpersonal difficulties experienced by people with BPD, of how these may be expressed in the therapeutic relationship, and the use of attachment-oriented techniques to support clients. The Mentalization Model helps me to appreciate the need for greater awareness of transference dynamics and appropriate expression when working with people with BPD, and the value of supervision in reflecting on the processes within therapy in order to maintain a healthy therapeutic alliance.

Whilst mentalization is a new concept, all therapies of different theoretical orientations for BPD appear to facilitate an attachment relationship with the therapist, and encourage thinking of own and others mental states (Fonagy & Bateman, 2008). MBT is one option, but general mindfulness of client
attachment and mentalization processes when working with people with BPD, regardless of therapeutic approach, could also be useful. As Bateman (2004) suggests, the skills and attitudes of mental health professionals may be as important as the therapeutic orientation due to treatments' reliance on interpersonal process. Thus, one of our roles as clinical psychologists may be to provide training and supervision to enhance understanding of the dynamic relational aspects of BPD to develop more consistent and integrated services.

_The benefit...comes through the experience of being involved in a carefully considered, well-structured, and coherent interpersonal endeavour...of being the subject of reliable, coherent and rational thinking – namely mentalization—about the patients' difficulties... that borderline patients [may] have been deprived of exactly such consideration and commitment during their early development... (Bateman & Fonagy, 2003, pp.208)._
REFERENCES


How are issues of risk understood and responded to within mental health services? What contribution can clinical psychologists make to a reconsideration of these ideas and practices?

Professional Issues Essay
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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration of my position</td>
<td>33</td>
</tr>
<tr>
<td>Introduction</td>
<td>33</td>
</tr>
<tr>
<td>How are issues of risk understood and responded to within mental health services?</td>
<td>35</td>
</tr>
<tr>
<td>Current Understanding and Practices within Mental Health Services</td>
<td>36</td>
</tr>
<tr>
<td>What contribution can clinical psychologists make to a reconsideration of these ideas and practices?</td>
<td>39</td>
</tr>
<tr>
<td>Application of Psychological Models and Research to Understanding Defensive Practice</td>
<td>39</td>
</tr>
<tr>
<td>Ways Clinical Psychologists Can Utilise their expertise to Promote Positive Risk Management</td>
<td>42</td>
</tr>
<tr>
<td>Discussion</td>
<td>48</td>
</tr>
<tr>
<td>Reflections and Conclusions</td>
<td>50</td>
</tr>
<tr>
<td>References</td>
<td>52</td>
</tr>
</tbody>
</table>

Helena Kaliniecka - Portfolio Volume I 32
DECLARATION OF MY POSITION
To allow for richer reflection on the development of ideas and practice pertinent to issues of risk I have chosen to focus this essay within the context of adult community mental health services (CMHS). This will enable me to draw from my pre-clinical training experiences of evaluating a CMHS Risk Management Panel, facilitating research with the Section for Recovery at the Institute of Psychiatry (IoP) of adults with severe mental illness’ (SMI) experiences of clinical decision-making, and from my first year adult placement within a Community Mental Health Team (CMHT).

INTRODUCTION
Risk is an inherent element to everyday life for everyone, with positive risk-taking leading to new learning and personal growth (Slade, 2009a). In mental health services, risk has become defined by acts of self-harm, self-neglect, suicide and homicide, potentially overshadowing more positive conceptualisations of risk. That said, 5200 suicides in 2000-2004, and 208 homicides in 1999-2003, occurred in people with mental illness who had recent contact with mental health services (National Confidential Inquiry [NCI], 2006). Preventing harmful risk has therefore become the focus of much research, service reports, and government guidelines; and an important part of everyday practice for mental health practitioners of all disciplines, with distressing personal and professional consequences for all involved if this is not effective.

In this essay I will illustrate how current thinking around risk has developed, exploring the extent to which policy, research and general public response have informed how risk is understood and responded to within mental health services. I will go on to explore how clinical psychologists can utilise their core competencies to support mental health practitioners and service-users to develop ideas and practice that hold both positive risk-taking and harmful risk management in mind. I will draw from recovery, systemic, narrative, psychodynamic, and cognitive neuroscience approaches.
I will reflect on my experiences, and critique presented literature within the service-user and psychology led frameworks of personal recovery and constructivism (Slade, 2009a). Personal recovery is a concept which prioritises quality of life, with the development of valued social roles, identity-enhancing relationships, self-management, and meaningful personal growth to re-frame their mental illness, as central components to recovery (Slade, 2009a).

This approach aligns with the Department of Health’s (DOH) papers that the mental health system must support people in whatever way they think is crucial to their recovery (DOH, ‘The Journey to Recovery’, 2001; ‘Equity and Excellence: Liberating the NHS’, 2010a). This orientation falls neatly onto the backdrop provided by recent DOH papers which focus on promoting well-being rather targeting mental illness (e.g. DOH, ‘New Horizons: Confident Communities, Brighter Futures: A framework for developing well-being’, 2010b). Through a constructivist viewpoint I hope to hold in mind that what service-users may perceive as risky to their recovery and important to their well-being, may be different to practitioners’ involved in their care.

The literature search terminology included the risk constructs (see below), “adult(s)”, “psychology” and “mental health services”. These were used in PsycINFO and the DOH websites. Papers focused on medication therapies and other population groups were excluded. Literature was selected on the basis of illustrating the development of how risk is understood and responded to within adult mental health services, the dilemma of balancing positive risk-taking with harmful risk management, and how clinical psychologists can influence thinking and practice. Further literature utilised in my previous research and clinical work was also explored.

Definitions of Key Constructs
Harmful risk = acts of self-harm, self-neglect, suicide and homicide.
Positive risk-taking/management = decisions that include elements of risk but hold potential for positive benefits to quality of life and recovery.

Personal recovery = "The establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self determination" (Andresen et al., 2003, p.588).

**HOW ARE ISSUES OF RISK UNDERSTOOD AND RESPONDED TO WITHIN MENTAL HEALTH SERVICES?**

**Development of Risk Management – Government Policies and Risk Research**

Since being introduced in 1990, research has demonstrated that community care for people with SMI has been effective, with no evidence of the safety of the public being compromised (e.g. Simmonds et al., 2001). Despite an overall increase in homicides, those committed by people with SMI have not increased, and have even found to have decreased over time (NCI, 2006; Taylor & Gunn, 1999). However, a number of high-profile suicides and homicides in the media have elevated the public’s perceptions of the risk people with SMI pose.

Pressure increased on the Government and mental health services to predict and prevent violence, with forensic research inevitably amplifying links with SMI (Slade, 2009a). Service-user and psychology led research argues that risk management practice can become discriminatory and restricting of service-users rights, with contextual variables (e.g. substance abuse) and base rates of violence in the general population being neglected when considering more suitable targets for intervention (e.g. alcohol drinking laws), which are perhaps not so politically acceptable (Langan & Lindow, 2004; Slade, 2009a).
At the same time more recent government papers emphasise the need to balance service-users care needs with their risk needs, promoting a recovery-oriented, collaborative, organisational and strengths-based approach to risk management and general practice (DOH, ‘The Journey to Recovery’, 2001; ‘Best Practice in Managing Risk’ [BPMR], 2007). The use of formulation and reflective principles in the BPMR framework align well with clinical psychology work. However, how much these principles are adopted in everyday practice is uncertain, and will be discussed further.

Whilst being advised to promote recovery principles, my own observations within CMHS have suggested that more often than not, mental health practitioners are left to independently manage high risk and their own fear of litigation, which inevitably affects the quality of person-centred practice.

**Current Understanding and Practices within Mental Health Services**

Despite government policy, risk avoidance and defensive practice is common in mental health services, with fear of litigation causing emotional and physical distress in the professional and personal lives of practitioners (Kennedy et al., 2003). In the early 2000’s a policy worker and a psychologist (with personal experience of using CMHS) conducted a qualitative study exploring service-users’ (defined as a risk to others), their carers’ and friends’, and their mental health practitioners’, perceptions of involvement in and helpfulness of risk assessment and management (Langan & Lindow, 2004). Participants included 17 service-users and 56 practitioners.

Many practitioners described an increase in defensive practice, with increased but unconfident use of risk assessment tools, due to the pressures of biased media portrayal, public’s insistence that all risk should be managed, and a culture of blame. Papers such as Kennedy et al.’s (2003), which provide recommendations of risk management practice for psychologists, may perpetuate a focus on self-protection rather client recovery. Whilst careful practice needs to be supported, I was disappointed
how non person-centred these recommendations, developed by psychologists, were.

The dominance of the nomothetic medical model in developing research, has yielded the perception that all high risk factors can be objectively examined and controlled, and therefore eliminated (Berman, 2006; Slade, 2009a). Yet people are active agents of their experiences, and such a view can be damaging to their engagement with services by conveying that services are there to only prevent risk for them, rather than support them to employ their strengths and self-determination to improve their quality of life.

Langan and Lindow (2004) found differing levels of agreement between service-users and their practitioners regarding their triggers for risk (e.g. contextual issues versus medication adherence), of disagreements or even unawareness of their risk assessment and management plans, many of which contained incomplete or inaccurate information due to lack of communication and sharing of information. Explicit risk management and relapse plans were rarely reported, with service-users and carers describing delays in effective responses to their crises.

They found confusion in all participant groups’ accounts over what involvement means, with perceptions of power over the process attributed to practitioners. This highlights that whilst there may be more inclusive government policies, until the BPMR framework (DOH, 2007) there was very little guidance on how to facilitate service-user and carer involvement in the process of risk assessment and management, and the extent to which these principles are currently implemented is unclear.

Most importantly, this research demonstrated a gap in perceptions and knowledge between service-users (their friends and carers), and mental health practitioners of risk assessment and management. Service-users and carers identified how support was not offered for risks they identified for
their recovery, such as cultural issues and racist attacks, and how they were unaware of the full range of services they could access, such as voluntary sector skills-training workshops. When facilitating research prior to training, my interviews with service-users regarding clinical decision-making revealed similar concerns.

All of these issues can reduce the likelihood of developing, and engagement with, effective and holistic risk management plans, which incorporates collaborative positive risk-taking as well as minimising harmful risk, to hold meaning for service-users and their recovery. Service-users in Langan and Lindow’s (2004) study identified good relationships and communication with their practitioners as important to managing risk, describing how they felt patronised by some medical disciplines. I also experienced this in my adult placement, wherein I felt compelled to articulate and check my client’s opinions regarding the services he was receiving in a Care Programme Approach (CPA) meeting, as his care-coordinator and psychiatrist had not been forthcoming in doing so.

This study highlights the power and ethical issues inherent in mental health work, with responsibility for risk management needing to be shared by the organisation to prevent defensive, therefore potentially constraining practice, and by service-users themselves, to facilitate greater self-determination and self-management important to personal recovery. As Slade (2009a) suggests, mental health services need to be able to experience and contain the uncomfortable tension between resisting constraining service-users activities to reduce overall risk, and allowing enough positive risk-taking to support them to pursue their recovery goals. In my adult placement I observed how the care coordinators were often overwhelmed in trying to reduce high-risks, leaving little time for positive risk-taking.

Only three psychologists were included in Langan & Lindow’s (2004) study, and I am left wondering how psychologists’ responses may have differed, if at all.
WHAT CONTRIBUTION CAN CLINICAL PSYCHOLOGISTS MAKE TO A RECONSIDERATION OF THESE IDEAS AND PRACTICES?

Clinical psychologists are well placed to inform and influence ideas and practices around risk within mental health services, due to the core competencies and expanding roles into leadership we are expected to hold (British Psychological Society [BPS], 'Core Competencies – Clinical Psychology', 2006; 'New Ways of Working for Applied Psychologists' [NWWAP], 2007a).

Application of Psychological Models and Research to Understanding Defensive Practice

Our competencies in transferrable skills, psychological assessment and formulation using multiple models can illuminate processes that may underlie defensive practice, helping us to form interventions at an organisational as well as at individual level to promote positive risk-management.

Systemic

Patterns of increasingly repetitive defensive behaviour and feedback loops may evolve within the system of CMHS, developing a circularity of behaviours and beliefs which may undermine the utility of service-user involvement and recovery (Dallos & Steadman, 2006). I would hypothesise that these behaviours and beliefs serve a protective, controlling function for teams, in response to the uncertainty that can surround risk-related actions from clients, and in the context of NHS pressures. These could form the basis of negative narratives regarding service-users (e.g. acts of self-harm in people with Borderline Personality Disorder [BPD] as manipulative, or that people with psychosis can never recover), with defensive practice allowing little opportunity for different perspectives to come to the fore and create incongruity between stories lived and told. Therefore potentially negative assumptions regarding practice and service-user behaviour can develop.
Mason (1993) postulates that many practitioners fall into the trap of offering positions and decisions of 'safe certainty', solutions which may alleviate initial worries, but also block new, creative alternative ways of understanding and managing risk ('safe uncertainty'). For example, the frequent use of inpatient care over developing more creative and effective preventative strategies. Practitioners who hold greater responsibility for client risk (e.g. psychiatrists and care-coordinators) may lean more towards this position, and I have observed this across my work experiences. On reflection, I have noticed how 'safe certainty' was a position I invariably took at the beginning of training when I was unconfident of my skills, and wonder how being a newly-qualified practitioner may also influence the position taken.

Research on group dynamics in jury teams by Weingart and Todorova (2010), and Weingart et al. (2010) can be applied to CMHS teams by suggesting that whilst diversity in viewpoints amongst practitioners can be useful in eliciting innovative ideas, it can also lead to gaps in how the team represent risk problems. These gaps can stem from relationship and process tensions within the team, with the need to create a delicate balance between group agreement and individual autonomy to understand, and frame the problems to be addressed. These gaps can interfere with group communication and coordination, and create conflict which undermines team performance and relevant information integration. Weingart and Todorova (2010) suggest that unstable group membership, high levels of emotional stress, and potentially high impact of decision outcomes exacerbate conflict dynamics. It is therefore unsurprising that CMHS teams can have high levels of discord.

**Cognitive neuroscience**

In cognitive psychology we understand that our responses to external events are determined by how we interpret them, which is influenced by our thoughts, physiological reactions, and emotions. Naqvi et al.'s (2006) neuropsychological research literature review presented physiological
studies which demonstrated that decisions that involved substantial risk and uncertainty within social contexts, elicited higher emotional and physiological arousal in the insular cortex than non-moral decisions. This disrupted rational decision-making, and biased choices to maintain homeostasis. Thus at an implicit level, choices that elicit a strong emotional response affects how risk is assessed and what behaviour is deemed suitable, leading people to rely on their ‘gut reactions’ which orientate them to minimise potential for punishment, and maximise potential for reward. It is quite possible that positive risk-taking decisions may elicit this response in practitioners, leading them to opt for risk avoidance actions, therefore minimising the potential for punishment.

**Psychodynamic**

Unconscious processes between service-users and practitioners may also drive defensive practice. For example, Fonagy (2000) theorises that deficits in mentalization capacities (to perceive and communicate one’s own and others mental states) in people with BPD elicits difficulties within interpersonal contexts and social functioning. Service-users difficulties in emotion regulation can lead to practitioners becoming vessels in which to project dissonant feelings, which if the practitioner identifies with, may lead to distress. Rejection of the thinking about the client’s needs would be a way to defend against this uncomfortable transference.

The ways individuals within a CMHS team respond to risk decisions may also vary, with different members responding to the unconscious communication of different distressing feelings from the service-users involved, depending on their own attachment experiences. The professional system may reflect the internal experiences of the service-users they work with, with fragmentation being echoed in all levels of the system, obstructing constructive information-sharing (Rocco-Briggs, 2008).
Ways Clinical Psychologists Can Utilise their Expertise to Promote Positive Risk Management.

Clinical psychologists are increasingly expected to demonstrate leadership in service delivery and in upholding best practice within teams (BPS, 2007a; 'NWWAP: Working psychologically in teams', 2007b). Leadership can be defined as “building and maintaining the team as a performing unit; and coaching and supporting the team to success” (BPS, 2007b, p.3). I have found systemic, psychodynamic and recovery framework ideas particularly useful in my research and clinical practice, and will discuss how these can be utilised across the different levels of CMHS under the umbrella of leadership.

Consultation

Consultation roles have been identified as a key strength that clinical psychologists can contribute to organisations (BPS, 2007a, 2007b). Via consultation, clinical psychologists can contribute skills of formulation and model integration to develop understanding of and practice with clients.

Clinical psychology led

Lake (2008) describes a systemic, cognitive and attachment theory-rooted Team Formulation Model which’s aims very much aligns with Mason’s (1993) position of ‘safe uncertainty’, to provide teams with a containing space to explore alternative viewpoints and new thinking. In this way teams can consider exceptions to the dominant discourses, so they can develop new, more person-centred and recovery-focused ideas, and a shared formulation for their work with service-users.

Clinical psychologists can facilitate team consideration of a client’s history using a biopsychosocial approach, of patterns in coping and managing relationships, the core beliefs developed, and how these impact on current interactions (Lake, 2008). The team are then encouraged to reflect on their own feelings and responses to this client (see figure 1.), on contextual issues, and the client’s strengths and personal resources, which Slade
(2009a) highlights as important in positive risk-management. An “informed understanding...can help us from becoming overly controlling and coercive...” (Lake, 2008, p.22).

Systemic techniques such as circular questioning and hypothesising could also be used to introduce new information and perspectives, helping to punctuate repetitive patterns of thinking and practice, and create awareness of how issues of transference and the team’s sub-systems interconnect (e.g. unconscious processes and development of culture of blame). Consultation could therefore help practitioners to reflect on potentially defensive practice, and on underlying relationship and process tensions, to seal the gaps that can rupture constructive information integration (Weingart et al., 2010).

However, the BPS (2007b, p.42) cautions that it should not be assumed that clinical psychologists will take this role in teams, and needs “to be negotiated locally in light of the nature of demand and the particular skill
profile of the local service, including the capacity of local psychologists to undertake this kind of work.”

**Multi-disciplinary**

It is therefore important that clinical psychologists also work in partnership with other disciplines expertise as part of consultation work. For example, a clinical psychologist set up a Risk Management Panel (RMP) consisting of multidisciplinary members in Surrey and Borders Partnership NHS Foundation Trust. Its aim was to support practitioners and their teams to positively manage clients who presented as high risk to themselves or others, by encouraging reflective case discussion, and taking collective responsibility for risk management plans (Kaliniecka & Shawe-Taylor, 2008), in-line with BPMR (DOH, 2007) guidelines.

In my evaluation I found that practitioners valued the support and expertise of the RMP greatly, founding it helped to alleviate their anxieties and consider new ideas (Kaliniecka & Shawe-Taylor, 2008). From my observations of discussions at the RMP, systemic and contextual issues such as culture and wider societal issues were considered in understanding risk, looking beyond mental illness as wished by participants in Langan and Lindow’s (2004) study. It is possible that containment of the practitioners’ anxieties may have helped to ameliorate the high emotional and physiological states that risk can raise (Naqvi et al., 2006), therefore promoted more rational decision-making which is more in-line with service-users interests.

**Interventions with service-users and carers**

As part of their service delivery competency, clinical psychologists are expected to facilitate service-user and carers involvement in clinical practice and service delivery (BPS, 2006). An initiative founded by a service-user is becoming more common-place in CMHS, challenging the medical model view in managing risk in CMHS. The Wellness and Recovery Action Plan (WRAP) program is client-driven, identifying strategies that keep
themselves well, personal triggers, early warning signs, crises signs, and action plans for each of these stages, which they can share with carers and practitioners. WRAP has been found to enhance psychosocial outcomes through promoting recovery and self-management (Cook et al., 2009).

I had the opportunity to co-facilitate a WRAP group with multidisciplinary colleagues in my first-year placement, a group which had been introduced to the CMHT by a clinical psychologist. I observed for myself how empowering a programme this was for the clients and carers involved, promoting risk self-management, focusing on quality of life, and harnessing approach motivation rather than avoidance (e.g. such as the development of advance directives for times of crisis), which are all aspects identified as important to personal recovery (Slade, 2009a) and in desired risk management by service-users (Langan & Lindow, 2004).

Facilitation being shared amongst disciplines can help personal recovery in the context of risk to come to the fore in CMHS thinking, with future directions for such initiatives including having a service-user peer to help facilitate the group, an idea which is currently being developed in the service of my first-year placement.

**Teaching**

Enhancing communication and teaching is another core competency that clinical psychologists can contribute to preventing defensive practice and promoting positive risk management (BPS, 2006). Training practitioners, service-users, and carers in how to relate and work with another as peers, and to avoid tokenism within CMHS delivery has been identified as a role clinical psychologists can take in working psychologically with teams (BPS, 2007b).

Whilst working at the IoP I observed Dr Slade (Head of Section for Recovery and Consultant Clinical Psychologist) deliver a number of training sessions on developing a focus on recovery to CMHS teams and
professional boards, with the support of service-user and carer spokesmen. Such sessions emphasised peer-working, creative strategies, and sharing of responsibility with clients, with personal recovery as central to all guidance. I was inspired by such training, and subsequently hold recovery-oriented principles in mind when working with clients from all populations. For example, in my first-year placement I linked a client who posed as high risk of suicide with a faith-based counselling service, as he identified his faith as being central to his recovery, although this was not standard practice in the CMHT I worked in. I also subsequently conducted presentations on recovery-focussed practice, drawing from Dr Slade’s publications (e.g. ‘100 Ways to Support Recovery’, Slade, 2009b) to similarly inspire other practitioners.

Audit, research, and service evaluation
Clinical psychologists are expected to evaluate clinical effectiveness of service delivery, acceptability and impact of interventions, and to conduct research to develop clinical practice (BPS, 2006).

Audit
With papers such as ‘The Journey to Recovery’ (DOH, 2001), the BPMR (DOH, 2007) and ‘Equity and Excellence: Liberating the NHS’ (2010a), positive risk-management, recovery principles, service-user and carer involvement, and organisational support should be common practice in CMHS. However, this is not known unless audits are conducted to compare practice with set quality standards. From discussion with my peers, I am aware performing audits can be viewed as ‘drudge’ part of our roles, however how can we expect guidelines and principles to be implemented if these are not checked?

Research
Langan and Lindow (2004) identified lack of research into exploring the processes by which practitioners balance the protection and autonomy needs of their clients. Qualitative research could build on Langan and Lindow’s
(2004) study, providing more in-depth understanding of how practitioners, service-users and their carers perceive risk management, what helps and does not help, and of their perceptions of current CMHS delivery. Research can also investigate the factors that mediate the extent to which practitioners adopt evidence-based practices (EBPs) that meets quality standards for risk management. Gioia and Dziadosz (2008) conducted a mixed-method study exploring the adoption of EBPs in CMHS, finding that ongoing training, and a supportive and consistent organisational climate and culture was important to such EBPs. This study highlights how training, consultation, and organisational support may be integral factors in promoting positive risk management, and such factors warrant further exploration in research.

Psychological research literature on quality of life and recovery-focussed practices is growing, with Acceptance and Commitment Therapy (Hayes et al., 1999) being found to improve quality of life, with depression symptoms reducing as a by-product rather than the aim of the intervention (Forman et al., 2007). It therefore can be argued that adopting a more positive risk-taking approach in clinical practice supports personal recovery, which in turn reduces harmful risk as clients' lives become more personally meaningful. However, such approaches would benefit from further research to explore the exact relationships between these many dimensions.

Service evaluation
Service-user and carer voices need to be heard in evaluating whether CMHS and practitioner working are helpful and effective in risk management, with DOH papers (e.g. 2010a) and Langan and Lindow (2004) reporting that such involvement should be integrated throughout the process of service delivery.

My service evaluation of the RMP in Surrey demonstrated that this service was helpful for practitioners (Kaliniecka & Shawe-Taylor, 2008). Whilst consultation practices such as the RMP is a step in the right direction in helping practitioners to reconsider their ideas around risk, my subsequent
experiences of working alongside service-user researchers at the IoP, and in therapy work in training has highlighted that these services need to undergo further development to truly define themselves as supporting positive risk management. For example, service-users' and carers' voices were noticeably absent in risk management plan discussions at the RMP, and in the service evaluation, with practitioners in the evaluation varying in their reports on whether their client found the RMP recommendations useful (Kaliniecka & Shawe-Taylor, 2008). Communication and true collaboration over their care plan is an identified requirement from research (Langan & Lindow, 2004) and government papers (DOH, 2007, 2010a), with actions needing to be meaningful for service-users to aid recovery (Slade, 2009a).

Risk assessment levels were also not found to have improved. Apart from methodological issues such as sensitivity and appropriateness of measurement tools used, this could suggest quality of life is still something that needs to be pursued in a more effective way (Kaliniecka & Shawe-Taylor, 2008). As the RMP develops I hope more strengths-based discussion can take place in balance with high risk discussion.

**DISCUSSION**

Forensic research and media focus on CMHS 'failures' has meant that defensive practice around risk has become common in CMHS, despite more recent government papers endorsing recovery-oriented and positive risk-management practices, with well-being promotion rather than mental illness reduction being at the heart of ideal service delivery (DOH, 2001, 2007, 2010a, 2010b). The dominant medical model in CMHS appears discordant with personal recovery and service-users and carers views on their own risk management, with risk being perceived as controllable and negative, and wishes for positive risk-taking and involvement not being met (Langan & Lindow, 2004; Slade 2009a).

Clinical psychologists' skills in developing formulations from multiple theoretical models and research, in consultation, delivering interventions
and teaching, and in research and evaluation, can broaden understanding
and responses to risk at all levels of CMHS. Through adopting a
collaborative approach with service-users and carers, providing containing
spaces, and owning our leadership skills, we can foster the development of
ideas and practice within CMHS that balances both positive risk-taking and
harmful risk management, with the aim to improve quality of life and
support personal recovery (DOH, 2007).

Recovery-oriented practice and non-tokenistic collaboration with and
involvement of service-users and carers in understanding risk issues and
Slade, 2009a) is still a relatively new way of working, which requires a
move away from more traditional, medical models of service delivery in the
NHS, and the adoption of a more constructivist stance. My evaluation of the
RMP is an example where more effective and meaningful service-user and
carer involvement could have been utilised. Clinical psychologists should be
actively facilitating involvement in all areas of practice, service
development and delivery as discussed above (BPS, 2006). Recovery-
oriented practice can also be disconcerting to many practitioners, possibly
leading to a loss of role certainty (Slade, 2009a).

Georgiades and Phillimore's (1975) paper cautions that organisational
change can take a substantial amount of time. They identified that, for the
goals of training in new ways of working to be achieved, there needs to be
careful consideration of the organisational climate into which it is being
delivered, with the need to cultivate cohesive, self-motivated, self-sustaining
and committed teams with additional energy for change to be effective. The
current climate of financial stress and cuts in the NHS, which demands
quick results, seems to conflict with this ideal.

Does this mean then, that there is no point teaching good practice? I would
argue not, as long as such teaching is delivered sensitively, and the well-
being of the work-force is also being attended to. Perhaps then, a supportive
climate within CMHS', developed through using clinical psychologists’ skills in consultation may need to be cultivated first, before change in everyday practice can be expected. I would say strong leadership using all the above skills is therefore necessary more than ever to ensure positive risk management of the people we work with.

REFLECTIONS AND CONCLUSIONS
My understanding of issues of risk has developed from the thin description as presented in the key constructs on page 5, to a more contextualised, theoretical, social and psychologically informed understanding wherein issues of risk and recovery is differentially defined depending from which viewpoint you are looking from, and couched in a spectrum of other needs and wishes that constitute the lives of people with SMI.

I became conscious of the impact risk issues can have on practitioners, and how much organisational support is valued, when evaluating the RMP. Through working at the IoP I became more aware of the frustrations service-users met in pursuing their recovery, with CMHS perceptions of risk becoming a great stumbling block on this journey. In my first-year CMHT placement I learnt for myself what it felt to hold such risk, whilst trying to promote recovery-focused principles with my clients. My experiences of the different perspectives on CMHS ideas and practices around risk have highlighted to me the complexities in working with such issues.

Through clinical training I have developed an understanding of how clinical psychologists’ theoretical, clinical and research knowledge can be used in roles of leadership, teaching and consultation, to uphold ideas and practice which meet, and can develop, government guidelines. However, I would also suggest we need to exercise caution in that we do not begin to perceive ourselves as above such thinking traps where we pigeonhole client groups, seek ‘safe certainty’ (Mason, 1993) or fall into defensive practice ourselves. Kennedy et al.’s (2003) recommendations for risk-management practice is a prime example of this. We also need to be sensitive to CMHS teams’
stresses in response to the current climate of the NHS, and offer our skills in consultation in hope of ameliorating some of the impact the stresses can have on person-centred care.

Whilst adult CMHS are slowly moving towards more recovery-oriented and positive risk management practices, there is still a dearth of understanding in how these practices are being implemented, and how practitioners are responding to such guidance. Further research and service evaluation is therefore warranted in this area. Further thinking and research into how recovery-oriented and positive risk management practices may look and be defined in other client groups would also be beneficial, exploring this with both practitioners and clients of services for people with learning disabilities, children and adolescents, and older adults.
REFERENCES


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‘The Relationship to Change’

Problem Based Learning Reflective Account One

March 2010

Year 1
In the first week of beginning the Clinical PsychD course we were given the Problem Based Learning (PBL) exercise of creating a presentation in 6 weeks around the title ‘The Relationship to Change’ within our allocated Personal and Professional Learning Discussion Groups (PPLDGs). My group decided to focus our presentation on reflections of change observed in our group and within ourselves across the first few weeks of training in working towards this exercise. I therefore feel it would be useful to structure my PBL reflective account around the work conducted over the weeks, relating our reflections and research to my subsequent clinical experience.

At the beginning there was a lot of anxiety around the exercise. The title was ambiguous so we felt uncertain of what was required of us, and as a group we had only known each other one day so we felt self-conscious and unsure of our contributions. We all initially appeared on our ‘best behaviour’, and I felt the need come across and ‘perform’ well. Through my clinical work I have reflected how it similarly takes time to build a trusting and emotionally honest therapeutic relationship with my clients.

Our discussions revolved around personal change, reflecting our inward focus at a time when everything about training was new and unfamiliar. Within our first session we established ground rules such as confidentiality and check-in/check-out of each member’s feelings at the beginning and end of each of our meetings. I think these rules and boundaries helped create a containing space for us to share our opinions and experiences, and I continue to adopt this structure in my clinical work with clients to facilitate a collaborative environment. I also valued the containing presence of our facilitator. Overall, our first meeting closely relates to Tuckman’s (1965) ‘forming’ stage of group development, where members are dependent on a leader and are driven by the need to identify boundaries to orientate themselves.

Our second PPLDG meeting was likened to an explosion of ideas, where change was discussed at wider socio-political and systemic levels, and
contributions were inspired and creative. However, it also occasionally felt uncontained, with members interrupting each other and overrunning our session time, breaking some of our ground rules. I often felt exhausted and left behind. On reflection, this followed Tuckman’s (1965) next stage of ‘storming’ in our group development, where we began to emotionally respond to the task and resist group influence.

I have been able to liken the experience to that of failing to establish clear goals or session agendas early on in therapy with a particular client. This resulted in some of our sessions feeling circular, and lacking direction, leaving us both feeling frustrated. These experiences have helped me appreciate the need for clear goals and structure to facilitate motivation and engagement in clinical work.

I also found the amount of information discussed in the meeting overwhelming, seeing the value of each contribution but also not feeling able to discriminate which was the most useful or appropriate for our presentation. I was similarly overwhelmed over the breadth of therapeutic resources available when formulating and planning interventions for clients on starting placement. However, as I have settled into the course and utilised discussions with peers and supervisors, I feel I have become more selective and integrative of choosing resources in my work, being able to draw from the information available, but not feeling as compelled to have to include all of it. A process initially modelled in my PPLDG as we moved towards our presentation.

Our discussion of change at a systemic level (e.g. the influence of systems around clients in facilitating positive change) took on greater significance when I began working with a client who belongs to a collectivist culture where ‘I’ does not exist, and his family were central to his motivation to change. Had I continued to adopt an individualist approach with him I would have missed the opportunity to include his family in our intervention,
which has proven to be essential in his engagement and motivation in therapy.

For our third PPLDG meeting we reported back on our individual research into different theoretical and therapeutic models perspectives on change. We noticed how a number of them closely reflected the processes going on in our group and individually, and led to our idea of structuring the presentation around our reflections of group and individual change, based on Rolfe et al.’s (2001) framework for critical self reflection. We also adopted Ernst & Martin’s (2007) idea of using a collage as a tool to facilitate creative exploration of our reflections and projections of the group process, and as a format for our final presentation (see Appendix A and B). I found this approach inspired the group, generating more in-depth reflections and reflexivity on how these may influence our clinical work.

For example, I found a systemic paper about learning narratives in group supervision particularly resonated (the theory and knowledge building level of reflection, Rolfe et al., 2001), which proposed that our previous experience of learning shapes how we communicate and approach collaborative group learning (Aggett, 2004). This led to each of us reflecting on our own previous experiences before starting the course (the descriptive level of reflection, Rolfe et al., 2001), and we realised how our fluctuating moods and motivations across the weeks may be linked to how our different learning narratives connected and fitted with each other.

I realised that I have a learning narrative based on structured, clear ‘right and wrong’ way of learning from school and undergraduate study, which is driven by a goal focus. This explains my initial discomfort in the explosion of ideas and lack of agreed presentation format in the early days of the exercise. However, other members had much more of a process-focused and creative learning narrative, and they reflected how they had sometimes felt rushed into making decisions. Our open discussion of our learning
narratives facilitated a greater awareness of how they interacted, and of their respective potential benefits and disadvantages.

If it were not for others more process-oriented narratives, we would have lost a lot of the richness and breadth of our final presentation, whilst the goal-focused narratives helped us to keep to time. Other members also realised that maybe they needed to be more assertive and confident in voicing their opinion rather than assume others know best, and these members continue to be vocal in our PPDLG meetings and in placement of their professional opinion.

I have also become much more reflexive on how my learning narrative now impacts on my learning and communication on placement (the action-oriented reflexive level of reflection, Rolfe et al., 2001), with a greater awareness of how my need to see results in therapy to feel I have learnt therapy skills, should be be balanced with valuing the process of therapy when progress may feel slow.

Our reflective discussions continued across to the next meeting, creating the opportunity to examine our self perceptions which were often quite negative, stemming from our anxiety on being competent enough for the course and our contributions on the PBL task (e.g. I felt that I was not as experienced as the others, and that I sometimes talked too much). These honest expressions facilitated the space for these negative automatic thoughts to be challenged by supportive and encouraging feedback from group members (e.g. of highlighting the unique experiences I do have, and that I drew points together in discussions), with thought challenging being a technique which Bennett-Levy (2003) describe as a mechanism of change in Cognitive Therapy. I have found my clinical supervisor continues to guide me in challenging my negative thoughts about my competence in clinical work, and personal experience of this technique has helped me in applying this approach with clients.
It felt the group became more intimate and cohesive following the revealing of our personal opinions, which matched Tuckman’s (1965) third ‘norming’ stage. We quickly moved onto the ‘performing’ stage of group development, channelling our energy into creating the collage and putting together the presentation. In our fifth session our attention turned to how our reflections will relate to our future clinical practice.

We considered how our fluctuating emotions and levels of motivation and engagement with the PBL task may mirror the experiences of clients and carers on their own pathways of change; where there may be points they feel unheard, frustrated and insecure. Our PBL experience emphasizes the need to create a safe space for clients and carers to be able to voice their concerns, for us to actively elicit these, to respond to them and not be defensive to ensure true collaboration and provision of personally relevant support. I find my anxieties of being a novice therapist may sometimes hinder this process of active exploration, and is something I feel I need to develop more in my practice.

The group members being open and receptive to each other’s differing beliefs, values and experiences helped us achieve an inclusive and rich presentation, and we reflected how a similar collaborative approach would be useful when working within a multi-disciplinary team, where it is important to value the skills and experience of other professionals to overcome disagreements and provide cohesive and holistic care to our clients. This is something that I still hold in mind when coordinating and networking with other professionals on placement, although this can sometimes be tested due to working in a time-pressured environment, where there may not be the atmosphere where staff feel safe in expressing their concerns, and where group consensus can be difficult to reach.

My clinical experience has helped me put our group reflection in a ‘real life’ context, where I consciously remind myself to value other professionals’ perspectives, but also be diplomatically assertive if I feel something is in a
client’s best interests (e.g. encouraging a care co-ordinator to bring a Care Plan Approach meeting forward to ensure coordinated efforts for a client). This links into another group reflection on how our roles as clinical psychologists are changing in the National Health Service (NHS), with the New Ways of Working for Applied Psychologists in Health and Social Care (British Psychological Society, 2007) delineating greater leadership and consultancy responsibilities.

This reflection has led me to be more conscious of developing adaptive and transferrable skills even at this early stage of training, and of harnessing the idea of the ripple effect of change by using my developing research and formulation skills to promote more person-centred and recovery-focused thinking in the service I work in. For example, I will be delivering a presentation to the team on the concept of ‘recovery’ in the near future, and hope to encourage more hopeful thinking for their clients compared to the low expectations I often overhear in the office.

We were the last group to deliver our presentation on the PBL presentation afternoon and I was concerned that people would be tired and bored from watching the previous presentations. However the suggestion of writing it up for publication following our presentation boosted my confidence in our approach. I hope our published article will offer insight for future trainee clinical psychologists into the experience of beginning clinical training, and help normalise the anxieties often felt.

Reflecting on those first 6 weeks of training I have realised how much our take on the PBL task facilitated a sense of togetherness and openness amongst our PPLDG. It helped us to reflect ‘live’ on group and personal processes during a stressful time in which they may have otherwise gone unnoticed, and I continue to adopt this actively reflective stance with my clinical work. Whilst our meetings had felt chaotic at times, I felt we learnt a lot from each other, drawing from the diversity of group members’ opinions and experiences to create a presentation which has continued to
resonate through my experiences on clinical placement. My PPLDG is a forum which I will continue to value throughout my training as a source of peer support, advice and expertise.
REFERENCES


Note: The collage illustrates the process of working towards the presentation across 5 weeks, starting from left to right.
Appendix B. Personal reflections collage
Problem Based Learning Reflective Account Two

February 2011

Year 2
In the second year of the Clinical PsychD course the Personal and Professional Learning Discussion Groups (PPLDGs) were given a Problem Based Learning (PBL) exercise of creating a presentation around a case study involving a Court request for a risk assessment and rehabilitation plan for the three year-old children of parents with learning disabilities (LD). The children were in short-term foster care, and the Local Authority wished to place them for adoption. The parents wished for the return of their children, but lived in poverty, and there were concerns around the mother’s depression, the father’s perpetration of domestic violence, and their ability to meet their children’s physical and emotional needs, despite parenting training interventions. The grandparents, who had fundamentalist evangelical Christian beliefs, wished to adopt the children, but they had not been approached. There were multiple agencies involved. Please find the full details of the task in the appendix.

My PPLDG decided it would be useful to continue our first year practice of reflecting on our personal and group processes during this task. Throughout this account I will predominantly focus on the reflections and research that relate most to my subsequent clinical experience within a LD placement. In our first meeting we had a general discussion regarding the various potential outcomes of a risk assessment and subsequent rehabilitation plans, the factors that need to be assessed and considered, and potential presentation ideas.

A tension emerged between wanting to offer the parents another chance to parent whilst receiving more appropriate support (rights of parents with LD), and the crucial nature of age and timing in the long-term impact of adoption (the needs of the child). We reflected on the extent our opinions were evidence-based or personal experience-based, with group members reflecting on their own experiences of adoption, and their previous work experiences. For example, I previously worked in a Looked after Children’s team and found myself aligning to protecting the children’s needs rather than considering the parents’ rights. Now I am nearing the end of my LD
placement, I notice how I have developed a greater awareness and understanding of supporting parents with LD, which I intend to carry into my future child placements when working with families.

I was struck how the grandparents' voice was lost in our initial discussion due lack of previous work experience with this group in the PPLDG, mirroring their lack of prominence in the case study, and in my subsequent placement how carers in general can be excluded from assessment and discussion in LD services, despite their wealth of knowledge. We also initially stereotyped social workers' handling of such cases, and I wonder how much this was attributable to our now strong membership to a clinical psychology group, leading to the undermining of members of other groups (Forsyth & Elliot, 1999).

Conscious of these biases and dynamics, my group decided we needed to gather more information around care proceedings, people with LD rights and parenting interventions, and the impact of domestic violence and various care options on children to more comprehensively inform our formulation of the 'problem', before considering potential interventions (i.e. rehabilitation plans) and presentation ideas. We also felt it important to explore the potential impact of family, inter-agency and group dynamics on working with such complex cases.

Compared to our first year PBL task, I observed how my group felt confident in expanding discussions and postponing solutions, more comfortably adopting a position of 'safe uncertainty' to allow for new meanings to emerge (Mason, 1993). I have found that one of my most important roles in my LD placement has been to similarly draw together information from multiple sources (observations, carer interviews etc.) to illuminate understanding around clients' current difficulties, be they mental health or challenging behaviour.
Over our meetings we reflected how it may be easier for clinical psychologists to hold this position and resist quick decisions due to our relative low responsibility for risk compared to that held by social workers, considering how we may provide a safe space within supervision and consultation to support other professionals to reflect and explore options beyond ‘safe certainty’ (Mason, 1993). I have subsequently provided such a space with a community nurse in joint-working with a client who poses as high risk of suicide, helping her to consider options beyond inpatient care.

In the next meeting we fed-back and learnt from one another’s research on the topics mentioned above. In particular I learnt that existing research and Government strategies (Booth & Booth, 2004; Coren et al., 2010; Department of Health, ‘Valuing People Now’, 2009) uphold people with LD’s rights to be parents, reporting the need to enable them by offering appropriate support (e.g. use of social learning theory in providing specific parenting interventions in the home). However, in subsequent discussion on placement, I have realised how little this is put into practice.

I co-facilitated a sexual education Women’s Group, and was shocked to discover how many of the members had children in the care system, or wished to have children, and either way were/will not be offered the support advised. I wonder now how, as clinical psychologists, we are well placed to challenge disempowering discourses that have developed in LD teams, through our cognitive and social functioning assessments to highlight abilities, questioning language used and punctuating patterns of disempowering communication (Dallos & Vetere, 2009), and providing supervision to help contain difficult emotional processes. Either formally or informally, I have consciously adopted this role on placement.

I raised the potential for how the non-verbal communication of attachment distress from children and parents in the care system can be projected onto services involved, with counter-transference leading to blame, dissonance, and broken communication within the professional system (Rocco-Briggs,
2008). Another group member’s research suggested these group dynamics are exacerbated when group membership is unstable, there is a perceived lack of resources, lack of clarity over professional roles, and decision outcomes have high long-term and personal impact (Barclay & Kerr, 2006; Weingart & Todorova, 2010). I wonder how many NHS teams suffer from these factors. I have reflected how the cohesiveness of my LD team could be attributable to the clear roles and responsibilities held by the disciplines (unlike in the case study), and the shared responsibility for outcomes, with good communication at multiple levels of the organisation.

For the following two meetings we struggled to develop a comprehensive risk assessment for the three potential outcomes; the children are returned to their parents with additional support offered, the children are adopted by the grandparents, or the children are placed for non-kinship adoption; and decide on a rehabilitation plan. We adopted a biopsychosocial model to consider potential risk factors, and considered protective factors which can often be neglected in my experience of professional discussions regarding clients. I observed how the group appeared more fractious or giddy, oscillating between off-topic conversations and heated debate over the needs of the respective parties in the case study.

We reflected how such oscillation may reflect our finding ‘safe uncertainty’ and responsibility of being advocates for all parties as intolerable, in respect to the risk issues and ambiguity/lack of the information provided. We found we tended to be organised around our new placements, for example I found myself increasingly advocating for the parents with LD. I wonder how this may also reflect what can happen in multi-agency working, with different professionals holding different positions regarding the best outcome for families, depending on the service, discipline, and politics within which they work.

The frustration over lack of information in the PBL task has helped me value how extensive psychology assessments can be on placement, allowing
discussions with all parties involved so both service-user and carers’ voices are heard, and through the variety of assessment skills we adopt. For example, in functional behaviour assessments, contextual issues are considered and observations are also conducted. Therefore potential issues around difference (e.g. socioeconomic status) and diversity (e.g. religious beliefs) as found in the case study can be further explored and understood before decisions need to be made. For example, through conducting an extended assessment, I found a client’s Christian beliefs to be a protective factor in the bereavement work we were doing together.

In consideration of the research and evidence-base, my group finally decided the most appropriate rehabilitation plan would be to provide time-limited support to the parents in caring for their children, providing more appropriate individual interventions as well as parenting, with kinship adoption as a follow-up if the original rehabilitation plan was not effective. However, I am conscious that this decision could construe clinical psychologists as risk naive, and I wonder how at times holding ‘safe uncertainty’ may be an unaffordable luxury in complex clinical settings when vulnerable individuals are at risk. In the spirit of the psychology ethos in LD services, more resources and interventions need to be allocated in preventative work, so reactive decisions, such as with the case in the PBL task, do not have to be so frequently made.

The rehabilitation plan we presented incorporated such preventative strategies, and I have reflected further on clinical psychology’s role in these. For example, using our leadership, consultation and training skills, we can educate staff in how to make materials and resources more accessible and appropriate for people with LD. By conducting an extensive neuropsychology and behaviour assessment with a client on placement, I have been able to advise the residential home staff of a more accurate representation of his abilities, and develop guidelines of communication and structure in consultation with staff to promote his quality of life and prevent placement breakdown.
I have also gained a greater appreciation for the power of indirect work through carers and staff, valuing the experience and knowledge of the system around the client in informing interventions. Often those with the least power (through education and income status) have the most contact with the people we are trying to help. Through the PBL task and our placement experiences, my group has realised how we need be aware of issues of power at multiple levels in our work, and to strive to enable rather than disable those at the centre of our work.

My PPLDG decided to base our final presentation on a snapshot of our discussions, using a reflecting team to reflect upon the personal and group processes that emerged as we explored ideas and tried to reach a decision regarding the best outcome for the family. We also appointed a narrator to introduce the presentation, to summarise the decision and rehabilitation we reached, and our overall learning points from this task. I felt our presentation reflected the approach we adopted for this PBL task as a whole, with strengths in taking time to deconstruct the case study, explore the different perspectives and relevant literature before making a decision, and noting key reflections on personal and group processes as they occurred to develop our reflective practice.

However, a limitation of our approach was that the volume of information gathered led to multiple formulations of the 'problem' being developed, which we found difficult to condense into one outcome and rehabilitation plan. Byron (2010) proposed that providing informed and concise statements regarding issues around mental health is a skill that clinical psychologists as a profession struggle with, which hampers the dissemination of psychological information to the general public and in turn perhaps conceals our leadership qualities. I, along with a number of my colleagues, have subsequently set up a Media Work Group to actively seek out training to develop more accessible, concise and public-facing ways to disseminate psychological knowledge.
Overall I found this PBL task useful in exploring my assumptions about the attitudes of different disciplines and stakeholders in such complex cases, and through my placement experiences acknowledging the different ways we may approach our work, and the necessity and value in joint-working to provide a holistic approach in assessing abilities, suitability and implementation of interventions with people with LD. Through our group process reflections and research, I have realised how diverse views in clinical practice can either impede or enhance communication depending on the way these perspectives are negotiated, and clinical psychologists can help provide a space for these to be discussed within extensive assessments and consultation work.

The task also helped me acknowledge that as a group, clinical psychologists are also vulnerable to risk avoidance, with my PPLDG exhibiting psychological defences such as mania to avoid discussing risk issues and making a decision regarding the family’s future. I would say there is a fine line between a position of ‘safe uncertainty’ (Mason, 1993) and risk avoidance, and I am conscious to utilise supervision when I am uncertain on which side my thinking falls.

I am also more aware of how my previous personal and professional experiences may influence the perspective I adopt in relation to emotionally charged dilemmas (e.g. initially focusing on the children’s needs), and that gaining experience through training of working with different client groups is broadening my thinking around complex cases (e.g. rights of people with LD). It has reinforced to me the importance of transferring knowledge across placements, and of continuing my personal and professional development beyond my future placement with Older Adults, into my career as a qualified clinical psychologist, so as to keep up-to-date with the research and training, and continually reflect on my clinical practice.
APPENDIX

Problem Based Learning Exercise

Child Protection, Domestic Violence, Parenting, Attachment and Learning Disabilities

The Family

The Staines Family

- Live locally
- Supportive

- Raised in the care system

- Twins: Sally, Sarah

- No contact with mother and father

The Professional network

- Foster Parents
- Psychologist
- SW
- LD Psychologist
- Solicitor
- CPN
- CAMHS Team
- SS Family Centre
- HV
- Guardian
- Men's Aid Shelter
- Peacidition

= Domestic Violence

Helena Kaliniecka - Portfolio Volume 1
The Problem

The twins, Sally and Sarah Staines, were placed in short term foster care, following a recommendation of a full child protection case conference, and enacted at an initial Court hearing, that the children continued to be at risk in the care of their parents. The children were on the child protection register, under the categories of emotional abuse and neglect. The children’s Guardian (Court Reporter) has approached you, and asked you to help the Court by conducting a full risk assessment, and if appropriate, to help the Court develop a rehabilitation plan for the children. This is a joint instruction by all parties to the proceedings. However the Local Authority wishes to place the children for adoption, before it is too late, in the belief that Mr and Mrs Staines will never be able to care adequately for their children. Mr and Mrs Staines are passionate in their commitment to have the children returned to their care.

Whose problem is it? Why?

Some Background Information......

Mr and Mrs Staines are white English. They live on State benefits. Mrs Staines is described as a woman with learning disabilities, in the mild range. Mr Staines attended a school for children with special educational needs. His parents are members of a fundamentalist, evangelical Christian church. Social Services has not approached them as potential carers for the children, although they would welcome such an approach. Mr and Mrs Staines do not read and write English. It should be noted that many long reports have been written about them, their children, their care of their children and so on. Their solicitors read the reports out loud to them, usually once, and sometimes on the morning of a Court hearing.

Mrs Staines has two older children living with separate adoptive families. She is not able to have contact with them at the moment, as it was closed adoption. This is because her first husband was extremely violent to her, and threatened violence to the previous social workers. Social Services staff feared for the safety of the adopters if their whereabouts were known. Mrs Staines promised herself it would be different with this marriage and for these children.

Mr Staines has physically assaulted Mrs Staines, during disagreements, and apparently only when inebriated. She minimises his behaviour, saying it is nothing compared to what her previous husband used to do to her. The two children have witnessed these arguments and assaults. Mr Staines has not been offered a service from the local drugs and alcohol agency.

Mr Staines’ parents are supportive. They buy clothes and toys for the children, and occasionally buy food shopping for the family. Apparently, they are willing to look after the children, despite Mr Staines mother suffering from a painful rheumatic condition. Mrs Staines was raised in the Looked After Children
system, in a residential children's home, and has no contact with her family of origin.

Mr and Mrs Staines live in conditions of deep poverty. They do not have many household appliances that work, and it seems that Mrs Staines struggles to understand the workings of the second-hand appliances donated to them by family. It would seem that Mr Staines understands their workings, but is not prepared to use them. Social Services staff are most concerned about physical neglect of the children's needs. Family Centre staff say they have tried to engage both Mr and Mrs Staines in parenting classes, but the couple do not attend on a regular basis. The Family Centre appointed a family worker to visit the home, and show Mrs Staines 'how to keep house'. The family support worker has not been trained to work with parents with learning disabilities. The Social Worker says the Department has offered the family everything, and it makes no difference to the care of the children.

Mr and Mrs Staines are desperate about the loss of their children. They want them to come home. They fiercely resent the foster carers, and the supervisor of their contact with the children. The children's Guardian (Court Reporter) believes the parents can learn to be 'good enough' to satisfy Social Services requirements. Mrs Staines was referred to the local AMH service for help with feelings of despair and depression. She is taking anti-depressant medication, and is seeing a CPN for counselling.

Prompt Questions

.....something about paying attention to the professional network (liaison, communication, respective roles, different agendas)

.....something about safety, risk assessment and risk management

.....something about parenting and learning disabilities

.....something about child witnesses to domestic violence and the intergenerational effects of domestic violence

.....something about the effects of poverty and class discrimination

.....something about literacy and verbal comprehension (effects of anxiety and stress on memory and comprehension, and willingness/ability to express concerns, and say, 'I don't understand these reports')

.....something about resilience, adversity, depression and coping

.....something about problem drinking, and unaddressed need

.....something about the role of grandparents in the care of children

.....something about children of parents with learning disabilities

.....something about gender issues and gender scripts

.....something about psychologists, child protection and the legal system
REFERENCES


Summary of Personal and Professional Learning

Discussion Process Account One

September 2010

Year 1
Over the first year of Clinical PsychD training we were encouraged to discuss clinical practice and complete Problem Based Learning (PBL) tasks for our personal and professional development in our Personal and Professional Learning Discussion Groups (PPLDGs). I reflected how my group’s approach to the first PBL task (reflecting on our relationship to our own change), as a group and individuals, continued to resonate throughout the year. Themes of parallel processes of group development (Tuckman, 1965) and the role of facilitator in placement therapy groups were explored. Creating an open space for clinical discussion and the sharing of genograms helped us develop a trusting, understanding and supportive group environment, increasing our psychological wellbeing (Forsyth & Elliot, 1999) and confidence in our clinical judgements.

Group discussions included influences of personal learning narrative styles (Aggett, 2000), levels of diversity and identity, of the dominant individual-focus of mental health services, and endings in therapy. Our discussions became increasingly more client-focused and integrative, with greater consideration for the social and organisational contexts of our work, and diversity of therapeutic practice. I reflected on how my experiences of self disclosure, negotiation of roles, and sharing of anxieties in the group may relate to clients’ experiences over the process of therapy. My PPLDG have developed into a cohesive group. However, caution for groupthink is proposed, to consider the influence of group identity in working with other multidisciplinary professionals, and the need for more ‘storming’ and debate for continued personal and professional development.
Summary of Personal and Professional Learning
Discussion Process Account Two

July 2011

Year 2
Over the second year of Clinical PsychD training our Personal and Professional Learning Discussion Groups (PPLDGs) continued to be a space to work on our personal and professional development, additionally informed by reading seminars and more structured case discussion.

I reflected how at the PPLDG had initially become less reflective and more professionally-focused, attributing this to the change in our system with a new facilitator, and following a sensitive sculptures exercise at the beginning of the year where we shared reflections of each members' role in the group. Reflection on the PPLDG's ability to contain anxiety, and subsequent defence mechanisms, are related to team dynamics observed in NHS services (Lawlor, 2009). How these dynamics affect personal and professional development in the PPLDG and NHS teams is discussed. The sculptures exercise led me to work on managing my anxiety more effectively, and led to discussion of how difference and diversity is valued in our PPLDG and clinical work.

Structured case presentations yielded more in-depth discussion of ethical dilemmas, different therapy approaches, and working with teams compared to the first year. Different styles of leadership and supervision are reflected upon, with positions of 'safe uncertainty' (Mason, 1993) and space for reflection upheld as models for personal and professional development. How these reflections influenced my practice in the NHS is discussed, including introducing a team formulation approach (Lake, 2008) to the NHS team on placement to encourage greater psychological awareness.
• Overview of Three Years Clinical Experience
• Case Report Summary 1
• Case Report Summary 2
• Case Report Summary 3
• Case Report Summary 4
• Oral Presentation Summary
Overview of Three Years Clinical Experience

September 2012

Year 3
Adult Mental Health Placement
This placement was in a Community Mental Health Team

Clinical work: I gained experience in conducting psychological assessments and interventions with female and male clients aged between 18 and 64 years old. The clients’ experienced a range of psychological difficulties such as social anxiety, depression, borderline personality disorder, and schizophrenia. Interventions involved the use of Acceptance and Commitment Therapy (ACT), Cognitive Behavioural Therapy (CBT), a systemic approach with a couple, and the assessment and management of risk. I was involved in a Systemic Reflective Group and contributed to clients’ Care Programme Approach meetings and joint-working with other professionals. I also administered three neuropsychological assessments to establish whether clients had Korsakoff’s syndrome and memory impairments.

Group work: I co-facilitated an Anxiety group with an occupational therapist (drawing on CBT), and a Recovery group (based on the Wellness and Recovery Plan approach) with my supervisor.

Service evaluation: I conducted a quantitative evaluation of an ACT group using a number of ACT specific measures, and service evaluation questionnaire which I developed.

Teaching and presentations: I delivered presentations on the Recovery Approach to CMHT staff and regional psychologists.

Learning Disabilities Placement
This placement was in a Joint Community Learning Disability Team.

Clinical work: I gained experience in conducting psychological and functional assessments and interventions with female and male clients aged between 18 and 54 years old. The clients’ experienced a range of psychological and behavioural difficulties, and learning disabilities, such as anxiety and depression linked to Autistic Spectrum Disorder (ASD), bereavement, and
behaviours which others found challenging. Adapted CBT, behavioural, and systemic interventions were used, and involved the assessment and management of risk. I also conducted two neuropsychological assessments which helped establish signs of dementia, and executive functioning deficits.

**Group work:** I co-facilitated a psycho-educational Women's group on safety in relationships and the community with another trainee clinical psychologist.

**Service delivery:** I conducted an audit on the referral pathways to the different work groups in the team.

**Consultation work:** I gained experience of delivering consultation to residential and day services staff and families, developing shared formulations are clients' difficulties.

**Teaching and presentations:** I delivered a presentation on the service referral pathway audit to the team.

**Older Adults Placement**

This placement was split between a Community Mental Health Team for Older Adults and an Improving Access to Psychological Therapies service.

**Clinical work:** I gained experience in conducting psychological assessments and interventions with female and male clients aged between 76 and 96 years old. The clients' experienced a range of psychological or organic difficulties such as anxiety, depression, borderline personality traits, and dementia. Interventions involved the use of adapted CBT and Interpersonal Therapy (IPT), and included sessions with a couple using a systemic approach. I also conducted two neuropsychological assessments to establish diagnoses of dementia with psychiatry.

**Teaching and presentations:** I delivered teaching on a Team Formulation Model to CMHT staff to increase reflective practice.

**Consultation work:** I gained experience delivering consultations sessions to staff in a care home, and provided consultation to CMHT staff in how to use the Team Formulation Model when thinking about clients.
Child and Adolescent Mental Health Placement and Advanced Competencies Placement

These two placements were conducted jointly across a Child and Adolescent Mental Health Team (CAMHS) and a Children Looked After service.

Clinical work: I gained experience in conducting psychological assessments and interventions with female and male clients aged between 6 and 17 years old. The clients’ experienced a range of psychological and developmental difficulties such as post-traumatic stress disorder, separation anxiety, obsessive compulsive disorder, bereavement, attachment difficulties, adjustment difficulties, abuse and neglect. Interventions involved the use of CBT, Narrative Therapy, attachment- and community psychology- informed approaches. I gained experience of delivering indirect systemic and attachment interventions to parents (e.g. surrounding the adjustment of a child following a traumatic bereavement) and foster carers. I also conducted two neuropsychological assessments to contribute to the assessment of ASD, and establish general cognitive functioning.

Group work: I co-facilitated a Foster Carers Reflective group with my supervisor, and contributed to the development of a young-women’s (in care) group.

Consultation and supervision work: I gained experience delivering consultations to social workers, foster carers, and adoptive parents in managing transitions, children’s emotional distress and behaviours. I also gained experience of supervising a skills worker in conducting CBT work with a Looked After Child who experienced anxiety.

Teaching and presentations: I delivered teaching on attachment theory to a group of potential foster carers, and on child development to multi-agency staff involved with the care system. I also delivered a presentation on the use of Narrative Therapy with young-people to CAMHS psychologists.
Cognitive Behavioural Therapy with a Woman in her Fifties Presenting with Anxiety and Low Self Esteem

Case Report One

April 2010

Year 1
A referral was received for a White-British woman in her fifties presenting with anxiety. She disclosed one previous suicide attempt but expressed regret over this action, and felt this was not a current issue. Recurrent depression was a co-morbid factor; however she reported that her anxiety was her current main concern, following successful cognitive behavioural therapy (CBT) at a Recurrent Depression Clinic.

We worked on her goals of managing her physiological symptoms, increasing her assertiveness, and identifying her relapse warning signs. A generic cognitive model was initially used to build a case conceptualization that allowed exploration of her whole experience, leading to Fennell’s (1998) cognitive model of low self-esteem. In the beginning it was agreed that a CBT approach informed by anxiety protocols could be beneficial, in line with the clinical research evidence-base (Borcovec & Ruscio, 2001; Clark et al., 2003). The intervention focused on developing coping strategies, identifying and challenging her negative thoughts and dysfunctional assumptions, and developing alternative beliefs. The intervention methods used overlapped with low self-esteem protocols (Fennell, 1998).

The work is ongoing but the client reports a substantial reduction in her physiological symptoms, an increase in her assertiveness and motivation to protect her own needs, and a greater awareness of her relapse signs. Further sessions were offered to work on her core beliefs; however these were declined as she felt she had achieved her therapeutic goals. We have therefore agreed to use our remaining sessions to review our work and develop a relapse prevention plan.
An Integrative Approach with a Man in his Forties
Presenting with Severe Depression

Case Report Two
August 2010

Year 1
A referral was received for an Asian-Indian man in his forties presenting with severe depression. He disclosed previous suicide attempts but felt that this was not a current issue. The cognitive model of depression was initially used for formulate his difficulties (adapted from Beck, 1995 and Fenell, 1989). An extended assessment was conducted with his wife present to consider systemic perspectives and issues of diversity. A counselling and motivational interviewing approach was also adopted to facilitate engagement and allow him space to tell his story of the multiple losses in his life.

Following the extended assessment his difficulties were reformulated using an Acceptance and Commitment Therapy (ACT) model (Bach & Moran, 2007). His goals were to accept his past troubles, and to be able to step back from rumination to engage more with his family and faith. We agreed that an ACT approach could be beneficial in consideration of his spirituality and values, and for its evidence-base in depression (e.g. Forman et al., 2007).

The intervention focused on developing mindfulness and defusion skills to increase acceptance of painful inner experiences, and on increasing actions in-line with his values. His scores on Beck’s Depression Inventory (BDI-II, Beck et al., 1996) remained in the severe category within 14 sessions. However, he and his wife reported increasing moments of engagement with the family, and lifts in mood. In consideration of the systemic context of his difficulties, we agreed that a referral to Family Therapy would be beneficial for the whole family.
A Neuropsychological Assessment of a 38 Year Old Man with Learning Disabilities for Executive Functioning Deficits

Case Report Three

April 2011

Year 2
This case report is a neuropsychological assessment of the general intellectual ability and executive functioning of a 38 year old man with mild learning disabilities (LD), hydrocephalus and possible Autistic Spectrum Disorder (ASD). James described getting “stressed” and not being able to control himself. James lived in a residential home for people with LD, where staff reported challenging behaviours (CBs) such as verbal and physical aggression to others, and destruction of property. A literature review was conducted around cognitive and socio-emotional functioning in people with LD, hydrocephalus and ASD, with particular attention to the characteristics of executive functioning (EF) deficits across these areas.

After information gathering from the client, his mother, and residential home staff, and considering literature around EF, I hypothesised that James’ challenging behaviours were due to extremely low general intellectual abilities (IQ) and EF deficits. Formal assessments were completed using the WAIS III, BADS, DKEFS (Trail Making), COWAT, Animal Naming, Weigl Colour-Form Sort Test, and Hayling Sentence Completion Tests.

The results of these tests supported the hypotheses that James had Extremely Low IQ, and that his CBs could be attributable to EF deficits in planning, problem-solving, self-regulation, mental flexibility, organisation of behaviour, working memory, and attention. It was recommended to staff to create more structure and routine in James’ day, and use visual prompts to support purposeful engagement in activities to prevent CBs from occurring. Behaviour management guidelines were developed with the staff team.
A Cognitive Behavioural and Systemic Approach with a 16 Year Old Girl Struggling with Trauma and Eczema

Case Report Four

May 2012

Year 3
A referral was received for a British Afro-Caribbean 16-year old woman presenting with post-traumatic stress following witnessing an assault on her mother. No previous suicide attempts were disclosed. Ehlers and Clark’s (2000) cognitive model for post-traumatic stress disorder (PTSD) was used to formulate her difficulties.

We worked on her goals of wanting to feel less anxious and more safe around other people, to re-build her trust in others, and create a better balance in her life between her school work, social activities, and looking after herself. A Trauma Focused Cognitive Behaviour Therapy (TF-CBT; Cohen et al., 2006) approach was adopted in line with the clinical research evidence-base (Cary & McMillen, 2012), and a systemic approach with a colleague seeing her mother separately for sessions. The individual intervention focused on psycho-education, relaxation skills, affective modulation, and cognitive coping and processing. Coping with eczema was also explored and a family systems perspective adopted in the re-formulation.

The work is ongoing but the client reports greater acceptance of her eczema, a reduction in feelings of frustration and ‘jumpiness’, of avoiding trauma reminders less, and a re-appraisal of her beliefs about her ‘weakness’ and of trusting people. At the mid-therapy review a reduction in her scores for dissociation, anxiety and post-traumatic stress on the Trauma Symptom Checklist for Children – Alternative Version (TSSC-A; Briere, 1996) was observed. We have agreed to continue with TF-CBT and begin joint-sessions with her mother.
RESEARCH DOSSIER

- Service Related Research Project
- Major Research Project
- Research Log
- Appendices to the Research Dossier
- Qualitative Research Project Abstract
An Evaluation of a Pilot Acceptance and Commitment Therapy Group for Anxiety and/or Depression

Service Related Research Project
July 2010

Year 1
ABSTRACT

Objectives: The current study aims to evaluate whether an ACT Group approach has been effective in helping clients with moderate to severe depression and/or anxiety in a Community Mental Health Team setting to; a) accept undesirable emotional experiences and functionally adapt their actions, b) increase mindfulness skills, c) reduce anxiety/depression symptoms. Clients’ perspectives and satisfaction of the ACT Group are also evaluated.

Design: A within-group repeated-measures design was used. Participants were asked to complete three measures (Hospital Anxiety and Depression Scale [HADS]; Five Facet Mindfulness Questionnaire, and Acceptance and Action Questionnaire) in the first and last of the 8-week ACT Group sessions, and a Satisfaction Questionnaire (SQ) at 6 weeks follow-up.

Participants: Six CMHT clients referred to the ACT Group completed the pre- and post-group measures (mean age 44 years, range 33-53 years; one male, five females).

Results: Group-level analysis found that only the positive change in the HADS-Anxiety scale was statistically significant ($z = -2, p < .05$). Individual-level analysis was precluded due to the lack of measure norms; however observations of change in individual scores were explored. Participants reported high satisfaction with the ACT Group, however the content of sessions was reported to be too dense and difficult to understand.

Conclusion/Implications: Whilst improvements in anxiety symptoms and ACT processes were non-significant, observations tentatively corroborate ACT’s approach in increasing mindfulness and willingness to perform previously avoided actions, independent from symptom improvement. The ACT Group format and material has been revised to be less complex following SQ feedback.
ACKNOWLEDGEMENTS

I would like to thank the clients who gave up their time to complete measures and offer feedback in the evaluation of the ACT Group. I am grateful to the ACT Group facilitators and my Clinical Supervisor for proposing the idea, and offering advice and support in conducting the project. I would also like to thank my SRRP and Research Tutors on the clinical psychology training course.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>102</td>
</tr>
<tr>
<td>Aims</td>
<td>104</td>
</tr>
<tr>
<td>Hyptheses</td>
<td>104</td>
</tr>
<tr>
<td>Method</td>
<td>104</td>
</tr>
<tr>
<td>Analysis and Results</td>
<td>106</td>
</tr>
<tr>
<td>Discussion</td>
<td>112</td>
</tr>
<tr>
<td>Conclusions</td>
<td>115</td>
</tr>
<tr>
<td>References</td>
<td>116</td>
</tr>
</tbody>
</table>
INTRODUCTION

Community Mental Health Teams (CMHT) provide ongoing treatment and care for those with moderate to severe mental health problems. The Department of Health's (DoH; 2002) 'Mental Health Policy Implementation Guide: CMHT' recommends that psychological therapies are routinely considered, with the National Institute for Health and Clinical Excellence (NICE; 2004, 2009) consistently recommending Cognitive Behavioural Therapy (CBT) for anxiety and depression, mental health disorders that are highly prevalent in CMHTs.

In recent years, a “third wave” of CBT approaches has been developed, with Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) being the most comprehensively developed and researched. ACT looks beyond symptom reduction as evidence of recovery, and towards enhancing quality of life as an equally valued outcome. Whilst traditional CBT focuses on modifying the form and content of undesirable personal experiences, ACT focuses on the context and function of responses (Hayes, 2004). Hayes (2004) suggests that attempting to control personal emotional experiences is itself problematic, and can actually obstruct leading a satisfying, meaningful life. It could therefore be speculated that ACT may be a suitable approach for people involved with CMHTs who have perhaps previously tried different therapeutic interventions with little success.

ACT therefore supports people to create a more meaningful and fulfilling life by; a) increase acceptance of undesirable personal experiences (i.e. thoughts, feelings, memories etc.) which cannot be controlled, and b) increase actions that are in accordance with personal values (Harris, 2009). ACT does this by enhancing psychological flexibility through teaching mindfulness skills to defuse from and accept painful thoughts, to engage in the present moment, clarify personal values, and change behaviours to act upon these values.
The ACT approach therefore aligns with the DoH (2001) ‘The Journey to Recovery’ policy which states that the Mental Health System needs to support people in whatever way they think is important for their recovery, with the widely held definition of personal recovery being “...a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness” (Anthony, 1993).

There is a growing evidence-base for the therapeutic benefits of ACT for a range of common mental health problems, including depression (Forman et al., 2007), and social anxiety (Dalrymple & Herbert, 2007). Whilst ACT does not aim to reduce symptoms, research has found clinical improvements for anxiety and depression, in addition to increased life satisfaction and reduced functioning difficulties (Forman et al., 2007).

The current study seeks to evaluate the effectiveness of a pilot ACT Group conducted within an urban CMHT setting for people experiencing anxiety and/or depression. The ACT Group was evaluated on whether the group was effective in achieving key ACT objectives and on indirect improvements in anxiety/depression symptoms. A predominantly quantitative approach was taken to optimise the validity and reliability of any reported changes; and group members’ perspectives were also gathered using a satisfaction questionnaire.

The CMHT chose to deliver ACT in a group format\(^1\) so more people could benefit from this approach. The few existing studies on group interventions of ACT have found the approach to be effective for social anxiety (e.g. Ossman et al., 2006) and depression (Zettle & Rains, 1989). However, the participants in these studies were recruited from the general population through local newspaper advertising. Thus the current study may contribute to research into the effectiveness of group provision of ACT by drawing

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\(^1\) Individual ACT is also offered at the CMHT
from CMHT caseloads so that results may be more widely generalisable to mental health service settings.

Aims

1) Evaluate the usefulness of running an ACT Group approach at the CMHT by using self-rated process measures to assess change in core ACT principles, and outcome measures to assess depression/anxiety symptom improvement.

2) Evaluate participants’ reactions to the ACT Group using a satisfaction questionnaire to gather their perceptions and satisfaction with the group.

Hypotheses

1) There will be significant improvements in self-ratings from pre-group to post-group of anxiety/depression symptoms, mindfulness skills, and acceptance and actions.

2) Participants will show high satisfaction with the content and delivery of the ACT Group.

METHOD

Participants

Participants initially included nine individuals (eight women, one man) seeking group therapy for the management of their depression and/or anxiety. Individuals were assessed for the ACT Group by one of the facilitators following a referral by their CMHT care-coordinators. During the assessment the facilitator provided a consent form that explained the purpose of evaluating the ACT Group approach and assurance their details would be kept confidential, and a request for the individuals to complete four measures over the course of the group.

However, of the initial nine participants who completed the pre-group measures, one declined to complete the post-group measures, and two
dropped out at varying points of the group. This left six people who completed (mean age 44 years), all of whom were of White-British ethnicity (see Table 1).

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age (years)</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female</td>
<td>44</td>
<td>Anxiety/Depression</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>39</td>
<td>Generalised Anxiety Disorder</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>33</td>
<td>Anxiety/Depression</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>45</td>
<td>Anxiety/Depression</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>49</td>
<td>Depression</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>53</td>
<td>Anxiety/Depression</td>
</tr>
</tbody>
</table>

Table 1. Participant characteristics

Measures

One outcome measure and two process measures were incorporated in the study. The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) (see appendix A), is a 14-item measure that is used across hospital and community settings, consisting of 2 anxiety and depression symptom subscales (HADS-A and HADS-D). The HADS-A has the mean internal consistency of 0.83, and the HADS-D of 0.82, and both subscales have the sensitivity and specificity of approximately 0.80 (Bjelland et al., 2002). The HADS scores are expected to decrease following the group.

Process measures: The Five Facet Mindfulness Questionnaire (FFMQ; Baer et al., 2006) (see appendix B) is a 39-item measure of mindfulness skills consisting of five subscales (observation, describe, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience).

The FFMQ has been found to have adequate to good reliability, with the internal consistency for the subscales ranging from 0.75 to 0.91 (Baer et al., 2006), and loadings of the five facets on the overall mindfulness construct ranging from 0.53 to 0.84, with variance in each facet accounted for by its
relationships with the other facets ranging from 0.24 to 0.41 (Baer et al., 2008).

The Acceptance and Action Questionnaire (AAQ-II; Bond et al., 2007) (see appendix C) is a 10-item measure of experiential avoidance and willingness. Berman et al. (2010, p.110) state that ‘the AAQ-II has been shown to have good psychometric properties and good convergent, discriminant, and incremental validity’; however the psychometric properties have yet to be published. Both the AAQ and FFMQ scores are expected to increase following the group.

A 9-item ACT Group Satisfaction Questionnaire (SQ; see appendix D) was developed in-line with measure development texts (Barker et al., 2002) to assess participants’ satisfaction with the content and delivery of the group. The SQ comprised of 7 likert-style questions, and 2 open questions to elicit what participants found most and least useful about the group. The SQ was inspected by a clinical psychologist experienced in ACT and group therapies to establish the content validity, clarity and structure of the questions.

**Procedure and Design**

The ACT Group consisted of eight weekly two-hour sessions, and was led by one academic clinical psychologist (who developed the ACT Group session protocol) and one CMHT clinical psychologist. Sessions were organised around the 6 core ACT principles of defusion, acceptance, contact with present moment, observing the self, values, and committed action. These were integrated into the sessions using experiential group exercises (e.g. mindfulness), metaphors and home-work to help participants to respond more flexibly to distressing content and act more consistently with personal values.

Participants were asked to complete three measures in the first and last group session to establish pre- and post-treatment data for each participant,
and the SQ at 6 weeks follow-up. The study was a within group repeated-measures design, and fell within the Trust remit of service evaluation therefore did not require ethics approval. All client information has been anonymised and data kept confidential.

ANALYSIS AND RESULTS

In consideration of the small participant numbers resulting in interval data that was not normally distributed, the non-parametric Wilcoxon signed-rank test was chosen to analyse change in repeated measurements on the same participant group. There was a statistically significant decrease in the HADS-A scores from pre-group (median = 15.5) to post group (median = 15), \( z = -2, p < .05 \). There were no other significant results.

There was a trend of small improvements in all four measures when inspecting the pre and post group means (see appendix E). However, the standard deviations were predominantly large; suggesting the positive change in measure scores cannot be reliably established.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>HADS-D: Pre-group</td>
<td>18</td>
</tr>
<tr>
<td>HADS-D: Post-group</td>
<td>14</td>
</tr>
<tr>
<td>HADS-A: Pre-group</td>
<td>16</td>
</tr>
<tr>
<td>HADS-A: Post-group</td>
<td>15</td>
</tr>
<tr>
<td>AAQ: Pre-group</td>
<td>12</td>
</tr>
<tr>
<td>AAQ: Post-group</td>
<td>20</td>
</tr>
<tr>
<td>FFMQ: Pre-group</td>
<td>80</td>
</tr>
<tr>
<td>FFMQ: Post-group</td>
<td>74</td>
</tr>
</tbody>
</table>

Table 2. Total measure scores

Results are therefore inspected for individual-level change, which is argued to be more important in clinical practice (Long & Hollin, 1995). See Table 2
for total scores. A decrease in scores on the HADS and increase in scores on the AAQ and FFMQ denote improvement in depression/anxiety symptoms, mindfulness skills, and acceptance and action.

Single case statistics were not possible due to the lack of norms for the measures used in the study, so tentative observations of change on the measures and SQ are offered here instead. Full results will be fed back to the service, and a presentation given to the service’s psychology locality meeting, the evidence for which will be presented in appendix H.

**Observations**

Four participants’ scores on the HADS-A improved post-group as hypothesized, with Participant 3 moving from severe (score range 15-21) to moderate (score range 11-14). However, the direction of change in four participants’ scores on the HADS-D was opposite to that hypothesized, with participant 6 moving from moderate to severe and only Participant 1 moving from severe to moderate. However, the reliability of change and its clinical significance is uncertain, as the majority of the participants HADS scores only moved by one point.

Three participants’ scores on the AAQ improved post-group as hypothesized, with one participant’s scores remaining the same, and one participant’s scores decreasing. Three participants’ scores on the FFMQ also improved at post-group as hypothesized, with one participant’s scores remaining the same, and two participants’ scores decreasing (opposite to that hypothesized.)

However, there was noticeable variation within the FFMQ subscale scores (see figures 1-6, appendix F for raw scores). Participant 2 and 4 improved on four subscales, Participant 1 improved on three subscales, Participant 3 and 6 improved on two subscales, and Participant 5 improved on one subscale. The majority of participants (five) improved on the ‘acting with awareness’ subscale in particular.
However these improvements cannot be established as trends in the data due to data being drawn from only two assessment points.

Figure 1. Participant 1 FFMQ subscale scores
Figure 2. Participant 2 FFMQ subscale scores

Figure 3. Participant 3 FFMQ subscale scores
Figure 4. Participant 4 FFMQ subscale scores

Figure 5. Participant 5 FFMQ subscale scores

Figure 6. Participant 6 FFMQ subscale scores
There was little variability on SQ closed questions (see appendix G for SQ results), with all participants reporting high satisfaction in feeling supported in the group (Question 2; except for Participant 4, relating to issues being “dug up” for her), that they had gained something from the group (Question 3), that the group helped them to accept their difficulties (Question 4) and overall finding the ACT approach helpful (Question 6). However, half of the participants reported that they were ‘undecided’ about whether the group was pitched at the right level for them, and two participants reported low satisfaction on whether the group helped them manage their life more effectively (see appendix G).

These lower ratings may relate to the comment themes of finding the informational content of sessions too dense and difficult to understand, following thematic analysis (Braun & Clarke, 2006) of the SQ open question responses. Positive themes included valuing small group work, ACT components such as acceptance and commitment, and relaxation/mindfulness. Following the group two participants felt ‘better’, one felt ‘the same’, one felt ‘different’, and two felt ‘worse’ (however both attributed this to events outside of the group).

DISCUSSION

The results will be discussed in the context of the study’s hypotheses.

Hypothesis 1

At group level only anxiety symptoms were found to have had statistically significantly improved, with no significant improvements observed in depression symptoms, self-ratings of mindfulness, acceptance and action.

Current ACT research has been criticised for not being as methodologically stringent as CBT research, therefore it is possible that actual effects sizes are not as large as reported, explaining the current study’s non-significant findings (Ost, 2008). However, research evidence is mounting for ACT (e.g.
Powers et al., 2009), and the criticism may more reflect ACT research's relative infancy, rather than the efficacy of the ACT approach itself. Additionally, reducing anxiety and depression is not the main aim of the ACT approach, which may explain the relatively small improvements observed in anxiety and depression symptoms.

The DoH (2001; ‘Treatment choice in psychological therapies and counselling: Evidence based clinical practice guideline’, p.35) suggests that therapies of 8 sessions or less are ‘unlikely to be optimally effective for most moderate to severe mental health problems’. Therefore extending the number of sessions for the ACT Group could be considered. Zettle and Rains (1989) suggest that group delivery may also reduce the effectiveness of ACT compared to individual delivery. However, the high level of need for psychological therapies in the NHS may necessitate initial group interventions.

Important limitations of the study were the small participant numbers and missing data points, which may have challenged the reliability and validity of group-level analysis results, therefore limiting the generalisability of the findings. In light of this, the service could increase the sample size through repeating the procedure with the next ACT Group to increase statistical power of analyses, and perhaps utilise a formal control condition to monitor for natural improvements over time.

Individual-level statistical analyses were precluded due to lack of norms for the measures used. Therefore individual change, which is particularly important for clinical practice, is relatively unknown. In light of this limitation, future group evaluations would benefit from using measures which have established norms, such as the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans et al., 2000), and be completed at multiple points across the intervention to be able to establish trends in data.
Whilst improvements in group-level scores were not significant in the process measures, there were patterns that suggested half of the participants improved in acceptance/action with personal experiences and general mindfulness skills, with all participants improving in at least one mindfulness skill. Therefore, for at least half of the participants, there appeared to be an increased willingness to perform actions and experience thoughts/feelings previously avoided, independent of depression/anxiety symptom improvement.

Therefore to a certain extent the ACT group achieved ACT’s aim to increase psychological flexibility in engaging with the present moment and accepting undesirable personal experience. Some of the participants were able to “achieve broader therapeutic gains” independent of depression/anxiety symptom improvement, in-line with other research findings (Ossman et al., 2006, p.411). However, these interpretations are presented tentatively in view of the non-significant findings, also particularly noting the AAQ’s psychometric properties are yet to be formally established.

**Hypothesis 2**

The SQ yielded predominantly high satisfaction with the ACT Group, with comments regarding small group work and certain components (e.g. mindfulness) of the ACT approach as useful. However, it was sometimes unclear whether it was the group context (e.g. group cohesiveness; Yalom & Rand, 1966) rather than the ACT approach that was being rated. There were also comments of feeling overwhelmed or confused by informational content of ACT Group sessions. This could suggest a presence of social desirability in the positive satisfaction ratings, but also that little improvement in measures may reflect how ACT was delivered, rather than the ACT approach itself.

Responses suggest that the academic facilitator’s more theory-oriented approach may have not suited a client group that is often difficult to engage.
Regardless of the potential limitation of the SQ, it elicited useful feedback and insight into participants' perspectives of the ACT Group, which would have been lost if only outcome/process measures had been used.

Conclusions
The pilot ACT Group was a creative initiative and joint venture between an academic clinical psychologist and a CMHT clinical psychologist to broaden choice of interventions for those with moderate to severe mental health problems. Whilst improvements in symptoms and ACT processes were non-significant, the patterns observed tentatively corroborate ACT’s approach in increasing mindfulness and willingness to perform previously avoided actions, independent from symptom improvement for half of the participants.
The format of the ACT Group has since been adapted by the facilitators to better suit the client group following SQ feedback by:

- Revising session material so less academic language is used.
- Increasing experiential exercises so delivery is less dyadic and theory-focused.
- Including small group work in every session.
- Covering content at a slower pace with less covered in each session.

Further to research suggestions already made, future evaluations would benefit from expanding on qualitative feedback (such as using an interview format) alongside standardised measures. This would gather richer information of participant perspectives, increase understanding of variances in scores, and of underlying change processes in the ACT approach. The latter of which is still relatively under-researched in treatment evaluation studies (Block & Wulfert, 2000).
REFERENCES


and action questionnaire—II. A revised measure of psychological flexibility. Manuscript submitted for publication.


### Appendix A. HADS

<table>
<thead>
<tr>
<th>A</th>
<th>I feel tense or ‘wound up’:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Most of the time</td>
</tr>
<tr>
<td></td>
<td>A lot of the time</td>
</tr>
<tr>
<td></td>
<td>From time to time (occ.)</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>D</td>
<td>I still enjoy the things I</td>
</tr>
<tr>
<td></td>
<td>used to enjoy:</td>
</tr>
<tr>
<td></td>
<td>Definitely as much</td>
</tr>
<tr>
<td></td>
<td>Not quite as much</td>
</tr>
<tr>
<td></td>
<td>Only a little</td>
</tr>
<tr>
<td></td>
<td>Hardly at all</td>
</tr>
<tr>
<td>A</td>
<td>I get a sort of frightened</td>
</tr>
<tr>
<td></td>
<td>feeling as if something</td>
</tr>
<tr>
<td></td>
<td>awful is about to happen:</td>
</tr>
<tr>
<td></td>
<td>Very definitely and quite</td>
</tr>
<tr>
<td></td>
<td>badly</td>
</tr>
<tr>
<td></td>
<td>Yes, but not too badly</td>
</tr>
<tr>
<td></td>
<td>A little, but it doesn’t</td>
</tr>
<tr>
<td></td>
<td>worry me</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>D</td>
<td>I can laugh and see the</td>
</tr>
<tr>
<td></td>
<td>funny side of things:</td>
</tr>
<tr>
<td></td>
<td>As much as I always could</td>
</tr>
<tr>
<td></td>
<td>Not quite so much now</td>
</tr>
<tr>
<td></td>
<td>Definitely not so much</td>
</tr>
<tr>
<td></td>
<td>now</td>
</tr>
<tr>
<td>A</td>
<td>Worrying thoughts go</td>
</tr>
<tr>
<td></td>
<td>through my mind:</td>
</tr>
<tr>
<td></td>
<td>A great deal of the time</td>
</tr>
<tr>
<td></td>
<td>A lot of the time</td>
</tr>
<tr>
<td></td>
<td>From time to time, but not</td>
</tr>
<tr>
<td></td>
<td>often</td>
</tr>
<tr>
<td></td>
<td>Only occasionally</td>
</tr>
<tr>
<td>D</td>
<td>I feel cheerful:</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td></td>
<td>Not often</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Most of the time</td>
</tr>
<tr>
<td>A</td>
<td>I can sit at ease and feel</td>
</tr>
<tr>
<td></td>
<td>relaxed:</td>
</tr>
<tr>
<td></td>
<td>Definitely</td>
</tr>
<tr>
<td></td>
<td>Usually</td>
</tr>
<tr>
<td></td>
<td>Not often</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>D</td>
<td>I feel as if I am slowed</td>
</tr>
<tr>
<td></td>
<td>down:</td>
</tr>
<tr>
<td></td>
<td>Nearly all the time</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>A</td>
<td>I get a sort of frightened</td>
</tr>
<tr>
<td></td>
<td>feeling like ”butterflies”</td>
</tr>
<tr>
<td></td>
<td>in the stomach:</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td></td>
<td>Occasionally</td>
</tr>
<tr>
<td></td>
<td>Quite often</td>
</tr>
<tr>
<td></td>
<td>Very often</td>
</tr>
<tr>
<td>D</td>
<td>I have lost interest in my</td>
</tr>
<tr>
<td></td>
<td>appearance:</td>
</tr>
<tr>
<td></td>
<td>Definitely</td>
</tr>
<tr>
<td></td>
<td>I don’t take as much care</td>
</tr>
<tr>
<td></td>
<td>as I should</td>
</tr>
<tr>
<td></td>
<td>I may not take quite as</td>
</tr>
<tr>
<td></td>
<td>much care</td>
</tr>
<tr>
<td></td>
<td>I take just as much care</td>
</tr>
<tr>
<td>A</td>
<td>I feel restless as I have</td>
</tr>
<tr>
<td></td>
<td>to be on the move:</td>
</tr>
<tr>
<td></td>
<td>Very much indeed</td>
</tr>
<tr>
<td></td>
<td>Quite a lot</td>
</tr>
<tr>
<td></td>
<td>Not very much</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>D</td>
<td>I look forward with</td>
</tr>
<tr>
<td></td>
<td>enjoyment to things:</td>
</tr>
<tr>
<td></td>
<td>As much as I ever did</td>
</tr>
<tr>
<td></td>
<td>Rather less than I used to</td>
</tr>
<tr>
<td></td>
<td>Definitely less than I used</td>
</tr>
<tr>
<td></td>
<td>to</td>
</tr>
<tr>
<td></td>
<td>Hardly at all</td>
</tr>
<tr>
<td>A</td>
<td>I get sudden feelings of</td>
</tr>
<tr>
<td></td>
<td>panic:</td>
</tr>
<tr>
<td></td>
<td>Very often indeed</td>
</tr>
<tr>
<td></td>
<td>Quite often</td>
</tr>
<tr>
<td></td>
<td>Not very often</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>D</td>
<td>I can enjoy a good book</td>
</tr>
<tr>
<td></td>
<td>or radio/TV program:</td>
</tr>
<tr>
<td></td>
<td>Often</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Not often</td>
</tr>
<tr>
<td></td>
<td>Very seldom</td>
</tr>
</tbody>
</table>
Appendix B. FFMQ

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>never or very rarely true</td>
<td>Rarely true</td>
<td>Sometimes true</td>
<td>Often true</td>
<td>very often or always true</td>
<td></td>
</tr>
</tbody>
</table>

1. When I'm walking, I deliberately notice the sensations of my body moving.
2. I'm good at finding words to describe my feelings.
3. I criticize myself for having irrational or inappropriate emotions.
4. I perceive my feelings and emotions without having to react to them.
5. When I do things, my mind wanders off and I'm easily distracted.
6. When I take a shower or bath, I stay alert to the sensations of water on my body.
7. I can easily put my beliefs, opinions, and expectations into words.
8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.
9. I watch my feelings without getting lost in them.
10. I tell myself I shouldn't be feeling the way I'm feeling.
11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions
12. It's hard for me to find the words to describe what I'm thinking.
13. I am easily distracted.
14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.
15. I pay attention to sensations, such as the wind in my hair or sun on my face.
16. I have trouble thinking of the right words to express how I feel about things
17. I make judgments about whether my thoughts are good or bad.
18. I find it difficult to stay focused on what's happening in the present.
19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.
20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
21. In difficult situations, I can pause without immediately reacting.
22. When I have a sensation in my body, it's difficult for me to describe it because I can't find the right words.
23. It seems I am "running on automatic" without much awareness of what I'm doing.
24. When I have distressing thoughts or images, I feel calm soon after.
25. I tell myself that I shouldn't be thinking the way I'm thinking.
26. I notice the smells and aromas of things.
27. Even when I'm feeling terribly upset, I can find a way to put it into words.
28. I rush through activities without being really attentive to them.
29. When I have distressing thoughts or images I am able just to notice them without reacting.
30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.
31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.
32. My natural tendency is to put my experiences into words.
33. When I have distressing thoughts or images, I just notice them and let them go.
34. I do jobs or tasks automatically without being aware of what I'm doing.
35. When I have distressing thoughts or images, I judge myself as good or bad, depending what he thought/image is about.
36. I pay attention to how my emotions affect my thoughts and behavior.
37. I can usually describe how I feel at the moment in considerable detail.
38. I find myself doing things without paying attention.
39. I disapprove of myself when I have irrational ideas.
Appendix C. AAQ-II

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>never true</td>
<td>very seldom true</td>
<td>seldom true</td>
<td>sometimes true</td>
<td>frequently true</td>
<td>almost always true</td>
<td>always true</td>
</tr>
</tbody>
</table>

1. It's OK if I remember something unpleasant. 1 2 3 4 5 6 7
2. My painful experiences and memories make it difficult for me to live a life that I would value. 1 2 3 4 5 6 7
3. I'm afraid of my feelings. 1 2 3 4 5 6 7
4. I worry about not being able to control my worries and feelings. 1 2 3 4 5 6 7
5. My painful memories prevent me from having a fulfilling life. 1 2 3 4 5 6 7
6. I am in control of my life. 1 2 3 4 5 6 7
7. Emotions cause problems in my life. 1 2 3 4 5 6 7
8. It seems like most people are handling their lives better than I am. 1 2 3 4 5 6 7
9. Worries get in the way of my success. 1 2 3 4 5 6 7
10. My thoughts and feelings do not get in the way of how I want to live my life. 1 2 3 4 5 6 7
Appendix D. SQ

The ACT group is a new addition to the CMHT Group Programme. We are still in the process of evaluating how useful it is and we would much appreciate your comments so we can improve and develop the programme. Please indicate to what extent each question is true for you by placing a tick in one box for each question.

<table>
<thead>
<tr>
<th>Question</th>
<th>No, definitely not</th>
<th>No, not really</th>
<th>Undecided</th>
<th>Yes, a bit</th>
<th>Yes, definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you think the group was pitched at the right level for you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did you feel supported in the group?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you feel you have gained something from the group?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Do you think the group has helped you to accept your difficulties?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you think the group has helped you to manage your life more effectively?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Overall, have you found the ACT approach helpful?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. After attending the group, do you now feel;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Alot worse □ Worse □ the Same □ Better □ Alot Better</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you feel worse, is this because of events outside of the group □ Yes □ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- If yes, would you mind telling us what they were?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. What did you find the most/least useful in the group?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Any other comments?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>
### Appendix E. Group means

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pre-Group</th>
<th>Post-Group</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Std. Deviation</td>
</tr>
<tr>
<td>HADS-D</td>
<td>13.5</td>
<td>5.36</td>
</tr>
<tr>
<td>HADS-A</td>
<td>15.83</td>
<td>3.25</td>
</tr>
<tr>
<td>AAQ</td>
<td>24.33</td>
<td>10.78</td>
</tr>
<tr>
<td>FFMQ Total</td>
<td>94</td>
<td>16.78</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subtests</th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Observation</td>
<td>20.17</td>
<td>6.11</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Describe</td>
<td>21.17</td>
<td>7.86</td>
<td>20.17</td>
</tr>
<tr>
<td></td>
<td>Act with</td>
<td>16.5</td>
<td>5.47</td>
<td>18.5</td>
</tr>
<tr>
<td></td>
<td>Awareness</td>
<td>20.83</td>
<td>5.71</td>
<td>18.83</td>
</tr>
<tr>
<td></td>
<td>Non-judge</td>
<td>15.33</td>
<td>3.5</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Non-react</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*(11 ≤ probable presence of psych. distress)*
Appendix F. FFMQ subscale scores

<table>
<thead>
<tr>
<th>FFMQ Subscale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe-1*</td>
<td>13</td>
<td>18</td>
<td>14</td>
<td>23</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Observe -2*</td>
<td>18</td>
<td>21</td>
<td>11</td>
<td>17</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Describe -1*</td>
<td>10</td>
<td>28</td>
<td>18</td>
<td>18</td>
<td>21</td>
<td>32</td>
</tr>
<tr>
<td>Describe -2*</td>
<td>9</td>
<td>29</td>
<td>14</td>
<td>21</td>
<td>17</td>
<td>31</td>
</tr>
<tr>
<td>Awareness -1*</td>
<td>15</td>
<td>25</td>
<td>12</td>
<td>10</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Awareness -2*</td>
<td>16</td>
<td>26</td>
<td>18</td>
<td>13</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>Non-judging -1*</td>
<td>31</td>
<td>24</td>
<td>16</td>
<td>18</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Non-judging -2*</td>
<td>19</td>
<td>27</td>
<td>9</td>
<td>19</td>
<td>22</td>
<td>17</td>
</tr>
<tr>
<td>Non-reactivity -1*</td>
<td>11</td>
<td>21</td>
<td>16</td>
<td>13</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Non-reactivity -2*</td>
<td>12</td>
<td>21</td>
<td>24</td>
<td>14</td>
<td>17</td>
<td>14</td>
</tr>
</tbody>
</table>

*1 = pre-group  2 = post-group
### Appendix G. SQ Results

<table>
<thead>
<tr>
<th>SQ Question</th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
<th>Participant 4</th>
<th>Participant 5</th>
<th>Participant 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you think the group was pitched at the right level for you?</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>Undecided</td>
<td>Undecided</td>
<td>Yes, definitely</td>
<td>Undecided</td>
</tr>
<tr>
<td>2. Did you feel supported in the group?</td>
<td>Yes, definitely</td>
<td>Yes, definitely</td>
<td>Yes, definitely</td>
<td>No, not really</td>
<td>Yes, definitely</td>
<td>Yes, definitely</td>
</tr>
<tr>
<td>3. Do you feel you have gained something from the group?</td>
<td>Yes, a bit</td>
<td>Yes, definitely</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
</tr>
<tr>
<td>4. Do you think the group has helped you to accept your difficulties?</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>Yes, definitely</td>
<td>Yes, a bit</td>
</tr>
<tr>
<td>5. Do you think the group has helped you to manage your life more effectively?</td>
<td>Yes, a bit</td>
<td>Undecided</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>No, not really</td>
</tr>
<tr>
<td>6. Overall, have you found the ACT approach helpful?</td>
<td>Yes, a bit</td>
<td>Yes, definitely</td>
<td>Yes, a bit</td>
<td>Yes, a bit</td>
<td>Yes, definitely</td>
<td>Yes, a bit</td>
</tr>
<tr>
<td>7. After attending the group, do you now feel*; *If you feel worse, is this because of events outside of the group?</td>
<td>Better</td>
<td>Worse *Yes</td>
<td>Different</td>
<td>Worse *Yes</td>
<td>Better</td>
<td>The Same</td>
</tr>
<tr>
<td>What did you the least useful in the group?</td>
<td>-</td>
<td>Mindfulness because still unsure of it.</td>
<td>-</td>
<td>Dug up issues from past, &quot;left me hanging&quot;</td>
<td>Maybe too academic.</td>
<td>Too much discussed in 1 session.</td>
</tr>
</tbody>
</table>
Appendix H. Anonymised Evidence of service feedback (Email)

Thank you Helena, and thank you for presenting it to the Locality Team.

wbw

Sarah

Dr. Sarah Jones
Consultant Lead Clinical Psychologist & Interim Therapies Lead
Adult Mental Health Services
NHS Foundation Trust
How is the NHS Socially Constructing Feeding Newborn Babies?

Qualitative Research Project Abstract

June 2010

Year 1
Objectives: This qualitative research study investigated how breast- and formula-feeding are presented in the National Health Service (NHS) literature for mothers, to see whether the two choices are differently constructed and positioned. Literature reviewed suggested discourses around newborn feeding have a powerful influence on how mothers socially construct themselves as mothers, and on the social actions they perform. So how is the NHS socially constructing feeding newborn babies?

Method: Prevailing discourses that may influence mothers' positions and responsibilities around infant-feeding were analysed in the ‘Feeding Your Baby’ section of a NHS information booklet (‘The Pregnancy Book’; Department of Health, 2009). Foucauldian Discourse Analysis was undertaken, as it addresses issues of power and ideology (Powers, 2007).

Findings: Dominant discourses found focused on the benefits of breast-feeding and the legitimacy of these (e.g. health benefits to the baby and mother, bonding/attachment between mother and baby, medical discourse), whilst degenerating formula milk feeding (Breast milk vs. formula milk, problem solving vs. threat). These discourses imply an action orientation where breast-feeding is superior, positioning the mother who does not breastfeed as doing so at the cost of her baby's physical and psychological wellbeing. A dichotomous subjectivity was identified (the moral breast-feeding mother vs. the amoral formula-feeding mother).

Conclusion/Implications: Despite the conflicting evidence as to whether breast-feeding is superior to bottle feeding from the perspective of physical and psychological wellbeing, it can be concluded from this study that NHS literature has taken a clear position that ‘breast is best’. The implications of the dichotomous subject positions around infant-feeding are discussed.
Coping with the Process of Forced Resettlement: A Qualitative Approach with Somali Refugee Young People and Front-Line Services

Major Research Project

June 2012

Year 3
I feel like you writing this... you never forget it, and you tell someone else...this is what happened, this is going on, and just think, it's not right, so you have to fix it... So the only thing that I'm going to say to the people is just, if we just hold our hands together, do help everyone, then we can fix the whole world, and no one can stop us.

Hassan (15 years old)
Abstract ......................................................................................................................... 136

Acknowledgements ....................................................................................................... 137

1. INTRODUCTION ......................................................................................................... 139
   1.1 Orientation to Thesis ............................................................................................... 139
   1.2 Overview .................................................................................................................. 139
   1.3 The Somali Refugee Experience ............................................................................. 140
   1.4 Mental Health in Refugee Young People and Engagement in Services .................. 141
   1.5 Limitations of a Narrow Research Focus on Understanding Mental-Health .......... 144
   1.6 Deeper Consideration of the Wider Context and Broader Understandings of Mental Health ................................................................................................................. 146
   1.7 An Alternative Conceptualisation of Refugee Young People’s Experiences: Ecology and Strengths ........................................................................................................... 151
   1.8 Summary and Current Study .................................................................................. 154

2. METHOD ...................................................................................................................... 157
   2.1 The Researcher’s Position and the Methodological Underpinnings ....................... 158
   2.2 Participants ............................................................................................................. 161
   2.3 Data Collection Methods and Materials ................................................................... 163
   2.4 Procedure ............................................................................................................... 164
   2.5 Data Analysis .......................................................................................................... 166
   2.6 Quality Assurance and Rigour ................................................................................ 167
3. RESULTS

3.1 Interviews

3.2 Theme One: Pre-migration: Threat as Ever-Present

3.3 Theme Two: Forced Resettlement as Affecting
Interpersonal Connections, Attachments, and Roles

3.4 Theme Three: Forced Resettlement as Negotiating
Difference: Struggles to Develop Sense of Self

3.5 Theme Four: Individual Coping Strategies:
‘Being Strong’ - Reframing for Control and Sense
of Agency

3.6 Theme Five: Coping within Relationships,
Communities and Contexts

3.7 Focus Group

4. DISCUSSION

4.1 Overview

4.2 Theme One: Pre-migration: Threat as Ever-Present

4.3 Theme Two: Forced Resettlement as Affecting
Interpersonal Connections, Attachments, and Roles

4.4 Theme Three: Forced Resettlement as Negotiating
Difference: Struggles to Develop Sense of Self

4.5 Theme Four: Individual Coping Strategies:
‘Being Strong’ - Reframing for Control and Sense
of Agency

4.6 Theme Five: Coping within Relationships,
Communities and Contexts

4.7 Implications for Clinical Practice, Service Development
And Policy
Abstract

Introduction: Somali refugees are one of the biggest refugee groups in the UK. Existing research suggests refugee young people are at increased risk of psychological distress and problems but under-utilise mental-health services. Despite these concerns, experiences of forced resettlement from Somali refugee young people’s and front-line services’ perspectives are under-researched.

Objective: This study aims to address the following research question with Somali accompanied refugee young people (SARYP): ‘How do accompanied refugee young people from Somalia negotiate and interpret the process of forced resettlement?’.

Method: A qualitative methodology employing semi-structured interviews was used. Four girls and one boy aged 13-19 years old, who had experienced forced resettlement from Somalia and were accompanied by a family member to the UK, were interviewed. The interviews were analysed using interpretative phenomenological analysis. A focus group was also conducted with four front-line service professionals who had experience of working with SARYP. The focus group was analysed using thematic analysis.


Discussion: Themes are discussed in the context of existing research and theory. Clinical practice, service development and policy implications,
limitations of the present study, and suggestions for future research, are also considered.

**Conclusion:** Findings suggest that whilst SARYP adopt active coping strategies in managing multiple adjustment difficulties throughout the process of forced resettlement, expression of their distress and their wish for support from others is concealed. The role of self-agency and availability of supportive others were central to facilitating coping for SARYP during this process.
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Anonymity

Names and details of the young people, professionals, and services in this project have been changed or removed to preserve all relevant parties' anonymity. This excludes the details of researcher, their supervisor, the charity and the interpreter, the last two of whom wished to be named.
1. **INTRODUCTION**

1.1 Orientation to Thesis

The UK hosts one of the largest Somali refugee communities in Europe. Somalia consistently remains in the top 10 of countries from which people are seeking asylum in the UK (Information Centre about asylum and refugees [ICAR] Briefing, 2007). From 2007 to 2008 applications for asylum in the UK had risen by 10 per cent, with the provisional number of citizenship decisions made in 2008 standing at 138,780 (‘2009 Global Trends’, Office of the United Nations High Commissioner for Refugees [UNHCR], 2010). 41% of the refugee population worldwide is under 18 years old (UNHCR, 2010).

Substantial research has suggested that the experiences of threats to safety, loss, and difficulties adjusting to a host country leads to increased risk of psychological distress and disorders in refugee children and young people\(^2\) (RYP) (e.g. Lustig *et al.*, 2004). Other research has found successful adaptation and low rates of psychological disorder symptoms (Silove, 2001). Many RYP do not access mental health services (MHS) (Michelson & Sclare, 2009).

RYP’s conceptualisations and meaning-making of their experiences remain under-researched, and may be important in helping to develop effective preventative and reactive services upon their resettlement in the UK.

1.2 Overview

This introduction will begin with a brief overview of current understandings of RYP’s experiences. Existing RYP mental health literature will then be reviewed and discussed, linking into a wider debate regarding conceptualisation of mental health, refugee experiences and MHS. Literature on Somali refugees will be drawn on throughout. Critique of the

\(^2\) From here on the term ‘young people’ will define both children and adolescents.
existing literature, and the gaps that the researcher believes to exist will be identified and a rationale given for the current study.

1.3 The Somali Refugee Experience

A refugee is defined by the Convention and Protocol Relating to the Status of Refugees (UNHCR, 2007, pp.6) as a person who;

"is outside his or her country of nationality...has a well-founded fear of persecution because of his or her race, religion, nationality, membership of a particular social group, or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country..."

Stages of Forced Resettlement to the UK – Contextualising Somali RYP’s experiences

Forced resettlement refers to the movements of refugees and internally displaced people as a result of armed conflict, persecution, or famine. Hart (2009) suggests that RYP experience three different transitions during forced resettlement: pre-migration, migration, and post-migration. Lustig et al. (2004) suggest refugees experience an insidious accumulation of numerous losses and threatening events across these experiences, with separation from family members common across the process of forced resettlement.

Somalia belongs to a region of the world which is plagued by political upheaval and civil wars (UNHCR, 2012). Since 1991 Somali has not had a central government, with conflict arising between the Transition Federal Government and Islamist insurgents in the central and southern regions. Around 146 million people are internally displaced, experiencing violations of human rights, xenophobia, lack of food, and violence (UNHCR, 2012).

Forced migration routes are predominantly via neighbouring countries Kenya and Ethiopia, with people often experiencing separation from family, poor living conditions, lack of security and discrimination. Further
separations are experienced on migrating to the UK, where upon resettlement (post-migration) refugees can experience adaptation difficulties to a new culture and language, loss of relationships and employment, widespread discrimination and poor living conditions (e.g. Lustig et al., 2004).

1.4 Mental Health in Refugee Young People and Engagement in Services

Hodes (2000) estimates up to 40% of RYP experience mental health problems. Post-traumatic stress disorder (PTSD) is the most researched, followed by anxiety and depression. When applying the most stringent criteria, 11% of RYP in Western countries were diagnosed with PTSD (compared to up to 50% if non-stringent), which is double the rate found in non-refugees (Ehntholt & Yule, 2006; Fazel et al., 2005). Comparable rates of anxiety and depression have also been found among RYP, ranging from 11% to 47% (e.g. Montgomery, 2010). Hepinstall et al. (2004) found that RYP’s depression was linked to resettlement stressors, whilst PTSD was linked to pre-migration events. Some RYP mental health difficulties have been found to endure over many years (e.g. Sack et al., 1999). However findings suggest substantial ethno-cultural variation in rates of mental health problems and RYP experience numerous symptoms which challenges the concept of a single disorder (Montgomery & Foldspang).

Risk Factors

Trauma Experiences

Large scale quantitative studies of Somali adult refugees in the UK and USA found a ‘dose-effect’ of cumulative traumatic experiences in the development of depression, anxiety and PTSD (Bhui et al., 2003; Jaranson et al., 2004; Halcon et al., 2004). These findings are consistent with the wider literature on refugees (e.g. Montgomery, 2010).
Resettlement Stressors

Bhui et al.'s (2003) research suggested that Somali refugees who had lived in the UK for longer experienced greater levels of mental health problems and suicidality than new arrivals. Secondary stressors in post-migration factors are associated with increased psychological distress (Ehntholt & Yule, 2006), depression (Sack et al., 1996), and PTSD severity (Ellis et al., 2008), and as equally important in predicting mental health problems as pre-migration factors (Schweitzer et al., 2006).

Family and Social Factors

De Haene et al. (2007) found that the family buffers or exacerbates the impact of trauma and resettlement experiences through relational processes (e.g. RYP’s mental health problems associated with parental trauma; Montgomery & Foldspang, 2006). Separation from caregivers has been associated with poor mental health outcomes (Derluyn et al., 2009).

Experiences of discrimination and difficulties with integrating and adapting to resettlement countries also impact on Somali RYP mental health (Ellis et al., 2010b, 2008). Discrimination is explored further in section 1.6.

Gender and Age

Somali refugees of an older age (early 20s) and/or female gender were found to have higher levels of social and psychological problems (Halcon et al., 2004). In contrast, Hodes et al. (2008) found greater PTSD symptoms with younger age. Somali girls have also been found to struggle more with discrimination and adjustment due to being more commonly seen as ‘keepers of culture’ (Ellis et al., 2010b).

Engagement in Mental Health Services

Interventions Offered

Within the MHS, RYP are often offered interventions which are evidence-based on settled Western populations of young people (e.g. Cognitive Behavioural Therapy). Evaluative research on the adequacy and efficacy of
these for RYP is limited, with existing studies utilising small sample sizes and few randomised controlled trials (e.g. Ehntholt & Yule, 2006).

**Barriers**

Low numbers of Somali refugees are accessing UK MHS (Palmer, 2006), with underutilization found in RYP in general (Hodes, 2000). Numerous factors have been suggested in research, such as language barriers, and stigma (e.g. Murphy et al., 2002; Tribe, 2002), however barriers remain largely non-understood.

Lack of cultural fit of MHS with RYP in terms of access and expression of mental health has often been cited (Barenbaum et al., 2004; de Anstiss et al., 2009). Smith et al.’s (2011) meta-analytic review found that culture-specific adaptations were four times more effective than multi-ethnic generalised approaches, suggesting culture has substantial impact on ways of managing mental health.

Ellis et al. (2010a) mixed methods study with Somali RYP demonstrated a tension between Somali RYP’s strategies in seeking help for emotional difficulties (focusing on school and friends who linked up to MHS) and the Somali community seeking help for behaviours that conflicted with religious and cultural values (through family and religious leaders). Fear of being negatively stereotyped due to the rapid sharing of verbal information in the community, and a fear of not being understood, meant that many RYP in this study chose to conceal their problems. However some were receptive to counselling at school by non-mental health professionals, with help from MHS conveyed as outside of their cultural norms. Additional barriers identified were the lack of cross-over between the community and school in linking RYP to support, with divergent views on what would be helpful.

There is therefore a potential lack of match between the priorities and interventions of MHS and the different stakeholders in refugee populations. The feasibility and usefulness of clinic-based MHS has been questioned by
Miller (1999). Flexible multi-agency working has been found to increase engagement in and acceptability of MHS, supporting RYP’s broader needs in school-based projects (e.g. Chiumento et al., 2011). Despite their suggested integral role, only two studies (in the researcher’s knowledge) have explored front-line service professionals’ (e.g. educational and charity staff) experiences and perspectives (Arnot et al., 2009; Yohani, 2010).

1.5 Limitations of a Narrow Research Focus on Understanding Mental Health

The Problem-Focused Biomedical Model

Positivist epistemology asserts that mental illness is trans-cultural, whereas social constructionist perspectives asserts that it is culturally-specific, focusing on the cross-cultural variation (de Anstiss et al., 2009). Minas and Silove (2001) suggest that cultural factors pervade all levels of mental health, from conceptualisation and manifestations to community responses and help-seeking approaches.

Conducting a literature review revealed how research into the experiences of refugees is dominated by a focus on trauma, in particular PTSD. A number of studies have highlighted the importance of a diagnosis of PTSD in understanding and treating young RYP (e.g. Hodes, 2000). Other literature criticises the PTSD framework for being over-simplistic and culturally inappropriate (Montgomery & Foldspang, 2006). Whilst reviews have suggested evidence for cross-cultural validity for PTSD (e.g. Hinton & Lewis-Fernandez, 2010), variability in symptoms, the individual focus, the ignoring of trauma cultural expressions and the totality of a person’s experiences are still proposed as issues with this conceptualisation (Miller & Rasco, 2004).

Psychological and psychiatric research investigating refugees’ experiences has been criticised as being “…based largely on a western biomedical model which focuses on the psychological sequelae of trauma”, which does not allow for descriptions of post-traumatic growth, resilience, or more
developmental understandings of trauma (e.g. Khawaja et al., 2008, pp.490). Yule (2002) emphasises that many RYP demonstrate good adjustment.

This calls into question the suitability of the dominant individualist, professionally-defined biomedical models in mental health research and practice with the refugee population. Their underrepresentation in the NHS MHS may reflect refugee communities' differential conceptualisations of their experiences of transition, resettlement and distress (Webster & Robertson, 2007). In trauma research RYP are often: "...portrayed as passive recipients only, and not as active survivors" (Summerfield, 1999, p.1456). MHS and research can potentially perpetuate power hierarchies through focusing on symptom amelioration, which undermine the strengthening of community and traditional sources of support and resilience (Miller & Rasco, 2004; Summerfield, 1999). A report by Harris (2004, pp.13) on the Somali community in the UK critiques existing research:

"The agenda...is determined from the outset - to identify difficulties and suggest solutions...Somalis are presented in terms of the obstacles they face, as 'problems', or victims of circumstance. Indigenous Somali culture expects a high degree of self-reliance from both men and women within the context of accepted relationships of authority, so this investigative angle flies in the face of an ideal Somali self-perception rather than acting as an agent of empowerment."

Therefore greater attention needs to be paid to cultural contexts and beliefs regarding mental health and well-being (Lustig, 2010) so as to not provide interventions which conflict with pre-existing coping strategies (Jeppsson & Hjern, 2005).

**Quantitative Methods**

Studies are dominated by the use of positivist quantitative methodologies (due to their biomedical and psychopathological orientations; Silove, 2001),
which make a-priori assumptions about which variables are relevant to assess, and do not explore the processes by which refugees interpret, negotiate and utilise these variables. Whilst these studies have been useful in examining some factors relevant to refugees’ experiences (e.g. socio-economic factors relationship with psychological disorders; Hodes et al., 2008) they provide only a narrow description of complex phenomena.

Cross-cultural validity of measures have also been called into question, with Western values and norms, difficulties with language, category fallacy and non-equivalence of concepts affecting their utility, validity and reliability (Hollifield et al., 2002; Tempany, 2009). Therefore reliance on quantitative methods in developing our knowledge of how to understand and support refugees’ experiences in our mental health practice is limited.

**Time Periods Explored**

Research predominantly focuses on the pre-migration or post-migration phases, ignoring the temporal nature and transitional factors inherent in refugee experiences (Khawaja et al., 2008). Lustig et al. (2004) proposes that each phase has its own set of challenges. Pre- and post-migratory stressors can create a ‘dose-effect’ in developing mental health problems (Montgomery, 2010; Silove et al., 2005), with new adverse experiences potentially re-triggering earlier traumatic experiences and challenging coping strategies (Pynoos et al., 1999). Fazel et al. (2011) therefore stress the importance of understanding RYP’s experiences as a whole and a process rather than an event.

1.6 A Deeper Consideration of the Wider Context and Broader Understandings of Mental-Health

**Adjustment and Acculturation**

Ellis et al.’s (2008) US quantitative study with 135 Somali RYP found that perceived discrimination, acculturative and post-migration stressors were all associated with PTSD symptoms. These factors need to be considered for RYP to benefit from psychological therapies.
The most commonly referred to theory in refugee research, following biomedical conceptualisations, is acculturation theory (changes in two cultural groups when they make contact with each-other; Berry, 2001). Studies with RYP often used highly structured interviews, focusing on post-migration experiences, and heavily drawing from acculturation theory to interpret how they have adapted to life in their resettlement country (Poppitt & Frey, 2007; Gibson, 2002). Many studies have indicated that adjustment to a new culture through integration is the most adaptive, whilst marginalisation is the least (e.g. Sam & Berry, 1995). Research suggests that RYP acculturate faster than their parents, which can place strain on the family and contribute to experiences of acculturative stress (Lustig et al., 2004).

However, acculturation theory has been criticised for oversimplifying experiences of ethnic minorities by relying on a-priori assumptions about cultural difference rather than the careful study of the populations involved, and ignoring wider socio-economic factors and processes beyond culture (Hunt et al., 2004). The host cultures themselves can also consist of multiple fluctuating communities (Kovacev & Shute, 2004). For example, Polck et al. (2010) found differences in perceived discrimination between immigrant groups depending on the host society’s hierarchy of favoured groups (e.g. due to cultural similarity and visibility). The majority of acculturation studies also focus on behavioural acculturation, providing a narrow picture of multidimensional biculturalism (Schwartz et al., 2010). Schwartz et al. (2010) suggest that acculturation should be conceptualised as multilevel, with perceptions of the refugees, the immigration history of the resettlement country, and degree of discrimination experiences also heavily impacting on acculturative stress.

**Discrimination, Belonging, Gender and Identity**

Somali RYP experience discrimination against multiple levels of their social identity, and are particularly targeted compared to other ethnic groups
(especially girls) due to their refugee status, Muslim faith, gender roles and black ethnicity (Dion, 2001; Ellis et al., 2008).

Two quantitative US studies with Somali RYP found that discrimination was associated with poorer mental health outcomes, and depression in particular (Ellis et al., 2010b, 2008). Ellis et al.'s (2010b) mixed-methods study found gender differences, with reduced discrimination and mental health problems experienced by girls through greater acculturation with Somali culture (e.g. wearing the headscarf as an act of claiming Muslim identity), and the boys experiencing the same outcomes through greater acculturation with American culture. Further gender differences were found by Guerin et al. (2003), where Somali girls appeared to experience more difficulties through feeling more divided between the two cultures.

Ellis et al.'s (2010b) study suggests that personal meaning-making of their social identity moderates the correlation between mental health and discrimination. Acculturation and post-migration stressors are suggested to complicate the achieving of normal adolescent developmental tasks (i.e. a cohesive sense of identity), with Valentine and Sporton's (2009) qualitative study with 50 Somali RYP finding self-identity positions varied according to context and time (e.g. 'British', 'Somali' and 'Muslim'). Sense of identity is therefore suggested to be a fluid central tenant in RYP's experiences.

Kia-Keating and Ellis' (2007) US quantitative study of 76 Somali RYP found that sense of school belonging was associated with greater self-efficacy and lower rates of depression. Other longitudinal studies with RYP have similarly found social inclusion a significant predictor of psychological well-being, with existing literature criticised for not considering the influence of the host society's broader social structures (Correa-Velez et al., 2010). Therefore existing research frequently fails to take an inclusive view of internal, social and political factors and processes that impact RYP's lives, adjustment and mental health.
Family and Attachment

Changes in family structure are experienced across the process of forced resettlement. Whilst the importance of family environment in psychosocial adjustment and mental health outcomes has been well documented (e.g. Lustig et al., 2004), only a few studies have explored the processes involved in moderating its emotional regulator role (De Haene et al., 2010a).

De Haene et al. (2010a) proposes that the cumulative experiences of forced resettlement may lead to a long-term activation of RYP’s attachment systems, which may or may not be deactivated by caregivers depending on separation or their own emotional difficulties. Attachment styles have been suggested to have a pervasive affect on relationships with in-groups and out-groups (e.g. Mikulincer & Shaver, 2001), perspectives on acculturation (Hofstra et al., 2005) and social and coping styles (e.g. Cooper et al., 1998). Attachment theory therefore could be helpful in understanding RYP’s experiences. However, only two published studies explicitly explore attachment in refugee families.

McMichael et al.’s (2011) Australian mixed-methods longitudinal design found that trust, attachments, discipline, and conflict challenged refugee family life. Gender differences were found in family attachment tendencies (girls’ decreasing) and experiences of discipline (greater in girls). Overall McMichael et al. (2011) found that the family supportive context weakened over time upon resettlement.

Somali Cultural Understandings of Mental Health

Johnsdotter et al. (2011) and Guerin et al.’s (2004) qualitative research with Somali adult refugees in Sweden and America suggested severe mental illness is perceived as shameful and stigmatising, with fear of community rejection due to an oral culture where verbal information is circulated quickly. Participants identified spiritual possession and psychosocial stressors (e.g. separation from family members) as causing mental health problems, disregarding biological causes. Mental health professionals and
Somali refugees suggest a non-equivalence of psychological childhood disorders or Western mental health classifications of depression, anxiety and PTSD in Somali culture (e.g. Davies & Webb, 2000).

Traditional Somali classifications of mental health were found to be more fluid, connected to social, community and transcendental events, and with a focus on healthy qualities rather than absence of illness (Guerin et al., 2003, 2004). Only the concept of 'waali' (crazy/not feeling themselves) was seen as needing professional MHS. Traditional coping strategies therefore revolve around social and familial networks, prayer and Koranic readings, with suspicion of the individual-focus of MHS. Social networks hold the power to promote or complicate psychological well-being (Jorden et al., 2009; Palmer, 2007). Whittaker et al.'s (2005) UK qualitative research with Somali refugee young women found themes that emphasized resilience, strength, concealment and distancing as valued ways of coping with psychological distress. They reported cultural norms around not burdening others and fears regarding confidentiality in the community.

Cultural beliefs and practices therefore pervade identity-making, help-seeking, psychological processes and coping strategies, with variation of beliefs and practices varying between and within groups and individuals (de Anstiss et al., 2009; White & Lehman, 2005). Somali RYP's relationship with these processes requires further exploration.

**Summary**

Much research on the above areas have been criticised for presenting them as categorical variables, whilst underlying belief systems and constructions have been neglected (Tribe, 2007). Therefore a broader way of conceptualising RYP's experiences is suggested.
1.7 An Alternative Conceptualisation of Refugee Young People’s Experiences: Ecology and Strengths

A growing area of literature on RYP’s experiences draws on ecological approaches based on Bronfenbrenner’s (2005) developmental theory of multilevel systems of interactions (Figure 1). Lustig (2010) proposes that each level of development can be threatened for RYP, such as experiencing separation from parents (microsystem), fragmentation between mesosystems they actively participate in (e.g. school and family), refugee parents’ experiences of social policies (exosystem), and cultural beliefs and individualist host societal ideologies (macrosystem). Therefore normal RYP development within these systems can be disrupted by forced resettlement, with acculturative stress felt across multiple systems. This theory suggests greater consideration of broader beliefs and factors is more likely to capture and attend to the complexities of RYP’s experiences, rather than reducing them to purely a matter of mental health (Summerfield, 2000).

Health pluralism, which encapsulates individuals’ and communities’ multiple, wide-ranging beliefs and coping strategies, is therefore suggested (Tribe, 2007). There is a call to adopt “more complex, holistic and ecological models...for mental health and well-being” (Khawaja et al., 2008, pp.491) when conducting research with this population, with greater consideration of RYP’s strengths, resources, values and beliefs.
Strengthes, Resilience and Coping

Literature suggests resilience, coping, and positive adaptation are neglected areas of research in RYP (de Anstiss et al., 2009). Rutter (2003) emphasises that many RYP cope well, with Rousseau et al. (2003) finding positive psychosocial adjustment in RYP despite traumatic experiences. Consideration of post-traumatic growth (qualitative and transformative positive psychological change), resilience (withstanding pressures and retaining values and qualities), and coping (active efforts to regulate emotions and manage environment) creates a foundation for strengths-focused practice, rather than dysfunction, in supporting positive adjustment to negative life circumstances.

For example, cultural characteristics such as religion, family support in valuing hope, respect, and moral attitudes, were associated with high levels of post-traumatic growth in a Hungarian quantitative study with Somali adult refugees (Kroo & Nagy, 2011). Coping mechanisms and resilience can
therefore be considered across individual (e.g. belief of influence over environment; Ripley, 2008), family (e.g. communication and belief systems; Walsh, 2006), and community levels (e.g. “networked adaptive capacities”; Norris et al., 2008, pp.131), and also as context-dependent (e.g. culture; Ni Raghallaigh & Gilligan, 2010). Although many coping processes overlap, for clarity they have been divided into the following areas:

**Individual**

Active coping styles through re-framing of experiences through normalisation, survivor self-perceptions, and recognition of strengths have been found in qualitative research with refugees (e.g. with Sudanese UAMs; Goodman, 2004). Similarly, Ellis et al.'s (2010a) study found that Somali RYP wished to maintain a sense of agency and integrity over their difficulties. Comparison with others less fortunate, positivity, suppression of memories and internal experiences, and a selective focus on the future (e.g. on education) is suggested by adult and young refugees as a way of securing a sense of purpose, hope and perseverance across the process of forced resettlement (Goodman, 2004; Ni Raghallaigh & Gilligan, 2010; Schweitzer et al., 2007).

Religious belief systems have been found to contribute to resilience (Walsh, 2003), and associated with reduced social and psychological problems in a US quantitative study with Somali adult refugees (Halcon et al., 2004). 50-75% of participants found prayer helpful in managing sadness. Schweitzer et al.'s (2007) qualitative research with Sudanese adult refugees found that religion provided a sense of control, a way of meaning-making, and making social connections.

**Family and Community**

Quantitative research suggests increased support and flexibility from multiple cultures, community, and family, and culturally-integrated friendships as protective for RYP against acculturative stress and psychological problems for up to 9 years following resettlement (Bhui et al.,
2003; Montgomery, 2008; Padilla, 1980). Coping through collective meaning-making of experiences, maintaining continuity of culture, and a communal sense of responsibility has been reported by UAMs (Goodman, 2004; Ni Raghallaigh & Gilligan, 2010; Rousseau et al., 1998).

1.8 Summary and Current Study

High rates of mental health problems in RYP have been found, with trauma, depression and anxiety the most researched (e.g. Hodes, 2000). However, evaluation of the effectiveness of MHS interventions offered is limited (Ehntholt & Yule, 2006) and engagement in MHS remain low (Palmer, 2006), with community resources potentially more suitable.

A review of the literature suggests that a dominance of biomedical problem-focused research that informs service development lacks cultural fit with Somali refugees, who are suggested to focus on social and interpersonal influences on psychological well-being (Johnsdotter et al., 2011). Existing research of RYP mental health and experience remains narrow, often neglecting wider adjustment, familial, societal and ecological processes (Miller & Rasco, 2004), and only focusing on particular stages of resettlement rather than RYP’s experiences as a whole (Khawaja et al., 2008). Exploration of strengths, resilience and coping, which aligns more with reports of RYP self-identities as active agents (Goodman, 2004), are under-researched in RYP populations, despite calls for more holistic approaches (Davies & Webb, 2000).

Study Aims

- To allow Somali accompanied RYP (SARYP) to inform others of their meaning-making of experiences salient to them across pre-migration, migration, and post-migration stages of forced resettlement to the UK, unconstrained by a-priori beliefs.
• To explore the psychological and social processes SARYP used to manage or cope with the difficulties they experienced, drawing on existing theories.

• To improve understanding of SARYP views to inform the development and acceptability of community and NHS MHS services (Miller & Rasco, 2004).

Quantitative studies suggest numerous moderating risk and protective factors across the process of forced resettlement (Derluyn et al., 2009). However, Somali RYP have been given little opportunity to express what themes and actions they themselves feel has been important to their psychological well-being, coping and adjustment; to explore the role of meaning-making in their understanding of their experiences; or to describe the processes by which they manage the phenomena of resettlement. This is an issue raised repeatedly in existing research (e.g. McMichael et al., 2011). Therefore a qualitative methodology was chosen for this study as it allowed for a wider exploration of their experiences, and sensitivity to the Somali oral culture (Johnsdotter et al., 2011).

Existing qualitative research has begun to address the limitations discussed, predominantly using adult (e.g. Schweitzer et al., 2007) or UAM (Goodman, 2004) samples. Accompanied RYP’s voices appeared to be lost in family/parent research (e.g. Prilleltensky, 1993), despite research suggesting parent perspectives on RYP’s psychological distress and management as substantially different from RYP’s (Ellis et al., 2010a). Accompanied RYP experience high levels of psychological distress and disorders (e.g. Heptinstall et al., 2004). However, the potential protective function of arriving to the UK with a family member appears to have overshadowed the need to explore these RYP’s perceptions and experiences more inclusively.

Research suggests separation from particular family members (especially mothers) can lead to greater risk of mental health problems (especially in
girls; Derluyn et al., 2009). Parent migration before the young person can lead to confusion and sense of abandonment, impacting on how they perceive relationships (Dogra et al., 2010). Also arriving with a family member itself is not necessarily protective against psychological distress (Ellis et al., 2008). Such nuances in separation and experiences are being overlooked in the literature, with authors critiquing their family studies for not gaining a more in-depth qualitative understanding of how RYP perceive these experiences (e.g. Derluyn et al., 2009).

In addition relatively few studies have explored cultural dimensions of meaning-making in RYP experiences (Goodman, 2004). As reviewed above, culture pervades multiple levels of refugee experiences. Culture is not static however, with Silove et al. (2005) suggesting practices alter as they interact with each other and also engage with other identity factors such as age. Therefore further research on RYP’s experiences as separate from adults is required (de Anstiss et al., 2009). Culture- and age-specific research is important in engaging with important nuances of refugee experiences, with Ellis et al. (2010a) arguing that few MHS models include cultural knowledge and ways of healing. Caution is expressed in generalising across cultures and from existing research on ethnic minorities and immigrants (De Anstiss et al., 2009; Fazel et al., 2011).

Only a few studies to date have qualitatively explored aspects of psychological well-being from Somali RYP’s perspective (Ellis et al., 2010a & b). These had a specific focus on exploring help-seeking, mental health, and discrimination in the post-migration stage in the USA. With the Somali refugee community becoming one of the largest in the UK (ICAR, 2007), research with this population seems imperative in informing services of how to sensitively respond to their psychological and social needs (Miller & Rasco, 2004).
• To contextualise SARYP accounts by exploring how they resonate with front-line services' beliefs and practices.
• To explore the usefulness of the findings to front-line services.

Despite the acknowledgement of charity and educational services role in engaging and supporting RYP (e.g. Howard & Hodes, 2000; Miller & Rasco, 2004), and a call for research that combines RYP’s and such service professionals' perceptions (e.g. Poppitt & Frey, 2007), there is a paucity of research exploring their experiences and practices. Only a few studies have adopted an ecological approach in researching key stakeholders views with SARYP (e.g. Valentine & Sporton, 2009). Whilst the SARYP voices will be privileged in this study, a focus group with professionals from different front-line services was also conducted to triangulate their accounts. The focus group aimed to understand how wider social, cultural and ecological factors may influence the SARYP’s experiences, and to explore how SARYP’s perceptions of forced resettlement and support converged and diverged from the services that support them.

Research Question
‘How do accompanied refugee young people from Somalia negotiate and interpret the process of forced resettlement?’

2. METHOD

Figure 2. Diagrammatic representation of research process.
2.1 The Researcher’s Position and the Methodological Underpinnings

The Epistemological and Ontological Position

The researcher adopted a critical realist position (Bhaskar, 1977) in this study, where knowledge is perceived as fluid and ever changing. This position asserts that a definitive causal relationship of a phenomenon cannot be established due to the interaction between a materially present natural world, and the ever-changing constructions of a social world. Critical realists acknowledge the co-existence of a ‘material reality’ and human agency, where ‘social reality’ is construed through the personal meanings individuals attribute to their experiences and influenced by internal psychological factors, as well as by broader social, cultural, and political contexts. Language is assumed to reflect people’s experiences and the meanings attributed to them (Potter & Wetherell, 1987).

SARYP Interviews - Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is a qualitative method that aims to explore how participants interpret and make sense of their experiences of the world (phenomenology). It is interested in the individual’s perception of an event or significant experience rather than an objective statement about it (hermeneutics). It adopts an idiographic approach in that it aims to capture in detail the quality of an individual’s experience and an understanding of the meanings they attribute to it, before proceeding to explore similarities in the themes and patterns across individual subjective experiences (Smith et al., 2009).

IPA involves an analytic process by which internal processes are deduced from the participants’ verbal accounts, with the assumption that there is a relationship between participants’ cognitions, accounts and behaviour. The researcher acknowledges and accepts that analysis is ‘interpretative’ as direct access to participants’ life worlds is impossible (Smith et al., 2009).
IPA was considered the most suitable method to address the main research question given its specific focus and emphasis on phenomenology. It allows the researcher to gain detailed and meaningful accounts of SARYP’s experiences of forced resettlement, how they coped, and their appraisal and interpretation of their experiences. IPA is considered suitable for addressing questions around how individuals “perceive and understand significant events in their lives” (Smith & Eatough, 2007, pp.36). As there were likely to be differences between the researcher and the SARYP in regards to culture, gender, age and ethnicity, it was also important that the analytic process acknowledged the dynamic relationship between them, as allowed by IPA (see ‘About the researcher’).

**Focus Group – Thematic Analysis**

Focus groups elicit group-level themes based on quotes drawn from an interactive context. Therefore the idiographic approach of IPA is often deemed unsuitable for focus groups (Tomkins & Eatough, 2010). Instead Thematic Analysis (TA; Braun & Clarke, 2006), based on the same epistemological and ontological position as IPA, was used to analyse the focus group data to organise and richly describe themes. TA allows the researcher to explore social interpretations of the data in addition to psychological interpretations, and yields “qualitative analyses suited to informing policy development”, in keeping with an ecological approach (pp.97, Braun & Clarke, 2006). See Appendix A for more in-depth discussion of TA in this study.

**About the Researcher**

Reflexivity within research is of high importance to critical realists, with reflection of the researcher’s own perspective and position believed to shape interpretative processes, and how research progresses:

I am a 28 year-old white, British female with no personal experience of forced resettlement. However, I am the second generation of Polish refugees from World War II, and have grown up hearing the childhood experiences
of my grandparents’ forced resettlement to the UK, and in the ways and values of both British and Polish cultures. Having always admired my grandparents’ resilience, I have a particular interest in understanding how young people from different cultures process and adapt to such experiences, from a position contextualised by their cultural beliefs.

I have never experienced financial insecurity or an overwhelming lack of environmental mastery, but have been raised to not take these for granted. It is possible that I hold overlapping or diverging perspectives to the SARYP I interviewed in this study, and was therefore careful to remain curious of the processing and meaning-making they accorded to their experiences. I had an assumption that SARYP would feel proud of their cultural roots and was surprised in the interviews to hear them viewed as something they were bullied for and therefore to be concealed. I wondered how they managed this experience.

I worked in East Africa with marginalised young people as a NGO Counselling Assistant for a year before training. This made me aware of the multiple complex factors that can influence young people’s experiences and perceptions of the world around them. Societal attitudes and religious beliefs deeply influenced ways of understanding and supporting these young people, and I was left wondering if these would be the same for the SARYP. I began to question the suitability of some Western models of care in the context of more community-based cultures, noticing the resilience and personal/community resources so important to the young people were often not given prominence in Western approaches. This influenced the choice of method and analysis for this study, with the wish to promote SARYP’s voices in conceptualising and understanding their own experiences without making a-priori assumptions.

Contrary to potential expectations, I found all of the SARYP gave detailed and frank accounts of their experiences. I thought about how my being from a different cultural heritage and external to the services they engaged in
might have meant I was easier to confide in. I feel my previous experiences of working cross-culturally with young people helped me express genuine curiosity and own my cultural naivety, adapting my interviewing style and language use to respond to the ages and experiences of the participants.

During the process of completing this study I began working in a Children Looked After Team and undertook a week’s training in narrative therapy. I read literature around attachment, resilience, narrative and community psychology, coping, and child development, and had to be careful of the potential influence of this during the analysis stages. However, rather than this awareness of wider literature being a bias, I perceived this as helping me to listen closely to what the SARYP were saying rather than jumping to problem-focused conclusions, and helped me draw on theory when discussing the results.

During the focus group I was surprised by the how the professionals’ understanding of SARYP’s experiences juxtaposed with their lack of confidence in being able to support them appropriately. I was therefore mindful of how my training in theory- and research-informed practice increases confidence in working with vulnerable groups which may differ from other professional’s experiences, which in turn may affect the SARYP’s experiences of support from front-line services.

2.2 Participants

**Sampling and Recruitment**

For the interviews purposeful sampling was conducted identifying SARYP with refugee status and UK citizenship (living in the UK for 1-6 years), aged 10-19, who had experienced accompanied forced resettlement to the UK. Recruitment was conducted via the charity Salusbury WORLD, which provides support for RYP and their families in London (see Appendix B for information on the charity). Charity staff disseminated information about the research to parents and SARYP via information sheets (Appendices C
and D). SARYP then made themselves known to the researcher via the charity staff, with the parents’ agreement.

The inclusion criteria of length of time in the UK had been stipulated to ensure participants were resettled in the UK for a period of time in which allows for reflection back on their pre-migration, transitional, and post-migration stages of forced resettlement. UK citizenship was also specified to ensure homogeneity and relative safety in living status in the participant group. The process of seeking asylum has been identified as a distressing and uncertain time for refugee groups, where securing legal status is determined by the consistent presentation of their life histories (De Haene et al., 2010b), therefore possibly influencing the quality of responses to, and moral ethics of research interviews in this time period.

Anyone who the charity staff felt would find the experience too distressing, or who was accessing NHS MHS, were not recruited for the study. It was thought that involvement with MHS might influence the way the SARYP talked about their experiences, and the researcher was interested in looking at how SARYPs who were not receiving MHS support were making sense of and coping with their experiences.

**Situation of the Sample**

In total, five SARYP were interviewed out of 11 potential participants who had indicated that they would be interested in taking part. This reduced number reflects a range of complex experiences faced by this population (e.g. school refusal, and parents’ wish to protect their children), potentially indicating how difficult and rare a participant group this is to access for research.

All of the SARYP had come from the southern and central regions of Somalia and were of Muslim faith. The SARYP were living with all immediate family members at the time of interview. Table 1 provides further demographic information to help situate the participants.
Table 1. Demographic details.

For the focus group, the four participants consisted of teaching, charity and NHS MHS professionals. See Appendix A for further information on sampling, recruitment and situation of the front-line service professionals in the focus group.

2.3 Data Collection Methods and Materials

The SARYP Interviews

Semi-structured interviews were used as they allowed flexible dialogue and probing in exploring the SARYP’s responses (Smith & Osborn, 2008). They are considered an appropriate method for the qualitative method chosen and the age range of the participants (Smith et al., 2003; Smith et al., 2009). The interview schedule (Appendix E) was adapted from one used in an IPA study of adult Sudanese refugees’ experiences of forced resettlement, which was published in a peer-reviewed journal (Khawaja et al., 2008). Their aims overlapped with that of the current study with the only difference being in the age and nationality of participants.
The interview schedule was adapted following consultation with charity staff, and refugee parents and RYP from Somalia, to be culturally and contextually appropriate for the participants in the proposed study (e.g. removal of tribe as a demographic category due to sensitivity regarding clans in the community; Appendix F). This helped to ensure the interview schedule was community-informed and therefore upholding benefit-oriented research processes as advised by De Haene et al.’s (2010b) ethical recommendations for conducting qualitative research with refugee populations. Participants provided positive feedback stating that they valued the opportunity to tell their stories and had felt listened to and understood.

Focus Group
Information on the focus group data collection method and materials can be found in Appendices A, G, H, I and J.

2.4 Procedure
Interviews took place over a period of 8 months, lasting between 39 and 55 minutes. They took place in the participants' school where the charity also operates. The interviews were audio-recorded. Prior to the interview, informed consent was obtained from the parents (Appendix K) and the SARYP (Appendix L). Demographic information was collected from the participants and charity staff (Appendix F). All of the participants were given a debrief sheet following the interviews (Appendix M). The charity staff were aware that the interviews had taken place so could monitor the SARYP’s well-being.

The focus group was conducted following analysis of the SARYP interviews (see Appendix A for further information on the focus group procedure).

Use of Interpreter
Interviews in past qualitative research with refugees from the Horn of Africa have predominantly used English, with the option of having an interpreter present if the participant wishes (e.g. Goodman, 2004). The majority of
participants in these studies did not take up this offer. However, for the purpose of the proposed study, the presence of an interpreter was offered. Of the five participants, two requested interpreters as ‘back-up’. They were determined to carry out the interview in English but needed help in translating some specific words or concepts. The interpreter also acted as a cultural broker and a cultural consultant in discussions following the interviews (Raval, 2005).

The interpreter was not known to participants as advised by Jentsch (1998) to uphold confidentiality, which is suggested to be a concern in Somali populations (Whittaker et al., 2005), and to increase validity of translations. A half an hour session was organised with the interpreter prior to the interviews to brief her on the purpose of the study and the interview format. It also helped the researcher to gain a clearer understanding of the experience of the interpreter and to discuss the models of interpreting.

**Ethical Considerations**

Ethical approval was obtained from the University of Surrey Faculty of Arts and Human Sciences Ethics Committee (Appendix N). Permission to access the school was also granted by the head-teacher.

**Minimising Distress**

The researcher was aware of the potential vulnerability of the group studied. Whilst for some SARYP it may be a relief and empowering to talk about their experiences (De Haene et al., 2010b) for others it may have become distressing. De Haene et al.’s (2010b) paper on ethical qualitative research with refugees was used to optimise benefit-orientated and distress-minimising research processes for the participants. De Haene et al.’s (2010b, pp.1665-1666) advice was therefore incorporated in developing the procedure of the research to include:

"...the community-informed development of research questions, a processual care of informed consent, an emphasis on researcher's
subjectivity and engagement in all phases of the study, and a community-oriented dissemination and validation of findings.”

During the interviews the SARYP were offered the option of having an appropriate adult present in the room; however this was not requested by any of the participants. Verbal checks of their distress were used throughout the interview, and a ‘safe word’ agreed for the SARYP to use without any need for explanation to terminate the interview.

Anonymity and Confidentiality

The limits of confidentiality were explained to the SARYP, where if any harm to self or others were disclosed a pre-arranged procedure (agreed with the charity) would be actioned. This involved the researcher alerting charity staff so they could carry out their safeguarding procedure. On only one occasion did the researcher need to put this process in place, with the SARYP’s awareness, however the issue was resolved without the need for further formal safeguarding procedures.

The necessity for confidentiality and anonymity was also explained to the focus group participants (Appendices G and H), and the interpreter before the interviews take place (Appendix O). A Confidentiality Agreement was signed by the interpreter (Appendix P). Anonymity was sought throughout the study. Real names were only present on the consent forms, which were only seen by the researcher. All identifiable names and information were changed so that participants could not be identified from their interview or focus group contribution. All of the information was stored in accordance with the Data Protection Act (1998).

2.5 Data Analysis

The SARYP Interviews

The audio recordings were transcribed verbatim and analysed using IPA guidelines from Smith et al. (2009). The written transcripts were individually analysed descriptively with fore-knowledge ‘bracketed off’
(discussed further in section 2.6) following multiple listening to each interview’s audio to immerse in the data.

Initial coding highlighting areas of interest, both descriptive and interpretative, were made for each transcript. Possible emergent themes were then described and noted, capturing the researcher’s interpretations of the connections between initial codes and descriptions and therefore creating a deeper level of conceptual understanding and abstraction (Smith et al., 2009). See Appendix Q for three examples of sections of the annotated transcripts. The emergent themes were then examined and arranged into interpreted meaningful clusters to form super-ordinate (or master) and sub-themes for each transcript. Possible connections between, and several revisions of, the themes were conducted by the researcher, to ensure the themes were grounded in the data and confidence in the master themes was reached.

Patterns in themes across the five transcripts were then sought by comparing the theme lists for each interview, identifying master themes and sub-themes, and recognising new or contrasting themes. Finally a consolidated list of main themes and corresponding sub-themes was developed to reflect the experience of the group.

Focus Group
Description of TA of the focus group data, and examples of the transcript and theme clustering, can be found in Appendix A, R and S.

2.6 Quality Assurance and Rigour
Several guidelines are offered for assessing quality and credibility in qualitative research (e.g. Elliott et al. 1999; Yardley, 2000, 2008). They suggest that the following quality assurance principles should be considered:
**Respondent Validation**

In order to ensure the researcher had interpreted participant accounts appropriately and to enhance credibility, the themes were relayed back to the SARYP in a follow-up meeting as a way of member checking. De Haene et al. (2010b) emphasise that community-oriented validation of the findings and engagement throughout the research is important in ensuring qualitative research remains benefit-oriented for the refugee population. No themes needed to be changed on the basis of their reactions or feedback but some new aspects of the themes were discussed.

**Sensitivity to Context**

To enhance the trustworthiness of the analysis and sensitivity to the socio-cultural context of the research the researcher read relevant literature on the population and topic. The idiographic approach and purposive sampling for IPA also required sustained involvement with the charity and refugee population they work with. Verbatim extracts from participants’ accounts are used frequently in the results to support interpretations made and allow participants’ voices to take central place.

**Commitment and Rigour**

The researcher’s efforts to support participants to feel contained and closely listened to during the interviews and focus group, and the investment the researcher made in carefully analysing accounts, are ways in which commitment to the research was demonstrated. Rigour in the research process was attempted to be established through the careful selection of participants to match the research question and relative homogeneity in the SARYP sample. Rigour was also pursued in the researching and adapting of the interview schedule so it was best suited to the participant group, and a data analysis which was sufficiently interpretative and not solely descriptive. Quotes were also equally drawn from each SARYP’s account and focus group participants’ contributions to illustrate interpretations.
**Transparency and Coherence**

Transparency was enhanced through the clear description of the research process. Smith *et al.* (2009) suggests that the internal coherence of how arguments are written up and presented is an important way of assessing qualitative research. Interpretations were therefore clearly based on the data presented and any contradictions discussed and explored.

**Triangulation**

Triangulation is a method used to analyse research questions from multiple perspectives using different sources or methods for collecting data. There is a debate over whether triangulation fits with the epistemological position of qualitative research when it is used to seek validation and confirmation of findings, as this suggests there is a single reality where findings need to be assessed for accuracy (Cutcliffe & McKenna, 1999). However, triangulation can also offer 'completeness' in research, by allowing for different realities to be acknowledged by widening the 'landscape of inquiry, offering a deeper and more comprehensive picture' (Tobin & Begley, 2004, pp.393).

Therefore to enhance the understanding and usefulness of the IPA themes in service delivery by contextualising them within the different possible realities of the SARYP's immediate environment, method and analytical triangulation was conducted via the focus group with front-line services professionals.

**Reflexivity and Position of Researcher**

'Bracketing-off' is a method used to prioritise the phenomenon being researched rather than the researcher's own preconceptions whilst analysing data (Smith *et al.*, 2009). The researcher therefore kept a reflective diary to process their reflections, assumptions and emotional reactions, as a way to be explicitly reflexive regarding their position and potential biases with the research (see Appendix T for extracts). Also for readers to be able to interpret the analytic process and consider alternative perspectives, the researcher's epistemological position, background, values, and assumptions
in relation to the research are described earlier in section 2.1 (Elliott et al. 1999).

3. RESULTS

The aim of the current study was to provide a rich, in-depth account of how a group of Somali accompanied refugee young people (SARYP) experienced and coped with the process of forced resettlement, and to contextualise this within front-line services perspectives and responses. The interview analysis is presented firstly, followed by an overview of how the focus group analysis connected with the interviews.

3.1 Interviews

Five master themes emerged from the IPA analysis of the interviews. These master themes and their associated sub-themes (summarised in Table 2) will be presented in a narrative sequence that aims to capture the experiences of SARYP, moving from the impact of their experiences of pre-migration and civil war, and forced resettlement, to the ways they coped with these. Throughout these themes there was a sense the SARYP experienced a struggle for self-agency, identity and cohesion, and connectedness with others. This section discusses each of the master and sub-themes, with verbatim quotes drawn from the SARYP’s transcripts to support the interpretations made.

3.2 Theme One: Pre-migration: Threat as Ever-Present

This theme is concerned with how the SARYP experienced life during civil war in Somalia and, in the case of Sufia, life growing up in Ethiopia. The theme consisted of two sub-themes:

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3 Square brackets [] in quotations are used to clarify information for the reader. Ellipsis points (...) will indicate omitted information.
<table>
<thead>
<tr>
<th>Master Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| **Theme One:** Pre-migration: Threat as ever-present | a. Loss of containment and power  
b. Direct or vicarious trauma |
| **Theme Two:** Forced resettlement as affecting interpersonal connections, attachments, and roles | a. Loss and separation: inner conflict and ‘making do’  
b. Search for containment and belonging: A safe base.  
c. Social comparison to those left behind/parents: Opportunities and adoption of responsibility (UK)  
d. Challenge to and adaptation of familial bonds and roles |
| **Theme Three:** Forced resettlement as negotiating difference: Struggles to develop sense of self. | a. Loss of power and control through the loss of environmental and social mastery  
b. Multiple changes in ‘communities’: impact on self-concept. |
| **Theme Four:** Individual coping strategies: ‘Being strong’ - Reframing for sense of control and agency. | a. ‘I just help myself’: Efforts of control over internal and external worlds  
b. Being proactive and holding onto hope – Selective focus on the future |
| **Theme Five:** Coping within relationships, communities and contexts | a. Coping within families, communities, and in continued connection with others.  
b. Muslim faith as part of daily life: control, safety and positive sense of self.  
c. Nuanced investment and attunement of others in facilitating coping. |

Table 2. Table of IPA Master and Sub-themes
a. Loss of Containment and Power

Whilst the two youngest SARYP expressed no memory of the conflict, the other SARYP spoke of how threat was constant in their lives, unpredictable and uncontrollable. It seemed that the civil war disrupted their sense of safety, leaving the SARYP feeling lost and powerless, feelings that they had to habituate to:

*Life, you just live your life, you don’t know when like, you are going to die...sometimes they come to your house and like some relatives they can, like, die* (Fathia).

Constant movement to avoid armed conflict alternatively yielded experiences of support from friends in the community, or the loss of this support, leading to greater sense of vulnerability and stripping of distraction coping resources:

*...you go to other people’s houses and you stay there until there is a peace...* (Amina).

*I feel like when I go to another place I don’t have many friends and I don’t know much of the people. So it means like - like I’m lonely...there’s no friends that I’m easy, comfy, that means like...the only thing you do is just worried* (Hassan).

Whilst Sufia could not remember life in Somalia, she frequently compared levels of threat between Somalia and Ethiopia, also experiencing danger as a constant in her pre-migration life before the UK:

*...they are going to shoot on you with a rock...Sometimes they take guns up and they shoot each other* (Sufia).

We might therefore believe that for this group of SARYP they saw threat and danger as being an undesirable part of everyday ‘normal’ life.
b. Direct or Vicarious Trauma

This sub-theme centred on the powerful impact of witnessing or hearing about the injury and death of others in the civil conflict on two SARYP’s psychological well-being, fitting with the large body of trauma literature in refugee populations (e.g. Fazel et al., 2005). Whilst some of the SARYP described directly witnessing violence, only Fathia spoke of re-experiencing difficulties:

[Following witnessing a bomb explosion] I was like - me, my mum, she thinks I was like, getting a crazy [gestures ‘crazy’ sign by her head] because I see everything in the night, like, I couldn’t sleep... (Fathia)

Her reference to ‘crazy’ could be interpreted as a cultural or familial frame of understanding re-experiencing trauma symptoms, which are seen as undesirable. Whilst Nadifa did not express memories of directly experiencing such events in Somalia, she spoke of watching news items on TV and hearing of other’s tragedies within the Somali community in the UK. Though vicarious, it seemed that these experiences had a similar effect on Nadifa:

...I have nightmares and that. Like, sometimes my, my Grandma gets shot, it’s so sad. I get scared (Nadifa).

Thus it appears the nature of how violent events were known about (i.e. direct witnessing or vicarious news) did not determine how they were later experienced by the SARYP, rather the emotional response to, and internal processing of them.

3.3 Theme Two: Forced Resettlement as Affecting Interpersonal Connections, Attachments, and Roles

This theme centred on how the SARYP experienced shifts and changes in the systems and relationships around them, and their roles within them,
during the whole process of forced resettlement; from leaving Somalia through to developing a life in Ethiopia and then the UK. Four sub-themes emerged:

*a. Loss and Separation: Inner Conflict and 'Making Do'*

All the SARYP spoke about the distress of multiple losses of friendships and separations from loved ones as a result of resettlement to new countries, a common finding in previous research with adult refugees (e.g. Khawaja et al., 2008). Whilst they all came to the UK as accompanied minors, all of them experienced either their mother or father migrating to the UK before them, to prepare a life for their family:

...he [Dad] said like 'I will try get like a peace place so at least my family, I can move them where I am'... It was like a few months, it was really hard, that we couldn't cope. But this is like, don't worry, this is like our life, we have to cope (Fathia).

Here Fathia talks about the pain of the loss of and separation from her father, with her use of quotations suggestive of a vivid memory of the verbal exchange she had with him before he left. It seems that she describes a process of family mourning and re-building following the separation, with the necessity of survival and 'making do' suggested in the language of 'have to cope'.

The pain of separation seems to have been felt on a powerful physical level by Amina. This further quote highlights the distress and confusion the SARYP may experience from the sense of abandonment by loved ones, compounded by the withholding of resettlement plans:

_I was, basically saw the flight was going, I was physically screaming her name [mother]...I was like, 'how can she go without me?'

(Amina).
All of the SARYP experienced being both the people left behind, and the people who left others behind. The latter seemed to imbue a level of guilt and inner conflict in the SARYP, who longed for safety but seemed to perceive a level of unfairness in their opportunities to escape over their friends. Also the recognition that resettlement would lead to the loss of friendships:

-I was just like 50/50 if I am going here [UK] or if I am staying there [Somalia]... I was sad about, because I had lots of friends...And on the other hand it was a bit exciting because you were moving, because war is like everything, so you are moving to peace country (Fathia).

Experience of loss appeared to continue for Nadifa upon resettlement in the UK, with the loss of contact with new friends as a result of moving areas within London:

...to know lots of people and after that, I never got to say good-bye to them because we moved house again (Nadifa).

b. Search for Containment and Belonging: A Secure Base.
This sub-theme centred on how throughout the process of resettlement the SARYP sought and wished for places in which they felt they belonged, where they felt held and safe within relationships with others in the wider context of loss and threat. Many of the SARYP seemed to contrast the qualities of their friendships in Somalia to the chaos and cruelty of the civil war:

-They're [friends] really nice and looking after, we didn't be rude to each other, we were just nice to each other (Amina).

Amina’s repetition of ‘nice’ and use of ‘looking after’ suggests that she valued relationships that were nurturing. This further quote highlights the importance other SARYP placed on nurturing relationships, with Nadifa
finding a temporary mother-figure in the UK whilst waiting to be reunited with her mother:

...there was this woman [neighbour]? She was very nice, she was like a mum to me. She would do like my hair for me - it was nice of her, because she was keeping me - something - until my Mum came (Nadifa).

A pervasive longing to belong with their school peers was expressed by the SARYP, with many experiencing a sense of difference from others:

...you kind of feel like, 'I'm not part of them' (Sufia).

Two of the SARYP spoke of how the longing for belonging was so powerful that when they had not initially achieved this in the UK, they had wished to return to what they were familiar with in Somalia, despite the dangers:

...feel bad about - being new. Like wanting, wanting to get back to the war (Nadifa).

c. Social Comparison to Those Left Behind/Parents: Opportunities and Adoption of Responsibility (UK)

This sub-theme extends on sub-theme (a), with the inner conflict seeming to continue into their life in the UK. The majority of the SARYP compared their resources and opportunities in education with friends' and families' still in Somalia, noticing a stark contrast and privilege in their current positions. They spoke of feeling 'lucky' (Amina) and conveyed a sense of responsibility on optimising their opportunities to improve the circumstances of those left behind in the future:
...remember the people you left in your country, that they also need your help, because you came here so you need to get education so you can help (Hassan).

In contrast Sufia seemed to make social comparisons to her parents’ sacrifices for her and adopted a sense of responsibility of achieving for them, rather than the wider Somali community:

...I kind of feel sad, ‘imagine if you can’t, you don’t go to Oxford [University]. What is he [father] going to feel?’ It’s not like – I am just doing all this stuff for my mum and dad... [they] have done a lot of things for me... (Sufia).

Sufia had spoken of how all her family members were no longer in Somalia, and that she could not remember her life there. Therefore it is suggested that it is the social comparison to the quality of life of people familiar or emotionally close to the SARYP that influenced their sense of responsibility for others, rather than automatically for the wider Somali community.

d. Challenge to and Adaptation of Familial Bonds and Roles
This sub-theme centres on how experiences of separation and forced resettlement impacted on how the SARYP viewed family members’ roles, and the functioning of their family systems. The SARYP spoke with admiration of how their parents had protected and provided for them during the process of resettlement, adapting the roles in order to do this:

[In Ethiopia]...when he’s [father] not with us, she [Mum] is the one that becomes a Dad and a Mum..., after she can do the kitchen and like everywhere (Sufia).

Many of the SARYP spoke with sadness of a change in family cohesiveness upon final resettlement in the UK, even when re-united with absent family members:
...my Auntie said to me, that I’m going to stay with them for a while [separate from her father and brothers who she had been reunited with]...when I first saw them I was very quiet because I didn’t know who they were.

The family yea, like every night, we all sit together, just chatting, some people tell stories. Like, in Somalia there’s no TV, no games. Now you have like, here, we don’t really sit together now, what we do is go on our separate ways. Before we stuck together... (Nadifa)

Therefore cultural rules around family socialisation and gender appeared to have an influence over SARYP’s experiences. These breaking down under the pressure of new cultural norms (story-telling), or being upheld (being sent to live with a female relative) left Nadifa feeling as if the family was becoming more diffuse and her more alone. It seems conversely that the loss of personal space, and the adoption of new focuses or pressures in their lives, led to family relationships to become more distant or conflicted, which is further illustrated in these quotes:

...here it’s like, one house, one house, we [siblings] just fight everywhere (Fathia).

...on Saturdays I’m not with them [family], on Sunday I’m not with them. So in the night, when I come back, it’s just like, I don’t like, be with them. I just like go do my work... (Sufia).

Whilst some of the SARYP continued to feel able to rely on their parents for support, others perceived a change in roles:

...when something bad happens to me - I don’t like telling them. I don’t like making them feel sad... (Sufia)
Here Sufia seems to have moved from being the protected, to wishing to protect her family from the realities she was experiencing. The fluctuation of family cohesiveness and exposure to differential experiences across forced resettlement seem to have led to a diminished ability of some of the SARYP to rely on family members for support.

Many of the female SARYP spoke of questioning and challenging cultural and gendered expectations now they were in the UK, which they experienced as resulting in further conflict in their families:

...I have to clean, cook, wash the clothes, everything. I told them [brothers] like, 'Mum, if they don't help me, then I'm not going to help them'. And my Mum...she just shout at me 'You are the girl, you have to do this'. I'm like 'this is London Mum, come on, they have to help me, they have to do half...' (Fathia).

Here we might see Fathia beginning to struggle with the development of a self-concept and role which is connected to her family and Somali culture, but also being influenced by UK cultural norms, which conflicts with parents' beliefs. This seemed a common thread across many of the SARYP’s accounts.

3.4 Theme Three: Forced Resettlement as Negotiating Difference: Struggles to Develop Sense of Self

Two sub-themes help explain how the SARYP experienced and negotiated change and difference across the process of forced resettlement. Not only were losses and traumas from pre-migration life still relevant, but adapting to living in new cultures, communities, and environments led to their own set of challenges to the SARYP’s sense of identity, efficacy and belief:

a. Loss of Power and Control through the Loss of Environmental and Social Mastery
All of the SARYP spoke of finding their integration into new cultures difficult, of learning new languages and understanding new education systems (as found in previous research; e.g. Montgomery, 2010). Despite their efforts of preparation in Somalia, their accounts suggested that they thought themselves as ‘disabled’ in their new worlds in Ethiopia and UK:

...it was just like, I'm deaf (Sufia).

Many of the SARYP spoke of how the lack of language left them feeling powerless to make sense of their worlds, to communicate their distress, and defend themselves from peers:

*I cry in the class once, the teacher come up to me, and say ‘what she [bully] say? Are you OK’. I was - I don't understand it like - I just say like ‘mmm’, I just shake my head.

... you can't like, help them [bullies]. You can't say ‘Why did you do it?’.

(Fathia)

These feelings of powerlessness and disability led to all of the SARYP forming negative evaluations of themselves, eroding their sense of self-efficacy and belief:

*I felt like I was on another level, a lower level (Hassan).

*I see the baddest day of my life was the one that, the day that everyone was getting a certificate [at school]. And I didn't get anything. I was feeling really sad because seeing everyone being the best and I'm being the lowest (Sufia).
Being ‘low’ suggests they saw themselves at a lower social standing than their peers. This conceptualisation of the self was experienced as extremely distressing, as suggested by the phrase ‘the baddest day of my life’.

b. Multiple Changes in ‘Communities’: Impact on Self-Concept.
This sub-theme centres on the SARYP’s experiences of the fluctuating social systems they found themselves in across the process of forced resettlement, and how these impacted on how they viewed themselves. Despite the civil war, many of the SARYP described society in Somalia as social and community-driven, as ‘family’:

...our neighbours, they are like, brothers and sisters to us (Fathia).

Whilst they continued to experience other Somalis as kind and friendly in Ethiopia, the SARYP were confronted by their ‘difference’ from Ethiopians, for which they were discriminated:

...they just look at you very dirty like. Like, ‘oh my god, can this person leave me alone, just ‘cause I’m of a different religion’ (Nadifa).

Their sense of community appeared to shift again within the UK, perceiving a lack of community in London:

Basically in London...nobody comes to other people’s - neighbours and stuff (Amina).

Many of the SARYP found themselves confronted by discrimination from their peers, struggling with unwanted derogatory labels and forced to experience themselves as fundamentally different:

They say ‘you are at the lowest, you are like freshy’. That means people who don’t know anything.
...I start like crying everyday like saying ‘why is all this happening to me, why...What did I do to these people? Do they think I’m a bad person?...They’re all old Somalis, and Portuguese - everyone, its mixed.

(Sufia)

The last quote highlights an experienced change within the wider Somali community for Sufia. Whilst previously ‘old Somalis’ (i.e. Somalis who have lived in the resettlement countries for a long time) were found to be supportive and helpful (see Theme Five), the SARYP now experienced them as unkind and cruel. This distancing from a Somali identity could be interpreted as way of RYP changing their self-concept to align with their new social system and ‘belong’. This interpretation is further illustrated in the following quote:

...they forgot, yea if they like hang around with bad people. Like if you have a role-model that’s bad... (Nadifa).

Other SARYP saw their exposure to multiple communities as resulting in personal growth in their self-concept:

Here, I just like, I grow up. Before I was like a baby, my life it change, I met a lot of peoples (Fathia).

Fathia’s reference to previously being ‘a baby’ suggests she wishes to convey an image of herself as more mature, independent, as less vulnerable, a view echoed throughout the SARYP’s accounts.


This theme is concerned with privileging the views of the SARYP in understanding how they individually coped with the stress of pre-migration...
life and changes during the process of forced resettlement. Two sub-themes emerged which are believed to capture their expressed ways of coping:

a. 'I just help myself'⁴ - Efforts of Control Over Internal and External Worlds.

As a way of coping with feelings of uncertainty, loss, and powerlessness, all of the SARYP seemed to perceive themselves as increasingly responsible for re-claiming some control over their internal and external worlds. It seemed they perceived their ability or opportunities to rely on others had diminished over the process of forced resettlement, due to physical separation (e.g. a parent travelling ahead), their family’s lack of environmental mastery, or because they were unpredictable (e.g. fluctuating ‘communities’).

Attempts to gain control over the distress of transitions and separations are illustrated by the following quote:

...so I give them [friends] sweets and money and stuff like that, to say good-bye to them. And a picture of me - So they won’t like, really miss me. And they can just live without me. And just look at my picture...whenever they need it (Amina).

Here the physical giving of gifts and a picture could be seen as easing both Amina’s and her friends’ distress, with separation so painful it is almost seen as life threatening. Amina’s picture seems to symbolise a continued connection, and gifts an expression of continuing love and care.

The SARYPs seemed to frequently engage in avoidance and suppression, with their experiences seemingly overwhelming their abilities to process what was happening to them:

⁴ (Sufia)
I call her [friend] and say 'I'm going now'. Because I can't see her crying in front of me (Sufia).

...keep myself busy so I don't have to think about anything bad happening to my family (Nadifa).

The belief that negative inner experiences (i.e. emotions and thoughts) need to be controlled and concealed was pervasive amongst the SARYP, with them going through significant mental and observable efforts to maintain this:

Oh when I feel sad, no-one doesn't notice me. Always, I smile...You can see my tears are coming but my face is just like, a happy person (Fathia).

I start like just being like strong and leaving everything [bullying]. Ignore everything other people say, start forgetting everything. So try to forget. Be happy and don’t be sad (Sufia).

Here Sufia seems to equate control of inner experiences and external actions as way of being 'strong', as protective against feelings of vulnerability. All of the SARYP engaged in positive self-talk as ways of comforting and motivating themselves in the face of hardship and challenges:

Every night when I go to sleep 'I can go to Uni'. When I wake up 'I can go to - '. So in my head, I can like cope with everything (Fathia).

Fathia's repetition of 'I can go to Uni' indicates the amount of effort SARYP can expend to maintain a level of self-belief and motivation.

It was noticeable that the ways of coping the SARYP engaged in echoed the advice and views of their parents, suggestive that the SARYP had internalised familial and possibly cultural ideas around coping:
...they'd give me advice like 'just don’t give them time, just walk away, don’t listen to them...' (Nadifa).

b. Being Proactive and Holding onto Hope – Selective Focus on the Future

Following on from the previous sub-theme all of the SARYP spoke of their drive and focus in pursuing further education and careers, with many speaking of helping others in similar circumstances to them or going back to make a change in Somalia:

I want to do this, finish school, then go to University, do something better for me, for everyone, for my country... become a teacher or doctor. So I like can help more people, especially refugee people - I used to be like, lower class, so I see I don’t want that to happen to other people (Hassan).

This could be seen as a way of the SARYP coping with their own experiences of trauma, loss, and loss of environmental mastery, by working towards roles that represent power, respect and kindness, roles which will help them re-build their sense of agency and self-efficacy over their worlds.

...don’t give up your education. Even if they are bullying you, just be like, a strong person, and just go to your way and work hard (Fathia).

Strength and determination is a thread found through all the SARYP’s narratives. However there appears a danger when the sole focus on this way of coping with forced resettlement can lead to the neglect of their other emotional, social and physical needs, and reduce opportunities of receiving support from others:

I don’t even take off my uniform I just go to sleep. I wake at 5:30 in the morning and go to school early... I go to bed at 2 o’clock in the night.
So I'm tired...I don't like have the chance to speak to anyone...
Sometimes I'm so tired, yeah I don't even eat my food (Sufia).

It seemed that the SARYP felt they had to suppress confusing and difficult feelings or memories in order to maintain their sense of agency and ability to focus on their future goals:

...remembering makes me kind of, out of the mood, it makes me - confused. So I'm like, 'don't look back, just go forward, do your best, learn' (Hassan).

Yet they continued to experience intrusions and thoughts about their past selves, and turned to links to their past as ways of understanding themselves and their journeys:

I just totally forget about my friends now but at the same time I can't forget it... But my life, it changed (Fathia).

I had a diary. And I'd write every single day what happened - It makes me remember, like, what I wrote, when I was in Ethiopia and when I came here. (Amina).

It therefore seems that the SARYP are engaged in a struggle to process the extent and range of their experiences, oscillating in the strategies they adopt to try reconcile them with their current lives, self-concept and hopes for the future.

3.6 Theme Five: Coping within Relationships, Communities and Contexts

This final theme centred on how the SARYP made sense and coped with their experiences by drawing strength from the wider systems around them. It also aims to address the apparently paradoxical world the SARYP experience, where on one hand they feel they have to be self-sufficient,
whilst on the other valuing and wishing for support from others or from higher powers. This theme consists of three sub-themes:

a. Coping within Families, Communities and in Continued Connection with Others

The SARYP all spoke of the sustenance they experienced in the moments they felt connected with or supported by others within their families and Somali communities. This appeared to take a physical form in Somalia and Ethiopia, where their families' community provided shelter and protection, creating a space of safety for the SARYP:

_They [parents] basically put me to a safe place, somewhere you can actually stay, somewhere where I can know people like my friends, somewhere where it's safe (Amina)._ 

The SARYP also experienced support from the community and family as initiators and facilitators of a sense of belonging, helping them orientate to and feel part of their new worlds:

_She [from Somali community] came to our house and said, um 'you guys are new here, welcome to Ethiopia. If there's anything we can help you with we will try'...that was good. Because she's actually someone you can talk to, you feel that you have friends (Amina)._ 

Whilst friendships were cited as sources of support throughout the process of forced resettlement, alternative sources of support changed, moving from family and the Somali community in Somalia and Ethiopia, to family and community services (school and charity organisations) in the UK. The latter is expanded on in sub-theme c.

Connection through continued communication with absent family members was perceived as important and comforting to the SARYP across forced resettlement, acting as a balm on their inner conflict around being separated:
...makes it feel better because you...left your Mum behind, and at least you're getting to talk to her again (Amina).

...we feel like, he [father] might at least be the other side, like a shadow, but we can't see it, but we can hear his voice (Fathia).

The use of the word 'shadow' evokes an interpretation that absent others' presence is still felt. It seems that it is this continuity in community and family support which may provide a sense comfort and security to the SARYP.

b. Muslim Faith as Part of Daily Life: Control, Safety and Positive Sense of Self:

This sub-theme centres on the role the SARYP gave their religious faith in making sense of their experiences. When they felt powerless, a belief in a higher power helped them to try come to terms with the atrocities they had witnessed:

You see my Mum just say like, 'Allah got like everything', because we believe in God, so that's why we forget it [violence] (Fathia).

Some of the SARYP used prayer to manage their worries, and their faith as way of still feeling connected to, and being able to influence, the safety of absent others:

...there's a reason why there's Ramadan. When you don't eat and drink, it makes you feel how it's like the life for people the way they are living on. So you see how it feels...if you give money for charity - God will give you better than that - in future...It makes me feel like, like I'm so proud of myself (Hassan).

Hassan's quote extends this idea further, where he perceived a religious practice as a duty to others, as way of additionally instilling a positive sense
of self by being able to take up a stance of being caring and effectively helpful, a stance which civil war and resettlement had previously undermined.

c. Nuanced Investment and Attunement of Others in Facilitating Coping.

This final sub-theme helps to tease out the nature of support from external others which the SARYP found personally meaningful. This took the form of supporting the development of SARYP’s personal resources to gain a greater sense of mastery, self-belief and belonging (i.e. coming alongside their wishes to be the agents of change in their own and others’ lives), whilst also meeting their non-verbalised emotional needs within relationships.

When considering what support they perceived would be helpful for new SARYP to the UK from their own experiences, all of the SARYP indicated their sense of vulnerability, and therefore importance of other’s investment in helping them develop a sense of environmental mastery and security:

...it feels like that person’s lost, doesn’t know what to do. So you can help that person, show the ways, the ways the system is (Hassan).

The process of facilitating learning of the English language requires sensitive and attentive support from teaching and charity professionals (in addition to family), with the SARYP feeling their self-confidence needed to be built through protected individual support and flexible practice:

‘Cause I remember, she was year 7, some girl, she just came from Somalia, and they were just bullying her yea, and she just fainted... That’s why, first of all you, we have to make like their own rooms, so they can teach how to read and write the English... (Fathia).
Many of the SARYP valued the teachers’ and charity professionals’ support in facilitating a sense of belonging in their new social world, for example through developing a ‘buddy’ system:

...she like, helped me make friends as well...she calls that girl to like, walk, stay with me the whole day, and then another girl - And we all become friends...(Nadifa).

Friendships with their peers were identified as sources of strength in coping with challenges of re-settlement (e.g. bullying) and motivation in pursuing their goals in self-development:

So others [school peers] are like ‘I’m better than you, how can you get like A*s?!’ and [I’m] like ‘cause I work hard and I’ve got the help of my friends (Fathia).

It therefore seems the feeling of solidarity, of not being alone, was important to these SARYP. All of the SARYP spoke about the desire for consistent and constantly available support from the education and charity professionals:

Just like help, help them like 24/7, just be beside them (Fathia).

The need to be understood and attended to was prominent, despite their difficulty in expressing these needs. Attunement (Stern, 1985) therefore seemed important, where professionals needed to be attentive and responsive to the SARYP’s non-verbal communication of their emotional and physical needs:

Understanding that person, ‘cause later if you don’t understand that person, they’ll feel bad about - being new. Like wanting, wanting to get back to the war and that, feel bad, like not understanding about how they feel (Nadifa).
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They don't have no friends, so look after them, because if you just ignore that person they might get upset...Just, basically, um, try to make sure that the kids are actually happy (Amina).

The latter quote suggests others need to actively enquire about their psychological well-being, as SARYP efforts to control their inner experiences, and their difficulty relying on others, may conceal their wish for support. The combination of emotional and practical support, from people who they felt genuinely cared for them, seemed to hold the most value for this group of SARYP:

She's [charity professional] just like, my big sister and at the same time she's like my teacher (Fathia).

3.7 Focus Group

Analysis of the focus group revealed seven themes (Appendix U). Due to the wish to privilege the voices of the SARYP in this study, key focus group themes will only be discussed in terms of how they overlap, diverge, expand on or respond to SARYP's accounts. Full analysis of the focus group can be found in Appendix V.

The focus group themes mainly focused on the post-migration stage of SARYP forced resettlement to the UK, with some consideration of prior experiences. Focus group Theme Two: 'Adjustment to difference' and Theme Three: 'Struggles with integration' closely overlaps with the Interview IPA Theme Three: 'Negotiating difference'. Both SARYP and professionals indicated multiple differences in culture and society as overwhelming and de-skilling, with professionals noticing wider society discrimination (as well as from peers) as potentially having a negative impact on self-concept. Focus group themes around distancing from or aligning with Somali identity (Theme Four a.), expanded on the Interview themes around experiencing rejection from those of similar heritage, and
disconnecting from their past life (IPA Themes Three b. and Four c.). They explored how SARYP cope with the complex feelings around their heritage:

...because their identity is not respected, some of them tend to try and move away from their heritage and their identity. And you got that inner battle... (Head of Year).

The Focus group Theme Four b. (‘Concealment’) also overlapped with Interview IPA Theme 4 a. (‘Efforts of control over internal and external worlds...’), where suppression and concealment were identified as ways of coping. Professionals suggested this could complicate access to support as they only have behavioural cues to respond to:

So acting out...arguing with the teacher - is a way of not only getting out all those feelings that you have, but also then getting support afterwards... (Pastoral support worker).

...the problem is that the behavioural signs are the tip of the iceberg... (Mental health practitioner).

The focus group explored how the ‘Coping’ Interview themes (IPA theme four and five) could be understood and positively responded to by UK services, in the ‘How can UK services help?’ focus group theme. The strong wish of SARYP for self-agency and self-efficacy was expanded on in Focus group Theme Seven ‘Supporting integration and psychological well-being’, with sub-themes around increasing sense of mastery, and a focus on strengths and resilience as ways of increasing positive self-concept:

...being able to own, who they are, and who they are out of what they have experienced and the strengths that come from that (Mental health practitioner).
Celebration of cultural diversity and identity (Focus group Theme Seven b.) was a method suggested by which to facilitate belonging and friendships, which the SARYP identified as important (IPA Theme Six c. ‘Nuanced investment and attunement of others...’). Professionals suggested this may overcome the limitations of suppression and distancing, with the embracing of their cultural identity leading to a more coherent positive sense of self:

"Your identity are your roots and from there, unless you know yourself, then everything else kind of falls into place (Head of Year)."

Focus group Theme Six ('Ideas for SARYP and community engagement') offers ideas on how to acknowledge and overcome misalignment around norms of disclosure, cultural differences in understanding mental health, and the offering of support (Focus group Theme 5 b. and c.). It incorporates the SARYP wishes for more attuned and sensitive support from others (IPA Interviews Theme 6 c.). Ideas included outreach through active enquiry of their experiences (Theme Six c.) and the creation of opportunities to share within trusting relationships (Theme Six b.):

"All they want is somebody who cares enough to sit down and listen to what they got to say (Head of Year)."

However the professionals also expressed apprehension of addressing distress in the SARYP:

"My role is not to... re-traumatise people and drag their... You know, I'm not a therapist and I don't think that's appropriate (Charity family support worker)."

The focus group themes revealed thinking around wider service delivery, suggesting a paradigm shift in service models, delivery and roles is needed to effectively support SARYP and their families (Theme Seven b.). In particular, a move away from individual problem-focused orientations
which are based in clinics, to collective strengths-focused orientations which are community-based was identified. These ideas align with the SARYP ways of coping within communities and connections with others (IPA Interview Theme 6 a.) and acknowledge how forced resettlement has challenged bonds within systems (IPA Interview Theme 3 c.):

One of the kids here said ‘when I was in Somalia, we used to sit around and tell stories, while here it’s every man to themselves’ so, if you have the group, again they will come together and they’ll be telling stories... (Head of Year).

The focus group themes therefore suggested front-line services’ awareness of the pervasive themes found in the SARYP’s accounts of the struggle for agency, self-identity and cohesion, and connectedness with others. The discussion also appeared to elicit deeper consideration about the appropriateness, sensitivity and effectiveness of current service support for this group of young people, and the need to adapt practice.

4. DISCUSSION

4.1 Overview

This study aimed to explore how Somali accompanied refugee young people (SARYP) experienced and coped with the process of forced resettlement. IPA analysis of the interviews identified five master themes, and TA analysis of the focus group indentified seven master themes. How each of the master themes (and associated focus group themes) link with existing theory and research will now be discussed. The clinical practice and service development implications of the findings, limitations of this study, and suggestions for future research will also be considered.
4.2 Theme One: Pre-migration: Threat as Ever-Present

Many of the SARYP spoke about the presence of danger in their pre-migration lives, leading to a sense of vulnerability and powerlessness. It is therefore likely that their attachment systems were frequently activated to seek safety and containment. However deactivation by caregivers was challenged through their constant movement to avoid harm (De Haene et al., 2010a). Such challenging of attachment relationships has been suggested to disrupt hope processes (Yohani & Larsen, 2009), which could be reflected in the SARYP’s reports of struggling to continue using their distraction coping strategies.

The feelings of powerlessness, and the two SARYP’s experiences of flashbacks and nightmares, could be conceptualised within a PTSD framework, where the SARYP abilities to integrate and cope with their experiences were overwhelmed (American Psychiatric Association, ‘Diagnostic and Statistical Manual of Mental Disorders’, 2000). It is possible that media images and community conversation contributed to a ‘dose-effect’ (e.g. Halcon et al., 2004), triggering trauma symptoms for one particular SARYP.

4.3 Theme Two: Forced Resettlement as Affecting Interpersonal Connections, Attachments, and Roles

Loss and separation from others possibly disrupted proximal processes in the microsystem level of early child development (Bronfennbrenner, 2005). The SARYP’s reactions (such a sense of abandonment) reflect previous research’s emphasis that accompanied RYP are not necessarily protected against psychological distress and experiences of separation (Ellis et al., 2008). All of the SARYP were anxious to build nurturing relationships with others throughout the process of forced resettlement, relationships in which to feel safe and make sense of their experiences (Bowlby, 1977). This may reflect the ‘safety’ and ‘love/belonging’ needs in Maslow’s (1943) hierarchy. The latter was extended into their wider social environment, with a sense of lack of belonging with their school peers leading to a yearning for
their old attachment to pre-migration environments (Van Ecke, 2005). Low perceptions of school belonging has previously been associated with high rates of depression in research with Somali RYP (Kia-Keating & Ellis, 2007).

The SARYP cognitive re-framing of their resettlement experiences through social comparison with others less fortunate has been suggested as a way of making meaning of resettlement difficulties, and securing a sense of purpose, in qualitative research with African UAMs (Goodman, 2004; Ni Raghallaigh & Gilligan, 2010). Their sense of responsibility in being successful in their lives for the benefit of others, a common finding in RYP research (e.g. McCarthy & Marks, 2010), could be perceived as the SARYP’s attempt to reconcile inner conflict around leaving loved ones by taking an active role in creating change. Mental health is perceived as intertwined with family and community in Somali culture (Johnsdotter et al., 2011). The SARYP may have been sensitive to their success possibly being a source of hope for their parents (Almqvist & Hwang, 1999).

The SARYP recalling multiple losses and attempts to reorient to their changed social environments could be considered as akin to the oscillation between a loss-orientation and restoration-orientation in Stroebe and Schut’s (2001) Dual Process Model of bereavement.

Change in family communication, norms and roles were keenly noticed by the SARYP. Whilst distress is traditionally managed within families (Guerin et al., 2003) the process of forced resettlement was seen to put strain on family cohesiveness, and create greater inter-generational conflict over traditional female gender roles (with SARYP girls distancing themselves from these roles; Valentine & Sporton, 2009). These are acculturation factors associated with increased psychological problems in RYP (e.g. Kovacev & Shute, 2004). Research suggests that RYP are exposed to different experiences and acculturate faster than their parents (an issue also highlighted by front-line service professionals in the focus group), which
can contribute to experiences of acculturative stress, particularly for girls (Guerin et al., 2003; Lustig et al., 2004).

Some of the SARYP chose to conceal their resettlement difficulties (e.g. bullying) from their parents. This could be understood within an avoidant attachment frame-work, where instability in their relationships may have led to self-reliance (Ainsworth & Bowlby, 1991). These acts could also be understood as the SARYP not wishing to burden their family (as found in immigrant population literature; e.g. Dogra et al., 2010), reflecting how the RYP are conscious of and impacted by wider difficulties in their exosystem (e.g. parent experiences) (Bronfenbrenner, 2005). Whilst research suggests that the family supportive context weakens over time, especially for girls (McMichael et al., 2011), the role of normal adolescent development tasks of autonomy should also be considered, which themselves may be complicated by resettlement stressors for SARYP (Ellis et al., 2010b).

4.4 Theme Three: Forced Resettlement as Negotiating Difference:
Struggles to Develop Sense of Self

Loss of environmental and social mastery (as observed by both the SARYP and professionals) was experienced as distressing, with Montgomery and Foldspang (2008) finding a mutual association between these experiences, discrimination and mental health in RYP. The changes potentially threatened the SARYP’s developmental needs of ‘safety’ and ‘esteem’ (Maslow, 1943) and the identity development stage of ‘industry versus inferiority’ (Erikson, 1968). The SARYP’s negative evaluations of themselves based on these difficulties align with Taylor and Doherty’s (2005) findings of an association between second language difficulties and a sub-cultural identity in immigrant young people. Stress may develop from the discrepancy in the SARYP’s abilities to meet the demands of their new environments (i.e. lack of Person-Environment Fit; Caplan et al., 1975). Distress could be further contextualised within Somali society norms where verbal eloquence and humour are valued ways of demonstrating leadership
All of the SARYP spoke of the distress of experiencing discrimination from Ethiopian and/or UK populations across multiple levels of their social identity (as found in previous research; Ellis et al., 2008). Their religion and refugee status were targeted in particular. The school context was identified as a place where they felt disconnected from the UK community, with school belonging having been found in previous research to account for a high proportion of variation in RYP's self-efficacy (Kia-Keating & Ellis, 2007). The focus group themes also acknowledged how Somali refugee communities are specifically discriminated against in UK society, therefore the host society’s hierarchy of favoured immigrant groups (macrosystem; Bronfenbrenner, 2005) can be seen to have an influence on SARYP experiences (Polek et al., 2010).

The SARYP accounts suggested a struggle over their self-identity. Their forced resettlement experiences potentially complicated the development stage of ‘identity versus role confusion’ (Erikson, 1968). Both in the Interviews and Focus group, the SARYP were observed to distance themselves from or become rigidly ascribed, to their cultural heritage (i.e. a countercultural action), in order to create a sense of belonging and buffer against discrimination. These could map onto the assimilation and separation acculturation strategies (Berry, 2001), both of which have been found to inversely increase RYP vulnerability to discrimination (Viruell-Fuentes, 2007).

The struggle to consolidate pride in self-identity has been associated with increased anxiety and perceptions of lack of safety in SARYP, with social identity being found as a moderator between mental health and discrimination (Ellis et al., 2010b). According to labelling theory (Becker, 1963) the SARYP are therefore vulnerable to internal devaluation (as suggested in their accounts) as their cultural identities and behaviours are
ascribed derogatory labels and perceived as 'deviant' from the majority macrosystem cultural norms. Perceived discrimination has been found to be the biggest predictor of depression over post-migration and acculturative stressors in SARYP (Ellis et al., 2008). The current study’s findings therefore align with Schwartz et al. ‘s (2010) suggestion that acculturation should be conceptualised as multilevel, with perceptions of the refugees, the immigration history of the resettlement country, and degree of discrimination experiences also heavily impacting on acculturative stress.

Despite these struggles in negotiating difference, all of the SARYP wished to relate to others, and convey an image of strength and resilience. Some indicated personal growth in self-perceptions, and epistemology in the way they think, which Papadopoulos (2007) would term Adversity Activated Development (AAD).

4.5 Theme Four: Individual Coping Strategies: ‘Being Strong’ - Reframing for Control and Sense of Agency

All of the SARYP spoke of striving for control and agency across their resettlement experiences, also found in other research with Somali RYP (Ellis et al., 2010a). These concepts are suggested to be central to psychological well-being in RYP (Correa-Velez et al., 2010). The SARYP appeared to be engaging in active rather than passive coping styles (Colic-Peisker & Tilbury, 2003), cognitively reframing their situation (as found in qualitative research with adult refugees; Khawaja et al., 2008) to maintain a positive perception of their internal resources and sense of self.

Throughout the interviews and focus group the SARYP were perceived as wishing to be active agents in improving theirs and others lives (as found in previous research with RYP; e.g. McCarthy & Marks, 2010), with the SARYP conveying new perceptions of themselves and their purposes in life following the adversity they had overcome. Papadopoulos (2007) would term this as AAD, with Valentine and Sporton’s (2009) research interpreting such self-perceptions as ways Somali RYP manage their struggle over
identity. The SARYP’s focus on the future, positivity, and pursuit of helping professions, is consistent with previous research findings with RYP as ways of securing a sense of purpose and hope across the process of forced resettlement (e.g. Poppitt & Frey, 2007; Schweitzer et al., 2007; Whittaker et al. 2005). Moral attitudes and hope have been associated with high levels of post-traumatic growth in a quantitative study with Somali adult refugees (Kroo & Nagy, 2011).

However, Rutter (1993) expresses caution in not overlooking potential underlying distress masked by RYP overcompensating in particular areas, which may present as resilience. It may be a strategy to avoid distress by suppressing distressing memories and thoughts, as reflected by the Interview and Focus group themes. These experiences were previously reported as helping perseverance and reducing loneliness by UAMs (e.g. Goodman, 2004), with internalising difficulties found as common in RYP in the early stages of resettlement (Montgomery, 2008). Positive (re)appraisals and affect are suggested to support coping in Stroebe and Schut’s (2001) Dual Process Model of bereavement, though avoidance of negative affect is suggested to inhibit development.

The self-reliance and internal locus of control expressed by the SARYP, and potential difficulty in emotion regulation, could be a possible expression of anxious attachment patterns (Ainsworth & Bowlby, 1991), developed from the SARYP’s experiences of separation from caregivers, family acculturative stress, and multiple changes in community (some of whom were hostile). This would suggest the SARYP lacked confidence in others’ ability to support them, therefore avoiding seeking external support, although they might wish for this.

All of the SARYP conveyed deliberate efforts of concealment of their difficulties from others. This approach could be attributable to Somali cultural norms around expression of emotional distress as weakness and the need to be strong (Whittaker et al., 2005), and self-disclosure withheld so as
to not burden others (Ellis et al., 2010a). However, previous research findings also suggest Somali RYP fear not being understood (Ellis et al., 2010a). Family patterns around silencing and avoidance of past negative experiences decrease refugee parents’ attunement to their children’s emotional needs and efforts of meaning-making, which can lead to RYP concealing their forced resettlement experiences (Almqvist & Hwang, 1999). The long-term effects of such coping strategies are unknown, although Hunter (2001) suggests they may eventually be harmful to psychological well-being.

These findings conflict with the SARYP’s longing for past activities (e.g. story-telling) and attempts to review their journeys, suggesting a struggle in integrating and reconciling their range of experiences and emotional responses during the process of forced resettlement. This may be a struggle which is mirrored in the mesosystem and exosystem around them (e.g. with family, school, and peers; Bronfenbrenner, 2005).

4.6 Theme Five: Coping within Relationships, Communities and Contexts

Despite expressions of self-reliance, all the SARYP spoke of how they valued feeling connected with and supported by others within their families and Somali communities, particularly in the earlier phases of forced resettlement. This tension between concealment and family/community support has been recognised by adult Somali refugees in previous research (Whittaker et al., 2005). External systems seemed to support the SARYP’s expressed developmental physiological needs (e.g. somewhere to sleep), safety (e.g. against violence) and love/belonging (e.g. during transition in Ethiopia) in Maslow’s (1943) hierarchy. Flexibility of social support from, and cohesion with, family and multiple communities have been found to be a significant predictor of greater psychological well-being in refugees (Kovacev & Shute, 2004; Schweitzer et al., 2006). It is also associated with post-traumatic growth in Somali adult refugees (Kroo & Nagy, 2011), and found to be protective of RYP against acculturative stress and psychological
problems for up to 9 years following resettlement (e.g. Bhui et al., 2003; Montgomery, 2008).

When social and familial networks are strong, the SARYP’s accounts suggest they would draw from these traditional Somali sources of coping, which hold the power to promote or inhibit psychological well-being (Jorden et al., 2009; Palmer, 2007). Continued contact with absent loved ones appeared to help the SARYP to draw on internal representations of secure family relationships, restoring emotional closeness despite experiences of separation and adversity. The ability to hold onto internal representations has been found to have a similar impact on relationships in research with refugee parents (De Haen et al., 2010a).

The desire for constant, genuine relationships in which their difficulties were actively enquired after could be understood as the SARYP wishing for attuned, secure attachments with others to make sense of their experiences and explore their environment (Bowlby, 1977). Both Focus group and Interview themes acknowledged the SARYP’s wish for others to sensitively facilitate their development of environmental and social mastery; to increase their self-belief and sense of belonging in the host culture. This fits with an ecological approach where positive child development is attributed to the development of strong emotional attachments with people who support them to engage in increasingly more difficult activities over time (Bronfenbrenner & Morris, 1998), with resilience and coping mechanisms fostered within interpersonal contexts.

The findings suggested that upon resettlement in the UK the SARYP wished for support from others outside of the family and Somali communities (e.g. teachers and charity professionals) to pursue their esteem and self-actualisation needs within Maslow’s (1943) hierarchy. This may be due to the differential experiences of discrimination and rates of acculturation compared to their parents, which may obstruct familial sources of support. As found in the current study, research suggests RYP can continue to
function well (e.g., in academia; Rousseau & Drapeau, 2003) despite internal distress, so external others may be unaware of these needs, and/or, as found in the focus group, nervous of how to manage these (Yohani, 2010). A belief in God seemed to partially absolve the SARYP’s feelings of responsibility and guilt around traumatic events, providing a structure to make sense of their experiences and remain meaningfully connected with others. Similar findings were found in Schweitzer et al.’s (2007) qualitative research with Sudanese adult refugees. Religion was not given as much prominence in the SARYP accounts compared to research with adult Somali refugees (e.g. Guerin et al., 2004). However, prayer was still suggested by the SARYP to help them cope with worry and sadness (as previously found in research with Somali adult refugees; Halcon et al., 2004), and religious practices appeared to instil a sense of self-worth in the male SARYP. This may link with Walsh’s (2003) findings that religious belief systems contribute to resilience. Friendships were also found to be sources of coping and resilience in the current study, with previous research finding positive peer relationships as related to greater self-esteem and adjustment (Lustig et al., 2004).

4.7 Implications for Clinical Practice, Service Development and Policy

The findings suggest that the SARYP experienced a broad range of psychosocial and relational challenges across the process of forced resettlement, to which they actively responded to using a range of coping strategies.

The themes suggest approaches should not be problem-focused, nor problem-blind. Somali cultural expressions and management of distress needs to be acknowledged (e.g. a family focus and not wishing to burden others) but power of stigma also recognised, with family not necessarily a source of support as is Somali tradition due to different rates of acculturation and nature of experiences (e.g. bullying from peers). Supporting families and communities requires a holistic, multi-agency and strengths-focused approach to align with the SARYP’s existing coping
strategies in pursuing self-agency and narratives of resilience, building their confidence in social and academic areas as well as mental health.

However the impact of traumatic experiences, disrupted attachments and discrimination also need to be considered. Self-reliance may be a possible expression of anxious attachment patterns as well as a cultural norm, where relationships with others have been challenged or experienced as threatening (Ainsworth & Bowlby, 1991). Attachment and social relationships are fundamental in the development of a cohesive sense of identity (Rice, 1990), something all the SARYP struggled with. All the SARYP expressed the wish for nurturing and attuned relationships. Therefore space to develop these, and a positive social identity, could be central to SARYP psychological well-being.

Existing research proposes the need for more culturally appropriate, community-focused services, with interventions which consider resilience, strengths and a widened scope beyond therapies to explore preventative, psychosocial, and structural changes in aiding integration (Fazel et al., 2009; Halcon et al., 2004). This includes supporting adaptive systems that already exist. Miller and Rasco (2004) review an empirical base suggesting that clinic-based services are limited in their capacity to address the broad and potentially high psychological needs, emphasising the need to involve community members and charity services to support refugees via two parallel processes; a) managing trauma, and b) capacity building of communities in managing resettlement stressors.

The current study’s implications are considered within Bronfenbrenner’s (2005) ecological model and Miller and Rasco’s (2004) proposed six principles of community psychology (see Figure 3.). Papadopoulos’ (2004) Trauma Grid is also a helpful way to consider the range of consequences for SARYP following their experiences, (negative, neutral = resilience, and positive = AAD) across individual, family, community, and socio-cultural levels to inform therapeutic approaches.
Ecological Principles

1. “Psychological problems reflect the poor fit between the demands of people’s settings and the adaptive resources to which they have access.

2. ...interventions should prioritise and address problems that are of concern to community members...

3. ...preventions should be prioritised over treatment...generally more effective, cost-efficient, and humane...

4. Local values and beliefs about psychological well-being and distress should be incorporated into...community-based interventions.

5. ...ecological interventions should be integrated into existing community settings and activities to enhance community participation...

6. Capacity building, rather than direct service provision by mental health professionals, should be an intervention priority...reflects the ecological focus on empowerment”.

Figure 3. Miller & Rasco’s (2004, pp.376) six principles.

*Individual (microsystem)*

*Therapeutic Care*

Central to the SARYP’s accounts was the wish for attuned, containing relationships. Therefore the development of caring relationships should be prioritised before formal therapeutic activities commenced (Principle 2). Ehntholt and Yule (2008) suggest time should be taken to develop trust, and the SARYP’s pace of healing from their experiences should be respected. A ‘therapeutic witnessing’ stance (Blackwell, 1997) aligns with Papadopoulos’ (2002) concept of therapeutic care. Goodman (2004) recommends repressive coping (i.e. emotional avoidance) strategies should
initially not be challenged until RYP feel secure enough to explore alternative, possibly more adaptive, ways of coping where they are able to relocate their losses emotionally to develop new identities, roles and relationships (Stroebe & Schut, 2001).

**Exploration of Culture and Faith**

Space should be created to explore help-seeking barriers, such as the SARYP's conflict between wishing for support but advocating concealment (Whittaker *et al.*, 2005). Somali cultural beliefs around child development, expression and management of psychological distress, and how these have been impacted by the process of forced resettlement, should be considered (Ehntholt & Yule, 2006). Groen (2009) recommends 'cultural formulation' to explore individuals’ relationships with cultural norms, expectations and identities (Principle 4). Brune *et al.* (2002) found that when therapeutic interventions were valued by refugees, religious belief systems were helpful to the process only if they were not too rigid; therefore inhibiting ability to reflect. Erikson’s (1968) identity developmental stages may not fit with other cultural views of child development, with a broader approach which focuses on social competence and cultural meaning-making recommended by Garbarino and Kostelny (1996).

**Therapeutic Interventions**

A focus on agency, strengths, resilience, integration of experiences, and acknowledgement of socio-political and cultural factors were central in the SARYP and Focus group accounts as being important to SARYP developing a positive self-concept and psychological well-being (Principle 2). These factors are actively explored in narrative and testimonial therapies, which have been found to be acceptable and feasible among RYP (Lustig & Tennakoon, 2008). Narrative Exposure Therapy (KIDNET) was found to be effective in reducing PTSD and depression in a small-scale study of six Somali RYP, maintaining its effects at nine-month follow-up (Onyut *et al.*, 2005). However a dominance of Western models in MHS, and a paucity of literature on the clinical effectiveness of MHS and therapies with RYP
RESEARCH DOSSIER

remain. Michelson and Sclare’s (2009) service utilization study recommends integrating meeting RYP’s complex psychological and social needs through greater outreach work (Principle 5; discussed further below).

**Family and Peers (microsystem/mesosystem)**

**Therapeutic Interventions**

In consideration of the SARYP’s wishes to feel connected with others, and their expressed interpersonal difficulties or coping strategies with family and peers; family and group interventions (rather than individual) require further exploration. For example, running Somali fathers and sons days (Thorpe, 2007). RYP peer group approaches remain limited to a few small-scale CBT studies (e.g. Ehntholt *et al.*, 2005). Weine *et al.* (2006) suggests a family-based ecological approach which promotes flexibility of family beliefs and rules to build collaboration within families and with services to support RYP. This is suggested to repair attunement through increased communication of daily issues, and use of parent networks to support each other. Denborough (2006, 2008, 2010) also offers a number of narrative interventions through which collective and strengths-focused perspectives are centralised, and intergenerational conflict of refugee families contextualised. These group/family interventions are currently in the process of being evaluated, however are perhaps more aligned to Somali cultural beliefs of problems not being located within the individual (Scuglik *et al.*, 2007).

**Targeting Discrimination**

Lustig (2010) suggests connection with cultural heritage helps to stabilise RYP development within multiple systems. Whilst bi-cultural identities are associated with greater psychological well-being (Phinney *et al.*, 2001), numerous costs are also associated in navigating this. Blackwell and Melzak (2000) suggest continuity between cultures should be facilitated to aid internal cultural integration, increase positive self-concept, and ameliorate distress. Therefore celebration in school of all young people’s difference and diversity, and exploration of similarities, is suggested as possibly
preventative of discrimination and ‘othering’. For example, Chiumento et al. (2011) supported RYP’s integration through joint projects with British peers, which emphasised the universality of some experiences (such as bullying), reducing their loneliness and isolation.

**Community (microsystem/mesosystem)**

**School-based Interventions**

O'Shea et al. (2000) found that refugee families remained engaged with MHS following transfer from school-settings to CAMHS, therefore school poses a central position in providing and linking services. Developing school-based mental health programmes allows for intervention on multiple ecological levels, such as RYP’s adjustment and mental health difficulties, addressing many of Miller and Rasco’s (2004) principles (Lustig, 2010).

Literature suggests community services should offer child-centred, self-empowering activities (e.g. problem-solving, reflection). These activities, and unconditional support in working towards their goals within reciprocal relationships with significant people (e.g. teachers, charity professionals), have been suggested to facilitate hope and help RYP cope with environment and community changes (McCarthy & Marks, 2010; Yohani, 2010; Yohani & Larsen, 2009). Such programmes which support RYP to develop coping strategies, language capacity, sense of belonging, and control over their difficulties, have been found to be valuable and effective by both RYP and educational staff alike (e.g. Chiumento et al., 2011), increasing collaboration between families, charities, MHS professionals and school. However, greater consideration in how to engage Somali families may be needed, as strong connections between family and school do not exist in Somali culture (Guerin et al., 2003). Also such services remain small-scale, with generalisation of findings limited.

**Strengthening Links between Mesosystems**

In the context of current resource constraints in the NHS, and the expressed issues of the SARYP in the current study, strengthening community
structures and services (e.g. charities) has been suggested as the most effective way of reaching large groups of vulnerable RYP (De Jong et al., 2000) (Principles 2 and 4). Lane and Tribe (2010) suggest that there are many overlooked formal and informal service providers which support mental health in the community, therefore flexibility in, and collaboration between, different types of support should be explored (Ellis et al., 2010a). Ellis et al.’s (2010a) study suggests culturally appropriate service development is achieved through being informed by all key gateway providers (religious leaders who families consult, family, and school).

Multi-agency collaboration and flexibility also increases RYP engagement with MHS (e.g. Chiumento et al., 2011). Suspicion of MHS, lack of cultural alignment in conceptualisation, and RYP concealment could contribute to parents and adults not identifying mental health problems in RYP (e.g. Ellis et al., 2010a; Montgomery, 2008). Relative merits and preferences between Somali (e.g. cultural knowledge) and non-Somali (e.g. outside of community so greater sense of confidentiality) professionals in engaging SARYP and their families have been found (e.g. Whittaker et al., 2005).

Aligning with focus group suggestions, mental health co-ordinators or peer-workers from the Somali community could be beneficial for liaison and collaboration between parties (Guerin et al., 2004). This would help MHS learn about Somali culture and the active discussions and concerns in the Somali community (Johnsdotter et al., 2011), and in return enable the offering of NHS MHS, and consideration of ways of adapting service delivery and tackling stigma (Whittaker et al., 2005).

*Training, Supervision, and Consultation with Multi-Agency Professionals and Peer-Workers*

Gibson (2002) found RYP were willing to explore difficulties with those they trusted and felt were curious of their culture, but would not seek out support from professionals to do this. Therefore active enquiry from front-line service professionals, mental health co-ordinators, or peer-workers is necessary. However, as found in the current study, these people can feel anxiety and lack
guidance over how to manage and respond to the difficult issues raised by RYP (e.g. Yohani, 2010). Additionally, whilst teachers have been found to be able to detect and refer RYP for externalised distress (O’Shea et al., 2000), their ability to do this for internalised and concealed distress is less clear.

There therefore appears a two-way opportunity for training, supervision, and consultation as a preventative initiative (Principle 3), to enable everyone to effectively enquire after, contain and respond to SARYP’s experiences (Principle 6). This could include psycho-education of SARYP’s common psychological and adjustment issues (as valued by teachers in Chiumento et al.’s study; 2011), how resettlement experiences may have impacted on development (Davies & Webb, 2000), and to increase cultural competence (Henley & Robinson, 2011). Supervision and consultation can also create space for reflection on workers’ assumptions (e.g. cultural), emotional reactions, and practice (Gorman et al., 2003), and to nurture a hopeful stance important when working with RYP (Yohani, 2010).

**Policy (exosystem/macrosystem)**

The World Health Organisation’s (2004) ‘Prevention of mental disorders: Effective interventions and policy options summary report’ encourages ecological and family approaches in improving mental health and behavioural problems in RYP, which should inform local service and policy development. The Department of Health’s (2010) ‘New Horizons: Confident Communities, Brighter Futures’ report provides a framework for improving mental health and well-being in the community through the building of strengths, resilience and social capital, emphasising more preventative and early interventions compared to previous government policies. However refugees in general and RYP specifically are not well represented in this document.

Policies could therefore be improved through adopting community development-based approaches, being more informed through outreach with, and partnerships between, different agencies and stakeholders in order
to develop health-enabling community contexts. Lane and Tribe (2010) provide guidance on conducting community engagement to improve health (The National Institute for Health and Clinical Excellence, 2008) with black and minority ethnic communities.

4.8 Limitations and Future Research

The current study aimed to develop an in-depth and meaningful exploration of SARYP perspectives on the phenomenon of forced resettlement. Although all five transcripts were individually analysed in-depth, the inclusion of five participants has meant detail and nuances have inevitably been lost in order to develop master themes across all of the transcripts (e.g. the male participant's discussion of political issues in Somalia in comparison to the female participants). Future research would benefit from the use of case studies to allow for greater detail and quality when reporting findings (Smith et al., 2009).

The homogeneity of the sample, in terms of gender, may be a possible limitation in the current study. Literature suggests gender differences may exist in experiences of family relationships, culture, perceived discrimination and expression of psychological distress (Ellis et al., 2010b; Guerin et al., 2003; McMichael et al., 2011) whilst other research suggests little differences (Montgomery & Foldspang, 2008). Further exploration of male SARYP experiences should be considered in future qualitative research.

It should be acknowledged that the findings may only be relevant to comparable, local refugee populations (Smith et al., 2009). This study is therefore considered to be the first phase of on-going research using different samples. The implication of this study's findings for SARYP later in life and other groups of RYP needs further exploration (e.g. of how cultural socialisation occurs), including increased use of longitudinal research. The SARYP volunteered to participate in the current study, potentially reflecting specific active coping styles. Participatory action research therefore may be
beneficial to engage non-volunteering populations. In addition, exploration of family perspectives on SARYP experiences would also have been desirable if adopting a thorough ecological approach (Lustig, 2010).

Final possible limitations were the cross-cultural nature of the study, and not interviewing the participants in their first language. This may have lead to culture-specific concepts and nuances being overlooked or misunderstood, and aspects of their accounts of their experiences being constrained or withheld. Efforts to minimise the impact of these factors were taken by; a) the researcher gaining credibility and trustworthiness through being introduced by a charity professional who had strong relationships with the SARYP, and spending time at the charity bases interacting with the SARYP and their families, b) participants were given the choice of which language they would like to speak through offering an interpreter (as recommended by Hall, 2004), with all participants choosing to speak English, which appeared sufficiently fluent, c) the interview schedule and research documentation were community-informed, and member-checking of the findings was conducted by the researcher with the participants, d) the researcher read literature and had discussions with Somali RYP, parents, charity professionals and the Somali interpreter to develop an understanding of Somali culture, and e) the research aims and process were carefully explained to the interpreter so she understood the nature of information required (as recommended by Adamson & Donovan, 2002; e.g. to give a concept equivalence rather than literal translation), and involving her as a culture broker (link between two cultures; Raval, 2005) to privilege Somali concepts. Only two participants used the interpreter as back-up, and required this support in-frequently in the interviews. However the use of bi-cultural researchers may be beneficial in future research.

4.9 Conclusion

To the researcher’s knowledge, this was the first study that explored SARYP (13-19 years old) experiences of the whole process of forced resettlement. The SARYP identified loss of, challenges to, and wish for others to support
them in restoring self-agency, environmental mastery, sense of belonging, and relationships to increase their psychological well-being. Such support may subsequently enable them to process their experiences. Whilst this study aims to encourage Western professionals to reflect on the themes in their cross-cultural practice, further work is needed to develop feasible and effective approaches in helping SARYP, their families and front-line services to manage the SARYP's experiences of loss, separation, trauma, discrimination, family changes, and adjustment to new communities and environments.
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Appendix A. Focus Group Method

A.1 Qualitative Methodology
There is little research that explores front-line service providers’ experiences and practices (Yohani, 2010), therefore a qualitative methodology was chosen for this study to allow for wider exploration of their experiences.

Thematic Analysis
Thematic Analysis (TA; Braun & Clarke, 2006) is a qualitative method that aims to organise and richly describe themes. Following Braun and Clarke’s (2006) recommendation the researcher explicitly considered and adopted a critical realist and inductive approach, therefore keeping the same ontological and epistemological position adopted for the SARYP interviews.

Whilst the study focuses on the SARYP’s experiences of forced resettlement, the researcher was also interested in how services in the community which work directly with this population interpreted, understood and responded to these experiences to contextualise the findings. Therefore TA was considered to be a suitable method by adopting a rich semantic thematic approach in explicating the dominant themes in the data, and for considering the broader implications and significance of these. Braun and Clarke (2006) recommend this approach to TA when investigating under-researched views.

Previous studies using TA and focus groups as the method of data collection indicated that TA is suitable for exploring the knowledge and understanding of people who work with young people on a day-to-day basis (e.g. Molesworth & Crome, 2010). TA is also sensitive to exploring values across sub-cultures (Braun & Clarke, 2006), which may differ between front-line service professionals and the refugee populations they work with.
A.2 Participants

Sampling and Recruitment

Purposeful sampling was conducted identifying professionals from the charity and school within which it worked, and the NHS mental health services, who had a minimum of six months experience of working in their service and with refugees. The researcher disseminated information to the professionals via an information sheet (Appendix G).

Situation of the Sample

Six participants indicated that they would be interested in taking part, of which four actually completed the focus group. Two participants worked in education services, one in the charity, and one previously in the NHS. Table 3 provides further contextualising information to help situate the participants.

A.3 Data Collection Methods and Materials

A focus group was used as it is a convenient method that utilises group interaction in exploring group norms and cultural values, participants' experiences, attitudes and knowledge using everyday communication methods (Kitzinger, 1995). It was therefore considered an appropriate method for exploring different realities the professionals had about SARYP's experiences of forced resettlement, and suitable support (Krueger & Casey, 2000).

The researcher developed questions for the focus group following a format recommended by Krueger and Casey (2000). The questions sought to elicit front-line service professional’s perspectives and understanding of how SARYP process and negotiate the process of forced resettlement, their responses to the IPA themes, and how services could better support this population (Appendix J)
<table>
<thead>
<tr>
<th>Position</th>
<th>Service</th>
<th>Ethnicity</th>
<th>Length of time in service</th>
<th>Experience of working with refugees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Support Worker</td>
<td>Salusbury WORLD</td>
<td>White</td>
<td>4 years</td>
<td>Supporting refugee young people and their families in school and at home.</td>
</tr>
<tr>
<td>Head of Year School</td>
<td>School</td>
<td>Black</td>
<td>5 years</td>
<td>As a teacher in an area with a large population of Somali students.</td>
</tr>
<tr>
<td>Pastoral Care Support Worker</td>
<td>School</td>
<td>White</td>
<td>3 years</td>
<td>In the classroom with a large population of Somali students.</td>
</tr>
<tr>
<td>Consultant Clinical Psychologist and Family Therapist</td>
<td>NHS MHS and Private practice</td>
<td>White African</td>
<td>Over 10 years</td>
<td>In the Gatwick Detention Centre</td>
</tr>
</tbody>
</table>

Table 3. Contextualising information of participants

A.4 Procedure

The focus group lasted 75 minutes and took place in the school where the charity operates. The focus group was audio-recorded. Prior to the focus group, informed consent was obtained from the participants (Appendix H). All of the participants were given a debrief sheet following the focus group (Appendix I). The researcher took 'a backseat' to allow discussions amongst the professionals to naturally occur while following the questions devised (Kitzinger, 1995).

Ethical Considerations

Favourable ethical opinion was also obtained from the Faculty of Arts and Human Sciences Ethics Committee (see Appendix N).
Anonymity and Confidentiality

The necessity for confidentiality and anonymity of the young people discussed was explained to participants before the focus group took place, and their agreement to this was formally recorded in the consent form. Anonymity was sought throughout the study. Real names were only present on the consent forms, which were only seen by the researcher. All identifiable names and information were changed so that participants could not be identified from their interview. All of the information was stored in accordance with the Data Protection Act (1998).

A.5 Data Analysis

The audio recordings were transcribed verbatim and analysed using guidelines from Braun and Clarke (2006). The researcher immersed themselves by listening to the audio and repeated reading of the transcript, noting down initial ideas of meanings and patterns (See Appendix R for example transcript extract). Initial codes to identify semantic features of interest and patterns were then noted from the transcript, with extracts, using index cards. Coding of the data was data- rather than theory-driven. Themes were selected as patterns of meaning in the data which reflected an important quality of the responses in relation to the research question. The codes and respective data extracts were then sorted into potential themes and sub-themes using a thematic map (see Appendix S for example theme clustering).

The themes were reviewed and refined by all the coded data extracts for each theme being read to check whether they clustered together coherently, with some themes discarded and new themes developed for the thematic map if themes or data extracts did not fit. The coding was reviewed and refined until a satisfactory thematic map was achieved.

Finally each theme was defined and refined by organising the data extracts into "a coherent and internally consistent account, with accompanying narrative" (Braun & Clarke, 2006, pp.92). A detailed analysis was written
for each theme to clarify how its 'story' fits the research question and into the broader scope of the study (Appendix V).

A.6 Quality Assurance and Rigour
The same quality assurance principles of reflexivity, sensitivity to context, commitment and rigour, transparency and coherence as described in section 2 were followed for the focus group.
Appendix B. About Salusbury WORLD

Salusbury WORLD provides educational, social and emotional support for refugee children, and supports parents and the wider refugee community by providing home/school liaison, family workshops and outings, and also a comprehensive social advice service in London. They work to increase language ability and curriculum access as well as self-esteem and confidence. They also endeavour to raise awareness of refugee issues and to encourage integration. They welcome new children and their parents to school, with a planned induction programme, peer support and access to interpreters and translators as necessary.

They facilitate parental involvement in their children's learning, using family learning workshops, educational advice sessions, translation, interpreting and social opportunities. They hold regular, informal themed coffee mornings to build community links and networks of support. These have led to the provision of workshops from organisations in a variety of fields, for example educational and therapeutic. Emergency advice sessions are provided by the charity professionals, as well as advocacy on behalf of their clients. They provide a weekly session with the Citizen's advice Bureau (CAB), and refer on to suitable agencies where appropriate.

They run an After School Club and holiday activities to provide children with play opportunities, creative activities and outlets for self-expression. Positive outcomes include improved confidence and self-esteem, rapid acquisition of English, social skills and academic achievement. Salusbury WORLD gives guidance and support to schools and other education professionals via a comprehensive training package, custom-made INSET sessions, or individual consultancy. The training focuses on understanding issues facing refugee children and their families, and on offering positive responses for schools.
Appendix C. Parent Information Sheet

Refugee children's perceptions of forced resettlement.

PARENT/GUARDIAN INFORMATION SHEET

My name is Helena and I am a trainee Clinical Psychologist studying at the University of Surrey. As part of my 3 year training I have been asked to think about carrying out a piece of research. Your child is being invited to take part in this piece of research. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask me if you would like more information. Take time to decide whether or not you wish your child to take part.

What is the purpose of the study?
I would like to learn from your child about how they felt and coped with their experiences in their home country, of having to leave their home country and move to England, and about their life in England.

Why am I researching this?
I am passionate about listening to refugee children's experiences so that their stories can help others understand what it is like to have to leave your home country, to move to, and live in England. Your child's views are under-researched and not widely understood. Doing this research will mean the charity staff will be able to learn more about what has been helpful and unhelpful for refugee children moving to England. I also hope that by doing this research it will lead to other services understanding more about how it feels for refugee children to have to move to England and that improvements may be made so that your child and other refugee children in the future will feel more supported.

Does your child have to take part?
It is up to you and your child to decide whether or not they take part in this research. If you both agree your child can take part, I will ask you and your child
to sign a consent form. You and/or your child are still free to withdraw without
giving a reason, even after signing a consent form.

**What will happen to your child if they take part?**
Your child will be asked to come and have a talk with me about what it was
like having to leave their home country and move to England, and about their
life in England. They can bring someone with them if they want to and can
stop the talk at any time. They can also ask for an interpreter to be present to
help them with English if they want to. Usually talks last around an hour and
your child can chose not to answer any questions they do not want to.

**Will this talk be confidential?**
What your child talks about will be recorded and written up by me or a
transcriber. I may write some things your child and other children have said
down. An interpreter may also look over the transcripts to help me analyse the
interview. They will have signed a Confidentiality Agreement to not tell your
child's name, or what your child has said, to anyone. The only time we cannot
keep what your child says confidential is if they say something which suggests
there is a risk of serious harm to themselves or others. If this happens then I
will need to contact Salusbury WORLD, who will then check that your child or
others are safe.

Other people may read what I have written so they can understand what it's
like having to move from their home country to England, but no-one will be
able to tell it is your child that has talked to me. Any information about your
child will have their name removed so that they cannot be recognised. Unless
your child chooses to have you present at the interview, you will not be able to
know exactly what they have said to me, but you will be able to find out the
overall findings of the research when I have written them up.

Tape recordings will be permanently deleted once I have typed up what your
child has said. I will store written material in a locked cabinet. This will be
destroyed by shredding after 10 years. If I am worried about your child or
someone else, I will have to tell a member of staff at the charity so they can make sure your child is ok.

Therefore apart from me (and possibly an interpreter if requested) your child's identity will remain anonymous.

**What happens after?**
After the interview your child may feel upset. It is important that they talk to one of the staff at the charity or yourself if they do. Staff will be aware your child has been for an interview and will be on hand to offer support. If you or your child has any questions following the interview, please leave a message for a member of staff to contact me and I will arrange to visit again.

Eventually I hope to write up the research and publish it as part of my Clinical Doctorate course. I may in the future also present my results at meetings. Your child will not be identifiable in any of these results or presentations.

**What if I am not happy with the research?**
If you are not happy about the research or me, you should first raise this with me. If you are still not happy, please contact a member of staff at the charity and my supervisor.

**Contact for Further information**

Helena Kaliniecka  
University of Surrey  
Guildford  
GU2 7XH  
H.Kaliniecka@surrey.ac.uk

Professor Arlene Vetere  
(Supervisor)  
University of Surrey  
Guildford  
GU2 7XH  
a.vetere@surrey.ac.uk  
01483 692911

This study has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee at the University of Surrey.

**THANK YOU FOR TAKING THE TIME TO READ THIS**
Appendix D. Child Information Sheet

Refugee children’s perceptions of forced resettlement.

CHILD INFORMATION SHEET

My name is Helena and I am a trainee Clinical Psychologist studying at the University of Surrey. As part of my 3 year training I am asked to do a piece of research.

Why am I doing this research?

I would like to learn from you and other refugee children about how you felt and coped with your experiences in your home country, of having to leave your home country and move to England, and about your life in England.

Why do I want to ask you about these things?

I want to make sure that refugee children are listened to so that their stories can help others understand what it is like to leave your home country, to move to, and live in England.
Hopefully this will also help other refugee children in the future to feel supported.

**What will happen to me if I want to take part?**

If you and your mum/dad/guardian agree it is ok for you to take part, you will be asked to come and have a talk with me. You can ask me to get an interpreter to help you with English if you want to. You can also bring someone with you if you want to. You can stop the talk at any time using a special word that we agree together. You can stop talking to me whenever you want to.

**Do I have to take part?**

You do not have to take part – it is up to you and your mum/dad/guardian to decide if you want to. You can ask me any questions before you make a decision. If you decide you want to take part and then either you or your mum/dad/guardian changes your mind that is fine too. If you want to take part, I will ask you and your mum/dad/guardian to sign a consent form.

**Will what we talk about be kept confidential?**

What you talk about will be recorded and written up by me or a transcriber. I may write some things you and other refugee children have said down. An interpreter may also look over what has been written up to help me think about the interview. They will have signed a form to promise not to tell your name, or what you have, said to anyone. The only time we can’t keep what you say confidential, is if you say something which suggests there is a risk of
serious harm to yourself, or others. If this happens then I will need to contact Salusbury WORLD, who will then check that you or others are safe.

Other people may read what I have written so they can understand what it’s like to be a refugee child who has moved to England, but no-one will be able to tell it is you that has talked to me. This means unless you choose to have your mum/dad/guardian or charity staff present at the interview, they will not be able to know what you have said to me, but you can tell anyone whatever you want to about our talk. Tape recordings will be permanently deleted once I have typed up what you have said. I will store written material in a locked cabinet and keep it for 10 years. If I am worried about you or someone else I will have to tell a member of staff at the charity so they can make sure you are ok.

**What happens after?**

After we talk, you may feel upset, sad or angry or you may not. If you feel like this or have any questions you should talk to me, your mum/dad/guardian, or someone at the charity.

**Contact information**

Helena Kaliniecka  
University of Surrey  
Guildford  
GU2 7XH  
H.Kaliniecka@surrey.ac.uk

Professor Arlene Vetere  
University of Surrey  
Guildford  
GU2 7XH  
a.vetere@surrey.ac.uk  
01483 682911

This study has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee at the University of Surrey.

**THANK YOU FOR THINKING ABOUT TAKING PART IN THIS RESEARCH**
Appendix E. Interview Schedule

Pre migration life in Africa:
Thank you for participating in this study. I will be talking to you about your experiences/life in the country where you were born, the time between leaving that country and coming to England, and your experiences in England. I would like to begin by asking you about your experiences/life in ________ (your home country).

1. If you can remember, please tell me about your experience/life in ________ (your home country)?

Prompts:
Can you tell me about anything that was difficult/hard in ________ (your home country)?
Can you tell me about any worries you had at that time?
Did you feel safe at that time?
What were other people like to you?
Was anyone you knew hurt badly during this time?
How did you cope/try overcome these things?
How did you feel and what did you do about these things?
Was there anything you or others did that made it feel better for you?
What helped you feel more happy?
Was there someone to talk to when things were difficult/hard?
Was there someone to help your family when things were difficult/hard?
What got you through each day?
What was a normal day like? What did you do?
What were your wishes/hopes?

Period of Migration:
Now I would like to talk to you about your experiences/life during the time between leaving ________ (your home country) and coming to England.
Where did you go after leaving ___________ (your home country)?
How long did you stay in this / these country / countries?
Did you stay in any camp(s)?

2. Please tell me what happened between leaving ___________ (your home country) and arriving in England?

Prompts:
Can you tell me about anything that was difficult/hard in ___________ (transition country)?
Can you tell me about any worries you had at that time?
Did you feel safe at that time?
What were other people like to you?
Was anyone you knew hurt badly during this time?
How did you cope/try overcome these things?
How did you feel and what did you do about these things?
Was there anything you or others did that made it feel better for you?
What helped you feel more happy?
Was there someone to talk to when things were difficult/hard?
Was there someone to help your family when things were difficult/hard?
What got you through each day?
What was a normal day like? What did you do?
What were your wishes/hopes?

Post migration:
Now I would like to talk to you about your experiences/life in England.

3. Please tell me about your life in London.
Prompts:
Can you tell me if there is anything you find difficult/hard about living here?
Can you tell me about any worries you have?
Do you feel safe here?
What are other people like to you?
How do you cope/try overcome these things?
How do you feel and what do you do about these things?
Is there anything you or others do that made it feel better for you?
What helps you feel more happy?
Is there someone to talk to when things are difficult/hard?
Is there someone to help when things are difficult/hard?
What gets you through each day?
What is a normal day like? What do you do?
What are your wishes/hopes?
How do you find living in England compared to your country of origin?

4. If your teacher/a charity worker asked you to look out for another refugee child who has just arrived from your country, what kind of advice would you give them (from your own experiences)?
Prompts:
How would you help them?
If they were from a different country would you give them the same advice?

Is there anything else that you would like to tell us?
Thank you very much for your help.
Appendix F. Demographic Information Collection

GENERAL INFORMATION (can be collected outside of interview from charity staff and parents)

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<tr>
<td>1</td>
<td>Gender</td>
<td>Male</td>
<td>Female</td>
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<tr>
<td>2</td>
<td>What is their age?</td>
<td></td>
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<tr>
<td>3</td>
<td>Which country were they born in?</td>
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<tr>
<td>4</td>
<td>Main languages spoken at home?</td>
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<td>5</td>
<td>What is their religious background?</td>
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<td>6</td>
<td>When did they leave their home country?</td>
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<tr>
<td>7</td>
<td>When did they arrive in England?</td>
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<td>8</td>
<td>Did they stay in any other countries before England? If so, where?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Who is in their family? (brothers, sisters etc.)</td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td>When they first arrived in England were they separated from their mother/father?</td>
<td>Yes</td>
<td>mother</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Are they currently separated from their mother/father?</td>
<td>Not applicable</td>
<td>Yes</td>
</tr>
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<td></td>
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<td></td>
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<tr>
<td>12</td>
<td>Are they separated from other key family members?</td>
<td>No</td>
<td>Yes/who</td>
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<td>13</td>
<td>Who do they live with now?</td>
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<td>14</td>
<td>Did they go to school in their home country?</td>
<td>No</td>
<td>Yes</td>
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<td></td>
<td>What level of education have they completed?</td>
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<tr>
<th></th>
<th>Are they currently at school?</th>
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<tr>
<td>16</td>
<td>No</td>
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<table>
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<th></th>
<th>English skills?</th>
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<tr>
<td>17</td>
<td>Fluent</td>
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Accompanied refugee children's perceptions of forced resettlement.

STAFF FOCUS GROUP INFORMATION SHEET

My name is Helena and I am a trainee Clinical Psychologist studying at the University of Surrey. As part of my 3 year training I have been asked to think about carrying out a piece of research. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask me if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
I would like to learn from refugee children about how they felt and coped with their experiences in their home country, of having to leave their home country and move to England, and about their life in England, through interviewing them. I would also like to gather the perspectives of community services (education, charity, and the NHS) that work with this group, by discussing the shared main themes from the analysis of the interviews with you.

Why am I researching this?
I am passionate about listening to refugee children's experiences so that their stories can help others understand what it is like to have to leave your home country, to move to, and live in England. Refugee children's views are under-researched and not widely understood, nor are education and community service staff's views on the children they work with. I hope that by doing this research it will lead to other services understanding more about how it feels for refugee children to have to move to England and that improvements may be made so that refugee children in the future will feel more supported.

Do you have to take part?
No. It is up to you to decide whether or not to take part in this research. If you agree you want to take part, and you meet the inclusion criteria below, I will ask you to sign a consent form. You are still free to withdraw without giving a reason, even after signing a consent form.

Inclusion Criteria:
- Worked with Salusbury WORLD, Capital City Academy or the NHS for a minimum of 6 months.
- Experience of working with refugee children for a minimum of 6 months.
**What will happen if I take part?**
You will be asked to attend a meeting with other education, charity and NHS staff, facilitated by myself, to discuss your views and thoughts regarding the shared main themes from the analysis of the interviews with refugee children. The focus group should last around an hour to an hour and a half.

**Will this talk be confidential?**
What you talk about in the focus group will be recorded and written up by me. I may write some things you have said down, and other people may read this so they can understand the views of community services that work with refugee children, but no-one will be able to tell it is you that has talked to me. Any information about you will have your name removed so that you cannot be recognised. Therefore apart from me, your identity will remain anonymous.

Everyone who takes part in the focus group is encouraged to keep confidential what they hear during the meeting. This means unless you choose to tell anyone about your contributions to the focus group discussion, no one will know about what you said in the group. While discussion of your work with refugee children is encouraged, it is essential that you do not disclose any identifiable information in order to protect the identity of the children and respect the limits of confidentiality.

Tape recordings will be permanently deleted once I have typed up what has been said. I will store written material in a locked cabinet. This will be destroyed by shredding after 10 years.

**What happens after?**
If you have any questions following the meeting, please contact me and I will arrange to visit again. Eventually I hope to write up the research and publish it as part of my Clinical Doctorate course. I may in the future also present my results at meetings. You will not be identifiable in any of these results or presentations.

**What if I have a complaint?**
If you have a complaint about the research or me, you should initially raise this with me. If you are still not happy, please contact my supervisor.

**Contact for Further Information**
Helena Kaliniecka  
University of Surrey  
Guildford  
GU2 7XH  
H.Kaliniecka@surrey.ac.uk  

Professor Arlene Vetere (Supervisor)  
University of Surrey  
Guildford  
GU2 7XH  
a.vetere@surrey.ac.uk / 01483 682911  

This study has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee at the University of Surrey

THANK YOU FOR TAKING THE TIME TO READ THIS
Appendix H. Focus Group Consent Form

STAFF CONSENT FORM

Accompanied refugee children's perceptions of forced resettlement.

Name of Staff: ____________________________

Please initial

a) I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. □

b) I understand that my participation is voluntary and that I am free to withdraw this at any time, without giving any reason. □

c) I understand that I must not disclose any identifiable information of the refugee children I work/have worked with in order protect their identity. □

d) I agree to take part in the above study. □

Name of Staff member ____________________________ Date ____________ Signature ____________

Researcher ____________________________ Date ____________ Signature ____________

Helena Kaliniecka
University of Surrey
Guildford
GU2 7XH
H.Kaliniecka@surrey.ac.uk

Professor Arlene Vetere
University of Surrey
Guildford
GU2 7XH
a.vetere@surrey.ac.uk
01483682911
Appendix I. Focus Group Debrief Sheet

Staff Debrief Sheet

Thank you very much for agreeing to join the focus group today. By discussing your views and thoughts on the shared main themes from the analysis of the interviews with refugee children, you have helped me understand community services' perspectives on themes presented by the refugee children you work with. By discussing your views with me, I hope that other people will understand more how your services understand and support refugee children moving to England and how refugee children in the future can be helped.

If you would like me to, I can send you a summary of what this focus group found. If you have any questions, you can leave me a message and I will call you back as soon as I can.

My details:
Helena Kalniecka
University of Surrey
Guildford
GU2 7XH
H.Kaliniecka@surrey.ac.uk

My supervisor's details:
Professor Arlene Vetere
University of Surrey
Guildford
GU2 7XH
a.vetere@surrey.ac.uk
01483 682911

Thank you again for agreeing to take part.
Appendix J. Focus Group Questions

INTRODUCTIONS

1. From your experience, how do you see community and education services role in the Somali refugee community?

2. What is your understanding of what experiences of civil war and forced resettlement is like for Somali refugee children?
   - What impact do you think these have on them and their relationships?
   - What challenges do you think they have faced?
   - How do you think they cope(d) with these experiences?

HANDOUTS OF INTERVIEW THEMES DISTRIBUTED

3. What are your initial thoughts following reading the themes?

4. Looking at the themes, were they what you expected?
   - Anything that surprised you for being there/not being there?

5. How do you feel Somali refugee young people could be supported in light of these themes, and who by?

6. How do you view community and education services role in the Somali refugee community now?
   - What could you do the same/differently/more/less of?

7. Is there anything we have missed or you wanted to say but have not had the chance to?

FOCUS-GROUP CLOSED - DEBRIEF SHEET DISTRIBUTED
Appendix_K. Parent Consent Form

CONSENT FORM

Refugee children's perceptions of forced resettlement.

Name of Parent: ____________________________________________________________

Name of Child: ____________________________________________________________

Please initial

a) I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. [ ]

b) I understand that my child's participation is voluntary and that I am free to withdraw this at any time, without giving any reason. [ ]

c) I understand that my child may feel upset talking to Helena and that she will stop the interview if she is worried about my child [ ]

d) I agree for my child to take part in the above study. [ ]

Name of Parent ________________________________ Date __________________________ Signature __________________________

Researcher ________________________________ Date __________________________ Signature __________________________

Helena Kaliniecka
University of Surrey
Guildford
GU2 7XH
H.Kaliniecka@surrey.ac.uk

Professor Arlene Vetere
University of Surrey
Guildford
GU2 7XH
a.vetere@surrey.ac.uk
01483 682911
CONSENT FORM

Refugee children's perceptions of forced resettlement.

Name of researcher: Helena Kaliniecka

- Helena would like to talk to me about what my life was like in my home country, between leaving my home country and coming to England, and what it is like to live in England.
- Helena gave me some information to read with my mum/dad/one of the charity staff/guardian. I understand what it said.
- I may get upset talking about leaving my home country and coming to England, and if I want to I can stop talking to Helena at any time.
- I was able to ask Helena any questions I had.
- Helena will record what we talked about and write it up.
- I can tell anyone I want to about what we talk about.
- Helena will not use my real name so that other people will not know that she is writing about me.
- I can say 'no' to this.
- Helena will not mind if I say no.
- This will not affect any help I get.
- If I say yes I can change my mind without having to say why.
RESEARCH DOSSIER

My decision:

I agree to take part in Helena's research

OR

I do not want to take part in Helena's research

My decision about an interpreter:

I want to have an interpreter with me when I talk to Helena.

OR

I do not want to have an interpreter with me when I talk to Helena

My name:

My signature:

Today's date:

Witnessed by:

Name:
### Relationship to child:

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Date</th>
<th>Signature</th>
</tr>
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<tbody>
<tr>
<td>Helena Kaliniecka</td>
<td></td>
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<tr>
<td>University of Surrey</td>
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<td>Guildford</td>
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<tr>
<td>GU2 7XH</td>
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<tr>
<td><a href="mailto:H.Kaliniecka@surrey.ac.uk">H.Kaliniecka@surrey.ac.uk</a></td>
<td></td>
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</tbody>
</table>

| Professor Arlene Vetere |      |                    |
| University of Surrey    |      |                    |
| Guildford               |      |                    |
| GU2 7XH                 |      |                    |
| a.vetere@surrey.ac.uk   |      |                    |
| 01483 682911            |      |                    |
Appendix M. Child Debrief Sheet

Debrief Sheet

Thank you very much for coming to talk with me today. By talking to me you have helped me understand what it has been like to live in your home country, of having to leave your home country and move to England, and about your life in England. By telling me your story I hope that other people will understand more about what it is like for refugee children moving to England and that refugee children in the future can be helped.

It may have upset you today talking to me today. It is important that you tell your mum/dad/guardian, a member of staff from the charity, me or my supervisor if you feel upset so that we can help you. You can ask one of the staff to leave me a message and I will call you back as soon as I can. You may also like to ring Childline by phoning free: 0800 1111 or visit their website: www.childline.org.uk to talk about anything on your mind.

I will arrange to talk to you again, either face-to-face or over the phone, once I have written up what you had said in our talk. This is so I can check with you that I have understood the main points you were trying to say. If you do not wish to talk again, I can write a letter to you to let you know what I found out by talking to different refugee children about leaving their home country and moving to England.
Appendix N. Evidence of Ethical Approval from the University

Chair's Action

Ref: 620-PSY-11 (with conditions)

Name of Student: HELENA KALINIECKA

Title of Project: Perceptions of difficulties and coping with forced resettlement in refugee children from the Horn of Africa/Somalia: A qualitative approach

Supervisor: PROFESSOR ARLENE VETERE

Date of submission: 24TH MAY 2011

Date of re-submission:

The above Project has been submitted to the FAHS Ethics Committee.

A favourable ethical opinion has now been given.

Signed: Dr Almuth Mcdowall
Deputy Chair

Dated: 16th June 2011
Appendix O. Interpreter Information Sheet

INTERPRETER INFORMATION SHEET

My name is Helena and I am a Trainee Clinical Psychologist studying at the University of Surrey. As part of my 3 year training I have been asked to think about carrying out a piece of research. Please take time to read the following information carefully and discuss it with others if you wish. Feel free to ask me if you would like more information. Take time to decide whether or not you wish to take part.

**What is the purpose of the study?**
I would like to learn from refugee children about how they felt and coped with their experiences in their home country, of having to leave their home country and move to England, and about their life in England, through interviewing them.

**Why am I researching this?**
I am passionate about listening to refugee children’s experiences so that their stories can help others understand what it is like to have to leave your home country, to move to, and live in England. Refugee children’s views are under-researched and not widely understood. I hope that by doing this research it will lead to other services understanding more about how it feels for refugee children to have to move to England and that improvements may be made so that refugee children in the future will feel more supported.

**Do you have to take part?**
No. It is up to you to decide whether or not to take part in this research.

**What will happen if I take part?**
If one or more of the children request an interpreter to be present in their interview, you will be asked to meet with me so we can discuss the aims and nature of the research, and your role in the interviews.

The date, time and location of the interview(s) will then be arranged between myself, the child and their guardian, and you. You will be asked to interpret the child’s words in this interview and the interview will be audio recorded. The interviews with the children will be transcribed and analysed by me, and you may be asked to meet with

Helena Kaliniecka - Portfolio Volume 1  263
me following the interviews to check the accuracy of the language and cultural meanings in the transcripts.

**Will my involvement be confidential?**
It is up to you whether you would like to acknowledged by name, or as anonymous, in the reporting of the research.

**Will the interviews be kept confidential?**
The interviews will be recorded and written up by me or a transcriber. I may write some things the children have said down, and other people may read this so they can understand what it’s like having to move from their home country to England. Any information about the child will have their name removed so that they cannot be recognised. This means unless the child chooses to have someone present at the interview, no one else will be able to know what they have said to me and you. You will be asked to sign a Confidentiality Agreement form to agree to this. Tape recordings will be permanently deleted once I have typed up what has been said. I will store written material in a locked cabinet. This will be destroyed by shredding after 10 years.

**What happens after?**
If you have any questions following the interview, please contact me and I will arrange to visit again. Eventually I hope to write up the research and publish it as part of my Clinical Doctorate course. I may in the future also present my results at meetings. You will not be identifiable in any of these results or presentations unless requested.

**What if I have a complaint?**
If you have a complaint about the research or me, you should initially raise this with me. If you are still not happy, please contact my supervisor.

**Contact for Further Information**

| Helena Kaliniecka | Professor Arlene Vetere |
| University of Surrey | University of Surrey |
| Guildford | Guildford |
| GU2 7XH | GU2 7XH |
| H.Kaliniecka@surrey.ac.uk | a.vetere@surrey.ac.uk |

This study has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee at the University of Surrey.

**THANK YOU FOR TAKING THE TIME TO READ THIS**
Appendix P. Interpreter Confidentiality Agreement

INTERPRETER CONFIDENTIALITY AGREEMENT

Accompanied refugee children's perceptions of forced resettlement.

I have read and remembered the Interpreters Information Form concerning the research being conducted by Helena Kaliniecka. In my role as interpreter for Helena, I understand the nature and aim of the study, and requirements for confidentiality. I have had all my questions concerning the study and my role as interpreter answered.

A. Maintaining Confidentiality

I agree not to reveal in any way to any person, other than Helena Kaliniecka, any information gathered for the study in my services as interpreter.

B. Acknowledgement of My Services as Interpreter

I understand that Helena will acknowledge the use of my services in any reporting of the research. I have indicated below whether I wish that acknowledgement to be anonymous or by my name.

☐ I do not wish my name to be stated in the acknowledgement of the use of an interpreter in the research.

OR

☐ I agree that Helena can state my name in the acknowledgement of the use of an interpreter in the research.

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Appendix Q. Example Excerpts from Three Annotated Transcripts

Amina
RESEARCH DOSSIER

Major Research Project

Helena Kaliniecka - Portfolio Volume 1
said to them that I'll be back (laughs) so they...

I: So you told them?
P: If I don't say I won't be back, I'm just going go forever [yes] They were basically like saying 'why are you going to leave us in war, why don't you just stay with us?', stuff like that. Yes. So I just said that...

I: So you said that to them [yes]. And how were they with you?
P: mm?

I: What were they like with you, when you were saying good bye?
P: ... They were basically happy! They didn't want me to live in here, 'cause it's no good place. They want me to be happy; somewhere I can be. So they were happy, but I was sad.

I: You were sad, yea [yes]. And so you...had to...so you said goodbye to them, and was there anything else that you did, before you left?
P: Um, I give them presents like...um I said to my Mum...give me a present

I: And I can give to my friends, so I give them sweets and money and stuff like that, to say good bye to them. And a picture of me.

I: And a picture of you as well... And what did that mean to you, for you to be able to do that?
P: mm?

I: What, what did that mean to you, why was that important to you for you to be able to do that?
P: So they won't like, really miss me. And they can just live without me.

And just look at my picture when they, whenever they need it.

I: OK, so you said goodbye to them, and you gave them the sweets [yes] and so on. And how about did you have other family in Somalia or...?
P: Yea, um...my, my Dad's brother; basically my uncle, and his wife and his children...and they live in same area as us, and my grandmother...and that's all.

I: Did you know them quite well?
P: Yea, I used to go there all the time.

I: What...how was it to leave them as well?
P: ... It was alright for me, I just say bye to them [OK I was so young so I didn't (shrug), emphasizing it was OK. Here young ages are different.

I: OK, so it was more about your friends...

P: Yea (embarrassed laugh)

I: Yea, I can understand that. OK, so then you had to leave. So what, what did you feel like leaving, what happened? So you packed up your stuff...

P: Yea, I packed up my stuff, I had to pick everything up. I had to take...
Helena Kaliniecka & Portfolio Volume I
The people you lived with... your people. People who did not exist.

P: The people I lived with, they were alright, they were just nice, peaceful. they don't come to your house and just shout uninterruptedly, they were just peaceful.

I: OK, that's quite nice, so you said you made friends... [Yes] in Ethiopia as well. So the person who came to greet you, to meet you there [Yes] and... who else... who else did you meet?

P: Um... the girl that came to our house said that... she... has other friends that she know too... and she said to them that this girl is new, and welcome her' and that.

I: OK, so she introduced you to new people.?

P: Yes, she, that's what she did... I had a best friend who I was close to, and... yeah, I lived in Addis Ababa. That's where I lived.

I: So that's where you lived. So what happened with this best friend?

P: Nothing. Me and her were just best friends... 

I: And what was going good about that for you?

P: Um... because we... I used to spend the weekend there. She speaks the same language, the other people are Ethiopian. We used to meet and sometimes she stayed with us, we watched TV together, we spent alot of time together.

I: And that... so that... during that time, was that something that helped you having her there?

P: Yes, 'cause I had my really best friend... 

I: So what was it like leaving Ethiopia, and leaving her?

P: It was a bit sad, 'cause I had to leave my best friend. She was basically my best friend.

I: mm, really important to you.

P: And you have to leave all the good people, all the nice people that was so kind to you when you came for the first time. It was really sad to leave them.

I: I can imagine. And how did you cope with that feeling? It's hard feeling sad. 

P: Well, I try and think of something else instead, like... thinking... yeah.

I: What kind, what, what do you mean by something else?

P: Well I try forget all the things, like, I think of anything else but that.

I: And is that the same... now? If you find you're thinking about... the past?

P: No, I just forget, I want to forget something, something that people...

I: And when did you first completely, 

Helena Kaliniecka - Portfolio Volume 1
Emerging themes

Hassan - 47 mins

1. thing, one people, there's no different people.
2. I: OK, and how do you feel about that difference?
3. P: I feel like, if I'm in this country, I feel like I'm in the whole world in one place.
4. I: And how does that feel?
5. P: It feels happy.
6. (pause)
7. I: Thinking back to your, when you said learning and education are very important to you. So what's your, kind of, wishes and hopes for the future?
8. P: I hope I become a better... become a teacher or doctor. So like can help more people, especially refugee people. And also helping everyone, 'cause I used to be, I used to be... I used to be like, lower class, so I see I don't want that happen to other people. So I don't like to see the pain that I used to feel, in another person, 'cause I know what it was like, and I don't like it for them.
9. So, like, to make a change, to do like something different because there's a reason we learn history, to follow what people used to do, or whether it was a good thing to do.
10. I: So it's important to you to know about that.
11. P: Yes
12. I: And how would it make you feel if you could do that?
13. P: I feel like I'm changing the whole... changing something that there was to something else.
14. I: And is that different to what it was like for you when you were there?
15. P: Yea, and it's that something that's getting changing and getting better. So, I'd really like it.
16. I: I was thinking now, if somebody else asked you to look out for, or help out, another young person from Somalia who had just arrived. What kind of advice would you give them, from your own experience?
17. P: I would tell them, like, to do well in school, and also not forget what life was like. And also remember the people you left in your country, that they also need your help, because you came here so you need to get education so you can help, so you can give some money.
Also, in a mosque, for charity. Yea, especially this month coming up, Ramadan. Also you have to give...there's a reason why there's a Ramadan. When you don't eat and drink, it makes you feel how it's like the life for people the way they are living on. So you see how it feels. So why don't you like give them, 'cause you see this life is not better, you see how it feels, so you should give some money to charity. To the people.

I: So if someone new had just arrived, you'd say to remember people at home...And how could other people help them when they'd just arrived? How'd you think other people could help that person...because I remember you saying it was quite difficult when you first arrived.

P: Yea, everything is different. You see, some people came here and they just forget everything, they just want to do whatever they want, some young people just miss out. But, also, like to warn them, tell them this life is better, things are better, and also to remember who you are and what you are. Also, remember where did you came from. Remember that your friends and other people from your country, remember everything like...I do. I remember I used to move different places.

I also like to give more, I also like to tell these people who are fighting to just kill themselves, is a civil war. So I think they should just...they should just have peace. 'Cause the only thing changing Somali is the war, nothing else, but if there's peace there will actually be change.

I: And how do you feel, as part of all of that?

P: I feel so sad for all the people living there and so disappointed of people who are starting the wars, doing this and doing this. They actually...some of them doing some better stuff, they say we can do change, we can make a better life. WE have a better life.

The only thing we need is to just stop firing and killing more people, 'cause it doesn't make a change. I am 15 years old and I don't see any change, and there's a war that's 15 years old, I mean like 15 years there's a war, and I don't see change, and there won't be change if this war continue.
So I wish they would just stop and think, and use their brain, and see what it's like, to see this is what you're doing. You're ruining someone's life.

P: It's something that's really important to you.

I: Yes, that's all I would like to say.

P: I'm glad, thank you. Before we finish up, is there anything else you think is important for me to know about what it was like leaving Somalia and coming here?

I: I would just like you, if you could just pass to everyone, like, that if you help another person, that means God will help you and get you better. 10% different, better life than the one that you have. And also, the person is so pleased, and everyone is proud of you. If you do something good, you're proud of yourself. That's what you do.

And I'd like to let everybody know...there's people who's living a good life, and there's people who is living a bad life, so you can't compare them, so it's not fair. Everyone is a brother and sister, we need to make a change. Everyone's brothers and sisters, everyone. Even us in our religion, 'cause we all came from Adam and Eve.

Int: When I was there, I left Somalia in 1990. When we were there, there wasn't any tribe. We know what we are, we could say what tribe we are. But now they use it, what tribe you are, and they are killing each other.

I: That's all I wanted to say.

P: Yes, exactly, I forgot to say that. It's not good. You are who you are, I don't care what tribe you are. The only thing I know is that I'm Somali and I don't care. People in Somalia, they just use tribe. It's not good, it's ridiculous, it's not normal.

I: Yes, exactly. I don't see yourself as Somali/ P: I would tell that to follow and to make a change and to look to other countries. For example, this country, there's no anything. It feels like there, it's all, racist. Yes, racist.

P: How was it when you were there, about the different tribes? How was that for you?

I: You just have, especially for young people, you just have two options. They will say, what tribe are you, you're gonna kill you, or the other option that you have is that you can join us, and I don't like that. That's not good. I don't like holding a
but I failed, so yeah. It was great.
I: So you're saying, you were learning things in year 8 and 9
[until 10] until year 10. And what was it like in those... year 8
and year 9? You said it was like/
P: Oh ok, so like in year 8, I didn't know English, no-one was
bullying me. But in year 9, I was in the class, proper class,
and everyone did, cursing me, throwing like, some papers.
Yea, you know like, I couldn't, when I get up, I couldn't like
help myself. I would want to go to that person and slap them
or fight with them.
But in my head I was like no, even if you fight, they can
blame you, they can say 'she started it', and you don't know
English so don't get in trouble. Just like, be a nice person [Oh
Ok].
They was always like, bullying me, bullying me. I cry in the
class once, the teacher come up to me, and say 'what she
say? Are you OK?'. I was...I don't understand it like...I just
say like... 'm'm'm', I just shake my head (yes), and then that's it.
I: How did you cope during that time?
P: I couldn't cope. I just like, one day I used come to school,
one day I used to stop, so yea but, my Mum she say 'don't
let your friends stampede to you, just try, try always
she's pushing me, always my Mum and my Dad. They are
always like pushing me. They're like 'forget about it, when
you learn your English you can do whatever you like'.
And then year 10, the guy who tried to bully me, and I
couldn't, I didn't speak in the class, I was shy, but I
know the English. I learnt, I had help of my friends, my
neighbours, and my Somalian teacher.
So I just learned, and the next day, he threw the papers and
said 'watch what I'm going to do to this fresher girl' yea? He
turn the paper, I just turn around, 'Excuse me, what did
you call me? Freshy?'. And I was like, come here, and I just
shapped him, and all the class they were like 'boo, is that
you?'.
I was like [Click, pleased noise], just turn around, and they're
like 'oh my god, did she just...?', whispering yea 'since what
did she learn, oh my god!'. And I'm like 'excuse me, I know, I

Emerging themes

Isolation - safety
Integration without lang = dangerous
Rejection from peer attachment
Options for self-defense limited
Tact - seek that talk of thing
Lang = power
Struggle for self-restraint & anger - portrayed as your problem
To protect self.

Constant bullying overwhelming
Unable to communicate desires
Need to gain profile

Coping thru avoidance
Coping informed by others
Ignored others
- Encourage en courage
- Support to get to punitive self-development

Empowerment to deficit
Validity power of power assessing power & self-techno; an
achievement to be proud of.

Fantasy - 59 mins

Final reflection

Emotional bullying from peers, when pit with the
Ability for self-defense = protection

- Only option for self-defense physical

- Anger

Self-restraint = Reasoning

- Power = the same

- Need to be good all the time to avoid
   trouble

Bullying constant

- Other

-你可以

Bullying by lack of love, to understand of parents

- Unable to communicate needs

Bullying overwhelming

- PEOPLE

- Need for parental encouragement and support

- Friends

- School

- My own development & future goals

- Ignored others

- Learning requires support from multiple
   others

- Valid memory of finally being able to
   retaliate & bullying decides itself
   thru physical & verbal means

- Check his moment for maximum impact

- Sending a message to his peers
just don't talk in the class innit? So whatever you want to say
to me, just come to my face and say it’.
And they’re like ‘oh my god I’m sorry’ and the guy he was
like, he was scared of me. Yea [laugh], he never-like, since
that day he never touched me [Right!], never bullying me,
because he knows like, how I am now, and how I used to be
before.
I: And how did that feel for you?
P: I was excited, happy, because already like, I just (mumble)
that person. I was like, told them to stop what they was
doing. But before that I couldn’t understand it, and I was
feeling so low, I had like, low self-esteem but now my self-
esteeem was like building up.
So no-one didn’t touch me, they wanted to be my friend,
everything, they come to me, ‘oh, do you know how to speak
it?’ ‘of course I know how to speak it’, reading, I would read
for them, they are like ,wow, and the teacher was so
surprised, and then yea.
I: So you said people helped you, to kind of...there was Mr
Hassan [yea Mr Hassan] you said, and some friends as well,
did you say?
P: Yea my next doors’, some girl, she’s really nice. We used
to, she live like, my house is there, her house is there (next
to each other) but we never used to be friends because I
don’t know her. But when we see each other in school ‘oh i
know you’ , mm let me check my head, we always go the
house together, come back and my friends, school people,
they think me and her were best friends, but we wasn’t, it
was just like because she was helping me.
And now we are just like developed, every night she comes
to my house, whatever, we do a crossword and she would
like help me, and always like look in the dictionary, look
out the words I didn’t understand. Yea.
I: So other people were helping you (yea). So when you were
feeling really low, you had low self-esteem, was there
anything else that kind of helped, helped you or...? [No] Or
made you feel better about yourself?
P: No, just like, the English I learn, just like the
-Exhibition in being able to understand, therefore in having the means to understand and defend self
-Learning long = increased self-esteem
- makes you appreciate your own friends
Reveling in the admiration of others

- Building friendships a process
-Frequent. Completely see each other, sharing of home.
Friends are supportive of learning

Only learning English helped S.E.
communication with other peoples, my confidence was building up.

1: So its all around communication.
2: Yea, even now, that girl, she went to Uni, we still be friends, we always call eachother. Now, she told me you talk too much, you need to shut up!
3: I was like, 'listen, allow me, remember when back in the days, you used to say 'talk, talk, talk!', So when I talk now you're trying to stop me, oh please!' She was like, 'go ahead, I know you can't do it'.
4: And I was like, 'whatever'. Yea, we're still friends.

5: So at school, it was a bit difficult at the beginning [yaa] it got better [Yea] How about outside of school?
6: Outside of school I didn't have like no friends, I didn't, I can't understand the people, what they saying... but I don't know them. If there's a person and I don't know them, I don't talk to them. Yea, that's who I am [haha]. But if the person talks to me, I talk to them. [OK] So yea.
7: And you, we always go to shopping, she showed me like where's the shopping is. I always pick my Mum's money, she always come to my house like because, we just become like friend.
8: And whenever my friends, they don't know how to speak English, but now they learn it, they were always like, my Mum, she has the money, she's just like 'how much we need' she always take it out. My Mum, she shows her what she has and they always give it to her like whatever we want.
9: Even shopping we buy the clothes, the change we get? She always gives it back to my Mum. Mum's like 'you take the change' and she's like 'no Auntie'. We always like friends.
10: Even now we always talk.
11: She went to Uni, and now she gives me advice, because I didn't want to go to Uni before, before I was like 'ah yea, do yo have the comfort... confi... confident again'. She's like 'ayan, don't be silly, you used to be saying oh you don't know how to speak, now look at your better than me'.
12: And I was like 'yaa, but I hear Uni is really hard', even this country, when you come, it's really hard inimit, but what
about now? It's cool. She's like 'you have to go to Uni'.
That's why I want to go to Uni.
Before like, I wanted to be a nursery nurse, like helping
the children in school, because sometimes I do have lunch and
work with Miss [oh OK]. So I just go to her
playgroup, the playgroup she works and help the children,
yea. All these, all these schools, they like knows me now
(happiness in voice).
Yea, I wanted to do nursery nursing but I asked Miss
and she's like this... you are good at it but on the
other hand you have to go to Uni'. She just pushing me, even
now she is pushing me. Like when I write my personal
statement I give it to her and she read it, change it,
everything. Yea.
I: Right, and what was that like, her doing that, helping/
P: I'm like, now, this is my last year, I'm like 'I can go to Uni'.
Every night when I go to sleep 'I can go to Uni'. When I wake
up 'I can go to Uni'. So in my head, I can like cope with
everything, and then I think 'I'm going to finish this
education', so straight away I can go, I will go to Uni. But if I
make, like, myself low self-esteem, I will never going to go
to Uni. I'm just like ah (exasperated/tired noise)
I: So you keep telling yourself, that's what you do? [Yea] And
how does it feel having Miss going through, going
through your/ P: Oh, you ask me? I'm not going to lie. Me and she's
just like my big sister. Sometimes I don't call her like Miss.
I say 'Come here sister!' and all the teachers, they are
just looking at me, thinking 'this girl, she's crazy!' because all
my other friends, they call her like, 'Mia'. I'm used to
know her, Miss when she came to this school.
I was the first person to meet like, my Mum and her.
Because my Mum she couldn't, she couldn't like speak
English and they send us alot of bills to our house, like water
and electricity, like a 1000.
And my Mum and I meet her, we talk to each others, she's
like 'what you do?' and she's like 'I help about the
children... the people, about the house and everything'. So
my Mum, she has a problem, so she... And the first person
my Mum came to was Miss [Miss], and my Mum and her,
they become like friends, like, yea.
And her, still I help her. I told her when I left... when I left this
school 'don't worry, I will meet you, sure I am sure' (smiling)
She's just like, my big sister and at the same time she's like my
teacher.
Sometimes, my English, it's not well, need to do it right, it
needs more effort. Just write it the way I speak, no full stop
or anything. I always like, when I do my work, I give to Miss.
She will read it, she will make like... she will do like bullet
points for whatever I have to do, and she will put like a
red... red colour, this doesn't make sense, this sentence. So I
have to do it again, and I have to send to her.
I: How does that feel?
P: It's so... I just like, myself, I can't believe, I'm just like, this
situation. When I just like... You know sometimes when you
have a memory, when you sit and you just remember
something and you laugh. Me, when I went down, I used to feel
like 'Oh my God, year 8, year 9, year 10' I feel now, look at
the difference! Yea, it was just like, I help her. It's really
good.
I: How do you feel about yourself then (Now... or?) when you
look at yourself? Yea now?
P: I feel so great, so happy, just enjoying my life. My friends,
me, I have like, at lot of friends now. Teachers, friends,
outside school, inside, I have a lot of friends. They never see
me, as just like a sad person.
They always see me like smiling, talk, like happy. They always
just say 'what do you do? What do you like eat at night?', I'm
like 'nothing', 'what do you eat in the morning?', 'nothing',
'why are you always happy? I never see you sad!'. I'm just
like, that's who I am, I can't change myself, Yea.
I: And do you... do you think you've always been a happy
person?
P: Yea... yep... I'm always happy. Even if you see, like, if you
see me, like, before you see me you'd be like 'this girl, she is
so rude', but when you're used to me, like 'Oh my God, I

Friendships built on mutual support: should help to create
friendship with friends, family, and teacher.

Self-develop a struggle:

Content from security: friendships

I don't feel as happy.

Identification of self as happy person: being admired by others

Develop a primary that suits the client to be earned

The other
do challenge, develops

Friendships built on mutual support: should help to create
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Appendix R. Focus Group Transcript Extract

Mental health Practitioner:... I think actually it makes sense for the schools to fairly proactively address this issue, because the payback as in the behaviour... just makes, just makes for everyone much easier, management if like... class management. You know - As soon as you start attending to the issues of the individual, and the strengths of the individual, and I'll keep emphasising that because I think it's a really important thing, then you don't have people having to act out, because they have to show that they are cool and they can do it like these local people or whatever the case may be.

I mean for the local people as well, as again, I wouldn't exempt them from this thing of celebrating their culture, of who you are. So I think there's an advantage, if you are actively looking towards, I think I'm hearing this from you anyway, looking towards giving this person a healthy sense of his or her own identity, then you have got better behaviour, better results academically, better everything.

Researcher: What do you think about that kind of... what [the Mental-health Practitioner] saying?

Head of Year: I have to agree, obviously, because she is agreeing with me [laugh]. But yeah, I think it does come down to the individual. And you know, from the kind of little knowledge that I have got from the psychological perspective is all about - it has to be person-centred. That's my understanding and you know in terms if you are going to work with an individual, you have to work with that individual, so where they come from is a big part of who they are. And - so you know, giving them a healthy sense of where they come from is really, really important in addressing a lot of issues, because a lot of issues start from their roots. Your identity are your roots and from there, unless you know yourself, then everything else kind of falls into place. And you start to understand why did you certain things, and then again, onto other aspects of psychology. But initially - with
every human being you have to understand where they come from... And
you know - You don't have to come from there to understand where they
come from. I think just - Like you said the ability to come and give them the
space to speak and just be interested in them, it may go a long way.

'Cause you know, [Charity Family Support Worker] is far, in terms of
culturally and in terms of, you know, looking at people on the surface, you
wouldn't necessary put her to be working with a group of 20 Somali
mothers, but at the same time, the idea that she cares, that she is open
even enough to embrace them, that gives them the space to open up and the space
to embrace her as well. And you know, then they open up their world a little
bit to the outside because somebody else has opened up their world to them.
And I think in terms of building relationships, when we have someone
outside of their culture, to come, and that's when it takes a little bit of time
to build their trust, but once you have their trust, like in most cultures, once
you have their trust, it's there, it's not going anywhere because - you care.

And that's the same thing when working with young people, once you have
their trust, then it's there, they know you care. So they open up to you,
they're going to want to work with you. All they want is somebody who
cares enough to sit down and listen to what they got to say, you know, just
wanting to understand is probably just as good as knowing where they come
from. Probably even better, as you don't have assumptions and you don't
come with baggage, you don't come with your own experiences to put on
that person. You're just coming as a blank canvas and saying, 'you know
what, I actually don't understand, tell me a little bit about where you come
from', you ask enough questions then you help them figure out themselves
before you get to understand where they're coming from, which in itself is
very, very beneficial for them.

Charity Family Support Worker: And I think sometimes - what's maybe
helped me a bit in my job is like, as you say, like if you - 'cause I'm not
Muslim, I'm not Somali, I'm very white - appearance and all those things
but in a way sometimes - sometimes it’s a bit safer, because the women I’ve worked with, or the kids I’ve worked with in the past, I’m not going to make certain judgements that maybe I would about other kids, or have certain prejudices, or - expectations, of how they should be or how they should behave or - I’m not connected to people in the community in a way where I would tell anyone anything, or talk in an environment, and sometimes that helps because you have, you know - that sort of - different expectation and it’s a bit safer - and sometimes it isn’t. It depends really.

Mental health practitioner: And also it can make you curious. Like the thing that you said, I don’t think we need to understand every culture, we don’t anyway, you know, I think what we need to do is accept that we don’t and go ‘I don’t know anything about where you come from, tell me about it’ [agreement]. Make that person the expert rather than - thinking that we should have expertise on it.

Head of Year: That’s true, that’s true - and then that way, they re-affirm their own identities as well, they re-affirm where they come from, re-affirm who they are, and then through that, they begin to - heal themselves in a way, they get to help themselves, they do half the job for you so-to-speak.

Researcher: How do you think we could do that? So we’ve had some ideas, saying about mentoring and so on... I mean do you think there’s some things that should be done differently from how things are approached now, or things we could carry on doing the same but doing a bit more of - I’m wondering about comparing to what’s happening now...

Head of Year: I’m not too sure what is happening now, to be honest! I don’t know what could be done differently, but I think my suggestion would be to have...groups, that would help to kind of - if you have groups - I know someone here, one of the kids here said ‘when I was in Somalia, we used to sit around and tell stories, while here it’s every man to themselves’ so - if you have the group, again they will come together and they’ll be telling
stories, and they get to experience their own culture within themselves. You’re just there as the facilitator, but that in itself may be beneficial in helping them come together and it’s a good way of helping them to - to remain - to be able to integrate within this culture well enough but at the same time, still staying true to their own identity. And I think that’s quite important.

Mental health practitioner: Do you have classes in this school that would lend themselves to...something like ‘Education for living’ or something like that?

Head of Year: We have, uh...Religious Studies, a module they do for GCSE. And they have something called ‘Learning for Life’.

Mental health practitioner: ‘Learning for Life’, I guess that’s what I was thinking about.

Head of Year: ...teaching them social skills and all of that is covered under one umbrella. But within the humanities-based subject they do touch on...like citizenship, like [Pastoral support worker] said we have activities and events within the school that celebrate cultures as well.

Mental health practitioner: Because what I’m thinking, what would possibly be useful, and might be a role for - I don’t know, I wouldn’t say the NHS particularly, but is for - training of those teachers who are busy doing that sort of thing, in how to open up those kind of conversations in a useful way [agreement], which both means the teacher can apply that in a way, but also models they kind of attitudes you want in the community - Be it celebrating cultures, accepting the diversity of other people, or really being quite excited about the person sitting next to you has had really different experiences from you, instead of going ‘either be like me or you’re not cool’. So I guess I could see some....place for specific training around a model which is strengths-based...
Appendix S. Example Theme Clustering in the Focus Group Analysis

Theme Four: Coping
Theme Five: Awareness of Barriers in Supporting SARYP
Theme Six: Ideas for SARYP and Community Engagement
Appendix T. Extracts from Reflective Diary Kept by the Researcher

1st December 2011 – Following two interviews
I was really struck by the girls’ frustration around their roles at home. My gut reaction was frustration too. I know a lot of that may be down to my Western values of gender equality, but I can hear in the girls accounts how much they are struggling to balance a wish to pursue an education which takes up so much time, with having so many chores to do at home too. I admire how they seem to battle on, despite these frustrations, but can’t help wondering how life might be different for them if they were boys. I can’t remember the boy I interviewed describing these frustrations. I think I may need to be careful when analysing the transcripts, to make sure I bracket off my gut reactions about fairness and to listen to how these young people understand and cope with these experiences.

Another thing I really noticed was how much effort the girls exert into putting on a brave face when they are feeling low, that feeling or remembering sad things is undesirable. I could see them doing that in the interview too, cutting themselves off and changing topic. Is this a cultural thing, or is it because they don’t know how else to cope after such journeys of survival? They both said how important it is for SARYP to be cared for and listened to, but is there a risk that school wouldn’t know this if they are so good at hiding their emotions? They have been through so much, yet they keep on fighting. To say they were passive victims would miss the point entirely.

January 12th 2012 – during the process of analysis
There are so many potential themes! The more I read and the more notes I make, the more possible connections there could be. Trying to separate them into master themes feels difficult as I could go with a temporal sequence, so coping etc in pre-migration, transition, and post-migration periods, or across these but divided into impact and reactions to their experiences. I’m also noticing alternative sources of information creeps into
my thinking during analysis, such as the charity family support worker telling me about how badly one girl is being bullied, yet she didn't really go into this in her interview with me. I need to be very careful to bracket off this knowledge and my assumptions in general (especially as mine are more likely to be based on Western norms and values) and stay close to the text. I do wonder how researchers are able to analyse interviews they didn't conduct. When I'm reading the transcript I can hear in my head how they expressed it, see their facial expressions in the pauses. There's so much richness in tone of voice and so on, and I find that really helps to re-centre me back onto listening to how the young people are actively making sense of their experiences in the transcripts, privileging their meaning-making rather than what outside theories and sources have to say.
### Appendix U. List of Focus Group Themes and Sub-themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SARYP experiences from forced resettlement</strong></td>
<td></td>
</tr>
<tr>
<td>Theme One: Multiple forms of trauma</td>
<td></td>
</tr>
</tbody>
</table>
| Theme Two: Adjustment to difference | a. Difference overwhelming  
b. Generational differences |
| Theme Three: Struggles with integration | a. Prior-experience dependent  
b. Discrimination and negative assumptions |
| **SARYP responses to experiences from forced resettlement** | |
| Theme Four: Coping | a. Distancing from or aligning with Somali identity  
b. Concealment |
| **How can UK front-line services help?** | |
| Theme Five: Awareness of barriers in supporting SARYP | a. Services’ assumptions  
b. Misalignment around the norms of disclosure and the offering of support  
c. Cultural differences in understanding mental-health |
| Theme Six: Ideas for SARYP and community engagement | a. Support from people with shared or different heritages/experiences  
b. Creating space and building trust  
c. Outreach  
d. Community links |
| Theme Seven: Supporting integration and psychological well-being | a. Increasing sense of mastery  
b. Paradigm shift in service models, delivery and roles  
- Celebration of cultural diversity and identity with the focus on strengths and resilience  
- Community-based services and group interventions  
- External support for developing community-based services  
c. Increasing professionals’ awareness |
Appendix V. Full Focus Group Analysis

This appendix discusses each of the seven themes and sub-themes, with verbatim quotes drawn from the focus group transcript to support the analytic claims made.

V.1 SARYP Experiences of Forced Resettlement

Theme One: Multiple Forms of Trauma

This theme relates to how the professionals spoke about how trauma can be perceived in experiences of hardship, loss of home, and negative social experiences, as well as from witnessing violence. This theme therefore implies that PTSD may be an over-simplistic frame-work in which to understand SARYP experiences:

...their experience within their home counties, so it could be traumatic, or it could just be a trauma of having to leave - or - and being sort of ripped from your home and everything that you know. And then the journey, which can be pretty hard, so you are going through different countries...But then also how you're treated when you get here...you know, the police, immigration treat people absolutely atrociously (Charity family support worker).

Theme Two: Adjustment to Difference

This theme depicts the professionals' understanding of the challenges SARYP and their families face during the process of adjustment to life in the UK.

a. Difference Overwhelming

The difficulty of negotiating new cultural and social norms and systems was observed by all professionals, with differences having the potential to be perceived as 'intrusive' (e.g. involvement of social services) and overwhelming:
...moving from one country to another country, to a new school, different culture, different language. I think all of that can be quite hard to handle (Pastoral support worker).

b. Generational Differences
SARYP were portrayed as negotiating difference in a way their parents could struggle to understand in their cultural framework. This may reflect the different pressures the different generations are exposed to, where the SARYP are wishing to 'assimilate' with their peers, and their parents wish to maintain their culture (Berry, 2001):

...they get told that by their parents [about respect for teachers], but then they mix with the kids, and the kids don't emulate that. So that they will be rude to teachers...that's where the confusion can get worse. Because then you have got parents who can't speak fluent English, they don't understand the educating system, and now doesn't understand why their child who was so good before is now in compliant. (Pastoral support worker).

Theme Three: Struggles with Integration
The relative marginalisation and integration with British peers and the wider community was perceived to be a dominant struggle for SARYP.

a. Prior-Experience Dependent
Perceptions of integration varied depending on the forced resettlement experience of SARYP, with those arriving via Europe rather than Africa being seen as more familiar with Western systems and communication.

...those who came via Sweden and Holland, their behaviour tends to be a lot calmer and - they tend to be able to integrate into the school system a lot better than those students who haven't (Head of Year).
Those who lived in the UK for longer were also perceived as finding it easier to integrate due to greater socialisation experience with British peers, whilst those who arrived in their adolescence were seen as more isolated. Friendship groups were seen to have formed and consolidated by adolescence, with possible assumptions around the importance of conformity with peers as influential at this developmental stage (Erikson, 1968).

...they have kind of integrated, because they have known people from the primary school. So they have got that relationship already. (Pastoral support worker)

...the ones that have come over, later on as well, in their kind of like 13-14. And they are coming to the secondary school. Like you said, I do feel they are quite isolated (Pastoral support worker).

b. Discrimination and Negative Assumptions

This sub-theme refers to the rejection and persecution of Somali and wider refugee populations by peers, the wider society and as promoted by political-social environment, which makes integration difficult for SARYP and their families. Therefore the sub-theme suggests that the process of integration is influenced by multiple levels of the social and ecological system the SARYP find themselves in, which could have a significant impact on SARYP’s sense of self.

...they have experienced a lot of bullying at school (Charity family support worker).

The way they are seen, the way they are spoken about, the way they are treated as well within the ethnic groups, it's almost like they are an underclass (Head of Year).
...we have an issue at the moment with our economy and our debt. And whenever something like that happens where people haven't got jobs, it's easy to blame another community (Charity family support worker).

V.2 SARYP Responses to these Experiences

Theme Four: Coping

This theme centres on the professionals understanding of how SARYP cope with and manage the impact of forced resettlement. They perceived SARYP as active agents in adapting to their new lives, although in ways which meant a rigidity or rejection in identity, or ways that made it difficult for the professionals to feel able to support them.

a. Distancing From or Aligning with Somali Identity

The SARYP were observed by professionals as either distancing themselves from their Somali heritage, through bullying newer SARYP or trying to be similar to their British peers, or by joining exclusively Somali groups as a way of self-protection. The SARYP's self-concept therefore seems to become polarised in response to wider social judgements:

And I have heard new arrival kids being bullied by kids who were born here, or been here longer ... It's sort of a power thing (Charity family support worker).

...they will start to copy their behaviour, because it's a way of fitting in, and being accepted (Pastoral support worker).

...we have big groups that are coming together and then kind of being a force (Head of Year).
b. Concealment

SARYP were also suggested to be concealing their distress, either by becoming withdrawn or by being selective of where they expressed their difficulties. Suppression therefore may be being adopted as a coping strategy by SARYP, possibly reflecting cultural norms around emotional expression, or a vestige response to trauma from across their forced resettlement experiences.

He was just in his own little world. But when he was at home that’s not the way he was at all (Pastoral support worker).

V.3 How can UK Services Help?

Theme Five: Awareness of Barriers in Supporting SARYP

This theme focuses on the importance the professionals put on the need to understand and overcome the barriers in engaging and supporting the Somali community, in order for UK services to be able to support SARYP and their families appropriately and effectively.

a. Services’ Assumptions

Some of the professionals felt negative assumptions about the success of engaging a Somali community could prevent them from being offered support, with the need for more reflection on services’ assumptions and practice. Cognitive heuristics of generalisation and black-and-white thinking therefore may be obstructing further exploration in understanding this community.

I hear a lot of stuff, you know, generalised, oh, like Somali community don’t want to engage with schools. And actually my experience is just the absolute opposite, but I think that we have to think about how we engage with a community (Charity family support worker).
b. Misalignment Around the Norms of Disclosure and the Offering of Support

The professionals talked about how it was difficult to understand and support SARYP and their families due to the community’s reluctance in sharing this information. They suggested that the SARYP tended to express their distress through behaviour rather than verbally.

...they are quite a proud community as well, so they don't divulge that much when it comes to supporting them (Head of Year).

...refusing to do the work or arguing with the teacher - is a way of not only getting out all those feelings that you have, but also then getting support afterwards (Pastoral support worker).

This lack of disclosure, and form of communicating distress, led to some of the professionals feeling fearful of distressing SARYP further if they were to approach them to offer support, which meant support was only offered if difficulties were disclosed, and therefore the creation for a system which is not meeting the SARYP needs or wishes:

My role is not to, like, re-traumatise people and drag their - you know - I'm not a therapist and I don't think that's appropriate (Charity family support worker).

...it would have to be something that was divulged to us in order for us to put something [in place] (Pastoral support worker).

c. Cultural Differences in Understanding Mental Health

The professionals expressed opinions on how MHS are currently delivered may not be attuned or aligned with Somali understandings and approaches to mental health problems and general coping, leading to a lack of engagement or appropriate support being offered. Many of the professionals believed that mental health problems were a taboo in the
Somali community (viewing them as permanent and incurable) and therefore psychological distress as something to be kept private.

...when it comes to mental health, it's almost like, if you are crazy, you are crazy, there is no fixing it type thing. So that's why they would very much like to shy away from that. You know, if you even suggest to a parent that their child might have some mental health issues, it's a massive taboo (Head of Year).

...a lot of them come to this country with very much a village mentality, where you don't talk your business outside the house (Head of Year).

It was also suggested that Westernised models of health care may not be an appropriate or sensitive approach for supporting SARYP.

In the NHS, we have got a model, which is quite Westernised, it's like 1-to-1 and it's quite intimidating and it doesn't fit into everyone's idea of support (Charity family support worker).

Theme Six: Ideas for SARYP and Community Engagement
The professionals had a range of ideas of who, where, and how best to facilitate engagement with this group.

a. Support from People with Shared or Different Heritages/Experiences
The professionals explored the relative merits of support from people with shared heritage, who could facilitate engagement through creating links between communities and opening up understandings, and people of different heritage, who may make fewer judgements and be more curious in understanding their experiences.
...work with someone from their culture, who can come in and sit down and work with them so they trust you enough to allow you in (Head of Year).

...just wanting to understand is probably just as good as knowing where they come from. Probably even better, as you don't have assumptions and you don't come with baggage, you don't come with your own experiences to put on that person (Head of Year).

cause I'm not Muslim, I'm not Somali, I'm very white... sometimes it's a bit safer... I'm not going to make certain judgements that maybe I would about other kids, or have certain prejudices ....I'm not connected to people in the community in a way where I would tell anyone anything. (Charity family support worker)

b. Creating Space and Building Trust
Regardless of heritage, the efforts made to create space for SARYP to talk about their experiences were deemed as central to eliciting engagement. The professionals suggested it takes time and effort to gain trust before SARYP would engage with support offered:

...once you have their trust, then it's there, they know you care. So they open up to you, they're going to want to work with you. All they want is somebody who cares enough to sit down and listen to what they got to say (Head of Year).

It really is important to open up a conversational space (Mental health practitioner).

c. Outreach
The professionals suggested that a proactive outreach approach would be most suitable in engaging SARYP and their families, actively asking and giving them the opportunity to talk about their experiences, and raising
awareness of what services are available. This stands in contrast with or highlights necessary additions to current services approaches.

...allocate a person to them automatically...and for them to actually ask ‘How was it getting here?’ (Mental health practitioner).

...helping the communities to understand the purposes of the NHS as well. Because obviously, if we’re talking about mental health, in what formats does it come in, you know, when trying to break down that taboo in itself - maybe one way is going down [there]... (Head of Year).

d. Community Links
Greater links within community settings, especially schools, was thought to be the most effective way of engaging the Somali community, with location of power and ownership identified as important factors in engagement. This suggests clinic and hospital service bases are alienating the Somali community.

...services that the NHS does provide, being able to put that forward to families, to communities via - the community centres, wherever, via a school and that way the parents can engage (Head of Year)

Certainly outreach, and like you said, community centres - and spaces where people feel they have power, they feel safe and feel relaxed, they’re used to it and they know it. (Charity family support worker)

Theme Seven: Supporting Integration and Psychological Well-Being
The staff had a variety of thoughts of how SARYP and their families could be supported in their integration with British society whilst retaining their cultural identity, and improving their psychological well-being.
a. Increasing Sense of Mastery

Initiatives to help families to gain environmental mastery and a chance to contribute to their new country were suggested as ways of helping them feel part of and accepted by British society, and be less marginalised.

I work with about 20 parents...So, one, they could learn how the system works, and we can support you with that... And then it sort of invites parents to come in the school, and they feel like this is their community as well (Charity family support worker).

I think if the government actually encouraged people to work when they are new to the country, and set up these schemes... as opposed to just throwing money at people. I don't think we would have that animosity (Pastoral support worker).

b. Paradigm Shift in Service Models, Delivery and Roles

- Celebration of cultural diversity and identity with the focus on strengths and resilience

All of the professionals felt efforts to support all young people to embrace their identity and difference, and develop a coherent narrative about themselves, would help their integration and psychological well-being.

...celebrating specific identities and saying ‘this is who I am, I don't have to become a British lookalike, because I bring some other things to this country' (Mental health practitioner).

Your identity are your roots and from there, unless you know yourself, then everything else kind of falls into place. And you start to understand why you do certain things (Head of Year).

Instead of being problem-focused, the professionals believed exploration of the SARYP strengths and resilience would open up positive
connections with others, and develop sense of self. This sub-theme therefore suggests a paradigm shift from the dominant problem-focused models (e.g. CBT), to more positive psychology and social constructionist thinking (e.g. narrative therapy)

...doing something creative, or you know, I don't know, that's not so 'you've got a problem' (Charity family support worker).

...being able to own, who they are, and who they are out of what they have experienced and the strengths that come from that (Mental-health practitioner).

- Community-based services and group interventions

School and community centres were unanimously identified as locations support services should be based, rather than in clinics or hospitals. Therefore interventions and support that are more aligned with and attuned to the Somali community’s social and cultural norms within families and communities were thought to be more organic and helpful. Central to these suggestions seem to be an approach that is normalising and contextualised within systems, rather than medicalised and pathologising:

...the NHS could probably play a part, looking at family support and group support. So you are working with groups of people as oppose to targeting that individual (Head of Year).

One of the kids here said 'when I was in Somalia, we used to sit around and tell stories, while here it's every man to themselves' so, if you have the group, again they will come together and they’ll be telling stories, and they get to experience their own culture within themselves (Head of Year).
- **External support for developing community-based services**

For community-based and focused support to be effective and comprehensive, all the professionals expressed the need for support from external bodies. This suggests that the role and practice of NHS mental health professionals needs to be adapted to take more specific and supportive roles, such as developing more accessible services, providing specialist interventions when needed, and offering training to community professionals.

...best way of bridging that gap is going via community centres...so when there is a child with some serious problems...they can seek the clinical support that they need, and it's there and it's available for them when they need it (Head of Year).

I can see the benefits, like as you said of the clinical aspect, especially [for] those children who are suffering from serious trauma, I think that's necessary you know (Head of Year.)

...training of those teachers who are busy doing that sort of thing [running 'Learning for Life' classes], in how to open up those kind of conversations [celebrating difference] in a useful way (Mental health practitioner).

c. **Increasing Professionals' Awareness**

All the professionals felt that it was important for professionals to have information (such as that gained from the SARYP interview themes) to orientate and appreciate the potential experiences and issues experienced by SARYP, and refugee populations as a whole. This sub-theme therefore implies that professionals might value direction in how to open up conversations that explore people's difference and diversity.

I think it's really important for people to know. When you don't know about people there's this huge, unseen 'thing' and you don't
know what you’re dealing with - so raising some curiosity about that...it also goes for other communities (Mental health practitioner).
Research Log

September 2012

Year 3
<table>
<thead>
<tr>
<th></th>
<th>Research Log</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
</tr>
</tbody>
</table>
Appendices to the Research Dossier

Appendix A.

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix B:


[Copy can be accessed online]

Appendix C:

MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Appendix R. Focus Group Transcript Extract

Mental health Practitioner:... I think actually it makes sense for the schools to fairly proactively address this issue, because the payback as in the behaviour... just makes, just makes for everyone much easier, management if like... class management. You know - As soon as you start attending to the issues of the individual, and the strengths of the individual, and I’ll keep emphasising that because I think it’s a really important thing, then you don’t have people having to act out, because they have to show that they are cool and they can do it like these local people or whatever the case may be.

I mean for the local people as well, as again, I wouldn't exempt them from this thing of celebrating their culture, of who you are. So I think there’s an advantage, if you are actively looking towards, I think I’m hearing this from you anyway, looking towards giving this person a healthy sense of his or her own identity, then you have got better behaviour, better results academically, better everything.

Researcher: What do you think about that kind of... what [the Mental-health Practitioner] saying?

Head of Year: I have to agree, obviously, because she is agreeing with me [laugh]. But yeah, I think it does come down to the individual. And you know, from the kind of little knowledge that I have got from the psychological perspective is all about - it has to be person-centred. That's my understanding and you know in terms if you are going to work with an individual, you have to work with that individual, so where they come from is a big part of who they are. And - so you know, giving them a healthy sense of where they come from is really, really important in addressing a lot of issues, because a lot of issues start from their roots. Your identity are your roots and from there, unless you know yourself, then everything else kind of falls into place. And you start to understand why did you certain things, and then again, onto other aspects of psychology. But initially - with
every human being you have to understand where they come from... And you know - You don't have to come from there to understand where they come from. I think just - Like you said the ability to come and give them the space to speak and just be interested in them, it may go a long way.‘Cause you know, [Charity Family Support Worker] is far, in terms of culturally and in terms of, you know, looking at people on the surface, you wouldn't necessary put her to be working with a group of 20 Somali mothers, but at the same time, the idea that she cares, that she is open enough to embrace them, that gives them the space to open up and the space to embrace her as well. And you know, then they open up their world a little bit to the outside because somebody else has opened up their world to them. And I think in terms of building relationships, when we have someone outside of their culture, to come, and that's when it takes a little bit of time to build their trust, but once you have their trust, like in most cultures, once you have their trust, it's there, it's not going anywhere because - you care.

And that's the same thing when working with young people, once you have their trust, then it's there, they know you care. So they open up to you, they're going to want to work with you. All they want is somebody who cares enough to sit down and listen to what they got to say, you know, just wanting to understand is probably just as good as knowing where they come from. Probably even better, as you don't have assumptions and you don't come with baggage, you don't come with your own experiences to put on that person. You're just coming as a blank canvas and saying, 'you know what, I actually don't understand, tell me a little bit about where you come from', you ask enough questions then you help them figure out themselves before you get to understand where they're coming from, which in itself is very, very beneficial for them.

Charity Family Support Worker: And I think sometimes - what's maybe helped me a bit in my job is like, as you say, like if you - 'cause I'm not Muslim, I'm not Somali, I'm very white - appearance and all those things
but in a way sometimes - sometimes it's a bit safer, because the women I've worked with, or the kids I've worked with in the past, I'm not going to make certain judgements that maybe I would about other kids, or have certain prejudices, or - expectations, of how they should be or how they should behave or - I'm not connected to people in the community in a way where I would tell anyone anything, or talk in an environment, and sometimes that helps because you have, you know - that sort of - different expectation and it's a bit safer - and sometimes it isn't. It depends really.

Mental health practitioner: And also it can make you curious. Like the thing that you said, I don't think we need to understand every culture, we don't anyway, you know, I think what we need to do is accept that we don't and go 'I don't know anything about where you come from, tell me about it' [agreement]. Make that person the expert rather than - thinking that we should have expertise on it.

Head of Year: That's true, that's true - and then that way, they re-affirm their own identities as well, they re-affirm where they come from, re-affirm who they are, and then through that, they begin to - heal themselves in a way, they get to help themselves, they do half the job for you so-to-speak.

Researcher: How do you think we could do that? So we've had some ideas, saying about mentoring and so on... I mean do you think there's some things that should be done differently from how things are approached now, or things we could carry on doing the same but doing a bit more of - I'm wondering about comparing to what's happening now...

Head of Year: I'm not too sure what is happening now, to be honest! I don't know what could be done differently, but I think my suggestion would be to have...groups, that would help to kind of - if you have groups - I know someone here, one of the kids here said 'when I was in Somalia, we used to sit around and tell stories, while here it's every man to themselves' so - if you have the group, again they will come together and they'll be telling
stories, and they get to experience their own culture within themselves. You’re just there as the facilitator, but that in itself may be beneficial in helping them come together and it’s a good way of helping them to - to remain - to be able to integrate within this culture well enough but at the same time, still staying true to their own identity. And I think that’s quite important.

Mental health practitioner: Do you have classes in this school that would lend themselves to...something like ‘Education for living’ or something like that?

Head of Year: We have, uh...Religious Studies, a module they do for GCSE. And they have something called ‘Learning for Life’.

Mental health practitioner: ‘Learning for Life’, I guess that’s what I was thinking about.

Head of Year: ...teaching them social skills and all of that is covered under one umbrella. But within the humanities-based subject they do touch on...like citizenship, like [Pastoral support worker] said we have activities and events within the school that celebrate cultures as well.

Mental health practitioner: Because what I’m thinking, what would possibly be useful, and might be a role for - I don’t know, I wouldn’t say the NHS particularly, but is for - training of those teachers who are busy doing that sort of thing, in how to open up those kind of conversations in a useful way [agreement], which both means the teacher can apply that in a way, but also models they kind of attitudes you want in the community - Be it celebrating cultures, accepting the diversity of other people, or really being quite excited about the person sitting next to you has had really different experiences from you, instead of going ‘either be like me or you’re not cool’. So I guess I could see some....place for specific training around a model which is strengths-based...
Appendix S. Example Theme Clustering in the Focus Group Analysis

Theme Four: Coping
Theme Five: Awareness of Barriers in Supporting SARYP

[Handwritten notes on the page]
Theme Six: Ideas for SARYP and Community Engagement

1. p. 2: Good traditions, connect you with...
2. p. 7: Educate children, so more use well

Outreach
Supporting families to negotiate differences.

Supporting families in negotiation difficulties.

Radcliffe's work.

p. 7: The teacher says she would love to teach in...

1.3: Encourage parents to be active.

She told them their house of safety. 

If you need a family in their home of safety.

2.3: Give them that power...
Appendix T. Extracts from Reflective Diary Kept by the Researcher

1st December 2011 – Following two interviews

I was really struck by the girls’ frustration around their roles at home. My gut reaction was frustration too. I know a lot of that may be down to my Western values of gender equality, but I can hear in the girls accounts how much they are struggling to balance a wish to pursue an education which takes up so much time, with having so many chores to do at home too. I admire how they seem to battle on, despite these frustrations, but can’t help wondering how life might be different for them if they were boys. I can’t remember the boy I interviewed describing these frustrations. I think I may need to be careful when analysing the transcripts, to make sure I bracket off my gut reactions about fairness and to listen to how these young people understand and cope with these experiences.

Another thing I really noticed was how much effort the girls exert into putting on a brave face when they are feeling low, that feeling or remembering sad things is undesirable. I could see them doing that in the interview too, cutting themselves off and changing topic. Is this a cultural thing, or is it because they don’t know how else to cope after such journeys of survival? They both said how important it is for SARYP to be cared for and listened to, but is there a risk that school wouldn’t know this if they are so good at hiding their emotions? They have been through so much, yet they keep on fighting. To say they were passive victims would miss the point entirely.

January 12th 2012 – during the process of analysis

There are so many potential themes! The more I read and the more notes I make, the more possible connections there could be. Trying to separate them into master themes feels difficult as I could go with a temporal sequence, so coping etc in pre-migration, transition, and post-migration periods, or across these but divided into impact and reactions to their experiences. I’m also noticing alternative sources of information creeps into
my thinking during analysis, such as the charity family support worker
telling me about how badly one girl is being bullied, yet she didn’t really to
go into this in her interview with me. I need to be very careful to bracket off
this knowledge and my assumptions in general (especially as mine are more
likely to based on Western norms and values) and stay close to the text. I do
wonder how researchers are able to analyse interviews they didn’t conduct.
When I’m reading the transcript I can hear in my head how they expressed
it, see their facial expressions in the pauses. There’s so much richness in
tone of voice and so on, and I find that really helps to re-centre me back
onto listening to how the young people are actively making sense of their
experiences in the transcripts, privileging their meaning-making rather than
what outside theories and sources have to say.
# Appendix U. List of Focus Group Themes and Sub-themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
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<tbody>
<tr>
<td><strong>SARYP experiences from forced resettlement</strong></td>
<td></td>
</tr>
<tr>
<td>Theme One: Multiple forms of trauma</td>
<td></td>
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<tr>
<td>Theme Two: Adjustment to difference</td>
<td>a. Difference overwhelming</td>
</tr>
<tr>
<td></td>
<td>b. Generational differences</td>
</tr>
<tr>
<td>Theme Three: Struggles with integration</td>
<td>a. Prior-experience dependent</td>
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<tr>
<td></td>
<td>b. Discrimination and negative assumptions</td>
</tr>
<tr>
<td><strong>SARYP responses to experiences from forced resettlement</strong></td>
<td></td>
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<tr>
<td>Theme Four: Coping</td>
<td>a. Distancing from or aligning with Somali identity</td>
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<td></td>
<td>b. Concealment</td>
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<td><strong>How can UK front-line services help?</strong></td>
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<td>Theme Five: Awareness of barriers in supporting SARYP</td>
<td>a. Services’ assumptions</td>
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<td>b. Misalignment around the norms of disclosure and the offering of support</td>
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<td></td>
<td>c. Cultural differences in understanding mental-health</td>
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<td>Theme Six: Ideas for SARYP and community engagement</td>
<td>a. Support from people with shared or different heritages/experiences</td>
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<td></td>
<td>b. Creating space and building trust</td>
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<td></td>
<td>c. Outreach</td>
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<td></td>
<td>d. Community links</td>
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<td>Theme Seven: Supporting integration and psychological well-being</td>
<td>a. Increasing sense of mastery</td>
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<td></td>
<td>b. Paradigm shift in service models, delivery and roles</td>
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<td></td>
<td>- Celebration of cultural diversity and identity with the focus on strengths and resilience</td>
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<td>- Community-based services and group interventions</td>
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<td>- External support for developing community-based services</td>
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<td>c. Increasing professionals’ awareness</td>
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Appendix V. Full Focus Group Analysis

This appendix discusses each of the seven themes and sub-themes, with verbatim quotes drawn from the focus group transcript to support the analytic claims made.

V.1 SARYP Experiences of Forced Resettlement
Theme One: Multiple Forms of Trauma
This theme relates to how the professionals spoke about how trauma can be perceived in experiences of hardship, loss of home, and negative social experiences, as well as from witnessing violence. This theme therefore implies that PTSD may be an over-simplistic frame-work in which to understand SARYP experiences:

...their experience within their home counties, so it could be traumatic, or it could just be a trauma of having to leave - or - and being sort of ripped from your home and everything that you know. And then the journey, which can be pretty hard, so you are going through different countries...But then also how you're treated when you get here...you know, the police, immigration treat people absolutely atrociously (Charity family support worker).

Theme Two: Adjustment to Difference
This theme depicts the professionals’ understanding of the challenges SARYP and their families face during the process of adjustment to life in the UK.

a. Difference Overwhelming
The difficulty of negotiating new cultural and social norms and systems was observed by all professionals, with differences having the potential to be perceived as ‘intrusive’ (e.g. involvement of social services) and overwhelming:
...moving from one country to another country, to a new school, different culture, different language. I think all of that can be quite hard to handle (Pastoral support worker).

b. Generational Differences
SARYP were portrayed as negotiating difference in a way their parents could struggle to understand in their cultural frame-work. This may reflect the different pressures the different generations are exposed to, where the SARYP are wishing to ‘assimilate’ with their peers, and their parents wish to maintain their culture (Berry, 2001):

...they get told that by their parents [about respect for teachers], but then they mix with the kids, and the kids don't emulate that. So that they will be rude to teachers...that's where the confusion can get worse. Because then you have got parents who can't speak fluent English, they don't understand the educating system, and now doesn't understand why their child who was so good before is now incoherent. (Pastoral support worker).

Theme Three: Struggles with Integration
The relative marginalisation and integration with British peers and the wider community was perceived to be a dominant struggle for SARYP.

a. Prior-Experience Dependent
Perceptions of integration varied depending on the forced resettlement experience of SARYP, with those arriving via Europe rather than Africa being seen as more familiar with Western systems and communication.

...those who came via Sweden and Holland, their behaviour tends to be a lot calmer and - they tend to be able to integrate into the school system a lot better than those students who haven’t (Head of Year).
Those who lived in the UK for longer were also perceived as finding it easier to integrate due to greater socialisation experience with British peers, whilst those who arrived in their adolescence were seen as more isolated. Friendship groups were seen to have formed and consolidated by adolescence, with possible assumptions around the importance of conformity with peers as influential at this developmental stage (Erikson, 1968).

...they have kind of integrated, because they have known people from the primary school. So they have got that relationship already. (Pastoral support worker)

...the ones that have come over, later on as well, in their kind of like 13-14. And they are coming to the secondary school. Like you said, I do feel they are quite isolated (Pastoral support worker).

b. Discrimination and Negative Assumptions

This sub-theme refers to the rejection and persecution of Somali and wider refugee populations by peers, the wider society and as promoted by political-social environment, which makes integration difficult for SARYP and their families. Therefore the sub-theme suggests that the process of integration is influenced by multiple levels of the social and ecological system the SARYP find themselves in, which could have a significant impact on SARYP’s sense of self.

...they have experienced a lot of bullying at school (Charity family support worker).

The way they are seen, the way they are spoken about, the way they are treated as well within the ethnic groups, it's almost like they are an underclass (Head of Year).
...we have an issue at the moment with our economy and our debt. And whenever something like that happens where people haven’t got jobs, it's easy to blame another community (Charity family support worker).

V.2 SARYP Responses to these Experiences

Theme Four: Coping

This theme centres on the professionals understanding of how SARYP cope with and manage the impact of forced resettlement. They perceived SARYP as active agents in adapting to their new lives, although in ways which meant a rigidity or rejection in identity, or ways that made it difficult for the professionals to feel able to support them.

a. Distancing From or Aligning with Somali Identity

The SARYP were observed by professionals as either distancing themselves from their Somali heritage, through bullying newer SARYP or trying to be similar to their British peers, or by joining exclusively Somali groups as a way of self-protection. The SARYP’s self-concept therefore seems to become polarised in response to wider social judgements:

And I have heard new arrival kids being bullied by kids who were born here, or been here longer ... It’s sort of a power thing (Charity family support worker).

...they will start to copy their behaviour, because it's a way of fitting in, and being accepted (Pastoral support worker).

...we have big groups that are coming together and then kind of being a force (Head of Year).
b. Concealment
SARYP were also suggested to be concealing their distress, either by becoming withdrawn or by being selective of where they expressed their difficulties. Suppression therefore may be being adopted as a coping strategy by SARYP, possibly reflecting cultural norms around emotional expression, or a vestige response to trauma from across their forced resettlement experiences.

*He was just in his own little world. But when he was at home that’s not the way he was at all (Pastoral support worker).*

V.3 How can UK Services Help?
Theme Five: Awareness of Barriers in Supporting SARYP
This theme focuses on the importance the professionals put on the need to understand and overcome the barriers in engaging and supporting the Somali community, in order for UK services to be able to support SARYP and their families appropriately and effectively.

a. Services’ Assumptions
Some of the professionals felt negative assumptions about the success of engaging a Somali community could prevent them from being offered support, with the need for more reflection on services’ assumptions and practice. Cognitive heuristics of generalisation and black-and-white thinking therefore may be obstructing further exploration in understanding this community.

*I hear a lot of stuff, you know, generalised, oh, like Somali community don’t want to engage with schools. And actually my experience is just the absolute opposite, but I think that we have to think about how we engage with a community (Charity family support worker).*
b. Misalignment Around the Norms of Disclosure and the Offering of Support

The professionals talked about how it was difficult to understand and support SARYP and their families due to the community’s reluctance in sharing this information. They suggested that the SARYP tended to express their distress through behaviour rather than verbally.

...they are quite a proud community as well, so they don’t divulge that much when it comes to supporting them (Head of Year).

...refusing to do the work or arguing with the teacher - is a way of not only getting out all those feelings that you have, but also then getting support afterwards (Pastoral support worker).

This lack of disclosure, and form of communicating distress, led to some of the professionals feeling fearful of distressing SARYP further if they were to approach them to offer support, which meant support was only offered if difficulties were disclosed, and therefore the creation for a system which is not meeting the SARYP needs or wishes:

My role is not to, like, re-traumatise people and drag their - you know - I’m not a therapist and I don’t think that’s appropriate (Charity family support worker).

...it would have to be something that was divulged to us in order for us to put something [in place] (Pastoral support worker).

c. Cultural Differences in Understanding Mental Health

The professionals expressed opinions on how MHS are currently delivered may not be attuned or aligned with Somali understandings and approaches to mental health problems and general coping, leading to a lack of engagement or appropriate support being offered. Many of the professionals believed that mental health problems were a taboo in the Helens Kaliniecka - Portfolio Volume 1

294
Somali community (viewing them as permanent and incurable) and therefore psychological distress as something to be kept private.

...when it comes to mental health, it's almost like, if you are crazy, you are crazy, there is no fixing it type thing. So that's why they would very much like to shy away from that. You know, if you even suggest to a parent that their child might have some mental health issues, it's a massive taboo (Head of Year).

...a lot of them come to this country with very much a village mentality, where you don't talk your business outside the house (Head of Year).

It was also suggested that Westernised models of health care may not be an appropriate or sensitive approach for supporting SARYP.

In the NHS, we have got a model, which is quite Westernised, it's like 1-to-1 and it's quite intimidating and it doesn't fit into everyone's idea of support (Charity family support worker).

Theme Six: Ideas for SARYP and Community Engagement
The professionals had a range of ideas of who, where, and how best to facilitate engagement with this group.

a. Support from People with Shared or Different Heritages/Experiences
The professionals explored the relative merits of support from people with shared heritage, who could facilitate engagement through creating links between communities and opening up understandings, and people of different heritage, who may make fewer judgements and be more curious in understanding their experiences.
...work with someone from their culture, who can come in and sit down and work with them so they trust you enough to allow you in (Head of Year).

...just wanting to understand is probably just as good as knowing where they come from. Probably even better, as you don't have assumptions and you don't come with baggage, you don't come with your own experiences to put on that person (Head of Year).

d_RIGHT_ cause I'm not Muslim, I'm not Somali, I'm very white... sometimes it's a bit safer... I'm not going to make certain judgements that maybe I would about other kids, or have certain prejudices ....I'm not connected to people in the community in a way where I would tell anyone anything. (Charity family support worker)

b. Creating Space and Building Trust

Regardless of heritage, the efforts made to create space for SARYP to talk about their experiences were deemed as central to eliciting engagement. The professionals suggested it takes time and effort to gain trust before SARYP would engage with support offered:

...once you have their trust, then it's there, they know you care. So they open up to you, they're going to want to work with you. All they want is somebody who cares enough to sit down and listen to what they got to say (Head of Year).

It really is important to open up a conversational space (Mental health practitioner).

c. Outreach

The professionals suggested that a proactive outreach approach would be most suitable in engaging SARYP and their families, actively asking and giving them the opportunity to talk about their experiences, and raising
awareness of what services are available. This stands in contrast with or highlights necessary additions to current services approaches.

...allocate a person to them automatically...and for them to actually ask ‘How was it getting here?’ (Mental health practitioner).

...helping the communities to understand the purposes of the NHS as well. Because obviously, if we’re talking about mental health, in what formats does it come in, you know, when trying to break down that taboo in itself - maybe one way is going down [there]... (Head of Year).

d. Community Links

Greater links within community settings, especially schools, was thought to be the most effective way of engaging the Somali community, with location of power and ownership identified as important factors in engagement. This suggests clinic and hospital service bases are alienating the Somali community.

...services that the NHS does provide, being able to put that forward to families, to communities via - the community centres, wherever, via a school and that way the parents can engage (Head of Year)

Certainly outreach, and like you said, community centres - and spaces where people feel they have power, they feel safe and feel relaxed, they’re used to it and they know it. (Charity family support worker)

Theme Seven: Supporting Integration and Psychological Well-Being

The staff had a variety of thoughts of how SARYP and their families could be supported in their integration with British society whilst retaining their cultural identity, and improving their psychological well-being.
a. Increasing Sense of Mastery

Initiatives to help families to gain environmental mastery and a chance to contribute to their new country were suggested as ways of helping them feel part of and accepted by British society, and be less marginalised.

*I work with about 20 parents...* So, *one, they could learn how the system works, and we can support you with that...* And then it sort of *invites parents to come in the school, and they feel like this is their community as well* (Charity family support worker).

*I think if the government actually encouraged people to work when they are new to the country, and set up these schemes...* as opposed to *just throwing money at people. I don't think we would have that animosity* (Pastoral support worker).

b. Paradigm Shift in Service Models, Delivery and Roles

- **Celebration of cultural diversity and identity with the focus on strengths and resilience**

All of the professionals felt efforts to support all young people to embrace their identity and difference, and develop a coherent narrative about themselves, would help their integration and psychological well-being.

*...celebrating specific identities and saying 'this is who I am, I don't have to become a British lookalike, because I bring some other things to this country' (Mental health practitioner).*

*Your identity are your roots and from there, unless you know yourself, then everything else kind of falls into place. And you start to understand why you do certain things (Head of Year).*

Instead of being problem-focused, the professionals believed exploration of the SARYP strengths and resilience would open up positive
connections with others, and develop sense of self. This sub-theme therefore suggests a paradigm shift from the dominant problem-focused models (e.g. CBT), to more positive psychology and social constructionist thinking (e.g. narrative therapy)

...doing something creative, or you know, I don't know, that's not so 'you've got a problem' (Charity family support worker).

...being able to own, who they are, and who they are out of what they have experienced and the strengths that come from that (Mental-health practitioner).

- Community-based services and group interventions

School and community centres were unanimously identified as locations support services should be based, rather than in clinics or hospitals. Therefore interventions and support that are more aligned with and attuned to the Somali community’s social and cultural norms within families and communities were thought to be more organic and helpful. Central to these suggestions seem to be an approach that is normalising and contextualised within systems, rather than medicalised and pathologising:

...the NHS could probably play a part, looking at family support and group support. So you are working with groups of people as oppose to targeting that individual (Head of Year).

One of the kids here said 'when I was in Somalia, we used to sit around and tell stories, while here it's every man to themselves' so, if you have the group, again they will come together and they'll be telling stories, and they get to experience their own culture within themselves (Head of Year).
- **External support for developing community-based services**

For community-based and focused support to be effective and comprehensive, all the professionals expressed the need for support from external bodies. This suggests that the role and practice of NHS mental health professionals needs to be adapted to take more specific and supportive roles, such as developing more accessible services, providing specialist interventions when needed, and offering training to community professionals.

...best way of bridging that gap is going via community centres...so when there is a child with some serious problems...they can seek the clinical support that they need, and it's there and it's available for them when they need it (Head of Year).

I can see the benefits, like as you said of the clinical aspect, especially [for] those children who are suffering from serious trauma, I think that's necessary you know (Head of Year.)

...training of those teachers who are busy doing that sort of thing [running 'Learning for Life' classes], in how to open up those kind of conversations [celebrating difference] in a useful way (Mental health practitioner).

c. **Increasing Professionals' Awareness**

All the professionals felt that it was important for professionals to have information (such as that gained from the SARYP interview themes) to orientate and appreciate the potential experiences and issues experienced by SARYP, and refugee populations as a whole. This sub-theme therefore implies that professionals might value direction in how to open up conversations that explore people's difference and diversity.

*I think it's really important for people to know. When you don't know about people there's this huge, unseen 'thing' and you don't*
know what you’re dealing with - so raising some curiosity about that...it also goes for other communities (Mental health practitioner).
Research Log

September 2012

Year 3
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<th>No.</th>
<th>Activity</th>
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<td>Formulating and testing hypotheses and research questions</td>
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<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
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<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
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<td>Formulating specific research questions</td>
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<td>Writing brief research proposals</td>
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<td>6</td>
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<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
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<td>Presenting research findings in a variety of contexts</td>
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</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
<td>✓</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
<td>✓</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td>✓</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
<td>✓</td>
</tr>
</tbody>
</table>
Appendices to the Research Dossier

Appendix A.
Promoting positive risk management: evaluation of a risk management panel

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Introduction

Effective risk management of self-harm, self-neglect and violence by people with mental illness in the community has become an important issue within the mental health services, highlighted by recent government guidelines (Mental Health (Patients in the Community) Act (MHA) 1995, ‘Best Practice in Managing Risk’ (BPMR) DoH 2007) and reports (‘National Confidential Inquiry into Suicide and Homicide by People with Mental Illness’, Appleby et al. 2001, 2006, ‘National Suicide Prevention Strategy for England’, DoH 2002).

There were 1303 suicides per year in 2000-2004 and 52 homicides per year in 1999-2003 by people with mental illness (Appleby et al. 2006). Many of these individuals had had recent contact with mental health services. Research into risk management within the community is therefore of high importance. This paper aims to evaluate a local multidisciplinary model to support clinical practice and risk management.

Literature Review

The National Health Service (NHS) and Community Care Act introduced the policy of community care of people with mental health problems in 1990. Subsequent guidance were published (DoH 1994, 1995, MHA 1995) promoting the rights of people with mental health problems to have access to care in the least restrictive setting while also balancing the safety of the public. There has been much research...
supporting the efficacy of community care in treating high-risk people with mental health problems, without compromising the safety of others and with little need of hospitalization (Rudd & Joiner 1998, Snowden et al. 1999, Simmons et al. 2001). 'Stranger homicides' have not shown any increase since community care has become policy (Taylor & Gunn 1999, Appleby et al. 2006).

However, a number of high-profile homicides and suicides (West Midlands Regional Health Authority 1991, Ritchie et al. 1994) have exaggerated public perceptions of the risk people with mental illness pose to others and have led to widespread criticism of the approach (DoH 1998). New policies have been developed in response, creating a bias towards management of violence, making self-harm and general improvement of care for people with mental health problems of secondary importance (Marty & Chapin 2000, Munro & Rumgay 2000, Ryan 2000).

Public pressure to predict and prevent violence has increased the rates of false positives (falsey assessed as risk of violence) in people with mental illness, therefore unnecessarily restricting their rights and civil liberties (Munro & Rumgay 2000, Peck 2001; Crowe & Carlyle 2003; Raven & Rix 1999) emphasize the importance of mental health clients' therapeutic responsibilities in caring for these individuals in the face of this bias.

Defensive practice has also been fuelled by fear of professional litigation (Carron 1997). There has been a substantial increase in law suits against mental health professionals following suicide (Kelley 1996, Berman 2006), despite there being little evidence of poor professional practice (Boyd et al. 1996).

Public fears and the legal concept of foreseeability have led to a bias in research in the 1990s on developing effective risk assessments to predict violent or suicidal behaviour (Allen 1997, Carson 1997, Munro & Rumgay 2000). Empirical, actuarial data have demonstrated some clear correlations between risk factors and violence/suicide in people with mental illness. However, it has been found that such factors have little predictive utility for individual cases because of the rarity of the phenomena they are measuring, and the overlap of indicators with the general population (Allen 1997, Paris 2002, Rihmer et al. 2002, Berman 2006).

Rudd & Joiner (1998) emphasize that the value of risk assessments lies instead in informing the continuous process of risk management because of the dynamic nature of risk. The topic of day-to-day risk management within the community has been substantially overlooked by research (Snowden et al. 1999). The Care Services Improvement Plan (CSIP) and the Department of Health (DoH 2007) describe positive risk management as

"...promoting positive risk management

...improving the service user's quality of life and plans for recovery, while remaining aware of the safety needs of the service user, their carer and the public."

Previous publications regarding risk predominantly consist of literature reviews, with a focus on violence and risk assessment because of public inquiries. There is therefore the need for more clinically led research and accounts of positive practice that champion the rights of the individual as well as the public.

Reasons behind the risk management panel

The presented risk management panel (RMP) service model has been developed to support individual clinicians and teams in their positive management of individuals who present with high risk of harm to themselves or to others. Managing people with complex presentations within the community, under the threat of litigation, can be anxiety provoking for the clinicians involved. The RMP provides the opportunity to discuss in a fresh, reflective way the individual's situations, the risks they present and the ways they are managed. The Trust takes collective responsibility for any risk, with the aim to decrease individual clinicians' anxieties and therefore to increase positive risk management.

Risk management panel

The RMP is provided within the NHS Mental Health and Learning Disability Services, which cover a population of approximately 439,000 people and is available to all age groups. The panel consists of multidisciplinary members representing different services. The RMP offers three slots for case discussion on a monthly basis. Cases are referred to the RMP following discussion at local groups, and are presented by the care coordinator and consultant at the RMP meeting. Agreed RMP recommendations are written up into a risk management plan, which is then incorporated into the person's care plan.

Research aims

The cases referred to the RMP will be reviewed with regard to type of risk, diagnoses and demographics. The RMP will be evaluated through feedback provided by referring clinicians and through assessment of risk levels following implementation of RMP recommendations.

Method

A qualitative design was used to gather information from medical records and RMP reports, and to gather feedback from mental health clinicians.
Selection process and participants
Twenty-six out of 36 available slots with the RMP (three per meeting) were taken in January 2006-February 2007. Twenty-three of these were first-time case presentations, and the other three were case reviews. Questionnaires were sent to the 33 mental health clinicians (participants) who had presented the 23 first-time cases, but not to those who attended reviews because of the differing nature of these meetings. Demographic, diagnostic and risk information was gathered from the medical and RMP records of the 33 people with mental health problems from the corresponding presentations.

Data collection
The participants’ experiences of the RMP, the RMP recommendations and their overall opinion of the RMP service were collected using a staff questionnaire (SQ).

In Part 1, closed questions were used to collect easily encoded, quantitative information. The participants were asked to answer ‘yes’, ‘no’ or ‘don’t know’ to whether they agreed with the question statements. Spaces were provided to allow for any additional comments the participants might want to make. In Part 2, open-ended questions were used to collect more detailed, qualitative information of the participants’ views. In Part 3, a 5-point scale question to specify their level of agreement with a statement regarding the helpfulness of the RMP was included.

Each individual’s diagnosis and/or presenting problems, demographic information, identified risks, risk levels and RMP recommendations were collected using the ‘RMP Case Information Form’ (CIF). This information was collected from the individual’s medical and RMP records. The individual’s immediate and long-term risk levels were gathered from the Trust’s Risk Assessment Forms (TRAF) completed up to 3 months before presentation to the RMP and 3-6 months after.

All data were coded, and anonymity and confidentiality were assured.

Data analysis
Sections of text in the SQ and CIF were analysed using content analysis (Weber 1990), whereby information in the text was condensed into categories to reveal themes and patterns. Raw data were initially examined to establish categories. The SQ included open questions regarding the beneficial and disappointing aspects of the RMP as a whole, and other comments. The CIF included the list of RMP recommendations and identified risks for each case using pre-identified categories. Identified risks categories were established as risk to self (suicide, self-neglect and self-harm), risk to others (violence) and risk to self and others (suicide/violence, self-neglect/violence, self-harm/violence).

Descriptive statistics were used for risk levels on the CIF, on the closed ‘yes/no’ questions and on the 5-point scale question on the SQ.

Risk is divided into two categories on the TRAF assessment of immediate risk levels and assessment of perceived long-term risk levels. These categories are further subdivided into four risk subcategories; violence, self-harm, self-neglect and harm to children. Risk levels for each of these subcategories are scored on a 5-point scale: 0 = negligible, 1 = mild, 2 = medium, 3 = high, 4 = life-threatening. Risk scores from the pre-RMP TRAF (completed within 3 months before RMP presentation) and post-RMP TRAF (completed 3-6 months after RMP presentation) for each of the subcategories were collected for both the immediate and perceived long-term risk categories. These scores were then compared with detect any shifts in risk levels.

Results
Fifteen participants (45%) completed the questionnaire (five social workers, four community psychiatric nurses, four occupational therapists and two psychiatrists).

Information about individuals with mental health problems referred to the RMP

Demographics
Fourteen (61%) of the individuals referred to the RMP were female (mean age = 43 years, range = 27-68) and nine (39%) were male (mean age = 31 years, range = 18-59).

Diagnosis
Fifteen (65%) individuals were diagnosed with personality disorder, 12 (52%) of these with borderline personality disorder, of which 7 (33%) had co-morbid axis I diagnosis, most frequently depression (n = 6, 26%). Four (17.4%) people were diagnosed with schizophrenia.

Ten (71.4%) of the women were diagnosed with personality disorder, three (21.4%) of these had co-morbid diagnosis of depression. The remaining four (28.6%) were diagnosed with depression (n = 1), anxiety (n = 1), bipolar affective disorder (n = 1) or unclear (n = 1).

Five (55.6%) of the men were diagnosed with personality disorder, three (33.3%) of these had co-morbid diagnosis of depression. The remaining four (44.4%) were diagnosed with schizophrenia.

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The risk areas of the presented individuals are illustrated in Fig. 1. Thirteen (56.5%) of those individuals presented risk to themselves, six (26.1%) risk to themselves and others, and four (17.4%) risk to others. The majority of the women presented risk to themselves (8/9, 88.9%), with three (21.4%) risk to others, and two (14.3%) risk to themselves and others. The same number of men presented risk to themselves (n = 4, 44.4%) and risk to themselves and others (n = 4, 44.4%), with only one (11.1%) man presenting risk to others.

Changes in risk levels
Eight cases’ risk assessment scores were incomplete because of missing or incomplete TRAFs. The remaining 15 individuals’ data sets were analysed using descriptive statistics.

Shifts between the pre-RMP TRAF’s and post-RMP TRAF’s risk assessment scores for immediate and perceived long-term risk categories are illustrated in Figs 2 and 3. If no shifts occurred because of risk being perceived as negligible, these were excluded from analysis (27% of scores in immediate and 25% of scores in perceived long-term assessed risk levels). For both immediate and long-term assessed risk level categories, no change was found to be the most frequent shift, followed by decreased risk, then increased risk. No significant changes were found in risk level’s for the four risk subcategories.

Risk management panel recommendations
One hundred and nine recommendations were made by the RMP in January 2006–February 2007, which fell into four main categories: 6 (5.5%) in ‘referral to services outside the Trust’, 16 (14.7%) in ‘referral to another service within the Trust’, 40 (36.7%) in ‘endorsement of the existing care plan without any further recommendations’ and 47 (43.1%) in ‘advice on risk management within the current team’.
The coding of categories was found to be reliable (Cohen’s kappa = 0.75, recommended index for Cohen’s kappa = 0.7) (Miles & Huberman 1994).

Beneficial aspects of the RMP
Four subcategories emerged from the findings. A high frequency commented on the feeling of support and security the RMP provided for the clinicians and teams involved. A high frequency also commented positively on the case discussion at the RMP. They found the opportunity to discuss individual cases and related risks in a new forum useful. Other subcategories included the RMP’s endorsement of the referring team’s risk management plan and the RMP’s authority in enabling recommendations to be acted on.

Disappointing aspects of the RMP
Five subcategories emerged from the findings. These included the membership of the RMP (e.g. numbers of people, the risk management plan (e.g. lack of clarity), case discussion (e.g. absence of presented individual’s consultant psychiatrist), specific recommendation frustrations (e.g. not able to discharge individual as hoped) and scrutiny of professional practice.

Other comments
Two subcategories emerged from the findings. These included positive comments (e.g. ‘RMP very useful tool’) and negative comments (e.g. regarding RMP membership and their preparation for the case presentations) regarding the participants’ experience of the RMP.

Part 2 - Overall opinions
There were 33 comments provided in response to the open questions. Thirty-five (66%) described beneficial aspects of the RMP, 12 (23%) described disappointing aspects of the RMP, and 6 (11%) were additional comments. Overall, there were 39 (74%) positive comments and 14 (26%) negative comments regarding the RMP service.

Further subcategories emerged from the inspection of the data. These are illustrated in Table 1, along with the frequency with which they occurred.

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Frequency</th>
</tr>
</thead>
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<tr>
<td>Beneficial aspects</td>
<td>Support for professional team</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Case discussion</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Endorsement of risk management plan</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>RMP’s authority</td>
<td>3</td>
</tr>
<tr>
<td>Disappointing aspects</td>
<td>Membership of the RMP</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Risk management plan</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Case discussion</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Specific recommendation frustrations</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Professional practice structure</td>
<td>1</td>
</tr>
<tr>
<td>Other comments</td>
<td>Positive about RMP</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Negative about RMP</td>
<td>2</td>
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</tbody>
</table>

The focus of this paper is to evaluate a local RMP. The aim of the RMP is to support mental health clinicians in managing people with mental health problems who present a high risk of harm to themselves or to others. The clinicians’ (participants) opinions of the RMP service were gathered and changes in individuals’ risk assessment levels calculated. Trends in advice offered by the RMP, risk areas and individuals referred were also considered.

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People with mental health problems referred to the RMP

A high number of individuals referred to the RMP were diagnosed with personality disorders, many with co-morbid depression. The RMP is therefore providing a service to those who are normally given low priority (Burges et al. 2000). More women than men were referred to the RMP, with the latter’s average age being substantially lower than the former, which correlates with previous research findings (Rudd & Joiner 1998, Paris 2002).

Risk areas and levels

The findings show that risk to others was the least identified risk area, and risk to self the most. This therefore further counteracts the exaggerated perception of violence by the mentally ill (Magro & Rumgley 2000, Ryan 2000). Risk levels decreased in 33-40% of the cases following RMP presentation. However, over 50% of the cases’ risk levels did not change at all. The lack of the RMP’s effect on risk levels could be attributed to the high complexity of the cases referred to the RMP. Positive risk management is important in caring for those where ‘...risk can never be eliminated’ (DoH 2007, p. 10). It may be that by promoting positive risk taking, the RMP works to decrease long-term risks but has less effect on short-term risk.

Methodological issues could also contribute to these findings, such as the low number of complete data sets gathered and the questionable sensitivity of the TRAF as a tool to measure change in risk levels. These factors should therefore be considered in future research.

Risk management panel recommendations

Many of the recommendations emphasized multi-disciplinary team work and integrated services, corresponding with the BFMF (DoH 2007) philosophy. Recommendations were drawn up into a risk management plan that was subsequently incorporated into the referred individual’s care plan, as advised by Appleby et al. (2006). Recording the risk management plan provides legal means to demonstrate that reasonable attempts have been made to identify and manage risk (DoH 1995, Carson 1997). This lessens the clinician’s anxieties of litigation and therefore increases positive risk management.

It was unclear how many people with mental health problems referred to the RMP found the recommendations useful. Research would therefore benefit from their increased involvement in monitoring and evaluating mental health services (DoH 2007). Discussion with individuals regarding their referral and outcome of the RMP should be considered (CSIP 2007).

Staff opinions

Beneficial aspects of the RMP

The findings show that the majority of participants had a positive experience with the RMP. They felt that the preparation for the RMP, using an RMP referral form, was appropriate. The referral form uses a standardized format to review the individual’s risks, incidents and any additional information provided by their families/carers (as recommended by Allen 1997, Keitle 1997, Berman 2006).

The participants felt supported, secure and relieved to be sharing responsibility and decision making for the cases and risks they were working with. These findings mirror the strengths identified by the CSIP (2007) in an RMP. The RMP encapsulates the BFMF (DoH 2007) philosophy of the organization’s role alongside the individual clinician in effective risk management, with the involvement of senior colleagues to advise and support. Previous research demonstrates that such increased support eases feelings of isolation and stress in demanding environments (Davison 1997, Raven & Rix 1999, Burges et al. 2000, Valente 2002).

The participants found the RMP’s discussion of the case and risks useful, and the recommendations made appropriate and helpful. The participants valued the opportunity to discuss cases in a new forum and to consider alternative actions. Berman (2006) emphasizes the importance of sharing information on potentially deficient areas of the risk management plan to allow for further development. The RMP has therefore achieved its aim in providing staff with the opportunity to discuss risk management of cases in a new, reflective way.

Aspects of the RMP that require improvement

The findings show that only a minority of participants found some aspects of the RMP unhelpful. A few participants commented on the membership of the RMP. The CSIP (2007) suggests that the number of RMP members should be small (three to five people), whereas the current RMP can have up to 15 members. The CSIP’s (2007) suggestion of drawing from a pool of professionals should be considered to reduce numbers. It is also important to acknowledge that group decision making regarding high-risk cases is often cautious with possible implications for human rights (Kelly & Milner 1996). Investigation of group influence on risk management should be considered in future research.

The current RMP members’ knowledge and expertise were questioned, with a few participants commenting on the number of service managers present. Inviting representatives from other services (e.g., forensic services) and identifying relevant training should be considered to improve
quality of RMP input, as recommended in the BFM (DoH 2007). Risk management panel members’ level of preparation for the meeting could be improved, with referral forms being distributed and read before, rather than at the presentation. This would foster more free discussion (as advised by the CSP 2007) and increase time for the RMP to “get to know” the case and to develop a clear risk management plan.

The participants’ expectations of the RMP influenced their perceptions of the service, with some negative comments attributable to disappointment on not receiving new suggestions (i.e. RMP solely endorsed the current care plan). It may therefore be useful to ascertain the clinician’s expectations at the beginning of the RMP meeting to guide RMP input.

Improving risk management formulation

The BFMR (DoH 2007) emphasizes the need for both general and specific high and low risks to be considered when formulating a risk management plan. The RMP would benefit from widening its focus from solely high-risk concerns to further consider the recovery model. This includes identifying the person’s strengths, general aspects that help them stay at low risk and low-risk concerns salient to the person (e.g. social isolation). This would help improve quality of life and thus promote positive risk management (DoH 2007).

Conclusions

Responses from mental health clinicians working with high-risk individuals indicate that the RMP is achieving its aims to alleviate anxieties and encourage fresh, collective case discussion. This has been achieved through the multidisciplinary RMP taking collective responsibility for the risks involved, offering support in order to promote positive risk management. The RMP was found to have no significant effect on risk assessment levels. However, the aim of the RMP is to encourage positive risk management of individuals in the long-term, in cases where the risk may remain complex.

The study has shown that risk of self-harm/attempted suicide is the most prominent risk presented at the RMP. The RMP is therefore helping to resolve the imbalance in care where the primary focus has been on managing risk of violence, despite its unpredictability, rather than on providing better health outcomes for individuals in general (Petch 2001). Current findings support the use of an RMP, which promotes the concept that risk management is a “proactive tool” in community care (Carson 1997).

References


Acknowledgment

We would like to thank Surrey and Borders Partnership NHS Foundation Trust Research and Development for the funding of this study.
RESEARCH DOSSIER

Appendices to the Research Dossier

Promoting positive risk management

Appendix B:


[Copy can be accessed online]

Appendix C:

Embarking upon clinical psychology training: Our relationship to change within a learning group context

Rosie Powling, Manveer Kaur, Kaanan Butor-Bhavsar, Michelle Miles, Catherine Atnas, Jemeela Hutchfield, Helena Kaliniecka & Naomi Spokes

This article explores our relationship to change as trainee clinical psychologists commencing training. We offer some reflections about the first year of clinical psychology training and highlight the benefits of reflective group tasks.

At the start of clinical psychology training our cohort was divided into personal and professional learning discussion (PPLD) groups, each consisting of eight group members. These groups offered a safe space to reflect on our experiences of training – for example, in terms of clinical work, ethical and service development issues.

This article explores our relationship to change as trainee clinical psychologists, including what change means to us and how it impacted upon our clinical practice during the first year of training. Our aim is to offer some reflections about commencing clinical psychology training and highlight the value of group tasks in developing reflective practice.

Our reflections have arisen as a result of a problem-based learning (PBL) task on 'the relationship to change', with which we engaged within our PPLD groups, whilst preparing a presentation over a five-week induction period. We were given general prompts about how to proceed, but were encouraged to make our own interpretation of the task.

The group process

Initially, our discussions focused on personal change, which was understandable in the context of us all having commenced the course and perhaps having made life changes in order to do so. As a result, some of us felt resistant to further change, a defence perhaps to pre-training hearsay that suggested we would transform during the course and lacked control over this process ('I hope that the core of who I am will remain the same').

Our discussions shifted into the exploration of change within a wider framework, including social, political and cultural contexts. In order to engage with a cross-section of the literature, each group member investigated a different domain of change and reported back to the group. These domains included different theories, for example the Transtheoretical (stages of change) Model (Prochaska & DiClemente, 1983), ideas involving group processes (Bion, 1961) and changes in group identity (Elsak & Van Riel, 2005). We also considered change within ourselves and our clients, as a result of working within different therapeutic orientations, such as cognitive behavioural (Benneu-Levy, 2003) and psychodynamic models (Howard, 2005).

We finally decided to focus our presentation on the process of how our PPLD group was changing over time, by working within a critical reflections framework (Rolfé et al., 2001). This involved reflecting upon what we did (descriptive level of reflection), why
we did it (incorporating theory and knowledge) and what this means for our clinical practice (reflective level of reflection). We illustrated these ideas through a collage, which was an idea inspired by Ernst and Martin (2006).

**How the group evolved**

Establishing ground rules, organising a set format and assigning a chair and scribe for sessions helped to contain our anxieties and implement structure. There were many advantages of tackling the PBL task as a group. These included the fascinating group process that ensued, the rapid bonding of our PPLD group and the large amount of research and knowledge that could be investigated and shared by the involvement of eight people.

It was interesting to observe the group dynamics over time. In the first couple of sessions there was a lot of talking over one another. In hindsight, the need to articulate our opinions was perhaps a combination of feeling vulnerable and anxious, particularly in the context of establishing ourselves within such a competitive course.

Following these initial sessions, group members were able to share personal reflections with each other. Some group members believed that they should relinquish the urge to control. Other quieter individuals were concerned that their contributions might be less valid or that they would need to change their communication style in order to cope with the more dominant voices ('I need to jump in quickly with points or I won't ever get to say anything!').

A few group members felt more constrained when our facilitator was present, perhaps because they valued her wealth of experience and competence. Others felt more in tune in the presence of a perceived 'authoritative figure' and considered it was easier to conflict or stray from the rules when she was not present. Our facilitator was absent in the fourth session, which was the closest our group came to 'storming' according to Tuckman's (1965) model.

This storming was indicated by the collapse of structure within the session and the temporary psychological withdrawal by two group members, who felt that the conversation was circular and chaotic. Frustrations were also experienced by the chair who felt inadequate because of her inability to manage these issues.

As the group arrived at a consensus regarding how to proceed with the task, and the facilitator returned, the dynamics changed as group members felt more contained and there was a growing sense of teamwork. This led to the group 'forming' and 'performing' (Tuckman, 1965), through channeling our energy into the task.

**Difference and diversity**

As a group we were all females in our twenties and thirties, from a mixture of middle and working class backgrounds. The majority of group members were white Caucasian; two were of Asian ethnicity. Diverse cultural and religious backgrounds were represented by group members who had first-hand or familial experiences of growing up in a range of developed and developing countries across Europe and Asia.

We acknowledged that these differences within the group influenced multiple aspects of our personal and professional development. One example when this was highlighted was during a discussion about an article regarding learning narratives in group supervision, which proposed that our previous experience of learning shapes how we communicate and approach collaborative group learning (Agget, 2004).

We considered how our previous experiences and personal qualities impacted upon the group and its decision-making during the PBL task. This has helped us to appreciate group processes on placement and consider how our language and formulation styles negotiate more medical-oriented narratives within multidisciplinary teams (MDTs).

In terms of communicating as a group, we initially had a tendency to be over-polite with one another, which made rejecting ideas and progressing with the 'best' idea difficult at times, but also resulted in some richer, more meaningful
conversations, whereby we validated and developed one another's ideas.

We often struggled between establishing ourselves within the group context, striving to prove our competency and wanting to be liked. Similar difficulties can be experienced within therapeutic relationships we discovered, such as when we ask clients to engage in challenging tasks in therapy.

Over time we learned to revise initial judgements about each other, appreciate our different working backgrounds and use our strengths to the group's advantage. Hence we learnt not only to appreciate, but also utilise the group's differences and diversity. This appreciation and utilisation of individual differences is important within MDTs and therapeutic contexts.

**Impact on clinical practice:**

**Therapeutic change**

During group discussions we observed that change can be empowering and disempowering. This idea is of considerable importance in clinical work. The overall goal of many forms of therapy, for example cognitive-behavioural therapy (CBT), is to empower clients to make changes.

Additionally, our judgements about ourselves within the group were at times empowering us to change, but at other times acted as unhelpful, dysfunctional assumptions, which parallels our clients' experiences. Although CBT focuses on change within the client, the systemic effects of change can result in social and cultural change within relationships, families and communities.

Feelings that group members experienced during the task may parallel those of clients and carers, for example feeling unheard, unable to change, self-conscious and out of control. We found that our own emotional and motivation levels mirrored the group as a whole and over the year, we have noticed parallels in our therapeutic work.

For example, when clients feel motivated we believe we are better therapists. When clients appear de-motivated we can think that the therapy is 'stuck' and our self-confidence is reduced. We can feel frustrated and overwhelmed at the progression of therapy, the responsibility we feel as therapists and the struggle to work collaboratively at times.

As novice therapists, our anxieties may hinder active eliciting, exploring and appropriately responding to clients' and carers' concerns. Discussions at the start of therapy have highlighted the importance of adequately preparing clients and investigating the potential impact of change in order to assess readiness for treatment, enhance motivation and instil hope.

Over the year we have noticed how we place great emphasis on change as an outcome that can be measured, but on reflection, might there be therapeutic benefits for clients despite the evidence from outcome measures, particularly symptom-based questionnaires? Does psychological assessment always allow time to capture personal growth? And what about change as a means to enhance positive wellbeing, as opposed to simply reducing psychological distress?

This shift towards positive psychology has gained more momentum in recent times (e.g. Seligman, 2002). As such, we need to continue to facilitate the progression of mental health culture from the traditional perspective of symptom reduction to facilitating change towards a client's personal meaning of recovery.

Finally, the experience of the PBL task helped several group members to develop their facilitation skills in therapeutic groups on placement. We recognised similarities in our levels of anxiety and fears of being seen as 'incompetent', but also noted our abilities to rise to the challenge and defy our own perceptions of ourselves.

**Ethical issues**

Honesty and reflection in supervision are vital in the constant strive to develop as reflective scientists-practioners. As the roles of clinical psychologists develop within a shifting NHS (British Psychological Society, 2007), achieving change within MDTs is a challenge to which we believe clinical psychologists should rise when necessary.

For example, a derogatory comment was made about a client of one group member by another professional within
her placement team. She felt offended by this comment and thoroughly disagreed with him. However, she did not want to threaten her professional relationships and was aware that she was young and inexperienced in comparison to the professional, so lightly challenged him. As we develop in our professional roles, we hope to be able to act in such situations with more confidence and endeavour to achieve more enduring changes in MDT attitudes. These changes in our clinical practice are grounded in the endeavour for change and are vital for our professional development.

As encouraged by our facilitator, our discussions became increasingly client-focused and integrative over the year, developing our confidence in our clinical judgement and in critical discussion of NHS services. For example, one group member raised a dilemma about wishing to honour an Indian Hindu client’s request for his wife’s presence in therapy sessions, which contradicted the one-to-one standard practice of the specific service. Having the confidence to adopt an integrative approach following the group discussion secured the client’s engagement with therapy, as it valued his systemic and cultural beliefs (Sharma, 2000).

Final remarks
The PBL task gave us experiential learning of how multiple perspectives and peer support can enhance personal and professional development. The safe space that we created was vital for us to express our thoughts and concerns and it also enabled group consultation for members seeking assistance. This reflects the importance of a safe space within a therapeutic context and allowing adequate time to build a trusting therapeutic relationship, which is often considered the key component in aiding therapeutic change (e.g. Luborsky et al., 2002).

It would be interesting to consider how different the process may have been had the group consisted of different members. For example, if the group had not been all-female or if our personal qualities had impeded the development of collaboration. We believe it is important to note that our ability to work together, whilst also asserting our individual viewpoints, were crucial elements to us being accepted onto clinical training.

These skills will continue to be developed throughout our careers as we strive to strike a balance between collaborative interpersonal working and leadership, both of which are highlighted in the New Ways of Working for Applied Psychologists (British Psychological Society, 2007).

We hope this article develops readers’ awareness of group dynamics that can arise from course demands, highlights the initial process of becoming reflective scientists-practitioners and offers future trainee clinical psychologists some insight into the experience of the first year of training.

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Embracing upon clinical psychology training


