

**Post-Migration Stress among Adult Male Iraqi Refugees
and Its Implications for Counselling and Psychotherapy:
A Qualitative Study**

**Thesis submitted for the degree of Doctor of Philosophy in
Counselling and Psychotherapy at the University of Leicester**

By

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2013

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Abstract

This three-phase study explores how counselling and psychotherapy can address the post-migration stress that adult male Iraqi refugees can experience in later stages of exile (defined in this study as having lived in Sweden for a minimum of five years). In Phase 1 the exile-related experiences of ten Iraqi refugee men were explored with specific emphasis on social support, acculturation, racial discrimination, and support systems. In Phase 2 the counselling experiences of ten adult male Iraqi refugee ex-counselling clients were explored. In Phase 3 the views of eight professionals were explored regarding their experiences of counselling Iraqi refugee men. The adult male Iraqi refugee participants in Phase 1 and Phase 2 were individually interviewed using semi-structured interviewing. The twenty interviews were analysed using Interpretative Phenomenological Analysis (IPA). In Phase 3, the findings from Phase 1 and Phase 2 were used to design two focus group interviews using four mental health professionals in each group. The two focus group interviews were also analysed using IPA.

The main findings of Phase 1 were that Iraqi refugee men expressed feeling disempowered, racially discriminated against, and marginalised by society. The main findings of Phase 2 were that adult male Iraqi refugee ex-counselling clients expressed a reluctance to disclose to therapists issues pertaining to their ethnic minority status and experienced racial microaggressions from therapists. The main findings of Phase 3 were that professionals described avoiding and struggling with cultural issues. Another main finding of Phase 3 was that in spite of client feedback revolving around the need for practical help and the experience of post-migration stress, professionals emphasised pre-migration trauma in discussing their views on counselling this client group. Based on the findings of this three-phase study, a pluralistic counselling approach is proposed to address the different post-migration stressors that adult male Iraqi refugees can experience in later stages of exile in Sweden and perhaps other Western countries.

Acknowledgements

I would like to thank the following people for supporting me throughout the process of producing this thesis: My supervisors Professor Sue Wheeler and Dr. Valerie Owen-Pugh whose combined guidance and critical input were crucial to producing this work; the Swedish Red Cross team and all of the other mental health professionals who took the time to participate in this study; and my fellow Iraqis who participated in this study through sharing some of their most intense and personal thoughts and feelings.

I would also like to thank all of the people whose contributions were vital to producing this thesis: My fellow PhD students and supervisors who took the time to analyse pieces of transcript to strengthen the validity of my analysis; Dr. Ibrahim Al-Khamisi for his valuable assistance in translation and for his encouragement and support; and Tina Cartwright for transcribing interviews with exceptional speed and precision.

Last, but not least, I would like to thank my wife, family, and friends for their support and encouragement throughout the process of producing this thesis. But most of all, I would like to thank my daughter and son for being my main source of strength and motivation; especially during the difficult times when producing this thesis seemed to be beyond my capabilities.

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Chapter 1: Introduction

Overview

Background to the study

A growing body of research suggests that post-migration, or exile-related, stressors are responsible for much of the observed distress among refugees living in Western host countries (Gorst-Unsworth & Goldenberg, 1998; Harris, 2007; Miller et al., 2002a; Pernice & Brook, 1996). Pernice and Brook (1996), for example, found that experiences of discrimination, unemployment, and social isolation, were all significantly associated with levels of self-reported anxiety and depression in a sample of Southeast Asian refugees in New Zealand. Similarly, Miller et al. (2002b) found that the primary sources of distress among a sample of Bosnian refugees living in Chicago were: social isolation; the loss of community; separation from family members; the loss of important life projects; a lack of environmental mastery; poverty and inadequate housing; and the loss of valued social roles.

Some attempts have been made to identify ways of addressing these stressors in counselling and psychotherapy (e.g. Griffiths, 2001; Tribe, 1999). However, the bulk of the literature on refugee mental health remains focused on “the psychological impact of war-related experiences” (Miller et al., 2002a, p.378). Refugee post-migration stressors tend to encompass psychosocial and socio-political dimensions, and this can present a challenge for mental health professionals who attempt to address these stressors in counselling and psychotherapy (Blackwell, 2005a, 2005b; Century, Leavey, & Payne, 2007; Miller, 1999).

Additionally, “few studies have used narrative approaches that would allow refugees themselves to identify the range of stressors affecting them” (Miller et al., 2002b, p.343). These observations, coupled with my own experiences as an Iraqi refugee and later as a psychologist working with refugees, collectively formed the basis for this study.

Aims and design of the study

The study detailed within this thesis aims to explore one overriding research question: How can counselling and psychotherapy address the post-migration stress that Iraqi refugee men can experience in later stages of exile? In attempting to map out ways of exploring this overriding research question, I decided to conduct three separate, but related, studies (to be referred to as Phases 1, 2, and 3 from this point onwards). The three phases aimed to respectively explore the following sub-research questions: 1) How do adult male Iraqi refugees experience post-migration stress and help/support systems in later stages of exile?; 2) What are the counselling experiences of adult male Iraqi refugee ex-counselling clients in later stages of exile?; and 3) How do mental health professionals view and experience counselling and psychotherapy with Iraqi refugee men?

Phase 1 would entail asking ten Iraqi refugee men about their experiences of post-migration stress and the help/support systems available to them in later stages of exile. In addition to providing insight into the experience of post-migration stress, Phase 1 aims to give voice to refugee participants - who are often discussed in refugee mental health literature but rarely heard (Fernando & Keating, 2009; Miller et al., 2002b). Phase 2 would involve asking ten adult male Iraqi refugee ex-counselling clients, in later stages of exile, about their

counselling experiences. Phase 2 was inspired by qualitative change process studies in which clients are asked about their experiences of counselling and psychotherapy (e.g. Israel et al., 2008; Moertl & von Wietersheim, 2008; Rennie, 1992). Phase 3 was designed to elicit responses from two groups of professionals regarding their experiences of, and views on, counselling Iraqi refugee men - with specific emphasis on issues identified as relevant for the experience of post-migration stress.

Rationale for the study

This three-phase study was partly inspired by a pluralistic approach to psychotherapy research - that is “consumer-based research...engaged in ongoing dialogue and debate with counselling and psychotherapy professional groups” (Cooper & McLeod, 2011, p.119). Phase 1 and Phase 2 represent the ‘consumer-based’ emphasis which reflects the centrality of the client perspective in this study. Phase 3 represents the ‘dialogue and debate with counselling and psychotherapy professional groups’. The present study was also informed by the idea that “different things are likely to help different people at different points in time” (Cooper & McLeod, 2011, p. 6). In line with this idea, I decided to explore how counselling and psychotherapy can address the experiences of a specific client group, at a specific stage in their lives, and for a specific issue – Iraqi refugee men, in later stages of exile, struggling with post-migration stress.

While this focus suggests the need for understanding how Iraqi refugee men can experience post-migration stress, the ultimate aim of the study is to explore the implications of such an understanding for counselling and psychotherapeutic work with this client group. In other

words, it is not the actual phenomenon of post-migration stress, or how widespread it might be, that is the focal point of this study, but rather how counselling can address this experience if, or when, it is expressed by this client group in therapy.

The reason for focusing only on adults lies partly in the fact that refugee children and adolescents tend to have age-specific and developmentally-related issues that can be different from those of adult refugees (Berman, 2001; Tribe, 1999). Focusing only on refugee men, and not refugee women, was partly motivated by the differing experiences of refugee men and women that Griffiths (2001) has observed. Additionally, Iraqi women tend to have unique experiences that reflect their gender roles in Iraqi culture and in Western host societies (Al-Ali, 2005, 2007). Similarly, focusing on Iraqi refugee men specifically in later stages of exile is based on the observation that refugees tend to experience exile-related stress more profoundly in the later stages of exile (Griffiths, 2001; Tribe, 1999).

Iraqi refugee men in later stages of exile are considered to be representative of a specific client group because they share five common backgrounds: 1) culture; 2) language; 3) gender; 4) age group; and 5) some elements of the refugee experience (encompassing pre-migration, migration, and post-migration experiences). These five backgrounds are psychosocial, socio-cultural, and socio-political in nature, as opposed to being strictly psychological (i.e. individual and internal). This focus reflects the postmodernist and social constructionist perspective (e.g. Gergen, 1985; Sarup, 1993; Etherington, 2004) that is broadly adopted throughout this thesis. Each one of these five backgrounds can have implications for counselling and psychotherapeutic work with this client group. However, the present study focuses on a specific part of the refugee experience: post-migration stress.

Structure of the thesis

This thesis comprises five Chapters: 1) Introduction; 2) Literature Review; 3) Methodology, 4) Results; and 5) Discussion. Chapter 1 begins with the above presented overview of the thesis which describes the background to the study; aims and design of the study; rationale for the study; and structure of the thesis. Chapter 1 proceeds with a brief historical account of the Iraqi refugee experience, followed by a discussion of the terms ‘counselling’ and ‘psychotherapy’ as they relate to the contexts in which this study is carried out. Chapter 1 subsequently discusses some of the practice and research issues of most relevance to the study. Chapter 1 concludes with two autobiographical accounts that describe my background in relation to the study.

Chapter 2 presents a detailed argument for the research focus of the present study. Specifically, theoretical and empirical literature is used to demonstrate how Iraqi refugee men in later stages of exile are representative of a specific client group. Chapter 2 begins with an introduction to the literature on counselling and psychotherapy with refugees. Chapter 2 then goes on to discuss how Iraqi refugee men in later stages of exile are representative of a specific client group based on sharing five common backgrounds: 1) culture; 2) language; 3) gender; 4) age group; and 5) some elements of the refugee experience. Each one of these backgrounds, and their respective implications for practice, is discussed in turn. Chapter 2 goes on to discuss the diversity of therapeutic approaches that are commonly used with refugee clients. Chapter 2 concludes with a summary of the key points made in the review of the literature.

Chapter 3 discusses the methodology used in carrying out this research project. First, an overview of the chapter is presented, followed by an outline of the three-phase study. Then, a rationale for the chosen research methodology is presented – in which epistemological assumptions, researcher reflexivity, and data collection and analysis methods are discussed. Chapter 3 goes on to describe the participants recruited in each phase of the study by displaying socio-demographic information tables for each participant group, along with discussions of inclusion and exclusion criteria for each phase. Chapter 3 concludes with the description of the procedure for each phase - along the lines of recruitment process, data collection, and data analysis.

Chapter 4 presents the results of the analysis in each of the three phases of the study. Chapter 4 begins with a summary of the main findings arrived at as a result of the analysis across the three phases. Chapter 4 then provides an overview of the structure used in presenting the findings - starting with a table displaying all of the super-ordinate and sub-ordinate themes that emerged along with their respective frequency descriptions, followed by the analysis of each phase in turn. Chapter 4 concludes with some final reflexive observations revolving around the process and outcome of the study.

Chapter 5 begins with a discussion of the main findings in relation to the existing literature. This is then followed by an exploration of my contribution to the existing body of knowledge in terms of theory, practice, and research method. Chapter 5 proceeds with a discussion of the limitations of this research, followed by recommendations for future research. Chapter 5 concludes with a summary of the conclusions arrived at as a result of carrying out this research project.

Iraqi refugee history

Iraq has a rich history and was the home of five magnificent civilisations before coming to its current state. Since the overthrow of the monarchy in 1958 and the establishment of the Republic, Iraq has seen four coups ending with Saddam Hussein's regime taking power in 1968 (Tripp, 2000). During his time in power, Saddam committed many atrocities against the people of Iraq, not to mention neighbouring countries, and implemented many violent measures (such as torture and executions) designed to eliminate all potential rivals and voices of opposition (Coughlin, 2002; Makiya, 1998).

Under Saddam's dictatorship Iraq went to war with Iran from 1980 to 1988. Then there was the Iraqi invasion of Kuwait which led to the first Gulf War in 1991 and the second Gulf War in 2003 along with the American invasion of March 2003. The foreign military intervention ended Saddam's regime but inflicted additional hardships and trauma on the Iraqi people who had already suffered so much. The military invasion brought disorder, severe economic disruption, chronic shortages of electric power and clean water, terrorist attacks, and human rights abuses by the US military forces (Al-Ali & Pratt, 2009; Galbraith, 2006; Holmes, 2007).

In the first six months of the year 2007 a total of 19,800 asylum applications have been lodged by Iraqi citizens in 36 countries (UNHCR, 2007). Those lucky enough to be granted asylum are labelled as refugees in accordance with the regulations of the 1951 Geneva Convention (UNHCR, 2007). Following the fall of the Saddam Hussein regime in 2003, over 300,000 Iraqi refugees returned home during the first two years following the war

(UNHCR, 2007). However, by mid 2007 more than 2.2 million Iraqis were living outside of Iraq in different host countries such as Sweden; in which estimates of 23,600 Iraqi refugees and 9,329 Iraqi asylum applications have been documented in January 2007 (UNHCR, 2007). According to an estimate from the UNHCR Online Population Database there were 30,423 Iraqi refugees residing in Sweden in 2009; however this figure does not include non refugee Iraqis such as asylum seekers and those who have migrated to Sweden through other venues (e.g. marriage to a Swede). The total number of Iraqis (born in Iraq) living in Sweden has been estimated to be in the region of 127,860 as of 2012 (Statistics Sweden, 2013).

Although Iraqi refugees might differ in their ethnical, cultural, and/or religious backgrounds, most of them have been affected (to varying degrees) by the same historical tragedies: the regime of Saddam Hussein (1968-2003); economic sanctions (imposed 1990-2003); wars (Iran-Iraq war 1980-88, Gulf wars 1991 and 2003); and the current global Iraqi refugee situation. As refugees scattered across Western countries, many Iraqis have to deal with the same array of losses that most refugees experience. As Tribe and Keefe (2009, p. 414) explain, “multiple losses, not least of their country, family, sense of identity, status, culture, support systems and often the fundamental ability to communicate easily with other people through a shared language”. In addition to having to deal with these multiple losses, many Iraqi refugees have to struggle with mental health problems as a result of traumatic pre-migration experiences and stressful post-migration experiences (e.g. Gorst-Unsworth & Goldenberg, 1998; Jamil et al., 2002; Jamil et al., 2010).

Counselling and psychotherapy

‘Counselling’ and ‘psychotherapy’ have several definitions and different understandings of the differences and similarities between them. As Dryden and Mytton (1999, p. 3) note, “There is, and probably always will be, considerable debate about the differences between counselling and psychotherapy”. In some countries (e.g. Sweden), the use of the term ‘counselling’ is altogether avoided and ‘psychotherapy’ tends to be term used to describe this activity (Al-Roubaiy, 2012a). As Dryden and Mytton (1999, p. 3) explain:

“Historically the term ‘psychotherapy’ came first and is a combination of the words ‘psyche’ meaning mind and ‘therapeia’ meaning treatment. It was probably first used in the late 1880s (Efran & Clarfield, 1992) at a time when it was believed that if there were ways of treating the body then there should be ways of treating the mind”.

However, treating the mind as an entity, separate from body and spirit, stems from a reductionist western way of thinking about the human condition and can be, as Fernando (2009, p.21) notes, “very confusing to someone with a holistic worldview”. Similarly, Tribe (2007, p. 28) describes how Western notions of mental health may “not only be reductionist but also superimpose one set of constructions or a narrative devised in one part of the world onto another culture”.

A primary example of adopting a holistic approach can be observed in the notion of ‘health pluralism’, defined by Tribe (2007, p.21) as: “a multi-layered or diverse range of

explanatory health beliefs, and a concomitant wide range of coping strategies or help-seeking behaviours, as well as a varied range of designated helpers and healers”. Holistic approaches to mental health problems are more in tune with the emphasis placed on the collective in some non-Western cultures, as opposed to the emphasis placed on the individual in Western cultures (Fernando, 2009).

The term ‘counselling’ has a much younger history and, unlike the term ‘psychotherapy’, has often been used in the literature when describing activities in which the practitioner can be more of an active agent of social change (e.g. Katz, 1985; Kiselica & Robinson, 2001; Palmer & Parish, 2008). Historically, Dryden and Mytton (2009, p. 4) explain that:

“The use of the word ‘counselling’ applied to psychological problems appeared during the 1930s when Carl Rogers was developing his person-centred approach in the United States. At that time, in the United States, only medical people were legally permitted to practise psychotherapy. Calling his therapy ‘counselling’ enabled him and other psychologists to practise, thus side-stepping the legal restrictions”.

Dryden and Mytton (1999, p.4-5) quote some definitions of the terms, such as Brown’s and Pedder’s (1979) definition of psychotherapy as: “Essentially a conversation which involves listening to and talking with those in trouble with the aim of helping them understand and resolve their predicament”. After discussing the definitions they quote, Dryden and Mytton (1999, p. 5) conclude that:

“Looking at what counsellors and psychotherapists actually do, it is seen that often both are doing the same things. They use identical approaches so that one talks, for example, of psychodynamic psychotherapy or psychodynamic counselling. Counsellors and psychotherapists use identical techniques, for example both will use behavioural techniques to treat phobias. Both see the same kinds of clients. So perhaps the use of two different terms is purely historical”.

Similarly, in September 2000, the British Association for Counselling changed its name to the British Association for Counselling and Psychotherapy (BACP) because it had recognised that it represented psychotherapy as well as counselling. In line with Dryden’s and Mytton’s (1999) observation regarding the difference between counselling and psychotherapy being purely historical, the two terms will be used interchangeably in the present study - with the recognition of and respect for the alternative views that others might hold regarding the differences between the two terms.

The term ‘psychotherapy’ is the more dominant term in clinical and academic settings in Sweden, while the term ‘counselling’ is often avoided. A primary example of this avoidance is the fact that in Sweden psychologists can specialise in many fields, such as clinical or educational psychology, but counselling psychology simply does not exist (Al-Roubaiy, 2012a). Counsellors in Sweden are for the most part social workers who use different terms to describe their profession; depending on their different training backgrounds and work settings. A Social worker in Sweden might refer to himself or herself as ‘socioonom’, ‘socialarbetare’, and/or ‘kurator’ (Sandström, 2010). A Swedish

social worker might, or might not, use counselling as part of his or her work (Larsson & Trygged, 2010; Sandström, 2010).

Simply put, counsellors in Sweden are not as clearly defined as a professional group, as psychologists and psychotherapists are. It is also important to note that, at this point in time, counsellors in Sweden are not regulated or licensed by 'Socialstyrelsen' (The National Board of Health and Welfare). Psychologists and psychotherapists, on the other hand, are regulated and licensed by Socialstyrelsen. Mental health professions can overlap in training and practice in Sweden as well as in other European countries. Also, there is a form of corporate rivalry, which has been observed in several European countries, among the many mental health professions and the different associations that represent them (Ginger, 2009). In the present study, the terms 'mental health professional', 'therapist', 'counsellor', 'practitioner', and 'professional' will all be used interchangeably to describe counselling and psychotherapy professionals - irrespective of professional background and orientation in therapy.

There is also a wide-ranging debate regarding which approach to psychotherapy is most effective and which approaches are most suited for which problems. This debate includes issues such as whether the curative factors in psychotherapy are what the different schools advocate as specific to their orientations (i.e. specific factors) or what is common across the different therapies (common factors), and what evidence-based practice is and how it has marginalised less structured therapies (e.g. Chapman, 2012). For many professionals, these grievances are rooted in politics - not just theoretical differences.

For example, in carrying out a qualitative study to explore the dilemmas of identity experienced by qualified psychodynamic counsellors studying cognitive behavioural therapy (CBT), Owen-Pugh (2010b) found that students had initially negative views of CBT that were very much related to certain macro political interventions in the UK. As Owen-Pugh (2010b, p. 161) notes, “the currently polarised political relations between ‘CBT’ and ‘anti-CBT’ lobbies might be encouraging counsellors trained in other core theories to adopt defensive positions on CBT training courses”.

A major venue to explore these theoretical disputes and professional rivalries is through psychotherapy research. In psychotherapy, practice and research should ideally be viewed as two sides of the same coin; however, this consensus is not easily arrived at. While some emphasise the importance of research-led developments in psychotherapeutic practice (e.g. Castonguay et al., 2010), others are concerned that an increased reliance on research evidence might lead to a greater dehumanisation of clients and a possible loss of focus on client individuality and uniqueness (e.g. Cooper, 2007). Castonguay and colleagues (2010) argue that the possible gap between practice and research arises in part because counselling and psychotherapy research is often written and published in ways that non-academic practitioners might find inaccessible, which in turn can lead to a failure in appreciating the value of research in informing good practice. Bearing this theoretical gap in mind, the following two sections will be dedicated to exploring counselling practice and research issues that are of most relevance to the present study.

Relevant practice issues

It is still debated whether it is the specific components of different therapies or the factors common to most approaches that are the active ingredients responsible for the therapeutic change that occurs in psychotherapy. ‘Common factors theory’ proposes that it is the common components of the different approaches that mostly account for the outcome in psychotherapy and that the components which are considered unique to each approach have but a minor role in the induced therapeutic change (e.g. Frank & Frank, 1991; Imel & Wampold, 2008; Wampold et al., 1997). As Cooper and McLeod (2007, p. 135) observe, “no single therapeutic approach has a superior grasp of the truth”.

Grencavage and Norcross (1990) grouped common factors under five categories: 1) therapist qualities; 2) change processes; 3) treatment structures; 4) relationship elements; and 5) client characteristics. Wampold and Serlin (2000) and Wampold (2001) have established that common factors are the most influential to therapeutic outcome by differentiating factors based on contributions to outcome. Wampold (2001) displays a pie chart of Lambert’s (1992) therapeutic factors divided by: common factors (30%); techniques (15%); extratherapeutic change (40%); and expectancy or placebo effect (15%). Surprisingly the tendency towards technical competition between different approaches continues in spite of the evidence for the relatively small relationship (approximately 15%) of specific technique factors to treatment efficacy (Asay & Lambert, 1999; Lambert, 1992).

Among other things, Wampold (2001) observed that the type of treatment is not a factor nor are the theories behind the techniques used; however, the therapist's strength of belief in

the efficacy of the technique and the personality of the therapist were both identified as important factors. Wampold (2001) also identified the alliance between therapist and client as a significant and key factor. To explain the equivalent effectiveness of different therapies, it has long been argued that it is not the factors specific to each therapeutic approach that account for therapeutic outcomes rather it is the elements shared across the different therapies that are the active ingredients in therapy – the common factors concept. Since it was first suggested by Rosenzweig in 1936, the concept of the common factors has gained much support throughout the years (e.g. Duncan et al., 2010).

More recently, common factors have been conceptualised as “interdependent, fluid, and dynamic” (Hubble et al., 2010, p.34) as opposed to the earlier views of static pie chart and percentage values (e.g. Lambert, 1992; Wampold, 2001). One approach to transcend the limitations of unitary therapeutic models has been through the creation of integrative and eclectic approaches to therapy such as Ryle’s (1990, 2005) Cognitive Analytic Therapy (CAT) and Lazarus’s (1989) multimodal therapy. The terms ‘integrative’ and ‘eclectic’ have often been used interchangeably by practitioners, but when distinctions are made approaches emphasising technical skills are usually described as ‘eclectic’ whereas approaches emphasising theoretical mindedness as ‘integrative’ (Hollanders, 2003).

Norcross and Goldfried (2005), for example, describe four general routes to integration: common factors; technical eclecticism; theoretical integration; and assimilative integration. The first route to integration, ‘common factors’, “seeks to determine the core ingredients that different therapies share in common” (Norcross, 2005, p. 9). The second route to integration, ‘technical eclecticism’, is designed “to improve our ability to select the best

treatment for the person and the problem” (Norcross, 2005, p. 8). The third route to integration, ‘theoretical integration’, occurs when “two or more therapies are integrated in the hope that the result will be better than the constituent therapies alone” (Norcross, 2005, p. 8). The fourth route to integration, ‘assimilative integration’, simply recognises that most psychotherapists use a single approach as their foundation but end up incorporating different ideas from other approaches as time goes by (e.g. Castonguay et al., 2005; Stricker & Gold, 2005). There are also integrative approaches (e.g. Good & Beitman, 2006; Brooks-Harris, 2008) which do not necessarily fall into any one of the four different routes to integration described by Norcross and Goldfried (2005).

Eclectic approaches tend to involve a separating out or extraction process, whereas integrative approaches entail a bridging of theoretical perspectives together to create a new model (McLeod, 1993; Hollanders, 1999). Eclectic approaches often advocate “the use of diverse techniques without regard to their origins within a particular theoretical orientation” (Hollanders, 1999, p.483). For example, in describing Lazarus’s eclectic multimodal approach, Dryden and Mytton (1999, p.141) noted that “Lazarus was not so concerned with theory, preferring to leave the theorising to others”. As most eclectic therapists advocate, Lazarus “was much more interested in what works for whom and under which particular circumstances than in theories that might or might not be helpful” (Dryden & Mytton, 1999, p. 141).

Although eclectic and integrative approaches are more in tune with the fact that decades of research have not resulted in support of the superiority of one therapeutic approach over all others, they too carry certain limitations. Cooper and McLeod (2007) argue that one

limitation inherent in many integrative and eclectic approaches is that they end up reinforcing the same rigid theory thinking by simply becoming new brands of unitary models of therapy or by relying on predetermined unitary theories of therapeutic change in extracting techniques. Another major limitation is that “integrationist and eclectic approaches have not proved to be fertile in stimulating research and, as a result, have not generated the kind of cumulative body of knowledge that is associated with mainstream unitary orientations such as psychoanalytic, experiential or cognitive-behavioural therapy” (Cooper & McLeod, 2007, p. 136). Not surprisingly, policy makers and governments have tended to support and contribute to the unitary therapy model thinking as integrative and eclectic approaches have not managed to demonstrate the value of abandoning unitary and orientation-based models of therapy.

One approach that seems to transcend the debate about orientation by shifting the focus from modality to the therapeutic relationship, client factors, and therapist factors is Cooper’s and McLeod’s (2007, 2011) pluralistic approach to psychotherapy. The structure of the model is simple - therapists and clients are encouraged to work on “the formation and maintenance of a collaborative therapeutic alliance, emphasising dialogue around the goals, tasks, and methods of therapy” (Cooper & McLeod, 2011, p. 9). It should be noted, however, that Cooper and McLeod (2011) do not use the terms ‘goals’ and ‘tasks’ in the same manner as other theorists have (e.g. Bordin, 1979). Instead, goals are meant to fluidly represent what clients want from life (‘life goals’) and from therapy (‘therapeutic goals’), while tasks are meant to represent the macro-level strategies by which clients can achieve these goals. Similarly, the term ‘methods’ is meant to represent the micro-level activities that both clients and therapists undertake in helping the client achieve the desired goals.

As Cooper and McLeod (2007, p. 142) explain, pluralistic therapy is “not something which replaces unitary models of therapy, but something which exists in creative tension with them, informing and being informed by more specialised approaches to practice”. The pluralistic approach has the potential to embrace different theories and practices in bringing about therapeutic change – as long as it stems from the active collaboration of both therapist and client in deciding on the goals, tasks, and methods of therapy. The basis for building this collaborative relationship in pluralistic therapy is dialogue and metacommunication. As Cooper and McLeod (2011, p. 46) explain:

“Metacommunication refers to moments in the conversation where one or other of the participants stands aside or above (‘meta’) the flow of conversation and makes some kind of comment about what has been said or done. Metacommunication is communication about communication”.

In line with the emphasis that Cooper and McLeod (2011) place on establishing and maintaining a collaborative therapeutic relationship, many practitioners and researchers have come to view the therapeutic relationship as the most significant common factor across the different therapies (e.g. Boston Change Process Study Group [BCPSG], 2010; Hubble, Duncan, & Miller, 1999; Yalom, 2001). In the present study, theoretical orientation is seen as secondary to relational aspects as much of the focus will be on exploring how Iraqi refugee men experience post-migration stress (Phase 1), how ex-counselling clients experience therapy (Phase 2), and how counselling practitioners experience counselling this client group (Phase 3). In keeping with this focus, the next section will discuss one of the most important common factors: the therapeutic relationship.

Therapeutic relationship

Rogers (1957) argued that if the therapeutic relationship involved the therapist feeling and conveying the three core conditions (i.e. empathy, unconditional positive regard, and congruence) and the client perceiving the therapist's empathic understanding and unconditional positive regard to a minimum degree then the relationship itself would have all the necessary and sufficient elements required for bringing about therapeutic change. More recently, the BCPSG has attempted to offer a unifying paradigm for psychotherapeutic change in which the relational and implicit inter-subjectivity between client and analyst is emphasised over traditional psychoanalytic activities, leading the authors to conclude that "the relationship itself is the central force for change" (BCPSG, 2010, p. 194).

However, to understand the nature of the therapeutic relationship, several different concepts and theories have been proposed to explain what it is and how it works. One such concept is that of the working alliance or therapeutic alliance. Therapeutic alliance, which can be defined as "the quality and strength of the collaborative relationship between client and therapist in therapy" (Horvath & Bedi, 2002, p. 41) has repeatedly been shown to predict psychotherapeutic outcome, irrespective of theoretical approach (Horvath & Luborsky, 1993; Ogles et al., 1999; Wampold, 2001). Research has established that the therapeutic alliance is the most robust predictor of psychotherapy outcome (e.g. Norcross, 2002; Safran & Muran, 2000) and that this effect holds true for a variety of treatment outcomes including symptom reduction, social adjustment, and subjective improvement (Horvath & Luborsky, 1993).

Bordin (1979) suggests that the common aspects of the working alliance across therapies include an agreement on goals, an assignment of task/tasks, and the development of bonds. More recently, Duff and Bedi (2010, p.91) defined the therapeutic alliance as: “the client and counsellor’s subjective experience of working together towards psychotherapeutic goals in the counselling context, including the experience of an interpersonal bond that develops while engaged in this endeavour”. Throughout the years several definitions of therapeutic alliance have been offered (e.g. Bordin, 1979; Duff & Bedi, 2010; Gelsco & Carter, 1985) and different aspects of the alliance have been researched - including measurement (e.g. Horvath & Luborsky, 1993), ruptures and repairs (e.g. Safran & Moran, 2000), and client and therapist factors that might influence the alliance (e.g. Taft et al., 2004).

Instruments used to measure the working alliance can overlap in constructs as Horvath and Luborsky (1993) demonstrated when they found two of Borden’s core concepts (‘personal attachments’ and ‘collaboration’) across most instruments. In addition to these generally used constructs, instruments measuring the working alliance can also include measures of the client’s level of active participation in therapy, the participants’ capacity to form relationships, the degree to which therapist and client agree on therapy goals, and the degree to which the client accepts the tasks of therapy (Horvath & Luborsky, 1993).

Bordin (1979, 1994) suggests that it is the expected process of tear and repair in the relationship that makes it stronger and consequently leads to the therapeutic change. These processes of tear and repair in the alliance have been found to fluctuate in different ways

during therapy, and these fluctuation patterns have been linked to treatment outcome. For example, when the alliance is robust early in treatment, deteriorates in mid-treatment (rupture), and then rises again (repair), the client tends to achieve treatment goals (Horvath & Luborsky, 1993; Safran & Muran, 2000). However, other researchers have documented different fluctuation patterns to be associated with positive treatment outcome (e.g. Piper et al., 2004).

Although the working alliance is a dominant concept in the literature on the therapeutic relationship, there are other related concepts and other ways of understanding how the relationship can be therapeutic. Gelso and Carter (1985), for example, introduced the idea of the real relationship as a specific component of the therapeutic relationship, which they considered to be distinct from the other components of the relationship - mainly the working alliance, transference, and countertransference. It is worth noting that aside from the real relationship, defined mainly as genuineness and realism (Gelso, 2011; Gelso & Carter, 1985), these other components of the therapeutic relationship originate from psychoanalytic theory.

As Bordin (1979, p. 253) notes, “the terms of the therapeutic working alliance have their origin in psychoanalytic theory, but can be stated in forms generalizable to all psychotherapies”. Similarly, transference and countertransference were first conceptualised by Freud, and although our understanding of these concepts has evolved since then, these concepts continue to be cornerstones in psychodynamic approaches to psychotherapy to this day (e.g. Brusset, 2012). But how is the relationship actually used by the therapist and client to facilitate psychotherapeutic change?

While Rogers (1957) suggested that therapists need to provide certain conditions that are perceived by the client, Gelso's (2011) formulation seems to go further by adding that even therapists need to feel appreciated and valued in a genuine way for the relationship to be therapeutic. Similarly, in his studies of clients' reflexivity during psychotherapy, Rennie (2000) explored how the client as a self-aware agent "works" with the relationship between the self, the therapist, and the therapist's techniques in subtle ways that point toward a much wider range of outcomes than simple symptom relief.

Rennie's (2000) conceptualisation of the self-aware client 'working with the relationship' is very much in line with the more recent concept of 'processing the therapeutic relationship' in which both client and therapist "directly address in the here and now feelings about each other and about the inevitable problems that emerge in the therapy relationship" (Hill & Knox, 2009, p. 27). Processing the therapeutic relationship in the manner that Hill and Knox (2009) describe is very much the same as the metacommunication that Cooper and McLeod (2001) emphasise in their pluralistic approach.

In further support of the importance of the quality of the relationship, Asay and Lambert (1999) estimated that the quality of the therapeutic relationship accounts for as much as 30% of the variance in outcome. Even in CBT, which is promoted as one of the most evidence-based approaches to psychotherapy (e.g. Dobson & Dobson, 2009), when clients were asked about the most helpful aspects of their therapy they often indicated that the relationship with their therapist was more helpful than the cognitive behavioural techniques used (Keijsers, Schaap, & Hoogduin, 2000).

However, it is worth noting that Beutler and colleagues (2004) have found the quality of the relationship to account for only 7-17% of the variance in outcome, as opposed to the 30% noted by Asay and Lambert (1999). So was Rogers (1957) mistaken in thinking that the relationship itself would have all the necessary and sufficient elements required for bringing about therapeutic change? Cooper (2010, p. 188) answers this question in writing:

“many non-person-to-person therapies, such as web-based therapeutic programmes and self-help manuals, can be highly efficacious (Gould, 1993). Contrary to Rogers’ (1957) hypotheses, then, it would seem that certain relational conditions are not necessary (though they may be sufficient) for therapeutic personality development to occur”.

In this section, the importance of the quality of the therapeutic relationship was discussed with reference to the main theorists and practitioners behind it. Also, the different components of the relationship were discussed, with specific reference to the main ideas behind the concepts of the real relationship, working alliance, transference, and countertransference. Additionally, the idea of processing (or working with) the therapeutic relationship was also discussed. Issues pertaining to the quality of the therapeutic relationship are central to the present study since both practitioners and ex-counselling clients will share their experiences of the counselling process, with specific emphasis on relational issues.

Relevant research issues

Depending on the research questions and researcher stance, research in psychotherapy can be done using quantitative, qualitative, and mixed methodologies (Castonguay et al., 2010; Dallos & Vetere, 2005). Quantitative methods can, as Lutz and Hill (2009, p. 369) note:

“help us study the complex relations between the patient, the therapist, the process of therapy, external events in the life of patients, and in-session progress, post-session progress, and therapy outcome at the end of treatment as well as during the follow-up period; they can also help us aggregate and integrate findings about psychotherapy (e.g., via meta-analysis)”.

Qualitative methods, on the other hand, are concerned with the quality of experience rather than the identification of cause-effect relationships, and are therefore more geared towards exploring the meanings participants attribute to events (Willig, 2001).

Depending on the research aims and questions, psychotherapy research can generally be seen to focus on process, outcome, process-outcome, or change process (e.g. Castonguay et al., 2010; Dallos & Vetere, 2005). Process research aims to answer questions about how change is achieved in therapy and tends to focus on exploring issues such as the nature of the therapeutic alliance, significant events, client and therapist variables, etc. Outcome research focuses on what works in therapy using studies that determine either a treatment's efficacy (using randomised controlled trials) or effectiveness (using naturalistic clinical situations). Process-outcome research generally uses a correlational approach in which two,

or more, variables are observed and the degree to which they covary is assessed. Change process research focuses on “on identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change” (Greenberg, 1986, p. 4).

Randomised controlled trials (RCTs) have come to exert much influence in psychotherapy research, mainly though having promoted cognitive behaviour therapy (CBT) as the therapy with the strongest evidence-base (e.g. Dobson & Dobson, 2009). Cooper (2008) reviews both the evidence-based dominance of CBT and the counter ‘common-factors’ argument, and emphasises the repeated finding of multiple studies which states that when different therapeutic approaches are compared, no single approach consistently wins out. RCTs have also been used to show that psychodynamic therapies can produce large changes in target symptoms and are more effective than placebo and supportive therapy (Levy & Ablon, 2009).

Simply put, RCT research involves randomly assigning participants to conditions in which they receive different treatments - under the assumption that any statistically significant difference to emerge between conditions can be attributed to the treatment (e.g. Castonguay et al., 2010; Dallos & Vetere, 2005). However, RCT research outcome measures are based on symptom reduction whereas many therapies (e.g. psychodynamic therapy) strive to include broader definitions of what might constitute positive outcome (Milton, 2010; Wallerstein, 2003). As Milton (2010, p.162) notes, RCTs “cannot account for individual experience and the evolving and ongoing co-construction of meaning”.

Chapman (2012) describes the development of evidence-based practice in psychotherapy and examines its implementation in the Improving Access to Psychological Therapies (IAPT) programme in England, and the consequent routinisation and standardisation of psychotherapeutic practice - which collectively seem to downplay the role of the therapist and therapeutic alliance. Chapman (2012) also critiques the common belief, among advocates of evidence-based practice, in the superiority of RCTs and argues that the use of RCTs in studying the efficacy of most talking therapies (with the exception of CBT) is simply not an appropriate methodology.

There are several theoretical limitations to using RCTs in psychotherapy research. For example, the placebo group in RCTs can involve a supportive relationship albeit with no additional psychotherapy, but the relationship in psychotherapy is considered to be an active ingredient in itself; therefore it can not be considered a true placebo (Chapman, 2012). Also RCTs emphasise internal validity over external validity; the nature of the treatment is clear and specific enabling other researchers to replicate the study, but not necessarily representative of real psychotherapy practice. Similarly, Beutler (2009) calls for an expanded agenda for psychotherapy research, moving beyond RCTs to include quasi-experimental and naturalistic observational designs which might be capable of addressing a wider array of questions.

In the past several years, qualitative research has led to a new approach to change process research in which clients are asked about what they found helpful (or unhelpful) in their therapy (e.g. Israel et al., 2008; Moertl & von Wietersheim, 2008). Qualitative research methodologies that aim to explore psychotherapy clients' experiences of therapy are

consistent with the mental health consumer/service user movement and generally foster the view of clients being collaborative and active agents in research as well as in therapy (e.g. Knox et al., 2011; Levitt, 2001; Levitt, Butler, & Hill, 2006; Rennie, 1992; Rhodes et al., 1994). This approach gives a voice to clients which in turn allows for new and novel perspectives to emerge. For example, Levitt, Butler, and Hill (2006) reported what kinds of change clients described as important and discovered that symptom reduction per se was rarely mentioned as an important outcome; instead clients tended to discuss global changes, such as relating better with others or feeling better about themselves or others.

In one of the earliest studies on client experiences of therapy Rennie (1992) explored the experiences of 14 clients (six men and eight women) of therapy (mostly person-centred, rational-emotive, analytic, and Gestalt) through open-ended interviews which were then transcribed and analysed using grounded theory. In attempting to find out what clients experienced as helpful and unhelpful in therapy, Rennie (1992) came to the realisation that client agency and self-awareness (demonstrated through complex reflections on therapy experiences) were central features of what he termed 'clients' reflexivity' (i.e. clients' awareness of their agency in the therapeutic process).

In another study on clients' experiences of therapy Rhodes et al., (1994) discovered that the experience of being misunderstood by one's therapist in a hurtful manner can adversely affect the working alliance, leading some clients to drop out of therapy. The misunderstandings were all cases in which therapists either did not do something that clients wanted or expected (e.g. did not remember important facts) or did something that clients did not like (e.g. were critical of something the client did).

The participants in the Rhodes et al., (1994) study were all therapists discussing their own experiences of therapy as clients. Clients who disclosed feeling hurt by the misunderstandings usually received apologies from their therapists, enabling them to restore the working alliance. However, for those clients who did not disclose feeling hurt, the unresolved misunderstanding led most of them to terminate therapy soon after the misunderstanding events. This finding further demonstrates the need for both client and therapist to “directly address in the here and now feelings about each other and about the inevitable problems that emerge in the therapy relationship” (Hill & Knox, 2009, p. 27).

In this section, the main approaches to conducting counselling research were discussed, with specific emphasis on describing the strengths of qualitative research and the empowering and inclusive nature of change process research in which clients are asked about what they found helpful (or unhelpful) in their therapy. The present study uses a qualitative approach in trying to explore how counselling can address Iraqi refugee post-migration stress - and specifically uses a change process research approach in Phase 2 to explore the counselling experiences of adult male Iraqi refugee ex-counselling clients.

Having briefly touched on the concept of ‘reflexivity’ in psychotherapy practice, the next section will provide a brief introduction to the concept in psychotherapy research as well as in practice. Reflexivity plays an important role in this research project, which is why the concept is first introduced in Chapter 1 (seen below), later discussed as part of my research methodology in Chapter 3, and finally used in Chapter 4 throughout the analysis and under the heading of ‘Reflexive observations’.

Reflexivity

Reflexivity has different meanings and can be used in a variety of different contexts (Etherington, 2004). Lawson (1985, p. 9), for example, defines reflexivity as: “turning back on oneself, a form of self-awareness”, while Fischer (2009, p. 587) defines reflexivity as: “a person turning back to attend to how he or she has participated in forming a particular understanding or in taking action”. There is also a difference between reflexivity in counselling practice and reflexivity in counselling research (Etherington, 2004). In counselling practice for example, Rennie (2007, p.54) suggests that “clients are reflexive when becoming aware of their felt sense either prior to or at the outset of a meeting with their therapist. They are radically reflexive when thinking and feeling *about* this felt sense”.

Etherington (2004) suggests that in counselling practice reflexivity involves operating on at least two levels. On one level the counselling practitioner needs to be reflective and self-aware of his or her impact on the process of therapy. On a second level the counselling practitioner needs to be in tune with the story that he or she tells himself or herself while listening to the client and be able to move in and out of several levels of awareness during the process. It is particularly the second level which is closely related to the concept of reflexivity in that it enables the practitioner to understand how his or her own life experiences and background are impacting on their choices and agency in listening and responding to the client.

As for reflexivity in research, Etherington (2004, p.31-32) defines it as: “the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid

and changing) inform the process and outcome of inquiry”. Reflexivity in research is considered to be at the heart of feminist methodologies which aim to challenge the dominant discourses of patriarchy and aim to encourage researchers to “address power issues, not just in relation to women’s issues, but also issues of concern to other oppressed minority groups, espousing greater equality and transparency” (Etherington, 2004, p. 26).

At the time, McLeod (1994) suggested that there were six emerging trends in psychotherapy research: 1) greater awareness of the relationship between research and practice; 2) permission to be reflexive; 3) openness to new methods of inquiry; 4) discovery orientation rather than verification; 5) enhanced appreciation of power imbalances between researcher and participant; and 6) displacement of an excessively psychological concept of the person. Etherington (2004, p. 21) later commented on McLeod’s (1994) observations by noting that “since he wrote those words a great deal of those ideas have been put into practice in the world of counselling and psychotherapy research”.

From the six emerging trends outlined by McLeod (1994), four seem to have the most relevance for the present study: 1) permission to be reflexive (through the inclusion of autobiographical accounts and reflexive observations in the analysis); 2) discovery orientation rather than verification (through wanting to discover new meaning in participant accounts rather than to verify existing ideas; 3) enhanced appreciation of power imbalances between researcher and participant (in being an Iraqi refugee myself, I am better able to even out the power imbalance inherent in the participant-researcher relationship); and 4) displacement of an excessively psychological concept of the person (focusing on post-migration stress highlights the psychosocial and socio-political, not just the psychological).

Etherington (2004) also explains that reflexivity can be used in several different ways. Reflexivity in research can be used as a means of checking against subjective bias, as the main method of inquiry (e.g. autobiography, narrative enquiry, etc.), or as a means of constructing a bridge between research and practice (e.g. Etherington, 2000). The study detailed within this thesis aims to use reflexivity in all three ways. In including two autobiographical accounts, I disclose and reflect on my background in order to explore potential biases with myself and with the reader. The two autobiographical accounts also serve as a method of inquiry since they set the stage for the reflexive questioning of how and when this background was impacting on the process and outcome of the study. Last but not least, the present study aims to construct a bridge between research and practice by attempting to link the findings to implications for practice with this client group.

Including reflexive material in research reports also “allows readers to incorporate the investigator’s part of the story into their understanding and to adjust their understanding to compensate for the investigator’s biases” (Stiles, 1993, p.614). In being an Iraqi refugee myself I am too closely connected to this research matter, and possibly at times too emotionally attached to claim a purely objective research stance – if there is such a thing. It was therefore necessary to incorporate some reflexive material through which I could transparently explore this. Although there are no definitions of what constitutes the right amount of reflexive material in research, McLeod (2001, p.204) defines what constitutes the wrong type of reflexive writing as: “narcissistic, disguised autobiographies”. However, being so embedded in this research, I could not find a better way of exploring my potential biases with readers than through the two autobiographical accounts presented below.

Autobiographical accounts

My experiences as an Iraqi refugee

I came to Sweden with my parents and brother in 1993 as refugees from Iraq. The next six years were very difficult for me. During that time, I was burdened with trying to learn the Swedish language, adapt to the culture, deal with traumatic experiences from Iraq, tackle normal adolescent development, and create a social identity that could fit well with both my Iraqi cultural background and Swedish social atmosphere at the time.

During these first six years in Sweden, I came to understand some major differences between Iraqi and Swedish culture, and tried to adapt accordingly. But this process was very problematic and psychologically taxing for me. Part of the problem was that many Swedish cultural norms did not sit well with my own Iraqi and Arab cultural background. Another part of the problem was the societal racism that I had frequently encountered during these first six years in Sweden.

I was brought up to be outspoken and straightforward, but I slowly learned that Swedes often did not appreciate this manner of communication and tended to feel threatened by it at times. I gradually learned to formulate my arguments in a more diplomatic and neutral manner. Often having to say neither a clear yes nor no, instead I began using terms such as probably, most likely, unlikely, and maybe. This is not the straightforward communication that most Iraqis are accustomed to. It was particularly frustrating to have to deal with these responses from Swedes at a time when I was in desperate need of information and straightforward communication.

As a young Iraqi man, I noticed that I was much more likely to be perceived as aggressive and potentially violent in any communication that I might have with a Swede in which I might be direct, outspoken, or even worse slightly upset. Although I was very careful in such situations not to wave my hands, make sudden movements, raise my voice, or convey anger through facial expressions I was still often accused of being aggressive. Perhaps as a result of certain biased Swedish media (Kamali, 2009) or other negative Western media depictions of Arab and Muslim men (Shaheen, 2009), the general Swedish social consensus felt to me like it was suggestive of an image of the Muslim Arab man as being primitive, violent, and oppressive towards women.

This was a very distressing experience for me because I frequently felt a societal pressure to have to always prove that this stereotypical image of the Arab Muslim man was wrong. In order to do that, and be able to fit in, I felt like I was socially expected to be as submissive and timid as possible. This new social role that I was being handed did not sit well with the masculine and outspoken cultural identity that I, like most Iraqi men, was brought up to fulfill. Coming from a patriarchal Iraqi society (Al-Ali, 2005, 2007) to a country in which state sanctioned feminism defines the social atmosphere (Hübinette & Lundström, 2011; Pringle, 2010) was not an easy issue to understand and accept.

The most problematic aspect of accepting this submissive social role was that I felt like I was being pressured into this role on a daily basis through repeated subtle racist attacks which I experienced as extremely distressing. Many years later I came to understand these subtle racist attacks as 'racial microaggressions' (Pierce et al., 1978; Sue et al., 2007) and

became very aware of why some researchers have proposed that racism be conceptualised as a form of trauma for the sufferer (e.g. Carter, 2007; Helms, Nicolas, & Green, 2010).

Learning the Swedish language was not an easy task either. I was lucky to have had a solid grounding in the English language because it helped me make sense of the Swedish language due to the many linguistic similarities between English and Swedish. But even with this advantage the process of learning the language was still difficult and distressing. Approaching Swedes to try and practice speaking Swedish was often counterproductive, because I was usually either met with rejection from the onset or allowed to communicate only to be criticised or ridiculed for not pronouncing the words properly. However, with time I eventually learned the language and was speaking fluently within six years. But in order to thoroughly explore how these early years impacted on me I should go back to the beginning of these six years in Sweden.

Within a few months of arriving in Sweden I was enrolled at the local school in the area we lived in. Initially we lived in a heavily refugee populated area in the city of Malmö called Rosengård. We then moved to a slightly less segregated area in Malmö. There I attended a one year preparation class in which foreign students are put together according to age and length of stay in Sweden - irrespective of educational background. I had to attend the class with students that had never been to school in their home countries and were practically illiterate in their own languages. I was not allowed to speak English to the teacher because that would exclude other students, and I was not allowed to speak Arabic with Arab students because that would exclude the teacher and the non Arab students.

Having been forced to accept this new school situation was very spirit breaking. Throughout my life my parents had prioritised my and my brother's education over everything else. My parents had to go to extreme lengths to send me and my brother to the best schools they could afford. All of a sudden, their sacrifices felt meaningless. I was now, at fifteen, learning the alphabet. Algebra, essay writing, and the periodic table of chemical elements were nothing but a distant memory.

Luckily for me the International Baccalaureate (IB) Diploma programme was just being set up in Malmo at the time. I heard of it and knew that this was my only chance of leaving the preparation class. I applied and got called to attend the entrance exams. I passed the entrance exams and was offered a place on the programme. I was ecstatic. Unfortunately for me, the programme at the time was attended by mostly rich upper class Swedes, two Americans, and a few students of immigrant backgrounds that had lived most of their lives in Sweden. I was the only refugee student in the programme. For the next three years, I was socially excluded from many after school activities that the others were engaging in. I was also made to feel out of place by many subtle, and not so subtle, remarks from several students. Other students that were not engaging in this activity simply pretended that I did not exist and avoided contact with me.

As if this was not distressing enough, the IB coordinator at the time chose to make it her personal mission to get me to leave the programme. Since I was doing the required work, attending classes, and not failing any exams she could not force me to leave. But she tried to make me willingly drop out. She would tell me that I did not fit in and that I was too much of an 'Arab' and did not deserve to be with the other students. She would often try to

provoke me to get angry so that she would have an excuse to expel me from the programme. When I was alone in the corridor she would tell me things like “you Arabs are so violent and primitive” and just stand there waiting for a response from me. She would even ask me to go up to her office many times a week to check on my progress when I knew that she was not asking the students who were really struggling to do the same.

Perhaps the most soul crushing aspect of this experience was the fact that people, students and teachers alike, were choosing to either pretend that this was not happening, or simply join in. When I went with my parents to complain to the school principal we were told that the IB coordinator could not be doing this and that I was either misunderstanding her, or that she had good reason to suggest another programme of study for me. Even after three years of these continuous attacks, I still managed not to live up to my ‘violent and primitive nature’.

Instead, I passed all of my exams and successfully completed the programme by receiving an IB Diploma in 1998, instead of the IB certificate which so many others received at the time because they could not get the points required for the Diploma. Academically this might be considered a success story. But emotionally, this was a horrible experience. I always felt like those years were stolen from me. Instead of enjoying my youth at the time, I was engaged in continuous psychological warfare.

The pre-migration trauma aspect of my life during those first few years in Sweden was very tolerable. Although I experienced nightmares during the first two years in Sweden, these gradually disappeared. Of course my pre-migration experiences were merely having seen

and heard bombings, and witnessed some acts of violence – a far cry from the horrific imprisonment and torture that many Iraqis have experienced throughout the years in Iraq. Other than the nightmares and maybe some flashbacks, the only truly distressing emotions I had experienced at the time were an extreme sense of homesickness in which I was desperately longing for Iraq and survivor guilt.

The only real refuge that I had found during my first two years in Sweden was in the company of a group of Iraqi refugee teenagers. We were all roughly the same age and had met fairly soon after arriving in Sweden. Intuitively we used to play basketball for hours just to be able to sleep and not think about some of the horrible things we had all seen in Iraq. This therapeutic aspect of playing basketball, almost religiously for several hours every day, is very much in line with the principles of psychomotor therapy. Similarly, we often sat and talked about our experiences from Iraq in a way that felt very much like narrative therapy. We had managed to therapeutically work through major traumatic memories purely intuitively and with no adult or professional guidance.

Unfortunately this level of solidarity was hard to maintain throughout the years. Our once naturally collective thinking was no longer natural for us. Within six years in Sweden we had all developed Westernised and Swedish identities. To varying degrees, each one of us had become more in tune with the classical psychological Western needs of individuality, independence, privacy, and personal space. As a result, we were not as available or as supportive of each other as we once were. At the same time, none of us really forged that many new relationships with Swedes or other Iraqis. Somehow social support diminished from our lives.

Considering how these first six years of my life in Sweden were traumatising beyond the trauma of war and asylum seeking, I decided to use my IB diploma to study outside Sweden. After becoming a Swedish citizen I moved to England and did a BSc in psychology, an MSc in counselling psychology, and then moved back to Sweden and further trained towards becoming a licensed psychologist - which I did in December 2007. Since then I have worked as a psychologist in a heavily refugee populated district in the city of Malmö (Rosengård), where much of my work has revolved around counselling Iraqi refugees.

My experiences as a psychologist working with refugees

In the six years of working as a psychologist with Iraqi refugee clients, I came to observe several recurring themes in clients' accounts of post-migration stress in Sweden. Although pre-migration experiences are often described as a source of distress for many of my Iraqi refugee clients, exile-related issues seemed to also be of particular relevance for many of these clients – especially after having lived in Sweden for a few years. In line with the findings and observations of Griffiths (2001) and Tribe (1999) I came to observe that: 1) refugees in the early stages of exile usually experience a 'honeymoon' period with the host country that often does not last; 2) in the early stages of exile, basic human needs (e.g. physical safety) and the need to tell one's story are quite apparent; and 3) as time passes and refugees move towards the later stages of exile, the more sophisticated human needs (e.g. social acceptance) become more pressing and can give much rise to emotional distress when met with neglect and rejection by the host society.

Having been trained mainly in general CBT, my initial approach to trying to address exile-related stressors with Iraqi refugee clients was in the form of general or mainstream CBT (e.g. Westbrook, Kennerly, & Kirk, 2007). However, I eventually came to observe certain limitations to the applicability of CBT with this client group and for this specific set of problems. The CBT model proposes that thoughts and beliefs are considered as hypotheses to be investigated, data can be collected to test out these thoughts and beliefs (e.g. through behavioural experiments), and new beliefs can be formulated in light of the new evidence (e.g. through Socratic questioning and cognitive restructuring). CBT is very effective when working with clients who are interpreting social cues in a dysfunctional and unrealistic manner (Westbrook, Kennerly, & Kirk, 2007). But what about the clients who happen to accurately understand certain negative social cues and, as a consequence of this understanding, are feeling the negative and distressing emotions? How can CBT help such clients adopt healthy and positive beliefs about external stimuli that are clearly unhealthy and negative (e.g. racism)?

For example, biased scanning of social settings by a client continuously looking for racists will cause the client to perceive a room as full of racists when in fact there might be two racists in that room of six people. Such a client is likely to benefit from CBT, because he or she needs to understand that his or her perception of the room being full of racists is not rooted in reality and is instead largely due to biased scanning. But what if the room was really full of racists, how can CBT address that? Similarly, when a client always expects racist hostility from Swedes and therefore generally behaves aggressively towards them, and in doing so manages to elicit aggressive behaviour even from non-racists - which he or

she then interprets as evidence of their general racist hostility. CBT can be valuable in helping such a client understand the self-fulfilling prophesy scenario that he or she is stuck in due to this dysfunctional thinking and maladaptive behaviour. Helping such a client to behave differently, as in being polite, to assess the new responses he or she will get is very much at the core of CBT reasoning. But what can CBT offer the client if he or she still was met with hostility, even after consciously making an effort at being nice, friendly, and polite?

This limitation in CBT theory, in addition to some linguistic incompatibilities between CBT terminology and Arabic, suggested the need for another approach with my Iraqi refugee clients struggling with exile-related stressors such as racial discrimination. I needed an approach that was simpler than mainstream CBT and did not entail complex terminology and diagrams of vicious circles and feedback loops. I needed an approach that would not question clients' understanding and interpretation of negative social situations but that would instead help them adjust to these situations (as they perceive them) while experiencing as little emotional distress as possible. I needed to make it possible for my clients to have healthy ways of relating to clearly unhealthy phenomena – specifically lack of social support, acculturative stress, and societal racism. Although I was asking for a lot, I did indeed find a great deal of these requirements in Albert Ellis's Rational Emotive Behaviour Therapy (REBT).

REBT is based on Ellis's ABC model (Dryden & Mytton, 1999). The 'A' stands for Activating events. The 'B' stands for the Beliefs that people hold about the activating events. These beliefs can either be rational or irrational. The 'C' stands for the cognitive,

emotional, and behavioural Consequences of those beliefs. Simply put, Ellis's theory suggests that psychological disturbance is primarily determined by the irrational beliefs (absolutist thinking and rigid demands that are often expressed as musts) that people may hold about themselves, others, and the world. Ellis believed that by challenging irrational beliefs and replacing them with more rational ones people could live more productive and fulfilling lives. The counselling process in REBT is further incorporated in the ABC model by the additions of 'D' (Disputing the irrational beliefs) and 'E' (replacing the irrational beliefs with Effective rational ones).

In discussing my REBT conceptualisation of Iraqi refugee exile-related stressors, I (Al-Roubaiy, 2012b) described the psychosocial nature of these stressors and how REBT can be used to address this aspect of Iraqi refugees' distress. These stressors can be incorporated into an REBT formulation because of the ABC model's philosophy of conceptualising activating events (A) as either internal (psychological) or external (social and environmental) - thereby capturing both the psychological and social components of exile-related stressors. REBT also views social cues as purely activating events (A), having no significance beyond providing information about the beliefs (B) held about the activating events. It is the beliefs (B) which are thought to be responsible for the emotional and behavioural consequences (C), and REBT interventions are all geared towards challenging and changing clients' irrational beliefs (DE).

“Therefore, in REBT whether the activating event is perceived by the client in an accurate or distorted manner is of less importance than identifying and working with the beliefs held about the activating event. This theoretical stance in REBT is

reflective of a humanistic component to the approach and is very much in line with Rogers's belief in that clients can only be understood from their own personal and individual perspectives (Dryden & Mytton, 1999)" (Al-Roubaiy, 2012b, p. 46).

However, although I knew that this humanistic aspect of REBT can be emotionally validating since refugee clients' perceptions of oppressive social situations were not questioned (e.g. biased scanning), I often felt the need to do more. Early on in my career as a psychologist, I was often cautioned by colleagues and supervisors in Sweden not to breach boundaries with refugee clients by writing letters or making calls to government agencies (e.g. social services, migration, etc.). I was often told that I might be used by some of these refugee clients who might manipulate me into helping them because of my own 'refugee background'. In the first few years after receiving my license in December 2007, I tried to help some of my refugee clients with practical matters in a subtle manner, so as not to have to explain myself to my colleagues and supervisors.

However, in time I grew tired of having to explain my need to help refugee clients in practical ways, and my reasons for always trying to give clients the benefit of the doubt when asked for this kind of help. Firstly, the issue of boundaries in clinical practice is not as clear cut as some suggest, and quite often what constitutes a breach of boundaries in one context might not do so in another (Gutheil & Brodsky, 2008). Secondly, helping clients in practical ways when dealing with potentially oppressive attitudes in society has long been a feature of advocacy and the social justice movement in counselling (e.g. Jun, 2010; Kiselica & Robinson, 2001) – despite the criticism of this movement for being too political and lacking empirical support (Smith, Reynolds, & Rovnak, 2009).

Chapter 2: Literature review

As discussed in Chapter 1, the study detailed within this thesis aims to explore how counselling and psychotherapy can address the post-migration stress that Iraqi refugee men can experience in later stages of exile in Sweden. This research focus assumes that Iraqi refugee men in later stages of exile in Sweden are representative of a specific counselling client group because they share five common backgrounds: 1) culture; 2) language; 3) gender; 4) age group; and 5) some elements of the refugee experience. Each one of these backgrounds, and how they relate to counselling this client group, will be discussed in this literature review in Chapter 2. However, before discussing each one of these backgrounds, Chapter 2 will commence with a brief introduction to the main literature on counselling and psychotherapy with refugees. Chapter 2 concludes with a discussion on the diversity of therapies commonly used with refugee clients.

Counselling and psychotherapy with refugees

Research on therapeutic work with refugees is not scarce (e.g. Blackwell, 2005a, 2005b; Schwartz & Melzak, 2005). Throughout the years different theoretical approaches, such as psychodynamic (e.g. Blackwell, 2005a, 2005b; Papadopoulos, 2002) and cognitive behavioural (e.g. Basoglu, 1998; Grey, 2009; Regel & Berliner, 2007), have been used to work with refugees. The literature on counselling and psychotherapy with refugees generally focuses on pre-migration trauma and tends to offer suggestions on how to tackle this aspect of the client's distress (e.g. Basoglu, 1998; Drozdek & Wilson, 2004; Regel & Berliner, 2007).

As Miller et al. (2002a, p.378) note, “the primary focus of research on refugee mental health has been on assessing the psychological impact of war-related experiences”. Research on the mental health of refugees “has consistently found high rates of post-traumatic and depressive symptomatology in refugee adults as well as children, using both clinical and nonclinical community samples” (Miller et al., 2002a, p. 378). Similarly, in discussing the refugee experience, Sam and Berry (2006, p. 198) note that:

“much of the existing literature focuses on the prevalence of resultant psychiatric disorder and disability, with emphasis on posttraumatic stress disorder (PTSD), as well as specific phobia, generalized anxiety disorder, depression and physical disease”.

It is difficult to determine how much of this observed distress in refugee populations is due to the impact of pre-migration experiences and how much of it can be explained in terms of post-migration, or exile-related, stressors. As Miller et al. (2002a, p. 378) note:

“numerous clinical reports and a growing number of empirical studies suggest that what happens to refugees after they leave their homeland - the stresses encountered in exile - may contribute significantly to the high rates of observed distress”.

Traumatic pre-migration experiences can add to, or interact with, post-migration stressors in ways that can adversely affect mental health and psychosocial adaption for refugees. Griffiths (2001), for example, suggests that the relationship of refugees to the host

community can worsen the pre-migration trauma of refugees. Similarly, Miller et al. (2002a, p. 385) note:

“It seems likely that war-related trauma may significantly compromise people’s capacity to negotiate the challenges of life in exile...conversely, it may also be that distress related to the experience of exile may impede people’s capacity to heal from the trauma of war-related violence”.

Refugees can face several post-migration stressors which can add to, or interact with, pre-migration trauma in giving rise to this observed psychological distress (e.g. Harris, 2007; Gorst-Unsworth & Goldenberg, 1998; Miller et al., 2002a). In Australia, for example, a study with Tamil asylum seekers, refugees, and immigrants found that while pre-displacement trauma exposure accounted for a significant amount (20% of the variance) of post-traumatic stress symptoms, so too did post-displacement stress (14% of the variance) (Steel et al., 1999). While trauma and cross-cultural issues are often addressed (e.g. Basoglu, 1998; Griffiths, 2001; Regel & Berliner, 2007), post-migration stressors are generally simply referred to as areas of importance to be addressed without actual suggestions on how these issues might be addressed through counselling and psychotherapy (e.g. Harris, 2007; Pernice & Brook, 1996; Gorst-Unsworth & Goldenberg, 1998; Miller et al., 2002b). In order to tackle post-migration stressors some authors have advocated a socio-political stance in which the mental health professional acknowledges the social and political injustices faced by his or her refugee client as part of the counselling process (e.g. Blackwell, 2005a, 2005b; Toporek et al., 2006).

Blackwell (2005b), for example, discusses some of the politicised issues that a professional might struggle with in counselling refugee clients. One such issue is the possible sense of shame that a mental health professional might feel about the societal racism and prejudice refugees face in the professional's country. Another issue is when the political views of the mental health professional correspond closely with or diverge sharply from those of their clients, thereby creating an experience of the client as being either a political ally or opponent. Yet another issue is the terror and helplessness that mental health professionals might feel when confronted with the poverty and deprivation suffered by their refugee clients. As Griffiths (2001, p. 307-308) comments on the experience of refugees in later stages of exile: "In the context of their political struggle their trauma had meaning, and was perhaps more manageable. However, disappointed expectations in the new cultures could be experienced as deeply traumatic".

Culture

Although Iraqis are not a homogenous group and come from a variety of different religious and ethnical backgrounds, they do share a common culture. Only 75 percent of Iraqis are Arabs, 20 percent are Kurds, and the remainder is made up of minority ethnic groups such as Turkomans, Assyrians, Armenians, and some other peoples of Iranian origin (Nydell, 2006). Although there are Iraqi Muslims, Christians, and Jews the majority of Iraqis are of Muslim faith. Iraqis, even outside Iraq, tend to seek each other's company according to shared ethnic, religious, and socio-political backgrounds. As Al-Ali (2007, p.21) notes in describing the different Iraqi communities in London: "There is a clear division between the various communities, cutting across ethnic and class boundaries".

Al-Ali (2007) also discusses other Iraqi communities in the UK as well as in the United States and provides a very detailed description of the differences and similarities across the different communities with respect to time of arrival and place of origin in Iraq as well as other ethnic, gender, class, and religious issues. Although each of the different ethnically, religiously, and class divided groups may have unique experiences of the events that occurred in Iraq, most experienced the same major events. These major events are the regime of Saddam Hussein (1968-2003), economic sanctions (imposed 1990-2003), wars (Iran-Iraq war 1980-88, Gulf wars 1991, 2003), and current refugee situation of Iraqis everywhere. Although certain groups are right in arguing that they suffered more or less of these events depending on their specific backgrounds, the reality is that these events collectively affected most Iraqis.

Iraqis as Arabs and/or Muslims

Much of the literature on counselling Iraqi clients comes from research and clinical observations on counselling and psychotherapeutic work with Arab clients (e.g. Abudabbeh, 1996; Abudabbeh & Aseel, 1999; Jackson, 1995; 1997; Soliman, 1986). Since 75 percent of Iraqis are Arabs (Nydell, 2006) this type of research can certainly give us an insight into the cultural considerations that should be attended to when counselling Iraqi clients. Iraqi Kurds on the other hand have a more complex situation in terms of being considered Iraqi (Demir & Zeydanlioglu, 2010). Research on psychotherapy with Muslims (e.g. Al-Abdul-Jabbar & Al-Isaa, 2000; Bergin, 1980; Rizvi, 1989) has also a lot to offer in attempting to understand Iraqi clients as 97 percent of Iraqis are Muslim (Nydell, 2006).

Gender in Arab and Muslim societies

Gender, for example, can be conceptualised as both a cultural and religious issue in Islamic and Arab culture. Gender differences tend to be clear and emphasised in Islam and Arab culture (Barakat, 1993; Denny, 1985; Nydell, 2006). Traditionally, Arab gender roles are governed by a patriarchal kinship system that had already existed in the region before the spreading of Islam (Nydell, 2006). In Islam there is a preference for separating men from women in certain social settings (Denny, 1985; Nasr, 1966). This conceptualisation of gender differences and roles can explain some of the tension that a Muslim client might experience in the counselling encounter with a mental health professional of different sex (Mass & Al-Krenawi, 1994).

This is not to say that counselling Muslim clients can only work with same sex mental health professionals, or that gender is of greater relevance or importance than other factors, rather it is suggested that this aspect is considered when counselling Arab Muslim clients. An example of how this consideration can be expressed in counselling an Arab Muslim client, of different sex, is when the mental health professional pays extra attention to not getting too physically close to the client or engaging in intense eye contact because that might be experienced as inappropriate and uncomfortable by the client (Mass & Al-Krenawi, 1994; Rizvi, 1989). The relevance of gender in counselling Iraqi men will be discussed later in this chapter. It is merely considered in this section as one of several culturally relevant issues for Iraqis who are of Arab and Muslim backgrounds – as most Iraqis are.

Family in Arab and Muslim societies

Another important concept in both Islam and Arab culture is the concept of family. The family is the central structure of Arab culture. “Family loyalty and obligations take precedence over loyalty to friends or the demands of a job” (Nydell, 2006, p.71). In Islam, obeying one’s parents and respecting them is highly valued (Denny, 1985). It has been suggested that the development of an individual identity, separate from that of the family, is not valued or encouraged by the traditional Arab family (Abudabbeh, 1996). This aspect of Islam and Arab culture is perhaps suggestive of more family-orientated counselling interventions with less emphasis on independence and individualism as major treatment goals. It is also worth noting that traditionally when an Arab encounters a psychological problem he or she is encouraged to seek guidance from an older family member of the same sex and not a mental health professional (Jackson, 1997). Therefore many Iraqi men are traditionally inclined to seek advice from male family elders when dealing with distress.

Mental illness and the supernatural in Arab societies

There are two other aspects of Arab culture that have an impact on counselling and psychotherapeutic work with Arab clients - the stigma of mental illness and the belief in the supernatural. The stigma that is attached to mental illness in Arab societies can be partly understood when one considers the meaning of mental illness in the Arabic language and culture. The Arabic word for insane is ‘majnun’, essentially meaning possessed by ‘jinn’ or ‘jinni’. Denny (1985, p. 93) explains that: “One who is possessed by a jinni is rendered majnun, meaning insane”.

This social stigma that mental illness carries might be partly responsible for the observed underutilisation of mental health services by Muslim clients in Western societies (e.g. Patel et al., 2000). Inayat (2005) highlights six areas of functioning that can contribute to the underutilisation of mental health services observed in Muslim clients: 1) mistrust of service providers; 2) fear of treatment; 3) fear of racism and discrimination; 4) language barriers; 5) differences in communication; and 6) culturally-related concerns. This stigma might partly explain Iraqi mental health clients' somatisation of symptoms (e.g. Bazzoui, 1970; Jamil et al., 2002; Jamil et al., 2005; Shoeb, Weinstein, & Mollica, 2007).

The stigma attached to mental illness goes further than the meaning of the word insane (*majnun*) and extends to many other supernatural explanations for psychological problems. Psychological problems are traditionally explained as external interventions of the supernatural through avenues such as sorcery, the evil (or envious) eye, Jinn, and spirits (Al-Krenawi, 1999a; El-Islam, 1982; Morsy, 1993). Iraqi men who hold such beliefs tend to explain their emotional distress in terms of supernatural interventions which might require the help of some form of traditional healer. For example, in attempting to adapt the HTQ (Harvard Trauma Questionnaire) to the Iraqi context, Shoeb, Weinstein, and Mollica (2007, p.456) came to observe that:

“mental illness is stigmatized very highly among Iraqis - its presence in a family can lead to labelling that family's offspring unfit for marriage-the psychiatrists reported that popular labels of mental illness cover only indisputably psychotic behaviour and mental retardation. One such label is *majnun*, which is originally derived from the word *jinn* (supernatural spirit)”

The problem with the belief in the supernatural is that it externalises the source of the problem and undermines individual responsibility for the emotional and mental distress a person might be experiencing. Consequently the need for personal reflection in assessing and resolving a psychological problem is rendered useless. That is probably one of the major differences between the mental health professional and the traditional healer - the requirement of self reflection.

There are a variety of traditional healers in Arab culture. They have different methods of working, and often claim to be able to remedy most problems that are considered to be supernatural or spiritual. One possible stance to these healers could be to discard them because they lack scientific grounding and professional training. Another could be to work with them. Traditional healers actually have several strong points that are worth considering. Traditional healers tend to share the client's worldview, which has been suggested as an important factor in the efficacy of the traditional system (Torrey, 1986). The traditional healer emphasises the importance of family and generally engages the family as partners in the process of treatment and healing, and recognises the dominant figures as spokespeople for the client (Al-Krenawi & Graham, 1997c).

Like mental health professionals, traditional healers understand the importance of developing a good relationship with the client. Establishing a good relationship with the client enhances the client's belief in the traditional healer's supernatural powers (El-Islam, 1982). Understanding these traditional healing systems might enable mental health professionals to work more effectively with Iraqi clients who hold such beliefs.

Culturally sensitive practice

Psychotherapy has often been criticised for being too Western in its philosophy and foundations (e.g. Bhugra & Bhui, 2006; Moodley, 2007; Moodley & Lubin, 2008). As Tribe & Thompson (2011, p. 85) note, “health beliefs and views about emotional well being, as well as idioms of distress can vary with an individual’s cultural and religious background”. Therefore, attempting to understand when and how to address cultural issues in counselling Iraqi refugees requires, in part at least, some knowledge of Iraqi culture. Additionally, a therapist must have some awareness of multicultural/cultural competency skills in order to deliver culturally sensitive counselling. As Maxie, Arnold, and Stephenson (2006, p. 85) note:

“Cross-cultural psychotherapy dyads are inevitable, and differences between client and therapist may include ethnicity, race, socioeconomic status, sexual orientation, religion, age, and gender. Moreover, clients and therapists possess individual values, attitudes, and worldviews that may not be the same. Understanding if, when, and how therapists should address differences with clients is critical in knowing what works best in psychotherapy”.

One of the most challenging aspects for a Western mental health professional working with a culturally different client group is deciphering the cultural and linguistic codes. One way around this problem is in using interpreters (e.g. d’Ardenne & Farmer, 2009; Marcos, 1979; Tribe & Raval, 2003). Although using interpreters can be valuable in facilitating communication (e.g. Lago, 2006; Tribe, 1999; Tseng, 2004), therapists never really know

exactly how and what information is being communicated (e.g. Century, Leavey, & Payne, 2007; Tribe & Keefe, 2009). The use of interpreters and the relevance of language in counselling Iraqi clients will be discussed later in this chapter. Another way around this is through ethnic therapist-client matching. However, research on ethnic matching seems inconsistent. Some studies seem to suggest a client preference for ethnically similar therapists (e.g. Atkinson, 1983; Gim, Atkinson, & Kim, 1991) whereas others suggest this preference to be true only in certain ethnic groups such as Latin Americans (Sue, Zane, & Young, 1994). No research has been done to explore Iraq clients' possible preferences in terms of ethnic therapist-client matching.

Many therapists experience difficulties when faced with clients who are different from themselves in terms of the “big 7 identities” (gender, race, class, sexual orientations, disability, religion and age) (Moodley & Lubin, 2008). Considering how Iraqi mental health clients tend to engage in somatisation of symptoms (e.g. Bazzoui, 1970; Jamil et al., 2002; Jamil et al., 2005; Shoeb, Weinstein, & Mollica, 2007), have a tradition of explaining psychological problems as external interventions of the supernatural (Shoeb, Weinstein, & Mollica, 2007), and have generally been brought up in a patriarchal society (Al-Ali, 2005; Al-Ali & Hussein, 2003) poses the question of whether or not counselling is culturally syntonetic for this client group. Western counselling professionals who work with Iraqi refugee clients should use a culturally sensitive approach to working with this client group. A culturally sensitive approach to counselling entails, among other things, an in depth awareness of three major issues: 1) multicultural/cultural competency skills; 2) client's worldview and acculturation; and 3) challenges in counselling the culturally diverse. Each of these issues will be discussed in turn in the following sections.

Multicultural/cultural competency skills

One major approach to multicultural counselling is through the use of multicultural/cultural competency models. But what is ‘multicultural competence’ and is it different from ‘cultural competence’ and other similar terms? As Whaley (2008, p. 215) notes:

“Many authors freely interchange the terms *cultural sensitivity*, *cross-cultural competence*, *cross-cultural expertise*, *cross-cultural effectiveness*, *cultural responsiveness*, *cultural awareness*, and *culturally skilled*...they often appear in the multicultural literature as though they were synonymous”.

For some, this loose use of terminology might be a cause for concern. For example, Ridley, Baker, and Hill (2001) argued that equating “‘cultural competence’” and “‘multicultural counseling competence’” can create confusion. The terms ‘cultural competence’ and ‘multicultural competence’ are often used interchangeably in the literature and deciding on which term to use seems to be more of a tradition than anything else. As Whaley (2008, p. 221) observes, “cultural competence seems to be most prevalent in the clinical psychology literature, and multicultural competence is usually found in the counselling psychology literature”. In the present study, ‘cultural competency’ and ‘multicultural competency’ are used interchangeably depending on the referenced author’s choice of term.

Similarly, in discussing the difference between ‘cultural competence’ and ‘cultural sensitivity’ Trimble (2003, p. 17) argues that one can progress “to a proficient stage of competence by actively engaging in the study and expression of respect for others

regardless of their cultural or ethnic background’’ - suggesting that cultural sensitivity can be viewed as the first stage in achieving cultural competency.

This distinction is important because it implies that ‘cultural sensitivity’ is more of an awareness, respectful attitude, or knowledge base, while ‘cultural competence’ is more of a repertoire of skills which are necessary for successfully conveying this awareness and respect. However, it is also very common to use these two terms interchangeably in the literature (Whaley, 2008). In the present study, ‘culturally sensitive practice’ is used as an umbrella term to describe most of the theories and practices that are often discussed in the literature on multicultural counselling.

The multiple definitions of cultural competence tend to share the emphasis on the multilevel influences of culture, but can differ in their focus on cultural awareness, knowledge, or skills in defining the concept (Whaley, 2008; Whaley & Davis, 2007). Lopez (1997, p. 573), for example, considers the essence of cultural competence to be “the ability of the therapist to move between two cultural perspectives in understanding the culturally based meaning of clients from diverse cultural backgrounds”. While Sue (1998) views cultural competence as a multidimensional process in which the practitioner needs to acquire three important characteristics: 1) scientific mindedness; 2) dynamic sizing; and 3) culture specific resources.

The most comprehensive multicultural competency model developed to date is the Multicultural Counselling Competencies (MCCs) model. The model was originally developed by Sue et al. (1982) under the auspices of the Division of Counseling

Psychology of the American Psychological Association (APA). After several elaborations and updates the MCCs were eventually published by the APA as the ‘Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists’ (APA, 2003). The MCC model is comprised of three competency domains: (1) counsellor awareness of own cultural values and biases; (2) counsellor awareness of the client’s worldview; and (3) culturally appropriate intervention strategies.

Since its original conceptualisation by Sue et al. (1982), the MCC model has seen several expansions (Sue et al. 1992, 1998) and “continues to be widely accepted as the core multicultural competency model within the field of counseling psychology” (Worthington, Soth-McNett, & Moreno, 2007, p. 352). In conducting a content analysis of the empirical research on the MCC model, Worthington, Soth-McNett, and Moreno (2007, p. 358) concluded, among other things, that “the existing empirical MCC process/outcome research has shown consistently that counselors who possess MCCs tend to evidence improved counseling processes and outcomes with clients across racial and ethnic differences”.

One of the ways in which cultural competency can be applied in practice is through culturally adapting different kinds of therapies to make them culturally applicable and relevant for certain client groups. Findings from culturally adapted therapy studies suggest that cultural competency adaptations to CBT and interpersonal psychotherapy (IPT) were more effective at alleviating client distress compared to waiting list control groups and standard CBT and IPT groups. Rossello & Bernal (1999), for example, found that cultural adaptations to CBT and IPT were more effective in reducing depression among Puerto Rican youths compared to a waiting list control group. Kohn et al. (2002) went a step

further by examining the difference between standard CBT and culturally adapted CBT (e.g. changes to the language used to describe CBT, inclusion of culturally specific content, etc.) in treating depressed low-income African American women. Compared to the non-culturally adapted CBT intervention group, Kohn et al. (2002) found that the women in the culturally adapted CBT group demonstrated a larger drop in depression.

Similarly, Miranda et al. (2003a) examined the outcome effects of culturally adapting CBT with Hispanic clients and found that the clients who received the culturally adapted CBT (e.g. using bilingual and bicultural providers, translating materials to Spanish, etc.) had lower dropout rates than those who received standard CBT. Miranda et al. (2003a) also found greater improvement (i.e. symptom reduction and enhanced functioning) among those whose first language was Spanish rather than English in the culturally adapted CBT group. Further support for the effectiveness of culturally adapted interventions comes from the first, and to this date only, meta-analysis to examine the effects of culturally competent interventions with adults and children (Griner & Smith, 2006).

In their meta-analysis, Griner & Smith (2006) examined 76 studies and found that cultural competency interventions had a moderate positive effect (weighted mean effect size = 0.45). However, Griner & Smith (2006) acknowledged that their meta-analysis included all of the cultural competency research available at the time; regardless of quality and rigor. Considering the diversity of the studies examined by Griner & Smith (2006) makes identifying the precise factors that account for the positive effects on treatment outcomes difficult. To this date, the only other meta-analysis to address culturally competent interventions did so indirectly, since the researchers (Huey & Polo, 2008) first examined

the outcomes of evidence-based treatments with ethnic minority youths (i.e. not specifically culturally competent intervention studies). In contrast to the positive effect found by Smith & Griner (2006), Huey & Polo (2008) concluded in their meta-analysis that there was no compelling evidence that cultural adaptations promoted better clinical outcomes for ethnic minority youths. There has been no direct attempt at culturally adapting a therapeutic approach specifically for adult male Iraqi refugee clients, and as a result it is difficult to assess the relevance of this form of multicultural counselling practice with this client group.

Despite the strengths of multicultural counselling theories such as the MCC model (Sue et al. 1992, 1998) some authors have pointed out the limitations of these theories. One criticism of multicultural theories is that to ascribe typical characteristics and behaviours to members of cultural groups is inadvertently prejudicial, stereotypic, and fails to attend to the client's individuality (Hwang, 2006). Similarly, Satel and Forster (1999) offer another criticism in arguing that cultural competency is motivated by political correctness and is unsupported by an evidence base. These two criticisms of multicultural counselling theories are easily addressed as the following two paragraphs demonstrate.

Avoiding stereotyping clients lies at the heart of multicultural competency thinking, when applied correctly (e.g. Lopez, 1997; Sue, 1998). Sue (1998), for example, cautions against allowing stereotypes of certain cultural groups to excessively influence counselling practice with clients from such groups yet at the same time emphasises the importance of acknowledging cultural identity as shaped by links to cultural groups. To achieve this theoretically perfect balance between not losing the individual traits of the client and acknowledging and understanding the influences of the client's cultural identity Sue (1998)

proposed the skill of ‘dynamic-sizing’ which refers to the counselling practitioner’s ability to know when to generalise and when to individualise. Similarly, Lopez (1997) emphasised the importance of being able to move between the two cultural perspectives of practitioner and client in order to co-construct a narrative that is accessible and comprehensible to both practitioner and client.

Multicultural approaches to counselling and psychotherapy are not simply driven by political correctness and are currently very much part of the move towards evidence-based practice. Fuertes et al. (2006), for example, found that practitioners rated highly by ethnic minority clients on therapeutic alliance and empathy were also rated higher in cultural competency. Also the American Psychological Association (APA, 2003) recommends gathering culturally and socio-politically relevant information about client history that includes residency status (e.g. history of migration), fluency in languages, social status post migration, and level of acculturative stress. Similarly, the American Psychological Association’s report on evidence-based practice in psychology (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 271) defined evidence-based practice as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences”; thus acknowledging the importance of considering counselling clients’ cultural backgrounds in informing evidence-based practice.

However, one criticism that is difficult to address is that multicultural counselling theories can only foster an anti-racist attitude between an ethnic minority client and his or her therapist in the therapeutic encounter - yet these theories offer little in addressing racism in society. As Dei (2005, p.141) observes:

“the pleasant poetry of ‘diversity’ and ‘multiculturalism’ would suggest that when we learn about each others’ differences, we will learn to appreciate and celebrate what might otherwise be perceived as threatening and unknowable. But these naïve interpretations of difference do not implicate power relations or internalized oppression in the equation”.

Multicultural theories also fail to take into account the complexity of oppression as a system that extends beyond racism. As Keating (2000, p.83) argues, anti-racism theory:

“implies that racism is a system that operates independently from other systems of oppression and domination...What is absent from anti-racist theory is how racism intertwines or intersects with sexuality, gender, class and other forms of oppression”.

Oppression can occur at three levels: individual (e.g. discrimination); social/cultural (e.g., societal norms); and institutional levels (e.g., policies) (Hardiman & Jackson's, 1982). In emphasising tolerance of cultural diversity and anti-racism, multicultural theory fails to take into account the need for an anti-oppressive approach to counselling ethnic minority clients rather than solely an anti-racist one. An anti-oppressive approach entails:

“an understanding of one’s social location and how it informs relationships and practice behaviors; a challenge to existing social relationships in which powerful

groups maintain power and influence over less powerful groups; and specific practice behaviors and relationships that minimize power imbalances and promote equity and empowerment for users of service” (Larson, 2008, p.42).

Consequently, one of the most important forms of oppression that multicultural theory fails to address is classism. Collins and Yeskel (2005, p. 143) defined classism as:

“the systematic oppression of subordinated groups (people without endowed or acquired economic power, social influence, or privilege) by the dominant groups (those who have access to control of the necessary resources by which other people make their living)”.

Similarly, Vera and Speight (2003) offered a critique of multicultural competency theories and called for a more explicit focus on power, privilege, and the eradication of oppression in society. Others, however, argue that this has always been the intent behind the multicultural competencies (Arredondo & Perez, 2003). Of course this line of theorising will inevitably involve political and ethical issues. These potentially problematic issues will be discussed later under the heading of ‘challenges in counselling the culturally divers’. But before discussing these challenges, a brief discussion will be presented next to shed further light on two issues of relevance to counselling culturally diverse client groups – the client’s worldview and acculturation.

Client's worldview and acculturation

One major aspect of culturally sensitive counselling is incorporating the client's worldview; simply defined as the manner in which a client views his or her relationship to the world (Sue, 1978). Using 88 Asian American volunteer clients engaged in single-session counselling with 1 of 11 female counsellors who either matched or mismatched the client's worldview, Kim, Ng, and Ahn (2005) found, among other things, that clients in the worldview match condition perceived stronger client-counsellor working alliance and counsellor empathy than clients in the mismatch condition. In discussing their findings on worldview match, Kim, Ng, and Ahn (2005, p. 75) note that "to enhance client-perceived client-counselor working alliance and counselor empathy, it would be beneficial for counselors to focus on establishing a match on worldviews".

Similarly, in discussing her experiences of counselling refugees Tribe (1999) emphasises incorporating the client's worldview through interventions such as working with dreams according to client's cultural beliefs and involving community or religious elders in therapy. Traditional healers tend to share the client's worldview, which has been suggested as an important factor in the observed efficacy of some traditional healing systems (e.g. Al-Krenawi & Graham, 1997c; Torrey, 1986). As Tribe (2004, p. 115) notes, "local helpers provide important psychosocial and practical support and may serve communities in ways that western-trained psychologists and psychiatrists cannot".

For clients living in host societies with cultures different from their own, acculturation becomes an important aspect for understanding shifts or changes in the client's worldview

(e.g. Grieger & Ponterotto, 1995; Dass-Brailsford, 2012). Grieger and Ponterotto (1995) suggested considering six aspects, related to acculturation and worldview, in assessing culturally diverse counselling clients: 1) the client's level of psychological mindedness; 2) the family's level of psychological mindedness; 3) the client's/family's attitude towards counselling; 4) the client's level of acculturation; 5) the family's level of acculturation; and 6) the family's attitude towards acculturation.

Assessing the level of acculturation is far from a straightforward concept as there are several different conceptualisations and classifications of acculturation processes (Snauwaert, Soenens, & Boen, 2003). One of the more recent and dominant understandings of acculturation is that it is viewed as a continuous process in which an individual may adopt different acculturation strategies (mainly *assimilation*, *integration*, *separation* and *marginalisation*) at different times to deal with different life issues (Berry & Sam, 2006). Acculturation will be further addressed in this chapter under the heading of 'acculturation related difficulties'.

In spite of the complexity and lack of consensus in assessing and defining acculturation processes (Snauwaert, Soenens, & Boen, 2003), culturally sensitive practice requires some level of awareness of the client's acculturation (e.g. Grieger & Ponterotto, 1995; Dass-Brailsford, 2012). Considering the family's level of and attitude towards acculturation is also important in working with clients who come from collectivist cultures in which family unity and involvement takes precedence over individuality and independence, as is the case with traditional Arab families (Abudabbeh, 1996; Nydell, 2006).

As Dass-Brailsford (2012, p. 389) notes, “Based on different levels of acculturation, family members may hold differing cultural perspectives. For the culturally-astute clinician, a constantly changing cultural understanding provides fresh and unique opportunities to fine tune therapeutic skills”. In attempting to understand a client’s worldview, therapists should particularly be aware of the client’s ‘cultural identity’. Cultural identity refers to “an individual’s sense of belonging to a cultural group and the part of one’s personality that is attributable to cultural group membership” (Lee, 2006, p. 179).

Challenges in counselling the culturally diverse

Discussions of race in therapy tend to focus on the challenges in establishing a productive working relationship in white therapist-minority client encounters (e.g. Carter, 1995; Helms, 1984; Sue & Sue, 2008). In counselling clients living in host countries with cultures different from their own, therapists need to be aware of the client’s cultural identity more so than his or her ethnicity, as ethnicity says very little about a client’s acculturation and sense of cultural belonging (Lee, 2006). One challenge in trying to explore a client’s cultural identity with ethnically and culturally diverse clients lies in the discomfort that some white therapists can display in cross-racial interactions and their subsequent avoidance of racial and cultural material in therapy (Turner & Armstrong, 1981; Utsey, Gernat, & Hammar, 2005; Vasquez, 2007). This discomfort and subsequent avoidance of culturally sensitive material has been shown to adversely impact on communication and collaboration with culturally and ethnically diverse clients (e.g. Dovidio et al., 2002; Norton et al., 2006).

In avoiding cultural material with culturally diverse clients, white therapists can be seen as

neglecting the client's culture, which can be experienced by clients as a form of 'racial microaggression'. Racial microaggressions include a wide range of verbal and nonverbal communications, that convey insensitivity, neglect, and/or disrespect, both intentionally and unintentionally, regarding some aspect of a another person's cultural heritage (Pierce et al., 1978; Sue et al., 2007). Sue et al. (2007) define racial microaggressions as brief, everyday exchanges that send denigrating messages to people of colour because they belong to a racial minority group.

The 'Racial Microaggressions in Counseling Scale' (RMCS; Constantine, 2007) is the only known psychotherapy measure for assessing clients' perceptions of microaggressions in therapy. The RMCS was devised based on the first study of real experiences of microaggressions in actual therapy (Constantine, 2007). So far most studies of microaggressions in therapy are analogue-based (i.e. not based on real experiences). In analogue-based studies of microaggressions, a therapist's demonstration of a specific type of microaggression, colour-blind attitudes (the belief that race/ ethnicity is not important and therefore not considered) is related to the therapist's self-rating of empathy for a hypothetical client (e.g. Gushue, 2004; Neville et al., 2006).

In therapy, racial microaggressions occur when therapists send demeaning messages to their ethnic minority clients by conveying racist attitudes, doing culturally insensitive treatment interventions, or simply neglecting cultural issues (e.g. Constantine, 2007; Neville, Spanierman, & Doan, 2006). It has been hypothesised that clients' perceptions of microaggressions can negatively influence treatment outcomes by harming the working alliance (Constantine, 2007; Owen et al., 2011). Given the working alliance's established

importance in predicting therapeutic outcome (Horvath & Luborsky, 1993; Ogles et al., 1999; Safran & Muran, 2000; Wampold, 2001) it becomes clear how potentially damaging racial microaggressions can be for psychotherapy outcome.

In a study of clients' perceptions of microaggressions in actual therapy sessions, Constantine (2007) explored the role of perceived racial microaggressions by 40 African American clients with 19 white therapists. She found negative relationships between clients' perceptions of microaggressions and working alliance, satisfaction with therapy, and both general and multicultural competences of therapists. More recently, Owen et al. (2011) found that clients' ratings of microaggressions were negatively associated with their psychological wellbeing and that this effect was mediated by clients' ratings of working alliance.

However, Constantine (2007) found that working alliance mediated the relationship between microaggressions and clients' perceptions of their therapists' general and multicultural competence, but not satisfaction with therapy. In other words, the African American clients who perceived racial microaggressions from their white therapists, yet still perceived the working alliance to be strong, maintained a positive view of their therapists' competence. This finding can be difficult to understand when one considers that racial microaggressions entail some form of racist and/or culturally insensitive attitude from the white therapists that was communicated to the clients. How can such racist attitudes not lead to ruptures in the working alliance and a negative evaluation of the therapist's competence? Perhaps the answer lies in one of the most pathological reactions to racism - internalised racism (Speight, 2007; Williams & Williams-Morris, 2000).

Another major challenge in counselling culturally and ethnically diverse clients is when such clients avoid discussing issues pertaining to their ethnic minority status due to an anticipated lack of understanding or lack of empathy from their western/white therapists. Chang and Yoon (2011), for example, interviewed 23 ethnic minority clients to assess perceptions of race in their recent therapy with a white therapist. The majority believed that white therapists could not understand key aspects of their experiences and consequently avoided disclosing racial/cultural issues in therapy. The majority of participants also felt strongly that white therapists could not appreciate how their minority status and culture shaped their psychological development (e.g., identity and values) as well as their external reality of discriminatory treatment.

Minority clients' concerns, regarding the white therapist not acknowledging the reality of discrimination they face, are not necessarily unwarranted. Tucker (2011, p. 70), for example, explains how "there is the unconscious transmission of trauma of refugees to their descendents, such as children of political refugees living in peaceful tolerant communities perceiving their environments as constantly hostile and persecutory" - without much consideration for the possibility that such clients might truly be living in hostile and persecutory societies. Minority clients' reluctance to disclose feelings about racial and cultural issues (Cardemil & Battle, 2003; Chang & Yoon, 2011) makes it difficult for therapists to address such concerns. Several studies suggest the need for white counselling practitioners to convey their interest in discussing such issues with minority clients (e.g. Cardemil & Battle, 2003; Fuertes et al., 2002; Knox et al., 2003; Maxie et al., 2006).

Another major challenge in counselling culturally diverse clients is the inevitable discussion regarding the complex ethics and politics involved in applying multicultural counselling theories. For example, it has been argued that counselling culturally diverse client groups can only be ethical if it is rooted in cultural awareness and sensitivity (Corey, Corey, & Callanan, 2007; Houser, Wilczenski, & Ham, 2006; Pack-Brown & Williams, 2003). Many professional bodies have ethical standards and guidelines that promote anti-discriminatory practice and sensitivity to cultural diversity – such as the 2005 *American Counseling Association Code of Ethics* which states that “Association members recognize diversity and embrace a cross-cultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts. (p. 3).

However, counselling professionals are not simply guided by the ethical guidelines that their professional bodies might have outlined for them. Ethical counselling practice can be conceptualised from two perspectives: Philosophical ethics and professional ethics. When a therapist uses personal and moral values in deciding what is right and what is wrong in a given situation with a client, he or she is considered to be relying on philosophical ethics (Cottone & Tarvydas, 2003). When a therapist relies on professional ethical guidelines in deciding what the right or wrong attitude or course of action is, he or she is thought to be using professional ethics (Corey, Corey, & Callanan, 2007). Therefore, what constitutes ethical practice for one therapist might be considered unethical for another. Therapists with similar training and identical professional backgrounds are also human beings with personal beliefs and political ideologies that might or might not embrace diversity and multiculturalism in all its forms.

As Hill (2004, p. 186), observes:

“when professional counselors refer to ethics . . . it is often not clear whether they are referring to codes of ethics, moral values, legal limitations on behavior, community standards, or to some general sense of the term that is meant to encompass any one or all of these”.

In terms of multicultural theory in counselling, ethical practice is not as clear cut as some might think and political ideologies can influence therapists' decisions in working with clients from certain cultural backgrounds. Specifically, it has been suggested that while multiculturalism and feminism share many common principles, they are not always compatible (Okin, 1999). Reid (2002, p.107), for example, argues that “there are instances when cultural practices and familial roles may threaten, endanger, and grievously disadvantage women. Can therapists, counselors, or educators risk girls and women to protect a cultural tradition?” This line of thinking can have obvious implications for counselling Iraqi refugee men, especially considering the patriarchal nature of Iraqi culture (Ismael & Ismael, 2000).

Conversely, as a result of the depiction of Arab and Muslim men as female oppressors in some Western media (Shaheen, 2009; Kamali, 2009), a Western therapist might stereotypically view an Iraqi male client as insensitive to women's rights and communicate this to the client - who is likely to experience this as a form of racial microaggression which can negatively influence the process and outcome of therapy due to the harmful effects that such experiences can have on the working alliance (Constantine, 2007; Owen et al., 2011).

Language

One issue of high relevance for counselling linguistically diverse client groups, such as the Iraqi refugee clients in this study, is language. Most counselling practitioners do not usually share refugee clients' languages, and are therefore limited in effective communication and understanding, particularly if the refugee client is not fluent in the practitioner's language (e.g. Miller et al., 2005). Using interpreters in such counselling contexts can be done in several different ways, depending on the nature of the consultation or session. Tribe and Keefe (2009, p. 420) suggest that there are four interpretation models to choose from:

- “the linguistic mode (based on word-for word interpretation whenever possible);
- the psychotherapeutic or constructionist mode (where the focus is on the meaning of the words and emotions being expressed);
- the advocate or community interpreter mode (where the interpreter takes a role as an advocate for the individual client and on occasions for the community they represent);
- cultural broker/bicultural worker mode (where the interpreter interprets not only the language but also any relevant cultural variables)”.

The advantages to using interpreters are obvious when one considers the many different functions that an interpreter can fulfil. However, some counsellors seem to view the use of interpreters as unfortunate but necessary. In their study on the use of interpreters in psychotherapy with refugees, Miller et al. (2005, p. 37) found, among other things that clinicians may experience:

“feeling excluded from the interpreter-client relationship during the early phase of therapy, feeling self-conscious at a having a third person present in session, and feeling frustrated at what may be perceived as inappropriate interpreter behaviors”.

Similarly, in their study on counsellors’ experiences of working with refugees, Century, Leavey, and Payne (2007, p. 38) described counsellors’ attitudes towards the use of interpreters in counselling refugee clients by noting that:

“The use of interpreters, while regarded as necessary, is undoubtedly a disruption to the normal flow in the therapeutic relationship... Their involvement generally brings a sense of mystery and distrust about the session content and often too adds to the feeling of limitation and pressure”

However, for the refugee client the experience of having an interpreter present in the counselling encounter might differ from that of the counsellor’s as “research shows that many asylum seekers find the provision of an interpreter an empowering experience that assists them in communication” (Tribe & Keefe, 2009, p. 411). Even when interpreters are viewed as necessary in deciphering cultural meanings, their presence can still be a concern.

As Century et al., (2007, p. 30) note: “Even with trained and experienced interpreters some counsellors reported feeling that this counselling was ‘inferior’ or that the work felt ‘compromised’”. Similarly, Perez-Foster (1998) supports the use of interpreters for assessment and diagnosis but argues that having including an interpreter in the actual

therapy might be inappropriate; specifically in psychodynamic therapies as the issue of transference might be too complex to deal with when three people are involved.

These tensions that might arise as a consequence of using interpreters in counselling refugees can lead some practitioners to avoid working with them even when their contribution is viewed as valuable (e.g. Century et al., 2007). A more constructive approach would be to address these tensions and be aware of them early on. As Tribe and Keefe (2009, p. 412) note:

“the nature of interpreters’ relationships with colleagues and clients needs to be thought about and contained in such a group as the former can feel threatened by their presence and the latter place unrealistic expectations upon them due to cultural and linguistic links”.

The emotional impact of being able to express one’s self in one’s own mother tongue is often taken for granted by people who have not experienced this loss of language; which is one of many losses that refugees know all too well. The mother tongue holds strong emotional content and memories that might not be as accessible when thinking and communicating in another language (Perez-Foster, 1998; Burck, 2004; Greenson, 1950). As Tribe & Keefe (2009, p. 417) note, “Not speaking the mother-tongue could therefore be defensive, an attempt to avoid emotional intensity, or liberating: an opportunity to think about the unthinkable”. Encouraging clients to talk about how they experience the languages they use in counselling may help counsellors in making an informed decision as to when, with whom, and how to use interpreters (Tribe & Keefe, 2009).

Gender

Men and women are two different counselling client groups, not merely because of their biological differences, but because of their different gender identities and gender roles (Brooks & Good, 2001; Person & Ovesey, 1983; Stoller, 1976). The study detailed within this thesis focuses only on Iraqi refugee men partly due to the gender differences between men and women that have been highlighted by some researchers in mental health and psychotherapy studies. Similarly, the experiences of refugee women in Western host countries have also been shown to differ from those of refugee men in some respects. For example, in exploring Kurd asylum seekers' and refugees' experiences of exile as men, Griffiths (2001, p. 305) observed that:

“The asylum seekers' and refugees' view that women have the more difficult time seemed to be based on the continuation of their roles (e.g. childcare, cooking), whereas the men had lost roles they held in their country of origin. The support organizations, in both countries, recognized this loss of status in the men as well as their more restricted emotional expression and thus saw the men as having the more difficult experience”.

Gender has many implications for counselling that transcend biological sex differences. The term ‘sex’ is often used to distinguish men and women biologically whereas ‘gender’ is used to refer to the cultural, psychological, and social aspects of being female and male (Gilbert & Scher, 1999). Women, for example, have been shown to more frequently be diagnosed with depression than men, while men are more likely to be diagnosed with

disorders that relate to aggressive, violent, and impulsive behaviour (Weissman, 1991). Similarly, depression is believed to affect women of all social classes and races much more frequently than it affects men in several Western countries (Stoppard, 2000). It is difficult to know exactly how much of these gender-related patterns in diagnoses are due to genuine sex differences and how much can be explained by biases and gender role stereotypes (Adler, Drake, & Teague, 1990). It has also been suggested that men who experience mental and emotional distress tend to manifest it differently from women, and in ways that fit social expectations of gender roles (Cochran & Rabinowitz, 2000; Real, 1997).

While research has shown that psychotherapy outcomes do not vary, in any consistent manner, as a function of clients' gender (Clarkin & Levy, 2004; Garfield, 1994), gender biases from therapists have been documented in several studies on counselling male clients. For example, some therapists can stereotype male clients as generally 'hypo-emotional' and 'out of touch' with their emotions (Heesacker et al., 1999). Similarly, some therapists generally view male clients as impenetrable and difficult to work with, while some even view men who seek therapy in negative terms based on traditional notions of masculinity (Brooks & Good, 2001; Dienhart, 2001; Robertson & Fitzgerald, 1990). However, while stereotypically viewing male clients as emotionally out of reach or difficult to work with in counselling is not in line with the respectful attitude and appreciation of client individuality that all professionals ought to have, there is some literature that is supportive of the existence of such tendencies among some men.

Levant et al. (1992), for example, identified seven traditional norms of masculinity: 1) avoiding all things feminine; 2) restrictive emotionality; 3) toughness and aggression; 4)

self-reliance; 5) achievement and status; 6) nonrelational attitudes towards sexuality; and 7) fear and hatred of homosexuals. Similarly, Harris (1995) described how men are driven, by anxieties about being properly gendered beings, to practice unhealthy behaviours in order to prove their masculinity. Harris (1995, p. 44) also explains that these anxieties and unhealthy behaviours are maintained because “every young man has to keep proving himself...and has to keep on renewing this ‘proof’ until the day he dies”. It is also interesting to note that these norms of masculinity seem to “override differences brought about by class, race, sexual orientation, age, and place of origin” (Harris, 1995, p. 181).

Some authors have suggested that these masculine traits are stress-inducing and likely to lead to different levels of emotional inexpressiveness (e.g. Eisler & Blalock, 1991; Levant, 1998). Levant (1998), for example, suggests that some men’s difficulty in putting emotion into words can be conceptualised as a mild form of alexithymia which he termed ‘normative male alexithymia’. Levant (1998, p.37) also notes that this male emotional inexpressiveness makes it “less likely that such men will benefit from psychotherapy”.

Several other researchers have explored other masculine traits that make men less than ideal counselling clients. For example, White (2009) studied a sample of British men and found three coping strategies used by men in response to stress: avoidance, displacement (anger), and discussions with family and friends. White (2009) also found that the sample of men regarded counselling as a broadly feminine activity and held the profession in low regard. Similarly, Garde (2003) explained how the historical connection between madness and femininity is critical to understanding the relationship between masculinity and psychotherapy, partly in terms of men’s ambivalence to femininity and general avoidance

of emotion. Garde (2003, p.14) goes on to conclude that: “If psychotherapeutics is to promote male healing it must counteract masculinism”. But are all masculine traits counterproductive to male psychological wellbeing?

Levant (1998, p. 38) notes that: “traditional masculinity ideology fit better with harsh social conditions”. Considering the harsh social realities that Iraqi refugee men experienced in Iraq and then in exile, is it really ethical or theoretically correct to counteract their masculinity in psychotherapy? Perhaps some masculinity aspects can function as a form of resilience which might aid Iraqi refugee men in dealing with their traumatic experiences from Iraq and the stressors of exile. Being sensitive, emotionally responsive, and reflective might not always be adaptive. For counselling professionals working with Iraqi refugee men, understanding these masculinity and gender-specific issues can offer great insight into understanding some of the issues that this client group might bring to therapy.

However, while the general concept of masculinity is certainly relevant for understanding this client group as men, there is little in the literature on the culturally-specific notions of gender and masculinity as they relate to the Iraqi cultural context. The revival of tribal beliefs in Iraq in recent years, and the backlash against the issue of women’s rights in modern Iraq, is suggestive of a highly patriarchal society (Al-Ali, 2005; Al-Ali & Hussein, 2003; Ismael & Ismael, 2000). In the next section, masculinity and patriarchal norms will be discussed in further detail and with specific emphasis on how these constructs relate to Iraqi men.

Iraqi men

Iraqi men and women have similar as well as different experiences from Iraq and in exile. Very few researchers have managed to describe and explore Iraqi gender issues as thoroughly as Al-Ali (2005, 2007) has done. Al-Ali, who was born to an Iraqi father and a German mother, has through various works managed to explore almost every socio-political issue relevant to Iraqis in Iraq and in exile. Al-Ali (2005), for example, explored the role of Iraqi women in the reconstruction of Iraq by analysing the current situation with respect to gender ideologies over the past three decades in Iraq. Although Al-Ali's works are mainly from a feminist perspective and tend to highlight the plight of Iraqi women throughout the world, she still manages to cover most of the issues that are of relevance to Iraqi men. For example, Al-Ali (2005, 2007) discussed how Saddam Hussein's regime asked women to produce future soldiers while continuously engaging the public in a glorification of a militarised masculinity.

Al-Ali (2005) has also discussed how Iraqi women were historically very active in Iraq's labour force and how they had been considered among the most educated and socially influential women in the whole region. Similarly, Nydell (2006, p. 172) notes:

“The 1959 Code of Personal Status gave women equal political and economic rights and extensive legal protections. The ruling Baath Party was secular, and promulgated laws specifically aimed at improving women's status...Women were granted equal opportunities in the civil service sector, maternity leave, and freedom from harassment in the workplace”.

However, the issue of women's rights in Iraq has long been a political tool that was used by Saddam Hussein and later by the United States. As Al-Ali (2007, p. 265) notes, "the Iraqi state attempted to shift patriarchal power away from fathers, husbands, brothers, sons and uncles, in order to establish itself as the main patriarch". However following the Gulf war and the uprisings of 1991, Saddam Hussein radically changed his previous policies. As Al-Ali (2007, p. 266) explains, "one of Saddam Hussein's strategies to maintain power was to encourage tribalism...The regime accepted tribal practices and customs, such as 'honour killings', in return for loyalty". Similarly, Al-Ali and Pratt (2009) discuss how U.S. officials implicitly provided a justification for U.S. military intervention in Iraq by speaking publicly about the abuse of Iraqi women under Saddam Hussein's regime. Al-Ali and Pratt (2009) go on to describe the multifaceted abuses of Iraqi women under the occupation.

Women in Iraq have increasingly become marginalised in recent years. This marginalisation has been noted and explained as a feature of increased Islamisation and conservatism (Al-Ali, 2005; Al-Ali & Hussein, 2003) as well as . The issue of women's rights in Iraq is also rendered problematic because it is partly perceived as part of a Western agenda to impose Western values on Iraq. As Al-Ali (2005, p. 753) explains:

"Many Iraqis, who under different circumstances might have been sympathetic to or even supportive of women's rights, view women's roles and laws revolving around women and gender relations as symbolic of their attempt to gain independence and autonomy from the occupying forces".

Al-Ali (2007) interviewed almost 200 Iraqi women in Erbil, Sulaymaniya, London, Amman, Detroit, and San Diego on their experiences in and outside of Iraq from 1948 to 2007. While Al-Ali's (2007) project certainly offered deep and rich accounts of Iraqi women's experiences, her sample was not representative of all the different socio-cultural backgrounds that Iraqi women come from. Ali-Ali acknowledges the limitation of her 2007 project in a later work by stating:

“the majority of the women I talked to were educated middle class women of urban backgrounds. It is important to stress the limitations of this specific sample in terms of its representativeness. Hence while there has been a relatively large urban middle class in Iraq since the economic boom of the 1970s, my research does not explore the lives of women of the poorest strata of society nor women who were living in the countryside” (Al-Ali, 2008, p. 406).

In addition to the limitation of socio-cultural representativeness in Al-Ali's (2007) work, Al-Ali (2005) and Al-Ali and Pratt (2009) offered a highly politicised view of gender in Iraqi society and recent Iraqi history. Several other researchers have noted the oppression that Iraqi women have had to endure in recent years - albeit from different political stances (e.g. Inglehart, Moaddel, & Tessler, 2006). In considering Iraqi men's general masculinity traits (e.g. Levant, 1998), militarised Iraqi masculinity (Al-Ali, 2005, 2007), and the patriarchal nature of Iraqi culture (e.g. Ismael & Ismael, 2000) the case for focusing on Iraqi men as a specific client group becomes clear from a gender perspective.

Age group

This study focuses on adult male Iraqi refugees, not on child or adolescent Iraqi refugees partly for ethical reasons. In terms of ethical considerations, war traumatised Iraqi children and adolescents who might agree to participate in such a study might not be fully aware of their capacity to explore difficult experiences. As Al-Mashat et al. (2006) point out “war-traumatized children’s tough bravado may give the impression that they are mentally and emotionally prepared to explore difficult issues, when in reality they may not be”. In terms of theoretical considerations, refugee children and adolescents tend to have age-specific and developmentally-related issues that can be different from those of adult refugees (e.g. Berman, 2001; Tribe, 1999).

Adults are also considered a more specific counselling client group from a lifespan, or life course, perspective (Gabbard, Beck, & Holmes, 2005; Sugarman, 2004). When describing the foundation for counselling psychology, Kagan et al. (1988, p. 351) stated that the field’s orientation is based on, among other things, “a focus on development across the lifespan with attention to diverse developmental issues and paths, building upon the developmental models that form the cornerstone of counseling psychology”. From a lifespan perspective, psychotherapy in mid- and later-life focuses on “specifically age-related issues - such as diminution of potency, changing marital relations and/or empty nest syndrome; retirement or loss of effectiveness at work; aging, the race against time; and the inevitability of death” (Raphael-Leff, 2005, p. 377). In addition to the focus on age group, the life course perspective emphasises the major impact of life-changing events on normal development across the lifespan; hence the specific focus on the refugee experience.

Refugee experience

The pre-migration trauma history

A major aspect of the Iraqi refugee experience is pre-migration trauma. Obviously not every Iraqi refugee is traumatised, but most have experienced potentially traumatising events in Iraq (Al-Ali & Hussein, 2003; Al-Mashat et al., 2006; Amowitz et al., 2004; Holmes, 2007; Makiya, 1998; Tripp, 2000). A pre-migration history of potentially traumatising experiences such as political violence and oppression, war, torture, and imprisonment constitutes a risk for poor mental health among refugees (e.g. Blackwell, 2005a; Drozdek & Wilson, 2004; Lavik et al., 1996; Venables & Rodriguez, 1989). This phenomenon of poor mental health among refugees is often conceptualised in the language of the DSM-IV (APA, 1994) with numerous studies documenting a high prevalence of post-traumatic stress disorder (PTSD) and depression.

Mollica et al. (1998), for example, found a 49% prevalence of major depressive disorder (MDD) and 90% prevalence of PTSD in a sample of 51 Vietnamese refugee men who shared a history of torture in Vietnam. Similarly, Allden et al. (1996) found a 23% prevalence of PTSD and 38% prevalence of MDD among Burmese refugees in Thailand. Michultka, Blanchard, and Kalous (1998) also found a 68% prevalence of PTSD in their study of Central American refugee adults. Research into the relation between pre-displacement trauma and post-displacement mental health suggests a dose-response association whereby the severity of post-traumatic stress disorder (PTSD) symptoms increases as refugees' exposure to traumatic experiences increases (Carlson & Rosser-Hogan, 1991; Fawzi et al., 1997; Kinzie et al., 1990).

Traumatic experiences have also been shown to induce dissociative disorders (Vermetten & Bremner, 2000; Waller et al., 2000; Witzum, Margalit, & Van der Hart, 2002) and attention and learning difficulties (Vasterling et al., 1998; Vasterling et al., 2002). Although PTSD seems to be the dominant term used to conceptualise the poor mental health suffered by refugees as a result of experiencing war, torture, imprisonment, and similar atrocities, understanding and conceptualising trauma is far from a straightforward or simple task. Iraqi refugees have certainly had their share of potentially traumatising experiences in Iraq (Amowitz et al., 2004; Holmes, 2007; Makiya, 1998; Tripp, 2000) and have been shown, in several studies, to exhibit trauma-related mental health problems (e.g. Gorst-Unsworth & Goldenberg, 1998; Jamil et al., 2002; Kira et al., 2008).

Understanding and conceptualising trauma

In terms of diagnosis trauma is often conceptualised as PTSD. As Summerfield (1999, p. 1450) notes:

“Posttraumatic stress disorder (PTSD), first given official disease status in 1980, has emerged as the flagship of this medicalised trauma discourse. Its origins are rooted in the lives of US veterans of the Vietnam war, both as soldiers and later as patients of the Veterans Administration Medical System”.

In DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition- American Psychiatric Association, 1994) and later in the revised edition – the DSM-IV-TR (APA, 2000) – PTSD is used to diagnose traumatised individuals who display an array of

symptoms in reaction to a traumatic event. The essential feature of PTSD (i.e. Criterion A1) is described in DSM-IV-TR as:

“the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate” (APA, 2000, p. 463).

For a person to fulfil the other criteria (i.e. A2, B, C, D, E, and F) for the diagnosis of PTSD, he or she would have experienced intense fear, helplessness or horror, and after which the he/she experienced one or more of the following: intrusive recollections of images of the event; recurrent distressing dreams; experiencing the event as if it is recurring; psychological distress with exposure to the event; or physiological reactivity to stimuli similar to the event – in addition to experiencing symptoms for more than one month and as a consequence experiencing significant distress or impairment in social, occupational, and other functions.

In DSM-IV-TR (APA, 2000) PTSD is updated with information regarding associated features, comorbidity with other mental disorders, associations with general medical conditions, prevalence rates, and course (e.g. symptom reactivation in response to reminders of the trauma). A brief familial pattern section has also been added describing

evidence of a heritable component to the transmission of PTSD and the relationship between a history of depression in first-degree relatives and increased vulnerability to developing PTSD.

Although DSM-IV-TR provides a thorough conceptualisation of trauma some authors have suggested different diagnostic categories for severe trauma such as complex PTSD (Herman, 1992) and disorders of extreme stress not otherwise specified (DESNOS; Pelcovitz et al., 1997; Roth et al., 1997). Others have highlighted the importance of recognising that individuals can experience PTSD-like symptoms without meeting Criterion A for DSM-IV (the experience of an immediate extreme stressor) as seen in studies on the impact of long-term stressors such as bullying and childhood sexual abuse (Scott & Stradling, 1994; Van der Kolk, 1996).

Similarly, Seides (2010) has suggested that the current DSM-IV-TR definition of PTSD should be expanded to include serial and multiple ‘microtraumas’. Seides (2010, p.726) defines microtraumas as: “less significant traumas whose damaging affects accumulate over time until they are ultimately very significant”. Seides provides examples from studies on workplace harassment and bullying, highlighting the accumulating effect of minor insults and injustices on individuals who are not in a position of power to stop the attacks.

There are also different theories on what trauma really is and how it is manifested in traumatised individuals. Van der Hart and colleagues, for example, have suggested that the essence of trauma is a structural dissociation of the personality and that once the traumatised individual can overcome this division of the personality, he or she will have for

the most part overcome the trauma (Van der Hart, Nijenhuis, & Steele, 2006). Similarly, Liotti (2004) emphasised the role of attachment in the experience of trauma by suggesting a lack of integrative capacity (i.e. a predisposition to dissociation) in people with disorganised attachment who experience traumatic events.

The treatment of traumatised individuals also differs depending on the specific model used in conceptualising the trauma. As discussed later in Chapter 2 under the heading of '*The diversity of therapies used with refugees*', treatments can be based on several different theoretical models of trauma (e.g. cognitive, psychodynamic, etc.). For example, according to the behavioural model, the original traumatic event results in a learned association of the emotional trauma that has occurred with the stimuli (images, sounds, smells, etc.) of the traumatic event (e.g. Keane & Barlow, 2002). According to the behavioural model of PTSD, memories of the event (e.g. through associated stimuli) activate the traumatic experience resulting in intense anxiety which in turn leads to avoidance or numbing to decrease the anxiety, thereby reinforcing avoidance and consequently maintaining the traumatic association. Adherents to this model often incorporate exposure therapy in working with traumatised clients (Keane & Barlow, 2002).

Some have looked at the possible mechanisms underlying PTSD symptoms such as the existence of a fear network in memory that might become prone to misfiring or excessive responding to stimuli reminiscent of the traumatic event (Schauer, Neuner, & Elbert, 2005). Brewin and Holmes (2003), for example, have proposed a dual representation model of trauma, suggesting that information is encoded and experienced as verbally accessible memory (VAM) and as situationally accessible memory (SAM), with images, sounds, and

smells being experienced and stored as SAM while narrative aspects are experienced and stored as VAM. Adherents to this model believe that successful treatment of PTSD should incorporate both the narrative meanings (VAM) as well as the stimuli and sensations (SAM) associated with the traumatic event. A prime example of a therapy that addresses both SAM and VAM while adhering to the behavioural model of trauma is narrative exposure therapy (Mueller, 2009).

Besides being complex, PTSD is not necessarily applicable in the assessment of individuals from non-Western cultures. It has also been argued that PTSD imposes a Western and Eurocentric frame of reference on understanding and attempting to treat individuals who are labelled as traumatised (Summerfield, 1999, 2012). As Summerfield (1999, p. 1454) notes:

“Though the trauma literature suggests that PTSD has a worldwide prevalence, it is a mistake to assume that because phenomena can be regularly identified in different social settings, they mean the same thing in those settings”.

Summerfield (2012) also argues against the globalization of the Western mental health field which he sees as a reminder of colonial times when non-Western knowledge and beliefs were seen as inferior to those of the West. One way around the issue of limited cross-cultural applicability is through the cultural adaption of assessment measures and treatments. While culturally adapted treatments will be discussed later in Chapter 2, assessment will be briefly discussed here. One of the most widely used trauma assessment instruments is the HTQ (Harvard Trauma Questionnaire). The HTQ is a cross-cultural

instrument designed for the assessment of trauma by obtaining information about actual trauma events (e.g. torture) and by assessing DSM-IV symptoms and culture specific symptoms associated with post-traumatic stress disorder (PTSD) (Mollica et al., 1992; Mollica et al., 2004).

The HTQ is composed of five parts: (a) trauma events; (b) personal description; (c) brain injury; (d) posttraumatic symptoms; and (e) scoring of the instrument. These five parts are described in detail in Mollica et al. (2004). By 2005 there were six versions of the HTQ (Mollica et al., 2004). It was only a matter of time until someone decided to adapt this instrument to the Iraqi culture. Shoeb, Weinstein, and Mollica (2007) did precisely that by interviewing 60 adult Iraqi refugees (30 men and 30 women) living in Dearborn (Detroit, Michigan) and then interviewing four psychiatrists in Baghdad in order to adapt the HTQ to the Iraqi context.

In the Iraqi refugee interviews (which were conducted in the primary spoken language in Iraq: Arabic), the interviewer encouraged participants to provide chronological accounts of their experiences of life in Iraq, the decision to escape, the circumstances of flight, the situation in refugee camps, the conditions surrounding acceptance for resettlement by the US, early experiences in America, and the nature of their current social participation within the Iraqi community and the wider host community. Shoeb et al. (2007, p. 456) then discussed Iraqi mental health beliefs and local idioms of distress with four Iraqi psychiatrists in Baghdad and observed that:

“Minor psychiatric problems - depression and anxiety - most commonly are labelled

as medical illnesses. According to the doctors, this labelling provides the Iraqi patient with a medical sickness, which releases him or her from responsibilities and sanctions, while affording care. Furthermore, as there is virtually no psychotherapy available in Iraq and because indigenous healers and non-psychiatrist Western-style doctors handle the vast majority of minor mental disorders, the psychiatrists indicated that most psychiatric care is given under the guise of medical care”.

Shoeb et al. (2007) also defined several culturally specific idioms of distress that Iraqis used in the Dearborn interviews and went on to suggest their addition to part four (i.e. post-traumatic symptoms) of the adapted HTQ. While using this culturally adapted form of the HTQ might enable professionals to assess trauma among Iraqi refugees in a more culturally-relevant manner, it is important to note that basic reliability and validity measures are not available for this specific version of the HTQ. However, the psychometric properties of the original HTQ are reported in Mollica et al. (1992), and summarised by Campbell (2007, p. 632) in the following manner:

“Section I of the HTQ has shown an interrater reliability of .93, Test/retest (1 week) was $r=.93$ ($p<.0001$) for trauma events and $r=.98$ for trauma related symptoms. The lowest reliability was for questions relating to serious injury, whereas the highest reliability was for questions relating to the murder of a family member. The HTQ had a Cronbach alpha of .90 for trauma events and .96 for trauma symptoms. Section III showed an interrater reliability of .98. Mean scores on the symptom checklist were calculated separately for the PTSD group ($n=65$) and the non-PTSD

group ($n=26$). They were 2.95 and 2.20 respectively. This difference was significant ($t=-4.6672$, $p<.001$). The HTQ had a sensitivity of 93% (i.e. 93% of patients with PTSD were correctly classified by the HTQ). And a specificity of 84% (i.e. 84% of patients without PTSD were correctly classified by the HTQ)’’.

Although refugees are likely to have experienced many potentially traumatic events, it should be noted that not every refugee is traumatised. The view of refugees as helpless victims does not take into account the strength and resilience that most refugees display in dealing with the stressors of pre-migration, migration, and exile. Martin, Jaranson, & Ekblad (2000), for example, have argued that refugee mental health challenges may be better understood within the context of refugee resilience and coping capacity. Similarly, some literature (Tedeschi & Calhoun, 1996; Tedeschi, Park, & Calhoun, 1998; Tedeschi & Calhoun, 2004) suggests that people who undergo a traumatic event can experience Post-Traumatic Growth (PTG), that is, increased functioning and positive change.

It is argued that this positive change can coexist with the negative aspects of trauma (Tedeschi & Calhoun, 2004). Similarly, Frazier, Conlon, and Glaser (2001) noted the positive as well as the negative life changes following a traumatic experience. Another strongly related term in the literature is Adversity-Activated Development (AAD) (Papadopoulos, 2004, 2006). AAD refers to the positive developments that are a direct result of being exposed to adversity. Although AAD is similar to PTG, there are significant differences between the two terms.

According to Papadopoulos (2007) there are three major differences between AAD and PTG. The first difference is in the fact that PTG suggests that people who experience PTG must have been traumatised. AAD does not share this stance. By using the term ‘adversity’ instead of trauma, AAD differentiates between being exposed to adversity and being traumatised. The second difference is in the fact that PTG suggests that ‘growth’ occurs following the trauma. AAD does not agree with this suggestion because the adversity may still continue after the initial trauma (e.g. in the process of relocation) and because the positive effects may be experienced simultaneously with the ongoing adversity and not necessarily following the adversity. The third difference is in the fact that PTG uses the term ‘growth’ to describe the positive effects, whereas AAD uses ‘development’ which is a more neutral term that allows for a wider variation of positive responses.

The literature on responses to potentially traumatising experiences seems to be suggestive of high individuality, with reactions ranging from the negative as in the case of psychiatric disorders such as PTSD (e.g. Drozdek & Wilson, 2004; Young, 2009) to the neutral as in the concept of ‘resilience’ (Papadopoulos, 2007) to the positive such as in PTG (Tedeschi & Calhoun, 1996; Tedeschi, Park, & Calhoun, 1998) and AAD (Papadopoulos, 2004, 2006). To describe the entire spectrum of possible responses to traumatic events that a person might encounter, Papadopoulos (2004) devised the ‘Trauma Grid’ - a framework to understand the three possible reactions to trauma: the positive, neutral, and negative. The implications of this high individuality of responses to trauma suggests that counselling professionals should not automatically assume that their clients are traumatised as a result of experiencing potentially traumatic events in Iraq – nor should they assume that pre-migration trauma only results in negative mental health effects.

The effects of working with traumatised individuals

The effects of trauma on mental health professionals working with traumatised individuals have been explored by several researchers. McCann and Pearlman (1990), for example, conceptualised the negative cognitive and affective risks of working with traumatised individuals as ‘vicarious traumatisation’. McCann and Pearlman (1990) conceptualise vicarious traumatisation (VT) as pervasive (i.e. affecting all realms of life), cumulative (i.e. each story reinforcing gradually changing schemas) and arising from repeated empathic engagement with traumatic material. Similarly, Figley (1995) introduced the term ‘secondary traumatic stress’ to describe the behaviours and emotions resulting from working with traumatised individuals. Figley (1995) also suggested that secondary traumatic stress can be conceptualised as ‘compassion fatigue’, which he then defined as the natural consequence of working with people who have experienced stressful events.

In trauma literature the terms compassion fatigue, secondary traumatic stress, and vicarious traumatisation are often used interchangeably. However some authors view them as different and specific concepts (e.g. Jenkins & Baird, 2002). Regardless of terminology, the possible negative consequences of working with traumatised individuals are well documented in several studies (e.g. Shah, Garland, & Katz, 2007; Meldrum, King, & Spooner, 2002). Strategies used to protect against the negative impact of trauma case work include: utilising clinical supervision (Rich, 1997); personal self-care strategies; and social support (e.g. Chrestman, 1999; Rich 1997). It is also important to note that interpreters used in counselling traumatised refugees can also be exposed to the possible negative impact of this work, especially when the interpreter is, or has been, a refugee (Tribe & Keefe, 2009).

In addition to the negative effects that trauma work can have on therapists' emotional wellbeing, working with traumatised clients can contribute to tensions and disruptions in organisations that offer this type of service. Bustos (1990), for example, described how tensions can develop within such institutions that offer counselling to torture survivors as a result of therapists' unconscious projection of feelings engendered by their work onto the organisation. Consequently, conflicts can arise and organisations tend to respond by becoming more controlling in an attempt to deal with the anxieties provoked by such tensions; thus resulting in further organisational disruption and staff dissatisfaction.

Conversely, working with traumatised clients has been associated with some positive effects in professionals' wellbeing and capacities for traits such as empathy and tolerance (e.g. Arnold et al., 2005). Psychological growth that can follow vicarious exposure to trauma has been labelled vicarious PTG (VPTG; Arnold et al., 2005). Few studies have explicitly examined VPTG (e.g. Arnold et al., 2005; Splevins et al., 2010). Arnold et al. (2005) examined how a sample of trauma therapists had been affected by this work and found that while all therapists reported some type of negative response (e.g. intrusive thoughts and images and physical exhaustion), they all simultaneously reported some positive outcomes (e.g. gains in empathy, compassion, and tolerance). Similarly, Splevins et al. (2010) explored the concept of VPTG in a sample of interpreters who work with refugees and found that the interpreters reported similar negative and positive experiences to those noted in the Arnold et al. (2005) study.

The post-migration life situation

The post-migration life situation of refugees in their host countries is generally considered safe. However, the process of relocating to this new and safe location can often entail further hardships (e.g. Silove, McIntosh, & Becker, 1993). Even when this transitional phase of relocation is over, the process of life in exile can prove to be quite psychologically taxing for refugees. There are several studies on the psychosocial stressors that refugees can experience in exile (e.g. Gorst-Unsworth & Goldenberg, 1998; Hauff & Vaglum, 1995; Miller, 1999; Miller et al., 2002; Nicholson, 1997). Most of these post-migration/exile-related stressors seem to be of a psychosocial and socio-political nature.

Griffiths (2001), for example, explored the experiences of Kurdish asylum seekers and refugees in the early (days or weeks after arrival in Greece) and later (after several years of living in the UK) stages of exile using semi-structured interviews with three groups of respondents: 25 Kurds in the early stages of exile, 20 Kurds in the later stages of exile, and representatives from eight support organisations working with this client group from both countries. Using content analysis, Griffiths (2001) found several common themes in participants' accounts, mainly: a need in the early phases, to have the story of the traumatic journey to Greece witnessed and validated by an outsider; differing experiences of men and women; a change in identity over time; considerable fear in both the early and later stages of exile; and a common sense of frustration experienced by all the organisations working with this client group but expressed in different ways (e.g. language barriers, lack of support systems for workers, bureaucracy and politics, need for supervision, etc.).

Griffiths (2001) found that in the early stages of exile, participants described their homeland in an idealised manner; they referred to the ‘struggle’ and their ‘hope to return to the homeland’ and also had a romanticised view of Western Europe; all of which seemed to change in later stages of exile. Griffiths (2001) observed that in the early stages of exile the positive sustaining attitudes were apparent in participants’ idealisation of both the homeland and Western Europe, whereas the later stages of exile were indicative of disappointment in both the homeland and in Western Europe; as evidenced by the disillusionment expressed by Kurdish refugees at the harsh realities of refugee life in the UK, and the confirming accounts of people working in support organisations in the UK.

Similarly, Miller (1999) explored the mental health difficulties that refugees face in exile and conceptualised four exile-related stressors as major sources of psychological distress: 1) Social isolation; 2) The loss of social and occupational roles and the corresponding loss of meaningful activity; 3) The loss of environmental mastery; and 4) The loss of material and financial resources. Similarly, Miller et al. (2002b) used semi-structured interviews that covered three areas of adult Bosnian refugees’ lives in Chicago: life in pre-war Bosnia; the journey of exile; and, most centrally, life in Chicago. Miller et al. (2002b) discovered that the primary sources of distress for their Bosnian refugee participants were: social isolation; the loss of community; separation from family members; the loss of important life projects; a lack of environmental mastery; poverty and inadequate housing; and the loss of valued social roles.

Immigrants who had higher levels of education in their home country or whose socioeconomic status declined in the country of resettlement have been shown to have

worse outcomes than migrants who had a low level of education or less status in their home countries (Porter & Haslam, 2005). Similarly, those who reported the loss of meaningful social roles or of important life projects (e.g. Colic-Peisker & Walker, 2003; Miller, 1999) were more likely also to report lower levels of daily activity (Miller et al., 2002) and be socially isolated (e.g. Miller et al., 2002; Mollica et al., 2001; Pernice & Brook, 1996).

Jamil et al. (2010) examined the distribution of mental health disorders and treatment outcomes among Iraqi refugees as compared to non-refugee Arab immigrants using the charts of 191 Iraqi refugees and 94 non-refugee clients who attended a private psychiatric clinic in Michigan, which has the largest population of individuals with Arab ethnicity in the United States. The non-refugee group consisted of individuals who emigrated from various Middle Eastern nations. The private psychiatric clinic from which data was collected was run by one of the few known Arabic-speaking psychiatrists in the area. Many Arab immigrants, including Iraqi refugees who reside in Detroit, preferred to attend this clinic because they could communicate in Arabic.

Jamil et al. (2010) found that the Iraqi refugee group did not differ significantly from the non-refugee group with respect to the proportion diagnosed with either major depression (Iraqi 73% vs. non-refugee 68%) or anxiety-related disorders (Iraqi 11% vs. non-refugee 15%). Additionally, there were no significant differences in overall treatment outcomes for major depression (79% of Iraqis showed no response to treatment vs. 82% for non-refugees) or anxiety-related disorders (Iraqis 80% vs. non-refugees 79%). Differences in psychotic disorders were not accounted for but there was a category labelled 'other' to emphasise limiting the comparison to depression and anxiety-related disorders. Prior to

data analysis Jamil et al. (2010) had expected to find a significantly higher percentage of PTSD among the Iraqi refugees but were surprised when the data did not confirm this hypothesis; especially considering the well documented prevalence of PTSD among Iraqi and other refugee groups (e.g. Gorman, 2001; Gorst-Unsworth & Goldenberg, 1998; Takeda, 2000). Jamil and colleagues concluded that negative acculturation processes can explain the observed lack of significant difference in major psychiatric disorders between the Iraqi refugees and the non-refugees.

In looking at the post-migration life situation of migrants living in Sweden, several negative exile-related issues have been noted in the literature on migrants' and refugees' lives in Sweden. Kamali (1997), for example, explores the distorted government sanctioned integration policies that he views as responsible for making migrants long term clients of the welfare system. Societal racial discrimination in Sweden has also been documented in several studies (e.g. Hübinette & Lundström, 2011; Kamali, 2009; Pringle, 2010).

Refugee post-migration stressors can often be seen in three psychosocial areas of difficulty: lack of social support (e.g. Gorst-Unsworth and Goldenberg, 1998); racial discrimination (e.g. Pernice & Brook, 1996); and acculturation-related difficulties (e.g. Sam & Berry, 2006). Each of these psychosocial areas will be explored in the next sections with reference to international literature that can be applicable to the Swedish context in addition to literature that is specifically applicable to Sweden's refugees and migrants.

Lack of social support

Social support is an important factor in the lives of refugees living in exile. Gorst-Unsworth and Goldenberg (1998), for example, found that affective social support in a sample of Iraqi refugees in Britain was important in determining the severity of both post-traumatic stress disorder and depressive reactions; particularly when combined with a severe level of trauma and torture. They also found social support to be a stronger predictor of depressive morbidity than trauma factors. Similarly, Lindström, Sundquist, & Östergren (2001) found a marked reduction in poor self-reported health among immigrant and refugee participants after the introduction of a social support network in the city of Malmö in Sweden. Lack of social support has also been shown to predict continuation of PTSD symptoms among trauma-exposed adults (Brewin, Andrews, & Valentine, 2000).

The role of social support in adaption to acculturation has also been studied. For some, links to one's heritage culture (i.e. with co-nationals) are associated with lower stress (e.g. Ward & Kennedy, 1993); for others links to members of the society of settlement are more helpful, particularly if relationships match one's own expectations (e.g. Berry & Kostovcik, 1990); but most studies seem to suggest that supportive relationships with both cultures are the most predictive of successful adaption (Berry et al., 1987; Kealey, 1989). However, the situation is more complicated for refugees and migrants living in segregated areas where one hardly finds any natives. One such heavily segregated area in Sweden is the district of Rosengård in the city of Malmö (Al-Roubaiy, 2010). Many academics in Sweden seem to only emphasise the problematic aspects of such areas, and actually go on to blame the immigrants living there for the 'problem' (e.g. Rostila, 2010).

Rostila (2010) discusses the social pattern of migrants forming closed social networks in Sweden as a negative phenomenon that is health-detrimental to the migrants living in such networks. Rostila uses population registers and survey data that suggests migrants experience poorer health than native Swedes to argue that the poorer health experienced by migrants is due to negative social norms that are characteristic of these closed migrant social networks. “Assuming that homogenous migrant networks include norms negatively influencing health behaviour and social mobility, such networks might chiefly be health-detrimental if they are characterised by closure” (Rostila, 2010, p. 386). However, it can also be argued that these closed migrant social networks are externally imposed by the dominant groups in society.

For example, Rostila uses the term ‘homophily’ to describe how migrants prefer to establish relationships with each other and therefore live in these closed social networks, yet this observation might downplay the role of segregation and racism in limiting the choices of migrants. “Migrant homophily may contribute to the inequality of social capital...homophily might limit the job-related information and opportunities that are acquired by migrants in homogenous networks” (Rostila, 2010, p. 384). However, while there is some truth to Rostila’s argument about the negative consequences in terms of limited social capital and opportunities, it has been documented that foreign born citizens living in Sweden are generally financially disadvantaged.

Based on statistics covering education, the labour market, income and living conditions in Sweden a report was published in 2009 to illustrate which groups in Swedish society risk

ending up in vulnerable situations (Statistics Sweden, 2009). Among other findings in the report, it was concluded that “Unemployment, long-term poor health and temporary employment were also more common among foreign-born” (Statistics Sweden, 2009, p.102). More recently, income statistics according to median values by country of birth for the year 2010 clearly demonstrate that foreign born men and women of all ages earned less than Swedish born men and women of the same age (Statistics Sweden, 2011). The median annual income in Sweden for foreign born men (20 years old and above) for the year 2010 was 198 996 SEK (Statistics Sweden, 2011), which corresponds roughly to an average monthly income of 16 583 SEK. This figure was later used in the present study to represent average income in gathering participant socio-demographic information (see Appendix 5).

Therefore, Rostila’s (2010) ‘migrant homophily’ argument might be somewhat limited since it can not account for the fact that foreign born men and women of all ages earned less than Swedish born men and women of the same age (Statistics Sweden, 2011). Even in discussing societal racism, Rostila (2010, p. 385) argues that “Migrants who experience racism and who interact with other migrants to a high extent might reinforce the feelings of discrimination and racism existing among them by sharing such mutual experiences” – when in fact sharing experiences of racism amongst sufferers can be viewed as a form of social support that can be beneficial to their health. As a whole Rostila’s (2010) argument regarding migrants drawing from each other’s resources in closed social networks is valid from a social capital perspective – but somewhat limited in failing to consider the possibility that migrants might choose to live in such social networks because it can be a valuable ‘coping mechanism’ in the face of adversity.

Racial discrimination

Bulhan (1985) defined ‘racism’ as a system of oppression that is based on racial categories and domination that designate one group as superior and the other(s) as inferior, and which then uses these perceived differences to justify inequity, exclusion, or domination. According to Jones (1997), racism may occur at three levels: (a) individual (i.e., person against person); (b) cultural (i.e., devaluation of a racial group’s cultural practices or products); or (c) institutional (i.e., discriminatory laws and social policies). Some theorists have proposed that racism be conceptualised as a form of trauma for the sufferer (e.g. Carter, 2007; Helms, Nicolas, & Green, 2010). Spanierman and Poteat (2005), for example, suggest incorporating a “general category of oppression-based trauma” into the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV; American Psychiatric Association, 1994).

Similarly, Carter (2007) developed and defined “race-based traumatic stress injury,” which he considers to be “non-pathological” constellations of emotional reactions to racism stress (p. 88). Carter (2007) suggests that trauma symptoms may develop as a reaction to different types of racism including: (a) racial discrimination, avoiding or ostracizing the person because of her or his race or culture; (b) racial harassment, hostile race-based physical or verbal assaults; and (c) discriminatory harassment. Although Carter (2007) has made an important contribution to understanding the psychological injury caused by experiences of racism, his focus on specific encounters with racism might be narrow and limited for not addressing another major and perhaps more disturbing form of racism; internalised racism (Speight, 2007). According to Williams and Williams-Morris (2000, p. 255), “Internalized

racism refers to the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves”.

Experiences of discrimination and racism have been associated with high levels of distress and poor self reported health in two separate studies on Kurdish migrants in Sweden (Taloyan et al., 2006; Taloyan et al., 2008). Similarly, Noh and colleagues (1999) found high levels of depression and decreased adaption in south Asian refugees in Canada to be associated with experiences of perceived racial discrimination. Although there is some literature that does acknowledge the fact that migrants and refugees do face societal racism in Sweden (e.g. Hällgren, 2005; Pred, 2000) much of the research published in Sweden seems to downplay the widespread existence of racism (e.g. Rostila, 2010).

Kamali (1997), professor of sociology at the University of Uppsala in Sweden, conducted a study on Swedish social authorities and their role in state run integration policies by gathering 95 files of non-European immigrants who have been in contact with social authorities for more than three years. Through systematically reviewing the files and interviewing social workers when files were missing vital information, Kamali (1997, p.183) came to conclude that “negative integration, or clientization, of the immigrants seems to be the main consequence of the Swedish immigration and integration policy”.

Based on a European research project, in which research institutes from eight European countries (Austria, Cyprus, England, France, Germany, Italy, Poland, and Sweden) have participated, Kamali (2009) (the scientific director of the project) explored immigrant experiences of racism, xenophobia, and racial discrimination in these eight countries. The

methods used to explore these phenomena were primarily immigrant focus group interviews, expert interviews, discourse analysis, in addition to using already available statistics, studies, and reports of relevance from the eight countries. Amongst other findings, Kamali (2009) presents data from several national opinion polls demonstrating wide-spread anti-immigrant attitudes and goes on to discuss how these negative attitudes paved the way for racist political parties to gain popularity and enter the Swedish parliament. Kamali (2009) also discusses the way in which the Swedish media has been used to fuel anti-immigrant and specifically anti-Muslim attitudes. As Kamali (2009, p. 58) notes:

“some individuals with a Muslim background with strong affiliation with the majority society’s established discourses are frequently used by the media and majority society as ‘experts’ in order to confirm the established discursive prejudiced ‘truths’ about Muslims”.

Similarly, Khosravi (2012) explores the reasons for surname-changing among immigrants with Muslim names in Sweden and concludes that this practice reflects anti-Muslim attitudes in Sweden. Depicting Arab and Muslim men as barbaric, violent, and oppressive towards women has also long been a Hollywood tradition (Shaheen, 2009). In reviewing more than 1000 Hollywood films, Shaheen (2009) documents and notes the persistent depiction of Arabs in these films as brutal and uncivilised villains. As Shaheen (2009, p. 8) notes, “What is an Arab? In countless films, Hollywood alleges the answer: Arabs are brute murderers, sleazy rapists, religious fanatics, oil-rich dimwits, and abusers of women”.

Alleyne (2009) discusses how overt racism is easily recognised by the people at the receiving end and how it therefore can easily be conceptualised as a form of trauma that can be addressed by therapists. Alleyne, however, notes that the true challenge for both sufferers and therapists lies in the shift from overt racism into ‘subtle’ and ‘institutional’ racism. Alleyne goes on to explore some of the major damaging effects of racism on individuals such as: ‘the grinding down experience’; ‘racism as undermining identity’; and ‘cultural shame’. Particularly disturbing is the concept of ‘cultural shame’ which leads sufferers of racism to be ashamed of their own culture; thereby taking on the racist attitudes of the oppressors.

Cultural shame as conceptualised by Alleyne (2009) can be seen as a sub-type of internalised racism; defined as the internalisation of the oppressor’s racism by the victim (Fanon, 1952) or as “the acceptance, by marginalized racial populations, of the negative societal beliefs and stereotypes about themselves” (Williams & Williams-Morris, 2000, p. 255). As Wheeler (2006, p.8) notes:

“If we acknowledge the transference relationship with culture and society, the implications for the development of self and identity in a hostile and prejudicial society are frightening. For members of an oppressed minority group...internalising the negative reaction of the external world will inevitably have a damaging impact on their identity and sense of self”.

Acculturation-related difficulties

Iraqi refugees living in Sweden are also likely to struggle with adapting psychologically and economically to the host country (Takeda, 2000; Söndergaard, Ekblad, & Theorell, 2001). A major aspect of this struggle to adapt to the host country is the state of continuous cultural transition that many refugees are faced with in exile. Blackwell (2005b, p. 37) describes this state of cultural transition that refugees have to live with very eloquently:

“The reality of the refugee position is that it is one of cultural transition. Refugees do not occupy one culture. They occupy at least two: the one they left and the one they have arrived in. The state of transition, moreover, is not one they are going to pass through. It is one they are going to live with. There will be no time in their lives when they will be able to have not come from the country they left. And there will be no point in their lives when they will be able to return to their country and rejoin the culture they left because it will not be the same culture they left; and they, having lived in a different culture, will not be the same people”.

A similar phenomenon of continuous transition that refugees have to live with is that of acculturation. There are several theories on acculturation processes with different conceptualisations leading to different classifications (Snauwaert, Soenens, & Boen, 2003). Redfield, Linton, and Herskovits (1936, p. 149) define ‘acculturation’ as “phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups”. Acculturation can be viewed as change occurring at the group level (i.e. in the

cultures of the groups involved) or at the individual level (i.e. the psychology of the individual); a distinction that was first made by Graves (1967).

Acculturation in theory is meant to entail the changes that occur in both cultures as a result of this continuous first-hand contact, but in reality the minority group is likely to be the one pressured into changing according to the dominant and/or majority group values. As Berry (1997, p. 7) notes, “acculturation is a neutral term in principle (that is, change may take place in either or both groups), in practice acculturation tends to induce more change in one of the groups”. As (Berry & Sam, 2006, p. 19) note:

“Berry suggested that the acculturation process proceeds according to the degree to which the individual simultaneously participates in the cultural life of the new society and maintains his or her original cultural identity. The simultaneous participation and maintenance of the two cultures may lead to four different outcomes which Berry called *assimilation*, *integration*, *separation* and *marginalization*. These four outcomes are collectively referred to as acculturation strategies”.

Acculturation theorists generally do not believe the process of acculturation to be negative or stressful in its self, rather that different strategies are more adaptive than others. In defining the four acculturation strategies, Berry (1997, p. 9) explains that:

“From the point of view of non-dominant groups, when individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures, the

Assimilation strategy is defined. In contrast, when individuals place a value on holding on to their original culture, and at the same time wish to avoid interaction with others, then the *Separation* alternative is defined. When there is an interest in both maintaining one's original culture, while in daily interactions with other groups, *Integration* is the option; here, there is some degree of cultural integrity maintained, while at the same time seeking to participate as an integral part of the larger social network. Finally, when there is little possibility or interest in cultural maintenance (often for reasons of enforced cultural loss), and little interest in having relations with others (often for reasons of exclusion or discrimination) then *Marginalisation* is defined".

Berry and Sam (2006, p.19) also note that "these different strategies should not be thought of as 'additive', leading to where one can think of an individual as being fully 'integrated'. Therefore discussing integration as an end goal for immigrants and refugees might not be the best approach to such a complex matter. For example, Davidson, Murray, and Schweitzer (2008, p.163) state that "newcomers who integrate into mainstream society have better outcomes than those who approach resettlement differently". Similarly, Colic-Peisker and Tilbury (2003) suggest that refugees' active versus passive approaches to resettlement may explain why the medicalisation of the refugee experience in Australia can encourage refugees to take on a passive role. While there may be some truth to these observations regarding refugee and migrant integration 'choices', it should be emphasised that host societies have a collective responsibility in either allowing for integration (e.g. embracing multiculturalism) or enforcing marginalisation (e.g. discrimination in housing, employment, education, etc.).

“Acculturation strategies have been shown to have substantial relationships with positive adaption: integration is usually the most successful; marginalization is the least; and assimilation and separation strategies are intermediate” (Berry & Sam, 2006, p.51). To deal with the distressing aspects of acculturation, the concept of ‘acculturative stress’ was proposed by Berry (1970). Berry (1997, p. 19) later came to define acculturative stress as “a stress reaction in response to life events that are rooted in the experience of acculturation”. According to Berry and Sam (2006) acculturative stress reactions include heightened levels of depression (linked to the experience of culture loss) and of anxiety (linked to uncertainty about how one should live in the new society).

Taloyan et al. (2011) conducted individual interviews with ten Kurdish men (aged from 24 to 60 years) to explore the acculturation patterns reported by them on life in Sweden. Participants had lived in Sweden for 8 to 35 years. Narrative methodology was used to analyse the results which were grouped into three different periods of migration; pre-migration, initial migration, and post-migration. The main findings were formulated as adjustment strategies employed by participants to cope with acculturation processes mainly through: maintaining Kurdish culture and links to the home country; getting an education; building a family; achieving inner security and balance; being active and occupied; and coping with ongoing political instability in the country of origin.

Although the focus of the Taloyan et al. (2011) study was on exploring adjustment strategies used by Kurdish men to cope with acculturation processes, their participants were often describing experiences of racial discrimination and marginalisation rather than

describing strategies. The ‘strategies’ and ‘adjustment’ parts discussed in the findings were not apparent in most of the interview extracts quoted by the researchers in their study; instead participant accounts revolved mainly around their experiences of discrimination and exclusion in Sweden as demonstrated by the following participant accounts:

“I was treated badly in Turkey, I was tortured, but it didn’t hurt so much as it did in Sweden. I was prepared for the Turks, the system, and the torture. But here it was different: it doesn’t...a person is tortured psychologically. And this is worse” (Taloyan et al., 2011, p. 202).

Another participant describes his experience of discrimination in the job market:

“The fact that I am educated didn’t matter... I applied for a job and was turned down. Their explanation was that I was overqualified for the job...It hurts too much ...This society is a problem” (Taloyan et al., 2011, p. 202).

Similarly another participant describes being discriminated against and constantly reminded of being a foreigner even after having lived in Sweden for 20 years:

“When you are out and meet your colleagues, when you are at a restaurant, you are received differently. Sometimes you are not welcome at a restaurant just because of your appearance: black hair, not the Swedish or Scandinavian look: then you are stopped. You are reminded everywhere that you are not one of them” (Taloyan et al., 2011, p. 202).

While Taloyan et al. (2011) have included these Kurdish men's experiences of racial discrimination, exclusion, and marginalisation in Sweden, the findings were surprisingly formulated in a manner that downplayed the obvious societal discrimination expressed in the participants' accounts and somehow focused on Kurdish men perceiving their adaption to life in Sweden as being stressful.

Another puzzling conclusion stated by Taloyan et al. (2011, p.205) was that the majority of participants "responded actively and were able to handle the stressful situations in their life stories and to adjust to life in Sweden" - with very little mention of how they came to the conclusion that participants had actually adjusted to life in Sweden. While the word discrimination is mentioned a few times by Taloyan et al. (2011) in their study, it fails to find its way into the main conclusion. Also when the need for Kurdish men "to be included and acknowledged as individuals" is mentioned in both the abstract and conclusion, there is no further mention of this need nor is there any clarification regarding how this inclusion can be achieved.

Recent research on the role of post-migration stressors (e.g. discrimination) and cultural resources (e.g. perceived social support) in terms of their direct impact on psychological distress indicates a strong positive relationship between socio-cultural adversities (or exile-related stressors) and psychological distress (Ahmed, Kia-Keating, & Tsai, 2011; Jibeen, 2011). Simply put, in belonging to a minority group and encountering racism in society, acculturation-related problems and racism-related distress are likely to go hand in hand (e.g. Dhillon & Ubhi, 2003).

The diversity of therapies used with refugees

As demonstrated by the previous sections in this chapter, adult male Iraqi refugee clients can experience a variety of psychological and psychosocial problems that seem to require interventions on different levels. No single counselling approach can capture the multidimensional complexity of addressing the cultural, language, gender, age group, pre-migration trauma, and post-migration stress aspects that are specific to this client group. In the following section, the diversity of therapies and treatments that are commonly used by counselling and psychotherapy professionals with refugee clients will be discussed. While some of these therapies might be more geared towards addressing parts of the refugee experience, no single approach addresses the totality of Iraqi refugee men's experience of exile-related stress – including my REBT approach to working with Iraqi refugees (Al-Roubaiy, 2012b).

The major counselling and psychotherapy approaches to working with refugees are psychodynamic/psychoanalytic and CBT (Alayarian, 2007; Drozdek & Wilson, 2004), and there is still some debate as to which approach is more suitable (e.g. Alayarian, 2007). However, while the bulk of the literature on counselling refugees remains focused on unitary models of therapy, other approaches can be developed in time (e.g. pluralistic). A discussion of some of the core features of each of the commonly used approaches to counselling refugees will be presented next. CBT and psychodynamic/psychoanalytic therapies will be discussed first before moving on to the other less represented approaches in the literature on counselling refugees.

Cognitive behaviour therapy (CBT)

CBT has been shown to be effective with refugees in several studies. For example, based on the results of a randomized controlled trial, Hinton et al. (2009) examined a model of the mechanisms of efficacy of culturally adapted CBT for Cambodian refugees with pharmacology-resistant PTSD and panic attacks. The patients randomised to CBT had much greater improvement than patients in the waitlist condition on all psychometric measures. Similarly after receiving CBT, the delayed treatment group improved on all the same measures.

Using a case example and referring to relevant literature, Young (2009) focuses on how a mental health professional can work cognitively with the shame, alienation, and dehumanization that refugees often experience following torture. Young (2009) also briefly addresses, first, whether one should focus on treating post-traumatic reactions while clients might also have a range of serious social, economic, legal, and/or physical difficulties, and second, on how one can modify traditional treatments for traumatic stress for clients with multiple traumas, often extending over months and years. Young (2009) then reviews the body of research pointing to the effectiveness of CBT for PTSD in non refugees as well as the small but promising number of studies and articles suggesting that CBT can be used successfully to treat traumatised refugees.

Similarly, Regel and Berliner (2007) review and critique the current literature on therapy with refugees and survivors of torture. Through case examples, they present the use of CBT as an effective treatment intervention for this client group. Regel and Berliner (2007) also

describe the use of assessment and treatment approaches using CBT principles, demonstrating the flexibility and applicability of the model to common refugee problems as well as its utility in different cultural contexts.

When PTSD is formulated as the major refugee problem to be addressed in CBT, the general rationale behind the treatment is that the patient/client must re-experience the traumatic images and stimuli and learn that they are no longer dangerous instead of using his or her maladaptive ‘safety behaviours’ (behavioural and mental avoidance to inhibit the memories) which are maintaining the problem because they are preventing the processing of the traumatic memory, which in turn is leaving the memory disconnected and highly emotionally distressing (e.g. Ehlers & Clark, 2000).

CBT practitioners use several techniques when working with PTSD, but mainly they use: psychoeducation regarding the nature of PTSD; anxiety management techniques (e.g. relaxation, breathing); identifying specific ‘hot spots’ associated with increased anxiety (or numbing); repeated exposure to the narrative of the trauma (through imagination or in vivo exposure to elements in the fear hierarchy list); and cognitive restructuring (e.g. Ehlers & Clark, 2000; Grey, Young, & Holmes, 2002). However, it should be noted that CBT is not a single unified approach, yet the general terminology and principles are shared by most theorists and practitioners in mainstream CBT (e.g. Westbrook, Kennerly, & Kirk, 2007).

Psychodynamic/psychoanalytic

Psychodynamic and psychoanalytic approaches to working with refugees have been successful at capturing the complexity of working with refugees. For example, Blackwell (2005a, 2005b) explores the socio-political aspects of psychotherapy with refugees by highlighting issues such as the societal racial discrimination, poverty, and general poor living conditions that refugees often face in the host country. Diversity and issues pertaining to minority groups have also been addressed in recent years by modern psychodynamic perspectives (e.g. Fernando & Keating, 2009; Wheeler, 2006).

In his psychodynamic approach, Blackwell (2005b) emphasises the importance of addressing the practical and social problems that refugee clients might bring to counselling, even if some of these problems seem beyond the scope of therapy. Similarly, Blackwell (2005b, 2007) explores how psychodynamic approaches can capture the totality of what a refugee client might bring to therapy by emphasising the political, cultural, interpersonal, and intra-psychic levels of experience.

Among other things, Blackwell (2005b) discusses: psychic numbing (the inability to feel in response to overwhelming experiences); fragmentation (PTSD symptoms such as nightmares and flashbacks are conceptualised as fragments of experience); survivor guilt (guilt over having left others behind); overwhelming rage (feelings of anger and longing for revenge); and shame (particularly powerful for sufferers of rape and other forms of sexual torture). For the psychodynamic therapist, the meaning of the trauma for the individual and issues of anger and rage are central themes to be addressed in therapy (e.g. Marshall,

Yehuda, & Bone, 2000). As Blackwell (2005b, p. 57) notes:

“To be in touch with ones own feelings of rage, violence, destructiveness and longing for revenge is to simply close that gap and to recognize in oneself some of the characteristics of the persecutor...which has to be defended against through high levels of repression, denial and projection”.

Similarly, Bustos (1992, p. 336) describes the main objectives of psychodynamic treatment with torture survivors as “relief from distressing symptoms, working through of the traumatic experience, reconstruction of new expectations of life, and resolution of family and social problems”. According to Bustos (1992), the first phase of treatment involves linking the survivor’s traumatic memories to the symptoms and the corresponding affective states – primarily through the use of testimony. As Bustos (1992, p. 337) explains:

“Chilean psychologists have developed a special method for obtaining information during this phase. This method involves the use of testimony as a therapeutic technique. The aim of this technique is to facilitate the integration of the traumatic experience and the restoration of self-esteem, while also providing symptom relief”.

The use of testimony as a therapeutic technique also allows torture survivors to speak out against the injustice they have suffered so that “personal pain is transformed into political dignity” (Agger & Jensen, 1990, p. 115). Although the use of testimony has its roots in the psychodynamic approach, “Agger and Jensen (1990) have adapted this method for political

refugees living in exile but have included concepts and techniques outside the framework of the psychodynamic approach” (Bustos, 1992, p. 337).

Another strong feature of psychoanalytic and psychodynamic approaches is the utilisation of the concept of ‘home’. In group-analytic approaches such as those described by Papadopoulos (2002), and by Tucker and Price (2007), the experience of home is central to the work because loss of home is believed to be the cause of nostalgic disorientation which is partly addressed by creating a safe symbolical home within the group. The symbolic home within the group is then used to explore the client’s distressing experiences in a safe place and within a supportive group atmosphere.

Group-analytic approaches have also addressed issues such as racism and discrimination, most notably through the works of Dalal (1998, 2002, and 2012). Dalal tends to draw on both sociology (e.g. Elias, 1939; Elias & Scotson, 1994) and psychoanalytic theory (e.g. Freud, 1921; Foulkes, 1948, 1978) in much of his theorising. For example, Dalal (2002) discusses how racism is about denigrating people based on group belonging even when the grouping is not racial. In a later work, Dalal (2012) criticises some of the equality and diversity movements for vilifying the capacities for judgment and discrimination per se. Drozdek and Wilson (2004) provide an overview of the psychoanalytic group psychotherapies that can be used with refugee clients and further discuss their weaknesses and strengths.

Art, music, dance, and drama therapies

Dance/movement therapy allows for the treatment of complex psychological trauma (torture, rape, war experiences) and contributes to the healing process directly on a body level. The complex traumata in the life of refugees require creative therapeutic interventions on different levels. Koch and Weidinger-von der Recke (2009) present the research on art therapies, and specifically dance/movement therapy with traumatised refugees at the treatment centre REFUGIO in Munich, Germany. The centre offers a multifaceted therapeutic program that offers among other approaches an interface of dance and verbal psychotherapy. Individual and group cases are used to illustrate how the connection of both therapeutic modalities can be employed in a facilitative and clinically meaningful way.

Psychomotor therapy

Psychomotor therapy is “an eclectic treatment method that uses body experiences and movements as the portal of entrance and the vehicle for psychotherapy” (de Winter & Drozdek, 2004, p. 386). Among other things, de Winter and Drozdek (2004) discuss how active involvement in sports, gymnastic-like exercises demanding team cooperation, and other types of psychomotor activity can have a strong therapeutic effect as well as serve as an adjunct to other modalities of treatment. By carefully observing the emotions, movements, intensity of activity, and energy level of the client, much can be learned about the personality dynamics – “let me see you play and I’ll tell you who you are” (de Winter & Drozdek, 2004, p. 386).

As de Winter and Drozdek (2004, p. 386) explain:

“The psychomotor therapist develops and offers motor arrangements to clients with the purpose of observing their conduct. Analysis of their conduct can help clarify clients’ problems and encourage finding new behavioural patterns in problem situations. Then, the therapist can create another arrangement to train the new behaviour”.

One such motor arrangement is the survival track in which obstacles and barriers are meant to be crossed in a gymnasium – a motor arrangement “designed to observe and stimulate group cohesion” (de Winter & Drozdek, 2004, p. 401). For example, in working with a group of male refugees from the same town in Bosnia-Herzegovina, de Winter and Drozdek (2004) described how the men performed well in the survival track as a group but when the therapist asked the men to individually walk blindfolded through the gym – while the others were instructed to help the blindfolded man cross the obstacles safely – every blindfolded man employed a different strategy that enabled him to cross fully independently of the help from the others.

As de Winter and Drozdek (2004, p. 402) note:

“In this group the issue of trust became discussable only after the members had the bodily experience of a mistrust reflex and saw one another struggling with accepting the help of the others...psychomotor therapy adds unmasked bodily functioning to the therapy process”

Empowerment and advocacy-based counselling

Empowerment and advocacy-based counselling approaches aim to increase the client's awareness of oppressive strains in the external world (i.e. society) and aid the client in finding ways to deal with these psychologically taxing stressors (e.g. Holcomb-McCoy & Mitchell, 2007; Pinderhughes, 1994). As Dass-Brailsford (2012, p. 40) notes, the empowerment-attuned counselling practitioner is "attentive to societal treatment of clients, especially low-income ethnic minority clients, and engages in social justice actions that advocate on behalf of the client whenever necessary". Similarly, Simon (1994) suggests that empowerment is based on five principles: 1) a collaborative relationship with the client; 2) an expansion of the client's strengths and capacities; 3) a focus on the client within the context of his/her environment; 4) an assumption of the client's active agency; and 5) a focus on the client's experience of oppression.

Ethnic minority clients, such as refugees, are especially at risk of being discriminated against and marginalised by host societies (e.g. Griffiths, 2001; Tribe, 1999) and are therefore likely to benefit from empowerment and advocacy-based counselling. In addition to aiding individual clients through empowerment (e.g. Dass-Brailsford, 2012; Pinderhughes, 1994), advocacy-based counselling aims to promote social justice through active confrontation of injustice and inequality in society (e.g. Palmer & Parish, 2008; Kiselica & Robinson, 2001; Kiselica, 2004). As Smith, Reynolds, and Rovnak (2009, p. 483) explain, "the major focus of advocacy tends to be on issues related to power, privilege, allocation of resources, and various forms of prejudicial discrimination and violence toward underrepresented individuals or groups".

In terms of theory and practical application, advocacy is best understood through the ACA (American Counseling Association) Advocacy Competencies framework (Lewis, Arnold, House, & Toporek, 2002). The Advocacy Competencies include three levels of advocacy: 1) client; 2) community; and 3) public arena. Each level of advocacy contains two domains that stress advocacy with, and advocacy on behalf of the client. The client level entails empowering individuals and advocating on their behalf if the need arises. The community level involves collaboration with organisations to bring about change. The public arena level is concerned with shaping public policy and informing the public about systemic barriers that affect human development. The public arena level of the Advocacy Competencies is perhaps the most political, and consequently controversial, level as it:

“involves a shift in focus from the individual and his or her interpersonal difficulties to the contribution of the system in creating and maintaining such difficulties by sustaining policies that adversely affect members of the system” (Lopez-Baez and Paylo, p. 280).

This level of the Advocacy Competencies is often referred to as social advocacy, and it is closely associated with the social justice movement in counselling (Ratts, 2009). Goodman et al. (2004, p. 795) define social justice counselling as: “scholarship and professional action designed to change societal values, structures, policies, and practices, such that disadvantaged groups gain increased access to these tools of self determination”. In critically assessing the social advocacy movement in counselling, Smith, Reynolds, & Rovnak (2009) describe the main criticisms of social advocacy as revolving around its politicised nature and lack of empirical support.

Similarly, Hunsaker (2011) criticises supporters of social justice in counselling for not having empirical evidence for their claims, and for excluding counselling professionals who might not share their political views. Furthermore, while Vera and Speight (2003) argue that multicultural competence cannot be achieved without a commitment to social justice, Hunsaker (2011) argues that multicultural competence can, and should, exist without a commitment to social justice. As Hunsaker (2011, p. 339) explains:

“I am a believer in multicultural competence in the sense that it can be thought of as being focused on individual rights, rather than on what social justice activists think all counselors should do for whole minority groups”.

Holcomb-McCoy and Mitchell (2007) discuss the adverse effects of racial discrimination on the mental health of ethnic minority persons and how empowerment and advocacy-based counselling can shift the focus of counselling from a traditional model to more of a social action approach in which counsellors can act as agents of positive community change. These types of counselling approaches are very political in nature which, although troubling for some (e.g. Hunsaker, 2011), does not negate that these approaches have many strong points which traditional socially passive approaches lack. Empowerment and advocacy-based counselling approaches can address psychosocial problems that are rooted in social injustices (e.g. Jun, 2010; Kiselica & Robinson, 2001; Kiselica, 2004; McWhirter, 1997) – which makes them of very high relevance for addressing the racism and discrimination that refugees can face in exile.

Existential therapy

Barnett and colleagues (2009) describe using an existential approach with several client groups who have been confronted with mortality (e.g. refugees). The authors explore the concept of 'vitality of death' which is mostly about the energy that comes from confronting the greatest fears and anxieties, including the anxiety aroused by the idea of one's own mortality. Refugees who have often had much experience in seeing unnatural deaths of friends, loved ones, and political and religious figures can probably benefit from exploring death with a mental health professional using such an existential perspective. Many refugees have had to escape from their countries after risking being killed and might have mixed emotions about having survived; such as feeling 'survivor guilt' (Blackwell, 2005b).

Narrative exposure therapy

Narrative exposure therapy (NET) is a short-term treatment for traumatic stress disorders following experiences such as war, torture, and/or political violence. Mueller (2009) discussed the theory behind NET and its clinical applications. NET was developed through a collaboration of two teams of researchers and clinicians; one team from the University of Konstanz, and another team from the Vivo Foundation (specialists in trauma). NET was designed to be used with adults, but there is also a child-friendly version called KIDNET.

NET is considered to be cross-culturally valid because it builds on the culturally universal tradition of storytelling. In NET, the patient constructs a narrative about his or her life with

a particular focus on a very detailed account of the traumatic experiences. This is done to facilitate habituation to the trauma memories by exposure to the traumatic hotspots and to help promote the elaboration and contextualization of the trauma memory by developing a coherent chronological account of the person's experiences (Mueller, 2009). In a recent study, Halvorsen and Stenmark (2010) found that symptoms of PTSD and depression in 16 torture survivors (of which eight were Iraqis), assessed by Clinician-Administered PTSD Scale (CAPS) and Hamilton Rating Scale for Depression (HRSD), decreased significantly for from pre-treatment to six-month after receiving ten sessions of narrative exposure therapy (NET). Similarly, in a recent systematic review of randomised controlled trials of treatments for PTSD in refugees and asylum seekers, Crumlish and O'Rourke (2010) concluded that out of all the therapies used CBT and NET seemed to be the most evidence-based when used with this client group.

However, exposure therapies have also been criticised by some. Exposure therapies, especially the traditional methods of flooding, involve the client repeatedly re-visiting the traumatic memory in an attempt to desensitise him or her to the feared stimulus. This prolonged exposure to the memory of the traumatic even is thought to be too distressing for many clients to handle (Scott & Stradling, 1997). In a study which examined six case vignettes, Pitman et al. (1991) found re-occurring complications (e.g. exacerbation of feelings of guilt) in flooding therapy for PTSD which they used to argue that this type of therapy can produce adverse effects in traumatised clients.

Trauma-focused treatments

The treatments of choice for PTSD, as recommended by NICE (2005), are trauma-focused CBT and ‘eye movement desensitization and reprocessing’ (EMDR). EMDR was developed by Shapiro (1995) who argued that when traumatic experience occurs, the memory of the event is dysfunctionally stored in an isolated memory network. EMDR uses a structured approach which incorporates past, present, and future dimensions of the dysfunctionally stored memory. In the processing phases of EMDR, the client is instructed to attend to the disturbing memory in multiple brief sets (usually 15–30 seconds) while focusing at the same time on a dual attention stimulus (e.g. lateral eye movement). After each set of dual attention exercise, the client is asked about the associative information elicited during the exercise. This content becomes the basis for creating new associations between the distressing memory and the more realistic information thereby transforming the distressing memory.

However, there is a debate regarding whether EMDR’s results are due to reasons unique to its treatment approach or whether it is simply the exposure component in EMDR that is the active non-unique ingredient (Sikes & Sikes, 2003). Some researchers have questioned it by suggesting that it is “a hybrid cognitive behavioural approach” that works because it is “an unwitting vehicle for exposure” (Scott & Stradling, 2006, p. 116). However, Mollon (2005) presents research that is suggestive of superiority of EMDR to other approaches in that it seems effective in fewer sessions than CBT and other therapies. Mollon (2005) argues that EMDR’s advantage lies in the bihemispheric stimulation of the brain which is brought about by the dual attention stimuli procedures used by EMDR therapists.

Community-based interventions

Community-based interventions have several advantages over psychotherapy in addressing refugee mental health problems. Although community-based interventions can include a counselling component, they tend to include physical, social, and psychosocial activities as well (e.g. Tribe, 2004; Williams & Thompson, 2011). Community-based interventions tend to have culturally relevant and holistic views of mental health. For example, Tribe (2004) describes how the Family Rehabilitation Centre (FRC) invites indigenous healers to participate in all of their community-based interventions in Sri Lanka.

In a recent systematic review of the literature on using community-based interventions with refugees, Williams and Thompson (2011) reviewed 14 critically appraised articles on experimental research and discussions on best practice. The articles consistently demonstrated the benefits of community-based mental health services in improving the mental health of refugees. The most frequent themes to emerge across the 14 articles were: cultural awareness; language; setting; and post-migration stressors. As Miller (1999, p.284) notes:

“a considerable amount of the distress reported by refugees is related not to prior exposure to violent events, but rather to a constellation of exile-related stressors that lie largely outside the reach of psychotherapy (but very much within the reach of community-based interventions)”.

Key points from the literature

Since 75 percent of Iraqis are Arabs (Nydell, 2006) research on counselling Arab clients (e.g. Abudabbeh, 1996; Abudabbeh & Aseel, 1999; Jackson, 1995; 1997; Soliman, 1986) can be relevant for understanding Iraqi clients. Similarly, research on counselling and psychotherapy with Muslims (e.g. Al-Abdul-Jabbar & Al-Isaa, 2000; Bergin, 1980; Rizvi, 1989) has also a lot to offer in attempting to understand Iraqi clients as 97 percent of Iraqis are Muslim (Nydell, 2006). Iraqi mental health clients tend to engage in somatisation of symptoms (e.g. Bazzoui, 1970; Jamil et al., 2002; Jamil et al., 2005; Shoeb, Weinstein, & Mollica, 2007) and have a tradition of explaining psychological problems as external interventions of the supernatural (Shoeb, Weinstein, & Mollica, 2007), much like other Arab clients have been shown to do (Al-Krenawi, 1999a; El-Islam, 1982; Morsy, 1993).

Saddam Hussein's regime asked women to produce future soldiers while continuously engaging the public in a glorification of a militarised masculinity (Al-Ali, 2005, 2007). The revival of tribal beliefs in recent years and the backlash against the issue of women's rights in Iraq are suggestive of a highly patriarchal society (Al-Ali, 2005; Al-Ali & Hussein, 2003). Some men tend to struggle with expressing emotion (e.g. Eisler & Blalock, 1991; Levant, 1998) and this tendency, coupled with other traditional norms of masculinity, makes it less likely that such men can benefit from psychotherapy (e.g. Garde, 2003; Levant, 1998; White, 2009). Refugee men from traditionally patriarchal societies tend to struggle in Western societies with the loss of status and social roles they once had in their countries of origin (e.g. Griffiths, 2001).

A pre-migration history of potentially traumatising experiences such as political violence and oppression, war, torture, and imprisonment constitutes a risk for poor mental health among refugees (e.g. Blackwell, 2005a; Drozdek & Wilson, 2004; Lavik et al., 1996; Venables & Rodriguez, 1989). Iraqi refugees have been shown to exhibit the same mental health problems as other refugee populations, mainly posttraumatic stress disorder (PTSD), generalized anxiety disorder, and depression (e.g. Gorst-Unsworth & Goldenberg, 1998; Jamil et al., 2002; Jamil et al. 2010). The literature on responses to potentially traumatising experiences seems to be suggestive of high individuality, with reactions ranging from the negative as in the case of psychiatric disorders such as PTSD (e.g. Drozdek & Wilson, 2004; Young, 2009) to the neutral as in the concept of 'resilience' (Papadopoulos, 2007) to the positive such as in PTG (Tedeschi & Calhoun, 1996; Tedeschi, Park, & Calhoun, 1998) and AAD (Papadopoulos, 2004, 2006).

Refugees can face several post-migration stressors in the host countries which can add to, or interact with, pre-migration trauma in causing refugee psychological distress (e.g. Harris, 2007; Gorst-Unsworth & Goldenberg, 1998; Miller et al., 2002a). Refugee post-migration stressors can often be seen in three psychosocial and sociopolitical areas of difficulty: lack of social support (e.g. Gorst-Unsworth and Goldenberg, 1998); racial discrimination (e.g. Pernice & Brook, 1996); and acculturation related difficulties (e.g. Sam & Berry, 2006). "Integration can only be "freely" chosen and successfully pursued by non-dominant groups when the dominant society is open and inclusive in its orientation towards cultural diversity" (Berry, 1997, p. 10). Therefore racism and discrimination in society tend to limit genuine refugee/migrant integration (e.g. Berry, 1997; Kamali, 1997).

Widespread racism, and the marginalisation of refugee and immigrant groups in Swedish society, has been documented in many studies (e.g. Hübinette & Lundström, 2011; Kamali, 1997, 2009; Khosravi, 2012; Pringle, 2010; Taloyan et al., 2011). In belonging to a minority group and encountering racism in society, acculturation-related problems and pathological reactions to racism (e.g. internalised racism) are likely to be the resultant experience of the minority group individuals (e.g. Dhillon & Ubhi, 2003).

Counsellors who possess MCCs have been shown to have improved counselling processes and outcomes (Worthington, Soth-McNett, & Moreno, 2007). Similarly, culturally adapted CBT and IPT were shown to be more effective at alleviating client distress than non-therapy control groups (e.g. Rossello & Bernal, 1999) and were even shown to be superior to non-culturally adapted CBT in some studies (e.g. Kohn et al., 2002; Miranda et al., 2003a). Discomfort and subsequent avoidance of culturally sensitive material has been shown to adversely impact on communication and collaboration with culturally and ethnically diverse clients (e.g. Dovidio et al., 2002; Norton et al., 2006).

Clients' perceptions of microaggressions can negatively influence treatment outcomes by harming the working alliance (Constantine, 2007; Owen et al., 2011). Given the working alliance's established importance in predicting therapeutic outcome (Horvath & Luborsky, 1993; Ogles et al., 1999; Safran & Muran, 2000; Wampold, 2001) it becomes clear how potentially damaging racial microaggressions can be for psychotherapy process and outcome. Ethnic minority clients can avoid disclosing racial/cultural issues in therapy when

they feel that white therapists can not appreciate how their minority status shapes their psychological development (e.g., identity and values) nor can they relate to, or empathise with, clients' experiences of discrimination in society (Chang & Yoon, 2011).

Some have proposed that racism be conceptualised as a form of trauma for the sufferer (e.g. Carter, 2007; Helms, Nicolas, & Green, 2010; Spanierman & Poteat, 2005), while others seem to be unaware of, or insensitive to, the reality of racism and marginalisation faced by minorities (e.g. Rostila, 2010; Taloyan et al., 2011). Surprisingly, this tendency can even be found among some counselling practitioners as some counsellor views indicate in the Century, Leavey, and Payne (2007) study, and as can be seen in Tucker's (2011, p. 70) emphasis on "the unconscious transmission of trauma of refugees to their descendents".

Out of all the therapeutic approaches used with refugees, community-based interventions and empowerment and advocacy-based counselling approaches seem to have the most relevance for addressing refugee post-migration stress. Empowerment and advocacy-based counselling approaches address oppressive strains in the client's external world (i.e. society) by raising the client's and society's awareness of socially unjust practices - and by sometimes taking action with, or on behalf of, the client (e.g. Dass-Brailsford, 2012; Holcomb-McCoy & Mitchell, 2007; Pinderhughes, 1994). Similarly, community-based interventions tend to have a holistic approach to mental health and can involve physical activities, counselling, practical help, and participation from traditional healers and community leaders (e.g. Miller, 1999; Tribe, 2004; Williams & Thompson, 2011).

Chapter 3: Methodology

Overview

First an outline of the three-phase study will be presented. Then the rationale for the chosen methodology will be explored, followed by a description of participants' socio-demographic backgrounds and participant inclusion and exclusion criteria. Subsequently a section describing the entire procedure will be presented, followed by a section exploring the main ethical considerations. Finally a section describing the process of analysis will be presented to set the stage for the Chapter 4.

Outline of the study

The present study was designed and carried out in three phases. In Phase 1, the emphasis was on exploring how Iraqi refugee men experienced exile and the help and support systems available to them in Sweden. Five main areas (see Appendix 6 for the interview questions) were explored: 1) experiences of social support; 2) acculturation and related aspects; 3) experiences of racial discrimination; 4) negative experiences from Iraq compared to negative experiences in exile; and 5) the help and support systems available to Iraqi refugee men in Sweden. In line with the literature on post-migration stressors, Phase 1 specifically focused on three psychosocial areas of difficulty: lack of social support (e.g. Gorst-Unsworth and Goldenberg, 1998); racial discrimination (e.g. Pernice & Brook, 1996); and acculturation-related difficulties (e.g. Sam & Berry, 2006).

In Phase 2, the emphasis was on exploring the counselling experiences of adult male Iraqi refugee ex-counselling clients. Three main areas (see Appendix 10 for the interview questions) were explored: 1) client perceptions of self in therapy; 2) client perceptions of the mental health professional; and 3) client perceptions of the counselling process and outcome. In line with the literature on culturally sensitive practice, Phase 2 specifically focused on three practice issues from the client's perspective: perceptions of microaggressions (e.g. Constantine, 2007; Owen et al., 2011); reluctance to disclose cultural/racial material (e.g. Chang & Yoon, 2011); and perception of therapists' cultural competence (e.g. Worthington, Soth-McNett, & Moreno, 2007).

In Phase 3, the emphasis was on exploring the views and experiences of counselling professionals who have worked with adult male Iraqi refugee clients – mainly based on the themes that emerged from the analysis of Phase 1 and Phase 2. These issues/themes were identified as significant parts of the experience of exile and counselling from the Iraqi men's perspectives in Phase 1 and Phase 2 - and were therefore used as the basis for the interview questions that were put to the professionals in Phase 3 (see Appendix 17 for the full list of themes and corresponding interview questions). Additionally, Phase 3 focused on three practice issues from the therapists' perspectives: awareness of clients' experiences of racism and marginalisation (e.g. Kamali, 1997, 2009; Khosravi, 2012); awareness/implementation of multicultural competency skills (e.g. Sue et al. 1992, 1998; Worthington, Soth-McNett, & Moreno, 2007); and awareness/implementation of empowerment and advocacy-based counselling (e.g. Dass-Brailsford, 2012; Holcomb-McCoy & Mitchell, 2007; Pinderhughes, 1994).

Rationale for the methodology

Epistemological assumptions

In being influenced by a postmodernist and social constructionist perspective (e.g. Etherington, 2004), I wanted to give voice to my Iraqi refugee participants that could match, or rival, the dominant professional and Western voices theorising on and discussing this client group in the literature. Postmodernist theories reject the positivist belief in a single objective reality which can be observed irrespective of the observer's influence (Dickson-Swift, James, & Liamputtong, 2008). Postmodernism challenges the modernist notions of universal knowledge, objectivity, and certainty (Lyotard, 1979; Sarup, 1993). Social constructionism in particular has become a significant postmodern influence in the counselling literature (e.g. Cottone, 2001; Guterman, 1996; Rudes & Guterman, 2007).

Social constructionist approaches to research, such as Foucauldian Discourse Analysis (FDA) and discursive psychology, argue that realities are created through inter-subjective contact and language constructs (Parker, 1992; Potter & Wetherell, 1987). As Etherington (2004, p. 21) explains: "social constructionism invites us to see the world and ourselves as socially constructed and challenges us to view grand narratives (including those of science and mathematics) as one of many discourses that are possible among others that have equal value". Etherington (2004, p. 21) also describes postmodernism as an alternative method of inquiry which "invites other, often tentative, marginalized voices to be heard alongside those of the dominant western discourses".

Interpretative Phenomenological analysis

In prioritising richness of experience, open-endedness, and context, a qualitative approach was chosen from the start (Willig, 2001). Although it is often argued that one can not make generalisations from small-scale qualitative research, it can also be argued that “if a given experience is possible, it is also subject to universalisation” (Haug 1987, p.44). Similarly, Willig (2001, p.17) argues that:

“even though we do not know who or how many people share a particular experience, once we have identified it through qualitative research, we do know that it is available within a culture or society”.

Considering my own background in relation to the research questions, the need for adopting a reflexive approach was apparent early on. Individuality and uniqueness of participant experiences were also prioritised issues from the onset. In wanting to use a qualitative method that emphasises reflexivity and allows for exploring several participants’ common and particular experiences, Interpretative Phenomenological Analysis (IPA) was chosen as the method of data analysis (Smith, 1996). One of the reasons for choosing IPA lies in its phenomenological requirement to understand and ‘give voice’ to participant concerns (Larkin, Watts & Clifton, 2006). IPA was also chosen for its compatibility with the postmodernist and social constructionist perspective that is broadly adopted in this study. As Smith, Flowers, and Larkin (2009, p.196) note, “IPA subscribes to social constructionism but to a less strong form of social constructionism than discursive psychology and FDA”.

Smith, Flowers, and Larkin (2009) discuss what they refer to as the three major influences of IPA: 'phenomenology'; 'hermeneutics'; and 'idiography'. These three major theoretical influences make IPA an ideal choice for the present study. Simply put, phenomenology is the study of experience, hermeneutics is the theory of interpretation, and idiography is the analysis of the particular (often interpreted as the individual).

The first two theoretical influences (phenomenology and hermeneutics) are joined in IPA mainly through the work of hermeneutic phenomenologists - most notably Heidegger. Heidegger's formulation of phenomenology as an explicitly interpretative activity highlights IPA's stance regarding the researcher's interpretative role. IPA's hermeneutic position is one of meaning-making in that the researcher attempts to make sense of the participant's attempts to make sense of their own experiences (Smith, 1996; Larkin, Watts, & Clifton, 2006). However, combining philosophical hermeneutics with phenomenology can be complicated because phenomenology involves removing the interpreter from the analysis (i.e. bracketing one's assumptions) while philosophical hermeneutics involve immersing the interpreter into the analysis (i.e. projecting one's assumptions).

Bracketing is sometimes used in qualitative research to claim that one has suspended his or her preconceptions about the data, when in fact perspective, and even bias, never really get totally ruled out. Fischer (2009) describes the concept of bracketing as involving a reflexive and hermeneutic reading of the data in which the researcher repeatedly discovers what his or her assumptions and understandings were and re-examines them against his or her new emerging insights. Therefore, what the researcher really does in bracketing is hermeneutic

in that it leads him or her to an interpretation of the findings and reflexive in that it requires him or her to go back and re-examine earlier assumptions and influences on data in light of the new emerging understandings.

The concept of bracketing is especially important when the researcher has much previous knowledge about the subject being studied - as in the case of the present study. Being highly informed of the subject matter being researched is likely to bias the researcher and potentially influence the outcome of the study in several ways. One way of addressing this issue is by disclosure, in which the researcher describes for the reader his or her background and interest in the subject. One approach to disclosure is through the use of autobiographical accounts - as I have done in Chapter 1. Including an autobiographical account not only fulfils an aspect of the bracketing process but also highlights the researcher's reflexive stance (Fischer, 2009). As Willig (2001, p. 53) notes:

“Even though IPA aims to explore the research participant's experience from his or her perspective, it recognizes that such an exploration must necessarily implicate the researcher's own view of the world as well as the nature of the interaction between researcher and participant”.

However, while knowing too much about the research subject matter might present a challenge for researchers in the bracketing process, IPA sets no theoretical limitations on such previous knowledge. As Smith, Flowers, and Larkin (2009, p.42) note:

“it is not the case that there is such a thing as ‘too much’ or ‘too little’ in the way of

previous knowledge, but simply that you ought to be frank with yourself and, where appropriate, with your research team, about the likely consequences of your preconceptions...The IPA approach to data collection is committed to a degree of open-mindedness, so you will have to try to suspend (or bracket off) your preconceptions when it comes to designing and conducting your interviews or other data collection events”.

Therefore in utilising bracketing in the hermeneutic and reflexive manner described by Fischer (2009) my background and knowledge of the Iraqi refugee experience should not overtly and excessively impact on the findings of the present study.

As for the third theoretical influence on IPA (idiography), Smith, Flowers, and Larkin (2009) explain how idiography makes the approach valuable for capturing depth and detail in the particular and individual case. IPA pursues an idiographic commitment, situating participants in their own contexts, exploring their personal perspectives, and starting with a detailed exploration of each case before moving on. This approach to analysis fulfils my need for capturing individuality, but unlike single case study designs, IPA allows for movement and comparisons across participants. The analytic process begins with detailed examination of each case, but then cautiously moves to an examination of similarities and differences across the cases thereby producing accounts of patterns of meaning in both shared themes and even distinctive voices and variations on those themes.

Yet another reason for choosing IPA is the fact that IPA works with texts. IPA entails an attempt to unravel the meanings contained in participant accounts through a process of

interpretative engagement with the texts and transcripts (Smith, 1996; Smith, Flowers, & Larkin, 2009). Since IPA works with texts it must assume that language provides participants with the necessary tools to communicate their experiences to the researcher. In such a context it made perfect sense to conduct Phase 1 and Phase 2 using the Arabic language (Iraqi dialect) with the Iraqi refugee men since this enabled the participants to express themselves in a natural, spontaneous, and culturally-relevant manner. Similarly, in conducting Phase 3 in Swedish with counselling professionals in Sweden, participants could freely discuss their views and experiences in Swedish – in addition to comfortably using mental health terminology as all participants in Phase 3 were counselling professionals. Since IPA is interested in the actual experience in itself, regardless of how it is communicated, I was in a good position to understand what was being said irrespective of how it was being said – granted that my own interpretations of participant accounts are the only venue to accessing their experiences.

However, although I had decided to use IPA early on, I had also considered other qualitative methodologies. Grounded theory seemed to be appropriate at some point due to the fact that it is suitable for exploring psychosocial phenomena through the process of identification and integration of categories of meaning from the data (i.e. interviews). However, unlike IPA, grounded theory generally downplays the creative role of the researcher, which is a major flaw from my perspective considering how personally and professionally immersed I am in the research questions I am trying to explore. Glaser and Strauss (1967, p.1), the founders of grounded theory, describe the approach as involving “the discovery of theory from data”. The term ‘discovery’ suggests that the researcher uncovers something that is already there, reflecting the belief that phenomena create their

own representations without the researcher imposing onto the data. Through this process of discovery grounded theory ultimately aims to develop new, contextualised theories.

However this flaw of downplaying the researcher's role is remedied by one of the most widely used versions of grounded theory: constructivist grounded theory (e.g. Charmaz, 2006). This social constructivist version of grounded theory argues that categories and theories do not emerge from data, but are constructed by the researcher through an interaction with the data. However, even with the researcher influence on data acknowledged by constructivist grounded theory, the method still had another flaw which ultimately rendered it unsuitable for my research purposes: its pre-occupation with uncovering social processes.

Grounded theory was founded by two sociologists, Strauss and Glaser, and even though there are different versions of the method, the general consensus is that it aims to generate theories about social phenomena (e.g. Willig, 2001). Although post-migration stressors can be considered social phenomena, this study aims to explore how these stressors can be experienced (i.e. psychosocial) by adult male Iraqi refugees in later stages of exile and how/if counselling can address this experience – hence the appropriateness of IPA. Furthermore, my experiences as an Iraqi refugee, and as a psychologist working with refugees, are likely to be too influential on the process and outcome of the study for me to adopt an approach that does not account for this as thoroughly as IPA does.

Researcher reflexivity

Reflexivity in its different meanings and applications has been discussed in Chapter 1 as one of the most relevant research issues to the present study. In this section of Chapter 3, reflexivity will be specifically discussed as a method of approaching counselling research. McLeod (2001) distinguishes between constructivist and constructionist approaches to reflexivity. Constructivist approaches to reflexivity emphasise looking internally into one's personal thoughts, beliefs, and expectations in exploring their impact on the research process and outcome. Constructionist approaches, on the other hand, emphasise looking externally in reflexive research, so that thoughts, beliefs, and expectations are explored within cultural and social contexts.

As an alternative to constructivist and constructionist approaches to reflexivity, McLeod (2001) proposed the concept of 'critical reflexivity' which emphasises both the researcher's personal experiences in relation to the research, and the wider social and cultural context in which the research is conducted. As a concept, critical reflexivity is appealing because it aims to incorporate individual/personal as well as social/cultural reflections. In the present study, the reflexive approach taken is meant to adhere to the concept of 'critical reflexivity' as closely as possible – especially considering the fact that my experiences of Iraqi refugee post-migration stress are a reflection of personal and social influences which have ultimately collectively shaped this research project.

Individual semi-structured interviews

Individual semi-structured interviews were chosen as the method of data collection due to their open-endedness and compatibility with most qualitative approaches to data analysis (Willig, 2001; Tomkins & Eatough, 2010). Semi-structured interviewing was also chosen due to its emphasis on meaning rather than language (Willig, 2001). Since I knew that I was going to be translating the interviews before transcribing them, the words being used in the interview were going to be secondary to the meanings they hold. Semi-structured interviewing also allows the space for generating new and novel insights by not having a strict question agenda that might limit participants - instead it uses open-ended questions which can be further explored and elaborated on by both participant and researcher (Willig, 2001). The open-ended questions provide an opportunity to pursue areas not previously addressed by the researcher.

Also since participants in Phase 1 and Phase 2 of the study are Iraqi refugee men, rapport is established with ease due to our shared gender, culture, and refugee experience; hence the appropriateness of individual interviewing. In Phase 3, participants are counselling professionals; therefore rapport might not be as easily established between me and them. Doing individual interviews with counselling professionals on the subject of counselling Iraqi refugee men might have been experienced as intimidating by some of them, as they were going to be aware of my background and insight into this client group. Morgan (1988) advocates the use of focus groups in preference to individual interviews in contexts where participants might find the individual face-to-face interaction intimidating; therefore focus groups were deemed to be the more appropriate method for data collection in Phase 3.

Focus group interviews

Individual interviews were used in phases 1 and 2, whereas focus group interviews were used in Phase 3 as individuality was of less concern with the counselling professionals as participants. The reason for not prioritising individual voices among the participants in Phase 3 is that counselling professionals are not the focus of the study, and their views and experiences are meant to only highlight, and further explore, the experiences of Iraqi refugee men. Generally in focus groups, participants are brought together because they are identified as having a common circumstance or condition that forms the focus of the collective meeting (Parker & Tritter, 2006). The researcher is often considered outside the focus group interaction in terms of being a peripheral moderator of the group discussion between participants (Parker & Tritter, 2006).

However, for the researcher to be considered only as an outside moderator of the focus group interaction, he or she must limit their impact on the group - even though some impact is unavoidable. Smithson (2000), for example, explored how dissimilar cultural backgrounds of focus group participants and moderators can affect group processes. Similarly, Allen (2005) highlighted the role of the moderator's gender in talking about masculinity with participants. Therefore, the researcher's role can not be purely that of an outside moderator since his or her perceived/actual background can impact on group processes.

Historically focus groups were used in marketing strategies and sociology research yet their use has been reintroduced into many academic social research studies since the 1990s

(Morgan, 1997). Morgan (1997, p. 2) notes that “The hallmark of focus groups is their explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group”. The social and group context of the focus group can help elicit views that may otherwise be difficult to prompt in individual interviews (Kitzinger, 1994). Another more practical advantage of using a focus group method is its efficiency - it provides “the opportunity to observe a large amount of interaction on a topic in a limited period of time” (Morgan, 1997, p. 8).

A number of articles have been published using IPA and focus groups (e.g. Dunne & Quayle, 2001; Flowers, Duncan, & Knussen, 2003) and this approach seems promising but comes with its fair share of problems (e.g. Tomkins & Eatough, 2010). IPA’s idiographic stance presents a potential problem for researchers who want to use this method of analysis with focus group transcripts, because drawing themes from what was said, rather than who said it, can eclipse the individual in the group.

The possibility that certain voices might not be heard, or at the very least overshadowed, in focus groups is one of the main disadvantages to using this approach in data collection, irrespective of the method chosen for data analysis. This potential problem is very difficult to address by the researcher as he, or she, is limited to the role of group moderator who is supposedly outside the interaction of the group – leaving very little room to manoeuvre in terms of attempting to influence group dynamics so that all voices are heard equally.

Consequently, Smith (2004) suggests that IPA’s suitability with focus groups depends largely on whether individuals will feel comfortable in discussing sensitive issues in the

group or not. However, regardless of how comfortable individual participants are (or are believed to be by the researcher) in a focus group, the potential loss or eclipsing of the individual voice in the group remains an issue for IPA researchers. As Tomkins and Eatough (2010, p. 247) note, “Given IPA’s insistence on idiography, this loss of the individual is a problem for researchers working within this research paradigm”.

Another potential problem with using IPA with focus groups lies in the complexity of attending to yet another level of interpretation. In IPA, the interpretative process is seen as a “double hermeneutic,” with the participant trying to make sense of his/her personal and social world, and the researcher trying to make sense of the participant trying to make sense of that world (Smith 2004; Tomkins & Eatough, 2010; Willig, 2001). With focus groups, the hermeneutic takes on an additional dimension because the researcher will have to make sense of the participants trying to make sense both of their own experiences and of each other’s – a process referred to as “multiple hermeneutic” (Tomkins & Eatough, 2010).

Smith (2004) suggests parsing IPA focus group transcripts first for the group-level patterns and then for the individual accounts. This is in line with Morgan’s assertion regarding analysis in focus groups - basically that “the group, not the individual, must be the fundamental unit of analysis” (Morgan 1997, p. 60). Several researchers have used IPA with focus groups by clustering themes from the group data set as a whole entity – irrespective of which of the participants is saying what (e.g., Dunne & Quayle, 2001; Roose & John, 2003; Vandrevalla et al., 2006). Although these researchers do present the perspective of individual participants when they introduce individual themes, this seems to be limited to the theme display stage (Tomkins & Eatough, 2010).

Therefore, these researchers seem to have worked almost exclusively at the group level when analysing focus group transcripts using IPA. For example, when Dunne and Quayle (2001) do reflect on whether the themes that emerged during their analysis were shared or unique to individuals, they do not elaborate further on this; consequently their thematic summary remains based entirely on group-level themes. Similarly, Wilkinson (1998, p. 196) notes that “extracts from focus group data are most commonly presented as if they were one-to-one interview data, often with no indication that more than one person is present”. This seems to contradict IPA’s idiographic commitment which, as Tomkins and Eatough (2010, p. 247) note, “tends to be interpreted as a focus on the individual participant”.

Therefore, sacrificing the individual voice in the group (i.e. not incorporating who said what) for the sake of capturing the group voice (i.e. incorporating only what was said) might simply be a more attainable goal for researchers wanting to prioritise researcher influence and interpretation, which are at the core of IPA, over the idiographic stance of IPA. Tomkins and Eatough (2010) cite several studies (e.g. Dunne & Quayle, 2001; Roose & John, 2003; Vandrevalla et al., 2006) that have used IPA with focus groups in this manner, and note the apparent lack of elaboration on the reasons for this sacrifice of the individual voice for the group voice in these studies.

In contrast, the present study has clear reasons for using IPA with focus groups, and a rationale for, and acknowledgement of, the potential loss of the individual voice in the study phase that used this approach. Specifically, in Phase 3 of the present study the

research interest shifted from wanting to explore individual participants' views (as in Phases 1 and 2) to wanting to explore the common views and experiences among two different groups of counselling professionals. Individual interviews were used with the Iraqi refugee men, because their experiences of exile (i.e. Phase 1) and experiences of counselling (i.e. Phase 2) are the focus of the present study. The adult male Iraqi refugee participants recruited for Phase 1 and Phase 2 of the study represent the client group for which the researcher is trying to give voice to.

The participants recruited for Phase 3 were mental health professionals who have the influence and language skills to voice their concerns in a variety of academic, collegial, and clinical settings. Therefore the individual voices of these professionals are not likely to be those of a marginalised minority group. Another reason for having chosen focus groups as the method of data collection with the professionals in Phase 3 is the added level of comfort that participants are likely to experience in discussing counselling Iraqi refugee men as a group with the researcher – whom they know to be a psychologist with experience in counselling Iraqi refugees and an Iraqi refugee himself. Smith (2004) suggests that IPA's suitability with focus groups is largely dependent on individual participants' level of comfort in discussing the issues at hand in the group setting.

Having discussed the rationale for my choices of data collection and analysis, I will now discuss the recruitment of participants in each phase, present the socio-demographic information pertaining to each participant group, and discuss the inclusion and exclusion criteria for each phase of the present study.

Participants

This three-phase study involved using 25 participants altogether. Ten adult male Iraqi refugees were recruited in Phase 1, ten adult male Iraqi refugee ex-counselling clients (of which three had participated in Phase 1) were recruited in Phase 2, and eight mental health professionals with prior experience in counselling Iraqi refugee men were recruited in Phase 3. None of the participants were known to the researcher prior to the study – with the exception of two mental health professionals who participated in Phase 3. The recruitment process is discussed in detail later on in Chapter 3. Since IPA was going to be the method of analysis, participants in each phase were recruited in accordance with the “purposive homogeneous sampling” approach described by Smith, Flowers, and Larkin (2009, p. 49). Purposive homogeneous sampling simply entails trying to find a fairly homogenous sample in which participants can be considered to represent a common perspective rather than be conceived as representative of a population.

Phase 1 – Iraqi refugee men

In Phase 1, an information sheet (discussed later in this Chapter under the heading of ‘Recruitment process’) was put up on the notice board of the main Iraqi social club in the city of Malmo in Sweden in order to recruit ten Iraqi refugee men. Eventually, ten participants were recruited. Each of the ten adult male Iraqi refugee participants was asked nine questions prior to the interview process to document participants’ socio-demographical backgrounds (see Appendix 5). The results are displayed below in Table 1.

Participant	Age	Education	Employment	Income	Religion	Family	Length of stay in Sweden	Negative experiences from Iraq
P1	65	PhD	employed	above	Man.	both	21 years	P,WV,EV,I,T
P2	51	S. school	unemployed	below	Man.	Swed.	20 years	W,P,WV,EV
P3	34	Masters	employed	below	Mus.	both	20 years	W,P,WV,EV
P4	66	Bachelors	unemployed	below	Mus.	both	18 years	P,WV
P5	31	Bachelors	employed	below	Mus.	both	10 years	W,P,WV,I
P6	31	S. school	unemployed	below	Mus.	both	5 years	W,P,WV,EV,I
P7	21	S. school	unemployed	below	Mus.	both	5 years	W,WV
P8	28	S. school	employed	above	Mus.	both	12 years	W,P,WV,EV,I
P9	33	Bachelors	unemployed	below	Mus.	both	5 years	W,P,WV,EV
P10	29	S. school	employed	below	Mus.	both	20 years	W,P,WV

Table 1: Socio-demographic information for the Iraqi refugee men who participated in Phase 1.

Education classifications: *S. school* (secondary/sixth form school), *Bachelors* (BSc or BA), *Masters* (MSc or MA), and *PhD*. Income classifications: *above* or *below* an average monthly income of 16 583 SEK which roughly corresponds to an annual income of 198 996 SEK – which is the median annual income in Sweden for foreign born men (20 years old and above) for the year 2010 (Statistics Sweden, 2011). Religion classifications: *Mus.* (Muslim) and *Man.* (Mandaean). Family classifications: *Swed.* (family in Sweden) or *both* (family in both Sweden and Iraq). Negative experiences from Iraq classifications: *W* (war), *P* (political oppression), *WV* (witnessed acts of violence), *EV* (experienced acts of violence), *I* (Imprisonment), and *T* (torture).

Inclusion criteria

Ten adult male Iraqi refugees who had lived in Sweden for at least five years. As discussed earlier in Chapter 2, the experiences of refugees in earlier stages of exile tend to differ from those of refugees in later stages of exile (e.g. Tribe, 1999). The criterion of length of stay in Sweden was used to ensure that participants were well into the later stages of exile. The time span in the criterion of length of stay in Sweden (i.e. a minimum of five years) has come about through personal and professional observations of how much time it generally takes for a refugee to be considered living in the later stages of exile in Sweden. Including only men was also based on the literature discussed in Chapter 2 which suggests that refugee men can have different experiences from refugee women (e.g. Griffiths, 2001).

Exclusion criteria

Having lived in Sweden for less than five years was an exclusion criterion for Iraqi refugees because it would be suggestive of the participant being in an early stage in exile according to the cut off point suggested earlier. Children and adolescents were also excluded. The reasons behind not including any child or adolescent Iraqi refugees in the study are partly ethical and partly theoretical - as discussed in Chapter 2 under the heading of 'Age group'. Also refugee children and teenagers, compared to adult refugees, are likely to be experiencing different types and levels of intercultural contact that are likely to lead to different experiences and needs (e.g. Tribe, 1999). Therefore theoretically, child and adolescent Iraqi refugees can be seen to represent a different client group.

Similarly, Iraqi refugee women were excluded because Iraqi men and women can differ in their pre-migration and post-migration experiences (e.g. Al-Ali, 2007) – as discussed in Chapter 2 under the heading of ‘Gender’. Another reason for excluding Iraqi women lies in the need for specifically addressing Iraqi men’s experiences as some masculinity traits (e.g. Eisler & Blalock, 1991, Levant, 1998; Levant et al., 1992) might have specific implications for the experience of exile in Sweden.

Phase 2 – Adult male Iraqi refugee ex-counselling clients

In Phase 2, an information sheet (discussed later in this Chapter under the heading of ‘Recruitment process’) was put up on the notice board of the same Iraqi social club used in Phase 1 in order to recruit ten adult male Iraqi refugee ex-counselling clients. Eventually, ten participants were recruited, but only seven of them were new participants as three had already participated in Phase 1. Although considerable time had past since putting up this second information sheet, participants were not as easy to recruit in this phase - probably due to the cultural stigma (discussed in Chapter 2) that can accompany admitting having been a counselling client (e.g. Shoeb, Weinstein, & Mollica, 2007). Each of the ten adult male Iraqi refugee ex-counselling client participants was asked nine questions (the same questions used in Phase 1) prior to the interview process to document participants’ socio-demographical backgrounds (see Appendix 5). The results are displayed below in Table 2.

Participant	Age	Education	Employment	Income	Religion	Family	Length of stay in Sweden	Negative experiences from Iraq
P11/P3	34	Masters	employed	below	Mus.	both	20 years	W,P,WV,EV
P12/P6	31	S. school	unemployed	below	Mus.	both	5 years	W,P,WV,EV,I
P13/P2	51	S. school	unemployed	below	Man.	Swed.	20 years	W,P,WV,EV
P14	22	S. school	employed	below	Mus.	both	8 years	W,WV,EV
P15	21	S. school	unemployed	below	Mus.	both	8 years	None
P16	38	S. school	unemployed	below	Mus.	both	12 years	W,P,WV,EV,I
P17	29	S. school	unemployed	below	Mus.	both	7 years	W,P,WV,EV,I,T
P18	34	P. school	unemployed	above	Mus.	both	6 years	W,P,WV,EV,I,T
P19	32	S. school	employed	above	Mus.	Iraq	7 years	W,WV,EV
P20	24	S. school	unemployed	below	Mus.	both	9 years	W,P,WV

Table 2: Socio-demographic information for the adult male Iraqi refugee ex-counselling clients who participated in Phase 2.

Education classifications: *S. school* (secondary/sixth form school) and *P. school* (primary school), *Bachelors* (BSc or BA), *Masters* (MSc or MA). Income classifications: *above* or *below* an average monthly income of 16 583 SEK which roughly corresponds to an annual income of 198 996 SEK – which is the median annual income in Sweden for foreign born men (20 years old and above) for the year 2010 (Statistics Sweden, 2011). Religion classifications: *Mus.* (Muslim) and *Man.* (Mandaean). Family classifications: *Swed.* (family in Sweden), *Iraq* (family in Iraq), or *both* (family in both Sweden and Iraq). Negative experiences from Iraq classifications: *W* (war), *P* (political oppression), *WV* (witnessed acts of violence), *EV* (experienced acts of violence), *I* (Imprisonment), and *T* (torture).

Inclusion criteria

Ten Iraqi refugee men who had lived in Sweden for at least five years and have had some form of counselling during that time (i.e. ex-counselling clients). Iraqi refugee participants who had combined treatments (psychotherapy and medication) were also included; however the emphasis was on exploring their experiences of counselling not medication. The reason for including participants who had combined treatments lies partly in the difficulty of finding participants who have not used psychopharmacology, alongside psychotherapy, or even as the only method of addressing mental health issues. The use of medication is also hard to control for because even participants who have never been prescribed medication could have self-medicated.

The type of counselling or psychotherapy experienced by participants was not specified in terms of inclusion or exclusion criteria partly because of the linguistic limitations in describing some therapeutic approaches and their respective terminology in Arabic (Al-Roubaiy, 2012b). Another reason for not specifying the type of therapeutic approach was the likelihood of encountering Iraqi refugee ex-counselling clients who might have been either unsure of what type of therapy they have been offered, or were told by therapists that they were being offered a specific approach when in reality the therapist might have been practicing differently. Last, but not least, therapeutic orientation was not specified because this study focuses on the relational aspects of therapy – as discussed in Chapter 1 under the heading of ‘Relevant practice issues’.

Exclusion criteria

Iraqi refugees who have lived in Sweden for less than five years were excluded due to the emphasis on finding ex-counselling clients who were also in the later stages of exile. Iraqi refugee women, teenagers, and children were excluded for the same previously discussed reasons in Phase 1. It should also be noted that the variance in ‘length of stay’ as well as the variance in age among the Iraqi refugee men in both Phase 1 and Phase 2 represent possible methodological shortcomings – which were largely unavoidable in light of the difficulties encountered in recruiting such a specific sample of participants who were willing to discuss such sensitive and intimate subjects.

Phase 3 – Mental health professionals

In Phase 3, an information sheet (discussed later in this Chapter under the heading of ‘Recruitment process’) was sent to twelve mental health professionals in order to recruit ten participants with experience in counselling and psychotherapeutic work with Iraqi refugee men. Eventually, eight participants were recruited. The eight participants were divided into two groups in order to be interviewed using a focus group design. The rationale behind recruiting one group of professionals with extensive trauma experience (i.e. the Red Cross) and another group from different agencies was based on the need to explore possible differences in clinical experiences – specifically as a result of having a more or less trauma-focused approach to working with Iraqi refugee men. Participants were handed socio-demographic information forms (Appendix 16) to fill in prior to the interviews (see Appendix 15 for English version). The results are displayed below in Table 3.

Participant	Age	Ethnicity/ Cultural background	Gender	Profession	Years of counselling experience	Theoretical orientation	Level of experience with Iraqi refugee male clients
P21	63	Swedish	Female	Psychologist	34 years	Psychod+Tf	20 + clients
P22	61	Swedish	Female	Psychotherapist	5 years	Psychod	20 + clients
P23	50	Kurd Iran	Male	Psychologist	10 years	CBT	20 + clients
P24	34	Swedish	Male	Psychologist	5 years	CBT+Integ	20 + clients
P25	56	Arab Iraq	Male	Counsellor	8 years	Integrative	20 + clients
P26	45	Swedish	Female	Psychologist	5 years	Integrative	5-10 clients
P27	55	Swedish	Female	Psychologist	18 years	CBT+Integ	20 + clients
P28	53	Swedish	Female	Counsellor	15 years	CBT	20 + clients

Table 3: Socio-demographic information for the mental health professionals who participated in Phase 3.

Theoretical orientation classifications: *Psychod* (Psychodynamic), *Tf* (trauma-focused), *CBT* (Cognitive Behavioural Therapy), and *Integ* (Integrative). Level of experience with Iraqi refugee male clients classifications: *20 + clients* (20 or more adult male Iraqi refugee clients) and *5-10 clients* (5 to 10 adult male Iraqi refugee clients).

Inclusion criteria

Mental health professionals with experience in counselling adult male Iraqi refugees in Sweden. Considering the corporate rivalry (discussed in Chapter 1 under the heading of ‘Counselling and psychotherapy’) among the major professions in mental health (Ginger, 2009), the recruitment criteria was simply based on the professional being a counsellor, psychologist, or psychotherapist. Additionally, professionals belonging to one, or more, of these professional categories needed to have some experience in counselling Iraqi refugee men in Sweden. Also, therapeutic orientation was not an inclusion or exclusion criterion, partly due to the possibility of claiming to use a certain approach while practising in a different manner - but mostly due to the focus of this research being more geared towards relational factors as discussed in Chapter 2 under the heading of ‘Relevant practice issues’.

Exclusion criteria

Although psychiatrists and psychiatric nurses are also mental health professionals, they were excluded from this study. One reason for this exclusion lies in the tendency of most psychiatrists and psychiatric nurses to adhere to the medical model of explaining mental health difficulties; thus downplaying the psychosocial and socio-political issues of relevance to counselling Iraqi refugee men struggling with post-migration stress in later stages of exile. Furthermore, this study is influenced by a postmodernist and social constructionist perspective which is more in tune with voicing the concerns of Iraqi refugee men than voicing the already dominant voices of the medical and scientific community.

Procedure

Prior to the recruitment of participants in each of the three phases of the study, ethical approval was sought and subsequently granted by the University of Leicester (see Appendices 7, 11, and 18). Recruitment of participants for Phase 1 and Phase 2 was done through the Iraqi cultural association in the city of Malmo using information sheets. The actual information sheets used in Phase 1 (Appendix 2) and Phase 2 (Appendix 9) were written in classical Arabic. It should be noted that Arabic, as described by Nydell (2006), is often used in three distinct forms: classical (used in all writing and for formal discussions); colloquial (used in everyday spoken communication and is different for each region and dialect); and formal (used in semi-formal contexts and is a combination of classical Arabic and distinct regional dialect).

The actual consent form used in Phases 1 and 2 was written in classical Arabic (Appendix 4) but provided in English in Appendix 3. The actual interview questions in Phases 1 and 2 were put to participants using the Iraqi Arabic dialect but are provided in English in Appendix 6 (Phase 1) and Appendix 10 (Phase 2). Recruitment of participants for Phase 3 was done through direct contact of mental health professionals known to likely have experience in counselling Iraqi refugee men. The actual information sheet used to recruit participants in Phase 3 was in Swedish (Appendix 13) but is provided in English in Appendix 12. Similarly the actual consent form used in Phase 3 was in Swedish (Appendix 14) but is provided in English in Appendix 3. The interview questions in Phase 3 were put to participants in Swedish but are provided in English in Appendix 17. A more detailed description of the recruitment process is presented below for each phase of the study.

Recruitment process

Phase 1 – Recruiting the Iraqi refugee men

An information sheet was used to recruit ten adult male Iraqi refugee participants from the main Iraqi social club in the city of Malmö in Sweden. The Iraqi social club is known more accurately as the Iraqi cultural association in Malmö, or as it is commonly referred to in Swedish: 'Irakiska Kultur förening i Malmö'. The Iraqi social club is the largest Iraqi association in the whole southern region of Sweden and is additionally the only Iraqi social club/association to accept all different ethnicities and religious backgrounds from Iraq - as opposed to others with more political and religious affiliations.

The actual information sheet used in the recruitment was in Arabic but is provided in the Appendices in both English (Appendix 1) and Arabic (Appendix 2). The information sheet stated that this study requires ten adult male Iraqi refugee participants who have lived in Sweden for at least five years and that the two main research interests behind the study are: 1) The exploration of the positive as well as the negative social and psychological aspects of life in Sweden, and 2) The exploration of the various support and help systems available to Iraqi refugee men in Sweden.

Formulating the research interest in the information sheet as being the exploration of both the positive as well as the negative psychosocial aspects of life in Sweden, as opposed to just the negative aspects of exile, was done to ensure that the participants who decide to participate will not only be the ones with negative experiences and attitudes regarding life

in Sweden. This formulation aimed to engage the participant from the onset in a neutral manner without influencing him in any direction at such an early stage in the process. This neutral formulation was also used to hide the potential biases that the researcher already had regarding the subject being explored and was therefore theoretically able to attract a broader and more representative sample of Iraqi refugee men.

The information sheet also stated that the research process will be conducted with the most possible anonymity and that the identities of the participants will be kept out of any records or paper work. The information sheet also stated that participants have the right to withdraw from the study at any point during or after the interview process; as long as it is before data analysis. Finally, a phone number and e-mail address were provided for potential participants to contact the researcher on. Once contact was established, suitable participants were given a consent form to read and sign before beginning the interview process. The actual consent form used was in Arabic but is provided in the Appendices in both English (Appendix 3) and Arabic (Appendix 4).

Phase 2 – Recruiting the Iraqi refugee counselling clients

An information sheet was used to recruit ten adult male Iraqi refugee ex-counselling clients from the same Iraqi social club in Malmo from which participants were recruited for phase one. This information sheet was very similar in content to the previous information sheet in phase one, but focused instead on recruiting ex-counselling clients who also fulfilled the same inclusion criteria for phase one. This information sheet was also used in Arabic but is

again provided in the Appendices in both English (Appendix 8) and Arabic (Appendix 9). The information sheet stated that this study requires ten adult male Iraqi refugee participants who have lived in Sweden for at least five years and have had some form of counselling during that time. The information sheet also stated that the main research interest of this study is the exploration of Iraqi refugee men's counselling experiences.

The information sheet also stated that participants who have had combined treatment (i.e. counselling and psychopharmacology) were also suitable but that the emphasis of the interview would be on counselling experiences not medication. A phone number and e-mail address were provided for potential participants to contact the researcher on. Once contact was established, suitable participants were given a consent form to read and sign before beginning the interview process. The consent form used in this phase was the same as the one used in phase one; and as in phase one the actual form used was in Arabic but is provided in the Appendices in both English (Appendix 3) and Arabic (Appendix 4).

Phase 3 – Recruiting the mental health professionals

An information sheet was sent (via post and e-mail) to twelve mental health professionals known to be likely working with Iraqi refugee clients in different counselling agencies (both private and public) in the city of Malmö. Eventually eight professionals were recruited. The actual information sheet used to recruit participants was in Swedish but is provided in the Appendices in both English (Appendix 12) and Swedish (Appendix 13). The information sheet stated that the participants required for this study should belong to

one or more mental health professional categories and should have some experience in counselling adult male Iraqi refugees. The information sheet also stated that the research process would be conducted with the most possible anonymity and that the identities of the participants will be kept out of any records or paper work. The information sheet also stated that participants have the right to withdraw from the study at any point during or after the interview process; as long as it is before data analysis.

Finally, a phone number and e-mail address were provided for potential participants to contact the researcher on. Once contact was established, suitable participants were given a consent form to read and sign before beginning each focus group interview (there were two focus groups with four participants in each group). The actual consent form used was in Swedish but is provided in the Appendices in both English (Appendix 3) and Swedish (Appendix 14).

Data collection

In Phases 1 and 2 individual semi-structured interviews were conducted with participants. In Phase 3, two independent focus group interviews were conducted with participants. The interviews were then translated by the researcher, with some external guidance, from Arabic to English in Phases 1 and 2, and from Swedish to English in Phase 3. The translated audio-recordings were then transcribed externally into the English transcripts that were subsequently analysed using IPA.

Individual semi-structured interviews

In Phases 1 and 2 individual semi-structured interviews were conducted with participants. Before each individual interview socio-demographic information (see Appendix 5 for the questions asked) was gathered for each participant (results presented earlier in Chapter 3 under the heading of ‘Participants’). Each interview lasted between forty-five minutes to an hour. The interviews were done using open-ended questions that were elaborated on by both participant and researcher throughout the interview process. Smith and Osborn (2003) argue that the semi-structured interview is the optimum tool for collecting data in an IPA study since it provides a great degree of flexibility that enables the researcher to engage the participants in meaningful dialogues that are compatible with IPA’s theoretical principles. The interviews were conducted using a combination of colloquial Arabic (different Iraqi dialects) and formal spoken Arabic (combining classical Arabic with the Iraqi dialect) depending on each participant’s background.

The interview questions are provided in the Appendices (see Appendix 6 for Phase 1 and Appendix 10 for Phase 2). The interview questions as well as the socio-demographic questions are provided in the appendices only in English because the actual Arabic questions put to the participants were often formulated differently depending on each participant’s specific Iraqi dialect and background. Also the actual interviews were semi-structured and the questions functioned merely as prompts for the exploration of participant views - which often diverged from the original interview questions. The interviews for both Phase 1 and Phase 2 were held individually in a room at the Iraqi cultural association in the city of Malmo.

In Phase 1, five main areas (see Appendix 6 for the interview questions) were explored: 1) experiences of social support; 2) acculturation and related aspects; 3) experiences of racial discrimination; 4) negative experiences from Iraq compared to negative experiences in exile; and 5) the help and support systems available to Iraqi refugee men in Sweden. In Phase 2, three main areas (see Appendix 10 for the interview questions) were explored: 1) client perceptions of self in therapy; 2) client perceptions of the mental health professional; and 3) client perceptions of the counselling process and outcome. The audio-recorded individual interviews in Phases 1 and 2 were translated, transcribed, and then analysed using IPA. The findings from Phases 1 and 2 were used to create interview questions for Phase 3 that were meant to reflect the concerns raised by the Iraqi refugee men in Phases 1 and 2 - yet still allow for the emergence of new insights from the counselling professionals in Phase 3 (see Appendix 17 for the Phase 3 interview questions).

Focus group interviews

Phase 3 involved the facilitation of two independent focus groups geared towards exploring each group's experiences of and views regarding counselling Iraqi refugee men. As Smith, Flowers, and Larkin (2009, p. 71) note, "Focus groups allow multiple voices to be heard at one sitting, drawing a larger sample into a smaller number of data collection events". The participants in both groups were mental health professionals with prior experience in counselling this client group in Sweden. However, one group was made up of professionals who practice in different agencies (e.g. private practice, psychiatric departments, etc.) and

the other group was made up of professionals working in the Swedish Red Cross as colleagues. In using IPA to analyse focus group interviews, Smith, Flowers, and Larkin (2009, p. 73) suggest that “four to five is a good size for a focus group”. Therefore four participants were selected for participation in each focus group.

The number of participants in each focus group was limited to four participants, rather than five or more, mainly because the researcher wanted to explore with the professionals being interviewed *all* of the sub-ordinate themes that emerged from the IPA analysis of Phase 1 and Phase 2. Since there were many sub-ordinate themes to be explored, the number of focus group interview questions designed to address each sub-ordinate theme (see Appendix 17) made it necessary to limit the number of participants in each focus group to enable sufficient exploration and discussion among participants. Additionally, only eight participants were successfully recruited as opposed to the initial target of ten.

Although the number of questions and formulations used might seem to limit participant discussions, a great deal of flexibility was applied in asking the questions in line with what participants were discussing (for example in discussing question one, most participants ultimately ended up discussing other questions, negating the need for the researcher to use all of the questions). The group discussions were moderated in line with standard focus group practice (Krueger, 1988; Morgan, 1993; Stewart and Shamdasani, 1990) - with the end result being that all of the themes/issues identified in Phases 1 and 2 were covered in both focus group 1 (which lasted for 58 minutes) and focus group 2 (which lasted for 65 minutes).

Translation and transcription

The individual semi-structured interviews in Phases 1 and 2 were conducted in Arabic by the researcher, translated by the researcher with some assistance, and finally transcribed externally. The focus group interviews in Phase 3 were conducted in Swedish by the researcher, translated by the researcher, and finally transcribed externally. Although I consider myself proficient in the Arabic language, I still sought linguistic and translation consultation from Dr. Ibrahim Al-Khamisi who has professionally translated articles and books from and to Arabic on various subjects and in different languages. When in doubt regarding linguistic and translation issues from Phases 1 and 2, Dr. Al-Khamisi was consulted but without listening to audio tapes or viewing transcripts so as to preserve anonymity and confidentiality. I did not seek external help in translating the Swedish audio taped group interviews from Phase 3 since I had prior experience in writing and translating texts in Swedish (e.g. Al-Roubaiy, 2012a).

I translated each audio tape by re-recording each interview in English. Once the original Arabic (Phases 1 and 2) and Swedish (Phase 3) audio tapes were translated to English audio tapes, I had the English versions sent to a transcription specialist (Tina Cartwright) to be transcribed. Although the decision to have the interview tapes transcribed by an outsider was largely motivated by time issues, I also felt the need to distance myself from the transcripts at this stage because I was already too immersed in my observations from the interpretation process. However, Smith, Flowers, and Larkin (2009, p. 74) have argued that “transcription is itself a form of interpretative activity”. Similarly, Etherington (2004, p. 78) argues that “only by transcribing tapes personally could we remain close enough to the

speaker's meanings". Although transcription can really be part of the analysis and can aid in perhaps gaining deeper meaning, I felt that this is not necessarily true for my interview recordings as I had already gone to great lengths to analyse the content, and manner, of what was being said in translating the original audio recordings from Swedish/Arabic to English.

As for the translation process itself, I adopted a style that best captured the meaning within what was being said while trying to maintain as much of the original lexical content as possible. To understand what this manner of translation means one should understand the main two approaches to translation: formal equivalence and dynamic equivalence. Formal equivalence means translating literally and word for word even at the expense of meaning, while dynamic equivalence means translating the essential thought in the original language at the expense of literality and word sequence in the original language (Kasperek, 1983). Translation in the present study was carried out using a combination of both approaches – as most competent translators attempt to do (Kasperek, 1983).

Ethical considerations

In each phase of the study, I attempted to address what Willig (2001, p. 18) describes as the basic ethical considerations: informed consent; no deception; right to withdraw; debriefing; and confidentiality. Accordingly, in all three phases ethical approval was sought and obtained prior to recruitment of participants (see Appendices 7, 11, and 18). Participants were recruited using information sheets that transparently informed participants of the

researcher's background and research interests without the use of deception. Participants were informed in writing (in the information sheets) that they had the right to withdraw from the study at any point before data analysis. Participants were also given consent forms to read and sign to confirm their consent to being interviewed and audio taped, and to confirm their understanding of their right to withdraw. In order to maintain each participant's anonymity and to convey the proper respect for confidentiality, each interview tape and transcript was numbered (with no names used).

Participants were also informed in the information sheets that the interview transcripts will be kept for a maximum period of five years for potential publication purposes and that the interview tapes will be destroyed upon successful completion of the PhD course. The individual interviews for Phases 1 and 2 took place in a room at the main Iraqi social club in the city of Malmo in Sweden; thereby offering enough privacy yet ensuring safety due to the presence of others at the club. Similarly, in Phase 3 one focus group interview took place in the Swedish Red Cross in the city of Malmo and the other focus group interview took place in the headquarters of a government funded team of psychologists located in the district of Rosengård in the city of Malmo – 'Resursteam Barn Ungdom'.

Additionally, had a participant felt distressed by any of the issues raised during the interview, contact numbers to appropriate counselling agencies (as stated in the information sheets) were going to be offered. Participants were also informed in the information sheets on how to make a complaint if they felt the need to do so.

Data analysis

IPA was the method of analysis for all three phases of the study. Guided by the analytic process described by Smith, Flowers, and Larkin (2009), the analysis entailed using the following strategies: close line-by-line analysis of experiential material; identification of themes within this experiential material starting with the first case and then across cases; development of a dialogue between researcher and data; development of a structure which illustrates relationships between themes; use of collaboration in interpretation; and development of a theme-by-theme narrative which makes use of data extracts and visual aids to explore the researcher's interpretations.

As discussed earlier in this Chapter under the heading of 'Rationale for the methodology', IPA was used in Phase 1 and Phase 2 of the present study as it is commonly used with individual interview transcripts – treating each transcript as the particular/idiographic focus of the analysis (Smith, Flowers, & Larkin, 2009). However, in Phase 3 IPA was used to analyse the two interview transcripts from the two focus group interviews as if each transcript was a particular case – as most IPA studies do with focus group interviews (e.g. Dunne & Quayle, 2001; Flowers, Duncan, & Knussen, 2003). Several researchers have used IPA with focus groups by clustering themes from the group data set as a whole entity - irrespective of which of the participants is saying what (e.g., Dunne & Quayle, 2001; Roose & John, 2003; Vandrevalla et al., 2006). Although the perspective of individual participants is sometimes introduced in individual themes, this is often limited to the theme display stage in such studies (Tomkins & Eatough, 2010).

Reading and re-reading

This first stage involves the close line-by-line reading and re-reading of the first interview transcript, while noting the most powerful recollections of the interview and the most striking initial observations about the transcript. Noting such recollections and observations can “help to bracket them off for a while...allowing your focus to remain within the data” (Smith, Flowers, & Larkin, 2009, p. 82). In addition to aiding in the bracketing off process, noting these recollections from the interview and observations about the transcript sets the stage for entering the participant’s world which will later involve an active engagement with the data using only the transcript.

Re-reading the transcript also helps in getting a feel for the overall rhythm and structure of the interview, which in turn can “highlight the location of richer and more detailed sections” (Smith, Flowers, & Larkin, 2009, p. 82). In this three-phase study, the researcher had the chance to listen to the audio-recordings of the actual interviews for several times in order to translate the recordings into English versions. In translating the Arabic and Swedish audio-recordings, the researcher had the chance to formulate and reformulate the participants’ accounts to best capture the meaning contained within these accounts; thereby increasingly becoming more in tune with the rhythm and content of each interview. As Smith, Flowers, and Larkin (2009, p. 82) note “Repeated reading also allows a model of the overall interview structure to develop, and permits the analyst to gain an understanding of how narratives can bind certain sections of an interview together”. An example of noting recollections from interviews, and initial observations about transcripts, in this study is displayed below in Figure 1.

Figure 1: Example of interview recollections and transcript observations

Extract from participant transcript	Recollections and <i>observations</i>
<p>P2 I mean being so close to him, and all of a sudden he's one minute standing next to me, and the other he has his leg blown off, he loses his leg. And I recall....I mean just feeling helpless. What can one do in such a situation? What could I have possibly done for him when he lost his leg? I mean I just looked on.</p>	<p>In recalling this war-related incident in which a friend lost his leg, the participant became increasingly more intense in his tone and manner as he described feeling helpless and not being able to do anything for his friend at the time. In being</p>
<p>R Was it during the actual battle when you were taking fire from the enemy lines, or how did that happen?</p>	<p>overwhelmed by the participant's distress, I meaninglessly asked if this incident happened during actual</p>
<p>P2 No it was actually a land mine, he actually stepped on a land mine and it simply exploded. And although he was in pain and basically screaming, screaming at me not to approach, not to come any closer because it was full of land mines at the time. I mean this is just one incident that I can recall right now, but other incidents are just beyond description.</p>	<p>combat or some other event.</p> <p><i>Perhaps my focus on exile-related stressors can be interpreted as downplaying the impact of such traumatic pre-migration experiences.</i></p>

Initial noting

In this stage the analyst starts writing exploratory notes on the transcript to comment on anything of interest. Smith, Flowers, and Larkin (2009, p. 84) describe using three main types of exploratory comments: descriptive (describing content); linguistic (describing the specific use of language); and conceptual (describing early researcher interpretations). This stage can merge with the first stage in that the analyst will already be noting observations while reading and re-reading the transcript, as described above in the first stage. Already at this early stage, the researcher's subjectivity becomes influential in commenting mainly on what the researcher personally finds interesting; as Smith, Flowers, and Larkin (2009, p. 83) comment on this stage of analysis "There are no rules about what is commented upon".

However, Smith, Flowers, and Larkin (2009, p. 84) do note that "It is important to engage in analytic dialogue with each line of transcript, asking questions of what the word, phrase, sentence means to you, and attempting to check what it means for the participant"; thereby emphasising the need to approach the data with an open mind. Smith, Flowers, and Larkin (2009, p. 84) describe a simple way for differentiating between these three exploratory comments when writing on the transcript which entails writing descriptive comments using normal text, linguistic comments using italic, and conceptual comments using underlined. In using these three exploratory comments, Smith, Flowers, and Larkin (2009, p. 84) suggest that the best way to do the analysis is with "a hard copy of the transcript with wide margins. We use one margin to document the initial comments, leaving the other margin for the next stage". An example of initial noting in the present study is displayed below in Figure 2.

Figure 2: Example of initial notes/exploratory comments

Emergent themes	Extract from participant transcript	Exploratory comments
	<p>P1 I believe these issues have become more intense with time and I believe this is a direct consequence of my own increased understanding of how this society really works, and all of this makes me want to become even more determined at becoming integrated into the Swedish society. I think this integration aspect, and these other issues we discussed, is very important, not just for me but even for my family, so I simply have to do it.</p>	<p>Being affected by integration and language difficulties more intensely as time passes.</p> <p><u>Acknowledging the impact of exile-related issues.</u></p> <p>More determined to become integrated into society.</p> <p><i>Noting the importance and necessity of integration.</i></p> <p><u>Pressured to integrate for the sake of the family</u></p>

Developing emergent themes

This stage “involves an analytic shift to working primarily with the initial notes rather than the transcript itself” (Smith, Flowers, & Larkin, 2009, p. 91). Conceptual comments are of particular importance for this stage as they represent the interpretative and reflexive components in the analytic process. Although the potential for “reflexive engagement will differ from analyst to analyst and from project to project” (Smith, Flowers, & Larkin, 2009, p. 90), developing themes will always involve some degree of using the analyst’s own thoughts, feelings, and experiences. Analysing exploratory comments to identify emergent themes involves producing concise statements of what was important in the various comments attached to a transcript. Themes are expressed as phrases which “reflect not only the participant’s original words and thoughts but also the analyst’s interpretation” (Smith, Flowers, & Larkin, 2009, p. 91); thus implying a synergy between description and interpretation.

Emergent themes are written on the transcript in the margin that was left empty in the earlier stage of analysis; the left margin in the case of this study. Smith, Flowers, and Larkin (2009, p. 84) note that conventionally they “have written of this process as moving from the left margin (comments/notes) to the right margin (themes)” yet recently they have come to the realisation “that that order had actually come about because Jonathan is left handed and so most naturally moves from left to right”. An example of identifying emergent themes in the present study is displayed below in Figure 3.

Figure 3: Example of identifying emergent themes

Emergent themes	Extract from participant transcript	Exploratory comments
<p>Counselling to fulfil the need to talk</p> <p>Understand them better</p> <p>Therapist as a way into society</p> <p>Counteracting marginalisation</p> <p>Not worth talking to</p>	<p>P19 It was about my need to talk. I needed to talk to someone, and in talking to a Swedish man I thought I would somehow get closer to this society, understand them better. I mean to me he was my way in. Where else will I find a Swedish person who is willing to talk to me? Not that they are worth talking to. I mean the dialogue is a joke, it's one-sided, it's like talking to a wall, and I'm sure it's not my language.</p>	<p>Being driven to counselling by the need to talk and interact.</p> <p>Getting closer to Swedish society through contact with the Swedish therapist.</p> <p><i>Describing the contact with the Swedish therapist as a way in.</i></p> <p>Emphasising the difficulty in establishing contact with a Swedish person.</p> <p><u>Conflicting views on the value of interacting with a Swedish person.</u></p>

To strengthen the validity of the researcher's analysis, four transcripts were analysed externally by fellow PhD students and by my PhD supervisors. The externally analysed transcripts were then used to compare the emergent themes in these analyses to the researcher's own emergent themes. In utilising this strategy, I was able to develop coherence and plausibility. Although the external analyses were very similar in content to my own, there were some parts which differed; thus prompting the need for the reflexive exploration that was to come in later stages of analysis. An example of this external analysis (using the actual external analysis of participant 11's transcript) is displayed below in Figure 4.

Figure 4: Example of external analysis

Line	Theme
7	Confusion, lack of confidence
18-22	Anger, needing to be heard
26-28	Fear, suspicion
47-50	Need to feel safe, in control, need to understand
55-59	Suspicion, difficulty in trusting, elements of grandiosity?
85-90	Struggle to accept self and identity – unwanted self/self-rejection
91	Lack of control
102-104	Struggle with own identity
115-117	Emerging self-awareness. Need to be heard/understood
149	Defensive
160-162	Awareness of cultural difference/willingness to accept this

173-177	Cultural assimilation, conflict in understanding
194-198	Struggle to find meaning
204-205	Trying to understand the process
218	Emerging self-awareness
231-235	Intellectualisation
236-238	Need to feel safe / need to trust
262-263	Need to be accepted / feel safe
276	Transference / seeking to combine two cultures/looking for maternal figure
300-301	Mistrust
304-309	Gender bias
314	Mistrust
219-321	Seeking identity/role model
331-333	Seeking acceptance/understanding of self
342	Avoidance/defensive
351-356	Seeking safe ground/intellectualisation
385-389	Inner conflict/anger/pain
404-405	Avoidance of real issues
418	Self-awareness
443-445	Freedom/self-awareness
449	Mistrust
468-470	Self-awareness
478-479	Resistance/avoidance

494-497	Obsession/obsessive self
516	Feeling trapped

Searching for connections across emergent themes

This stage “involves the development of a charting, or mapping, of how the analyst thinks the themes fit together” (Smith, Flowers, & Larkin, 2009, p. 96). In this study, themes were written in chronological order and subsequently moved around to form clusters of related themes. The main strategies utilised in this study to search for connections across themes were ‘abstraction’ and ‘subsumption’. Smith, Flowers, and Larkin (2009, p. 96-97) describe abstraction as a basic form of identifying patterns between emergent themes which involves putting like with like and developing a new name for the cluster (i.e. super-ordinate theme), while subsumption is described as similar to abstraction but operates where an emergent theme (i.e. sub-ordinate theme) itself acquires a super-ordinate status if it helps to bring together a series of related themes. Another strategy that was used to search for connections across emergent themes was ‘contextualization’, which Smith, Flowers, and Larkin (2009, p. 98) describe as a way of looking for connections between emergent themes based on similarities in describing particular cultural narratives and key life events.

Once the process of exploring connections and patterns is completed, the analyst should attempt a graphic representation of the structure of the emergent themes which could be done using any form of visual aid to bring the process together. In the present study, visual aids were used in the later stages of analysis to represent the structure of group themes,

mainly in the form of the schematic tables of themes displayed in Chapter 4 and the master tables of themes displayed in the Appendices (see Appendix 19, 20, and 21). An example of a graphic representation illustrating connections across emergent themes (using the actual analysis of participant 14's transcript) is displayed below in Figure 5.

Figure 5: Example of connections found across themes

Seeking counselling	Exile not Iraq	<ul style="list-style-type: none"> • Racism • Made to feel unwelcome • Discrimination • Outsider • Financial issues • Finding work • Made to feel inferior • Psychological warfare
	Presenting issues	<ul style="list-style-type: none"> • Anger • Depression
Positive counselling experiences	Getting things off my chest	<ul style="list-style-type: none"> • Outlet • Get things off chest
	Counteracting marginalisation	<ul style="list-style-type: none"> • Friend • One of them
	Therapy as helpful	<ul style="list-style-type: none"> • Relief • I made it helpful • Talking is positive
Negative counselling experiences	Therapist microaggressions	<ul style="list-style-type: none"> • Denying racism in society • Client assumed to be violent • Client assumed to be sexist
	Client treated as political opponent	<ul style="list-style-type: none"> • Internalise Swedish norms • Let go of beliefs/traditions
	Therapist as incompetent	<ul style="list-style-type: none"> • Not understanding • Missing the point

Moving across cases

This stage involves moving to the next participant's transcript and repeating all the earlier stages discussed so far. In keeping with IPA's idiographic commitment, the next case is treated on its own terms by bracketing the ideas and themes that emerged from the first analysis as far as possible. But this is not easily done as Smith, Flowers, and Larkin (2009, p. 100) note "you will inevitable be influenced by what you have already found". However in rigorously following the earlier describes stages for each subsequent case/transcript, similar and different new themes will likely emerge. Once analysis for each case is complete, the researcher attempts to find patterns across cases through laying each participant's themes (e.g. Fig. 5 for participant 14) on a large surface and looking across them.

The idea is to try and find connections among the most potent themes, leading the researcher to reconfigure and re-label some themes while abandoning some themes altogether. This particular stage of analysis can be decisive for which themes end up in the final analysis, as the objective here is to arrive at super-ordinate and sub-ordinate themes that capture the shared group experience among participants in each of the three phases of this study. The final result for this process should ideally be represented using some form of graphical representation "showing how themes are nested within super-ordinate themes and illustrating the theme for each participant" (Smith, Flowers, & Larkin, 2009, p. 101) - as displayed in the master tables of themes for each phase of this study (see Appendices 19, 20, and 21).

In this study, the analysis at this stage also made use of the frequency categories recommended by Hill et al. (2005) in displaying the schematic tables of themes in each of the three phases of the study in Chapter 4. In their consensual qualitative research approach, Hill, Thompson, and Williams (1997) initially suggested that frequency labels/categories can be described using the terms ‘general’, ‘typical’, and ‘variant’ - so that ‘general’ is taken to apply to all cases, ‘typical’ to at least half of the cases, and variant to at least two or three, but fewer than half, of the cases. In this study, the more recent recommendations made by Hill et al. (2005, p. 201) were used in which they argued that they:

“now recommend that *general* include all or all but one of the cases, a modification that allows researchers to talk about findings that are true for almost all of the sample (allowing for one outlier). *Typical* would include *more* than half of the cases up to the cutoff for general (given that half does not seem typical). *Variant* would include at least two cases up to the cutoff for Typical”.

As illustrated in the schematic tables of themes in Chapter 4, the structure of super-ordinate and sub-ordinate themes and the frequency categories of sub-ordinate themes are displayed as a visual aid prior to the analysis process in Table 4 (Phase 1), Table 5 (Phase 2), and Table 6 (Phase 3). Although the themes and frequencies are based on my analysis, the influence of my fellow investigators (PhD students and PhD supervisors) was most apparent in the early stages of the analytic process as I was struggling between including themes such as ‘cultural distance’ and ‘awareness of difference’ instead of grouping such experiences under themes like ‘integration difficulties’.

Theme-by-theme narrative

This stage involves the development of a theme-by-theme narrative in which the researcher uses data extracts from interview transcripts and visual aids to explore the group themes arrived at through the earlier discussed stage. In this study, each of the three different phases is analysed in turn. As illustrated in Chapter 4, analysis of each phase begins with a short summary of the results with reference to the relevant master table of themes (Appendices 19, 20, or 21). Then brief descriptions and visual aids are used to present the results of each phase along three sections: 1) description of super-ordinate themes; 2) description of sub-ordinate themes; and 3) schematic table of themes. This is done to provide a macro-level view of the results from each phase which is then followed by the actual micro-level view – the analysis.

The analysis is where the actual analytic theme-by-theme narrative is developed. It is here that the researcher engages in analytic dialogue with each super-ordinate and sub-ordinate theme that emerged in the study. Analysis takes the form of a short explanation of what each super-ordinate and sub-ordinate theme means, followed by the demonstration of how, and how often, each theme applies to participants using extracts from interview transcripts as evidence for the researcher's interpretation. For a complete display of exactly which participants each theme applies to, and how/if it applies to them, master tables of themes are used (see Appendices 19, 20, and 21). For frequency categories and visual structures of themes, schematic tables of themes are displayed in Chapter 4. Analysis is then concluded with a section entitled 'Final reflexive observations' in which I explore how and when my background and actions might have affected the process and outcome of this study.

Validity, reliability, and quality

Since this study uses a qualitative approach, validity was addressed along the same guidelines described by Willig (2001). Willig (2001, p. 16) notes that “Validity can be defined as the extent to which our research describes, measures or explains what it aims to describe, measure or explain”, and goes on to describe how qualitative research methodologies can address validity in three ways: 1) qualitative data collection techniques tend to ensure that participants are free to challenge, and if necessary, correct the researcher’s assumptions about the subject being investigated; 2) qualitative data collection takes place in real-life settings, thus negating the need to extrapolate from an artificial setting; suggesting higher ecological and external validity; and 3) using reflexivity ensures that the researcher continuously reviews his or her role in the research. In addition to utilising these strategies, the present study further addressed validity through the use of external analysis (done by fellow PhD students and PhD supervisors) in order to reduce the bias inherent in a single researcher perspective (e.g. Hill, Thompson, & Williams, 1997).

One of the major requirements of the scientific method is ensuring reliability in research.

As Willig (2001, p. 17) notes,

“a measurement is reliable if it yields the same answer on different occasions...That is, the same data, when collected and analysed by different researchers using the same method, ought to generate the same findings, irrespective of who carried out the research”.

In sharing participants' Iraqi cultural background and refugee experience, I was able to establish rapport and gain access to participants' lived experiences in ways that might not be accessible to, or observable by, researchers with different backgrounds; consequently reliability is considerably limited in the present study. However, Willig (2001, p. 17) notes that "there is disagreement among qualitative researchers about the extent to which reliability ought to be a concern for qualitative research". Sacrificing reliability for the sake of giving voice to Iraqi refugee men is very much in line with postmodernist approaches to research which aim to empower "oppressed minority groups, espousing greater equality and transparency" (Etherington, 2004, p. 26).

Finally, in wanting to ensure the highest possible quality in research, I attempted to adhere to the strategies outlined by Elliot, Fischer, and Rennie (1999) in assessing the quality of the present study. Elliot, Fischer, and Rennie (1999) suggest that assessing the quality of qualitative psychological research should entail, among other things: owning one's perspective (demonstrated mainly in Chapter 1 – 'Autobiographical accounts' and Chapter 3 – 'Epistemological assumptions'); situating the sample (demonstrated in Chapter 3 – 'Participants'); grounding in examples (demonstrated in Chapter 4 in which interview extracts are used to illustrate examples of how themes apply to participants); and providing credibility checks (demonstrated in Chapter 3 through enlisting the help of fellow PhD students and PhD supervisors in 'Data analysis'). In assessing the quality of qualitative psychological research Elliot, Fischer, and Rennie (1999) further suggest addressing: coherence; accomplishing both general and specific research tasks; and resonating with readers – all of which I aim to address in Chapter 4 Chapter 5.

Chapter 4: Results

Having followed the steps outlined in Chapter 3, I arrived at the following results. In Phase 1, Iraqi refugee men expressed feeling disempowered, racially discriminated against, and generally marginalised by Swedish society. Iraqi refugee men in Phase 1 also expressed valuing social support from fellow Iraqis, and described maintaining links to Iraq and Iraqi culture as helpful strategies in dealing with post-migration stress.

In Phase 2, adult male Iraqi refugee ex-counselling clients described several counselling experiences such as: needing counselling as a result of experiencing racism and discrimination in Sweden, not as a result of negative experiences from Iraq and experiencing therapy as helpful and positive in terms of ‘getting things off one’s chest’ and ‘counteracting the experience of marginalisation. Conversely participants in Phase 2 also described negative counselling experiences such as: racial microaggressions in therapy; being treated as political opponents by therapists; being reluctant to disclose ethnic minority-related issues to therapists; experiencing a lack of competence and transparency from therapists; and experiencing therapy as unhelpful.

In Phase 3, mental health professionals described their views on, and experiences of, counselling Iraqi refugee men in terms of issues such as Iraqi refugee male clients’ need to maintain connections to Iraq and fellow Iraqis despite a level of observed distrust among them. Professionals also described Iraqi refugee male clients’ expressed distress as revolving around a loss of status as men, integration difficulties, and the experience of life in Sweden as more distressing than the negative experiences from Iraq. The professionals

in Phase 3 also described PTSD, somatisation of symptoms, and the use of metaphor as recurrent features in counselling Iraqi refugee men. The professionals also commented on what they believed to be their main limitations in working with this client group: difficulties in relating to the client's world view; discomfort in discussing certain cultural material; and limitations to the applicability of therapist transparency with regards to sharing with the client the therapist's theoretical orientation and educational background.

Finally, when professionals in Phase 3 were asked about the type of feedback that they often get from their Iraqi refugee male clients, they described how clients often express the need for help with practical issues and not just talking, even though talking is also often expressed as helpful *per se*. However, in spite of client feedback revolving around the need for practical help and the experience of post-migration stress, professionals in Phase 3 still emphasised pre-migration trauma and the notion of practical help being outside the realm of psychotherapy practice.

The super-ordinate and sub-ordinate themes that reflect these findings will be discussed in the following sections of Chapter 4 through the analysis of each phase in turn. As Smith, Flowers, and Larkin (2009, p. 109) note, the norm is "to take the super-ordinate themes one by one in a logical sequence and write them up in that order". A master table of themes is also displayed for each phase of the study (Appendices 19, 20, and 21), illustrating super-ordinate themes, sub-ordinate themes, and how each sub-ordinate theme applies to each participant (using key words and line numbers from participants' transcripts). In cases where a sub-ordinate theme does not apply to a participant, a "No" was displayed next to the participant number (e.g. P4: No).

Super-ordinate themes for Iraqi refugee men in Phase 1

In phase 1 three super-ordinate themes emerged from the analysis: **A. Support systems** (refers to participants' experiences and views regarding the help and support systems available to them in Sweden); **B. Disempowerment** (refers to participants' feelings of disempowerment in response to perceived oppressive and discriminatory attitudes in Swedish society); and **C. Exile stressors** (refers to participants' experiences of exile-related stressors).

Sub-ordinate themes for Iraqi refugee men in Phase 1

In '**Support systems**' three themes described participants' experiences and views regarding the help and support systems available to them in Sweden: '*Iraqi social support*' (refers to participants valuing social support from fellow Iraqis); '*Maintaining Iraqi culture*' (refers to participants' need to maintain connections with Iraqi culture); and '*Barriers to help seeking*' (refers to participant reluctance to seek professional help). In '**Disempowerment**' two themes described participants' feelings of disempowerment in response to perceived oppressive and discriminatory attitudes in Swedish society: '*Emasculation*' (refers to participants' perceived threat to their sense of manhood in response to certain Swedish cultural norms) and '*Primitive and inferior*' (refers to participants' experiences of being made to feel primitive and inferior in reaction to societal racial discrimination). In '**Exile stressors**' two themes described participants' experiences of exile-related stressors: '*Exclusion and marginalisation*' (refers to participants feeling excluded from and marginalised by Swedish society) and '*Exile worse than pre-migration*' (refers to participants' experience of exile being more distressing than pre-migration experiences).

Schematic table of themes in Phase 1

Super-ordinate themes	Sub-ordinate themes	Frequency
A. Support systems	<i>Iraqi social support</i>	Typical
	<i>Maintaining Iraqi culture</i>	Typical
	<i>Barriers to help seeking</i>	Variant
B. Disempowerment	<i>Emasculation</i>	Typical
	<i>Primitive and inferior</i>	Typical
C. Exile stressors	<i>Exclusion and marginalisation</i>	General
	<i>Exile worse than pre-migration</i>	Typical

Table 4: Structure of themes and frequency categories of the responses from the Iraqi refugee men in Phase 1.

Analysis of Iraqi refugee men's responses in Phase 1

A. Support systems

Iraqi social support

Participants valued social support from fellow Iraqis and repeatedly described it as adaptive and helpful in dealing with problematic and distressing issues in exile. Out of the ten participants, eight expressed views and described experiences that demonstrated this theme.

“when I came to Malmo it got considerably better. I mean there were some negative circumstances of course, but for the most part it was positive, especially the warm relationships with fellow Iraqis” (P2, line 96-98).

“I can always count on my fellow Iraqi friends to be there for me” (P8, line 10).

Social support seems especially important for participants as it has a specific cultural significance that can be traced back to the way participants lived and interacted with other people in Iraq.

“this kind of collective thinking exceeds the family and extends to neighbours [...] this is perhaps one of the most things I long for, or one of the major aspects of life in Sweden that I find disturbing, because I can't seem to find that same level of connection with others that I had in Iraq” (P2, line 23-31).

“in Iraq we do not really have the simple small family but it's all about the

extended family, it's all about the large extended family [...] you are not alone, you are not an individual in that isolated manner, you are part of a family [...] I mean this is a very problematic aspect for me here in Sweden” (P4, line 316-322).

Maintaining Iraqi culture

Participants needed to maintain connections with their Iraqi culture and heritage while in exile. Out of the ten participants, eight expressed views and described experiences that demonstrated this theme.

“for the past 20 years I’ve been here in Sweden, yet I still follow the news every day, every day, and the way that I react to the news, just watching TV and seeing something about Iraq, this responsiveness, this emotional reaction for me, someone who has not been in Iraq for the past 20 years, I think that in itself defines my Iraqi-ness” (P2, line 231-235).

While feeling connected to Iraq can provide a fulfilling sense of continued belonging it can also carry a painful sense of loss and longing for an Iraq that no longer exists.

“Iraq is always my country; it has always been my country and always will be my country. And a big part of this is the pain I continue to feel when I look at what we have become” (P1, line 323-325).

“Sometimes, if I see an Iraqi friend, he might remind me of these aspects and

somehow make me feel this side of my personality. And although this is comforting, it can also be distressing at the same time” (P3, line 488-490).

One of the explanations for this need to maintain Iraqi culture, even after having resided in Sweden for many years, is the experience of rejection from Swedish society.

“I found myself being even more in touch with my Iraqi cultural identity because of the rejection I faced in Sweden. I mean the need for the feeling of belonging was not fulfilled in all these years I have lived in Sweden, I mean even after receiving the actual Swedish citizenship, it’s just something that is formal, on paper, it’s not real [...] I have actually in many ways become much more traditional” (P4, line 128-135).

Barriers to help seeking

Some participants were reluctant to seeking professional help in Sweden. Out of the ten participants, five participants expressed views and described experiences that demonstrated this theme. One of the reasons for this reluctance is the perception that professional help can be ineffective and possibly harmful to mental health.

“I saw it had no effect, it did not give results. And this seemed to be true for quite a few people [...] Some of them even actually seem to have gone crazy, they seem to have become insane because of these issues and the quality of what they received in the form of help did not seem to be efficient enough” (P5, line 393-399).

Another reason given for not seeking counselling and other forms of professional help was having the support of friends in dealing with distressing issues.

“when things really get difficult and I need to talk to let off some steam to basically feel better, I go to my friends” (P8, line 318-319).

The stigma attached to counselling and mental illness in Iraqi culture had also contributed to some participants’ reluctance to seeking professional help.

“You know that in Iraqi culture we tend to view these things negatively” (P9, line 672).

B. Disempowerment

Emasculation

Participants perceived threat to their sense of manhood, or masculinity, in response to certain Swedish cultural norms. Out of the ten participants, eight expressed views and described experiences that demonstrated this theme.

“I really feel sorry for us as Iraqi men, especially we Iraqi men who came from tribal backgrounds from Iraq. I mean we come from a certain status, we come from a certain way of living that is not only undermined but challenged in a very

demeaning way here in Sweden” (P6, line 163-166).

Our ancestors would actually be ashamed of us. If I look at my grandfather, I am no longer truly the grandson of my grandfather in terms of maintaining status and honour in every aspect as an Iraqi man” (P9, line 206-208).

For some participants, this experience seems to involve a sense of mourning over the loss of the traditionally patriarchal role.

“this society has tried continuously to strip me of my role as a man. I mean as a man in Iraq I have a certain status, I demand a certain level of respect from my wife, from my children, now this is not really the case in Sweden. I mean through many different venues society manages to strip me from these rights or from this status” (P6, line 145-148).

While this experience might reflect the cultural distance between a generally feminist society and a traditionally patriarchal one, other explanations do exist. When Iraqi men encounter individuals in Swedish society who seem to convey a sense of wanting to protect and empower the women in the lives of these men, this is experienced as an oppressive attitude - which has more to do with the stereotypical image of the female oppressing Iraqi man than it has to do with gender equality.

“it feels like feminism and racism somehow belong together when you look at how they are applied here” (P4, 536).

Primitive and inferior

Participants experienced being treated as, and/or made to feel, primitive and inferior due to discriminatory and oppressive attitudes in Swedish society. Out of the ten participants, eight expressed views and described experiences that demonstrated this theme.

“the way I have always been treated by Swedes is that I am always expected to be beneath them [...] I am always made to feel or understand that I am not from here and that I should know my place” (P3, line 195-198).

“I do feel inferior, even though I do know in my heart that I should not. I mean how am I to react when the person outside does not want to help me, when my neighbour closes the door in my face? How am I to react towards this racism?” (P6, line 93-96).

For some participants, their reaction to racial discrimination in Swedish society seems to be indicative of an internalisation of some of these stereotypical and racist attitudes.

“Dialogue or different points of view are generally foreign concepts for the Iraqi man [...] there is a great level of tolerating violence, and Iraqi men, with relative ease, apply violence and aggression to hold the family together I mean hitting children, hitting even wives, is not as much of a taboo as it is in Western societies” (P1, line 195-202).

“Iraqis who are living in Sweden nowadays, they are the ones that came from Iraq with a certain attitude towards law, towards actually being psychologically in tune with the concept of cheating, manipulating, and this is a very specific class of Iraqis that has come to Sweden” (P9, line 8-11).

Views suggestive of internalised racism were expressed only by the above mentioned two participants (P1 and P9), yet they both described (as most participants did) being treated as, and/or made to feel, primitive and feel inferior by Swedish society. Only two participants (P2 and P5) did not describe being treated as, or made to feel, primitive or inferior; however they still described experiencing some forms of racial discrimination in Swedish society.

It is worth noting that my interpretation of internalised racism in the accounts of P1 and P9 is partly rooted in my own personal issues with the stereotypical image of the violent, female oppressing, system cheating Iraqi refugee man. While it could be argued that these accounts can be reflective of ‘cultural distance’ and/or can be accounted for in terms of other explanations, my interpretation was that these descriptions, while possibly holding some truth, were more reflective of internalised racism. I address this in further detail towards the end of the analysis under the heading of ‘Reflexive observations – Phase 1’.

C. Exile stressors

Exclusion and marginalisation

Participants felt excluded from and marginalised by Swedish society. All ten participants expressed views and described experiences that demonstrated this theme.

“I am still isolated; I am still socially rejected by Swedes” (P4, line 293).

“although there are people all around me I am often made to feel that I am not really one of them, I am not really part of what’s going around me socially” (P5, line 346-347).

“Unless you are ethnically Swedish and you have Swedish parents you cannot really get into society” (P8, line 94-96).

While this experience of marginalisation might be interpreted as a sign of failure or reluctance to integrate into Swedish society, societal intolerance and rejection were experienced as the main reasons for this sense of exclusion.

“I needed to establish a relationship with native Swedes to understand the culture, to understand the laws, the regulations, and I knew that this was not really possible if I was just to stay within my normal boundaries of talking to Iraqis and fellow immigrants. But I found out that it was not possible. I was always met with rejection from Swedes” (P5, line 39-43).

Exile worse than pre-migration

Participants experienced exile as being more distressing than the negative and potentially traumatic pre-migration experiences in Iraq. Out of the ten participants, seven expressed views and described experiences that demonstrated this theme.

“I clearly remember the bombing. And we survived. I mean when I remember the chaos that I saw in Iraq, even in the process of fleeing from Iraq, all of these experiences don’t seem as bad as what I came to experience later on in these latest years that I have lived here, in Sweden” (P3, line 369-372).

“Well if I was to ask myself if suffering was war or suffering was life in Sweden, I would have to arrive at the conclusion that suffering, true suffering is life in Sweden, in which I am socially made to understand that I am not wanted, that I am disliked, that I am not welcome, I am oppressed, I am alone, I am isolated. And to me, this is suffering, not war, not physical danger” (P8, line 284-288).

Although all ten participants had experienced potentially traumatising events in Iraq, most of them still described experiencing exile-related issues as more distressing. One participant even compares his life in Sweden to the likely death he might have encountered in Iraq only to arrive at the conclusion that death in Iraq would have been more humane.

“it is more humane to die in a fast manner as opposed to a more lengthy and painful death [...] In Iraq if I die I will die once, if I end up surviving I can go back to my old life. In Sweden I die many deaths” (P9, line 643-648).

Reflexive Observations – Phase 1

In Phase 1, I had made up my mind to recruit participants in the later stages of exile so as to explore their specific experiences of what I came to understand as exile-related stressors as a consequence of the literature that I had read (covered in the ‘Literature review’ in Chapter 2) and as a result of my own personal and professional experiences of Iraqi refugee post-migration stress in Sweden (covered in the ‘Autobiographical accounts’ in Chapter 1). However, I was unfortunate enough in the beginning to have interviewed two Iraqi male refugees who had both lived in Sweden for more than 20 years, yet still described being distressed by their traumatic experiences from Iraq (P1, line 284-287 and P2, line 559-561).

Consequently, I was hesitant to move forward with my focus on post-migration stress. I was also suddenly aware of the fact that my own personal pre-migration experiences were very mild compared to many fellow Iraqis as I had experienced bombing in Iraq and witnessed acts of violence, but was never imprisoned or tortured as so many Iraqis have been. However, as Iraqi men who had lived in Sweden for at least five years began to describe their experiences of both pre-migration and post-migration, my approach to the research question began to shift towards an inclusive account of all that was perceived to be relevant and important for Iraqi refugee men in their current lives in Sweden; thus giving rise to many interesting accounts in which participants compared their distress in exile to their distress from the negative experiences in Iraq. The major influence that this early encounter with P1 and P2 had on me was that I became even more respectful of, and sensitive to, the fact that for some participants the traumatic experiences they experienced in Iraq were always going to be a major source of their distress.

Another challenging point in Phase 1 of this study was when I first encountered attitudes from Iraqi refugee participants (P1, line 192-202 and P9, line 578-580) that were suggestive of internalised racism and cultural shame; exactly as I had read and covered in Chapter 2 under the heading of ‘Racial discrimination’ and similar to the internalised racism that my own Iraqi refugee clients sometimes exhibit in therapy (Al-Roubaiy, 2012b). However, this time encountering what I perceived to be reflective of internalised racism was difficult, as I was not in a position to respond as I would normally do as an Iraqi or as a counselling professional. As a researcher I had to encourage participants to express themselves freely while limiting my influence on what was being said and how it was communicated. However, these accounts were so unsettling for me that I did not further probe the subject. Of course I did not explicitly communicate feeling this way to the participants who expressed these views - instead I simply changed my line of questioning and avoided further exploration of the subject. Although my own discomfort (in not being able to deal with these issues in this context) has limited the exploration of this experience, I still attempted to incorporate it in the analysis as part of the *‘Primitive and inferior’* subordinate theme.

However, feedback from my PhD supervisors brought to my attention that parts of these accounts can be reflective of a ‘cultural distance’ theme and not necessarily reflective of internalised racism. Although this observation is valid as an alternative interpretation, I ultimately did not include ‘cultural distance’ as a separate theme partly because I felt that my interpretation is also valid, and partly because cultural distance is more than implied in most of the accounts reported in the super-ordinate theme of **‘Support systems’**.

Super-ordinate themes for counselling clients in Phase 2

In Phase 2 three super-ordinate themes emerged from the analysis: **A. Seeking counselling** (refers to participants' reasons for seeking counselling); **B. Positive counselling experiences** (refers to participants' main positive counselling experiences); and **C. Negative counselling experiences** (refers to participants' main negative counselling experiences).

Sub-ordinate themes for counselling clients in Phase 2

In '**Seeking counselling**' two themes described participants' reasons for seeking counselling: '*Exile not Iraq*' (refers to participants' accounts of needing counselling as a result of experiencing racism and discrimination in Sweden, not as a result of negative experience from Iraq) and '*Presenting issues*' (refers to participants' descriptions of the mental health difficulties they brought to therapy).

In '**Positive counselling experiences**' three themes described participants' main positive counselling experiences: '*Getting things off my chest*' (refers to the perceived benefit of simply verbalising one's thoughts and feelings); '*Counteracting marginalisation*' (refers to participants' experience of therapy with Swedish therapists as a unique opportunity to transcend the feeling of marginalisation in interacting with and being acknowledged by an ethnic Swede); and '*Therapy as helpful*' (refers to participants' experiences of how therapy was helpful).

In **‘Negative counselling experiences’** six themes described participants’ main negative counselling experiences: **‘Therapist microaggressions’** (refers to participants’ experiences of racial microaggressions in therapy); **‘Client as political opponent’** (refers to participants’ experiences of therapists forcing their political ideologies on them); **‘Client reluctance to disclose’** (refers to participants’ accounts of not discussing issues pertaining to their ethnic minority status in therapy due to the perception that Swedish therapists would not understand or empathise); **‘Therapist as incompetent’** (refers to participants’ experiences of therapists as incompetent); **‘Lack of therapist transparency’** (refers to the recurrent counselling experience of participants not being informed of therapist education, orientation in therapy, and treatment structure and goals); and **‘Therapy as unhelpful’** (refers to participants’ experiences of not being helped by therapy).

Schematic table of themes in Phase 2

Super-ordinate themes	Sub-ordinate themes	Frequency
A. Seeking counselling	<i>Exile not Iraq</i>	Typical
	<i>Presenting issues</i>	General
B. Positive counselling experiences	<i>Getting things off my chest</i>	Variant
	<i>Counteracting marginalisation</i>	Typical
	<i>Therapy as helpful</i>	Typical
C. Negative counselling experiences	<i>Therapist microaggressions</i>	Typical
	<i>Client as political opponent</i>	Typical
	<i>Client reluctance to disclose</i>	Typical
	<i>Therapist as incompetent</i>	Typical
	<i>Lack of therapist transparency</i>	General
	<i>Therapy as unhelpful</i>	Variant

Table 5: Structure of themes and frequency categories of the responses from the adult male Iraqi refugee ex-counselling clients in Phase 2.

Analysis of counselling clients' responses in Phase 2

A. Seeking counselling

Exile not Iraq

Participants claimed to need counselling as a result of experiencing racism and discrimination in Sweden, not as a result of their negative experiences in Iraq. Out of the ten participants, seven expressed views and described experiences that demonstrated this theme.

“I mean the depression, the cold weather, the snow and the racism, the lack of respect for immigrants, Iraqi immigrants as well as other immigrants and this negative view of us. I mean a simple thing like going to the shops [...] although you would get the help but they still manage to somehow make you feel unwelcome” (P14, line 55-60).

“What I had experienced in Iraq was nothing compared to what I have come to experience in Sweden. Even the horrible experiences from Iraq cannot compare to the horrible experiences I have had here in Sweden. Here, it tastes bitter. I mean I am hit and beaten here psychologically” (P19, line 481-484).

One participant had actually been pressured to seek counselling after he got into a fight at school:

“I got into a physical fight with two Swedish boys. These boys at the school actually

accused me of stealing a mobile phone, which of course I did not do, so somehow we ended up exchanging blows and this turned into a big problem between us. Afterwards the police were contacted and there was a trial, but before the actual trial I was actually asked to attend counselling sessions with a counsellor or maybe psychologist” (P20, line 3-9).

Later in the interview, this same participant reflects on how he experiences his problems in exile as difficult to identify and more distressing than what he had experienced in Iraq:

“in our country the suffering is tangible, it’s clear, you know where it is coming from. But the suffering here is hidden, it’s hard to pinpoint, it’s in their hearts, it’s in the way they tend to backstab and hurt and somehow scheme to cause the suffering” (P20, line 475-479).

Presenting issues

Participants described the mental health difficulties they brought to therapy. All ten participants displayed this theme as they described their presenting issues in terms of pre-migration and post-migration distress –with the use of metaphor and psychological terms.

Some participants referred to their psychological states in formulating the issues that brought them to therapy, as one participants spoke of being *“psychologically disturbed”* (P11, line 3), while another spoke of being *“psychologically under stress”* (P13, line 4).

Other descriptions included the use of metaphor and reference to exile-related stressors.

“mostly it was about my financial situation at the time. I mean when someone struggles financially it kind of gives you the feeling of being choked somehow, it was suffocating, and that led to some serious distress for me at the time [...]angry most of the time, frustrated [...] psychological pressure, feelings of being choked somehow, and the only option that was available is this professional doctor to help me talk and maybe get some of these things off my chest” (P14, line 40-50).

“I was upset. I was stressed out, depressed. I had this feeling that would not let go, of having some kind of rock or big object lying on my chest” (P16, line 8-9).

For others, it was the classical PTSD symptoms from pre-migration trauma, as one participant explains:

“I sought counselling because I was feeling very troubled by some of what I had seen in Iraq. I had nightmares, I had visions, I used to see what happened in our neighbourhood [...] even if I am talking to other people in a coffee shop I suddenly remember the torture that I had experienced when I was imprisoned” (P17, line 3-8).

It is worth noting that out of the ten participants four (P11, P14, P16, and P19) had sought counselling themselves as opposed to being referred for it as most participants were.

B. Positive counselling experiences

Getting things off my chest

Participants appreciated the benefit of being able to verbalise their thoughts and feelings in counselling. Out of the ten participants, five expressed views and described experiences that demonstrated this theme.

“Yes generally helpful, at least I know there is somewhere to go when I get these feelings again, when I need to talk to someone regarding these issues I have somewhere to go basically” (P11, line 395-397).

It was a relief to get some of these things off my chest” (P17, line 582-584).

Although participants expressed generally feeling better as a consequence of talking in therapy, one participant stood out in terms of his attempt to formulate exactly what it is that was helpful in talking about his inner thoughts and feelings:

“by talking about my own thoughts I was somehow more able to organise them. I mean emotionally I felt better by simply letting out all of these thoughts, talking about all of these feelings. And after talking about them, somehow getting access to them and being able to re-organise my thoughts in a way that made me feel better” (P14, line 606-609).

Counteracting marginalisation

Participants experienced therapy with Swedish therapists as a unique opportunity to transcend the feeling of marginalisation. It was important to interact with, and be acknowledged by, the Swedish therapists. Out of the ten participants, six expressed views and described experiences that demonstrated this theme.

“it really felt like I was seeing yet another person from this elite, but this time I was paying this person, she actually had to sit there and listen to me talk about my problems, she could not just simply sign a paper and change my life, I got to say something, I got to express myself. That was one aspect that was beneficial [...] if I had not paid someone like her to talk to me, I don’t think someone like her would choose to talk to me outside of this type of relationship” (P16, line 294-300).

“it was just nice to be able to practice my Swedish. I haven’t had anyone to speak to, not Swedish at least. I mean I speak with my parents, I speak with my sister, but we don’t speak Swedish obviously. So just having a Swedish person to speak to was, I guess, good for me to feel more comfortable speaking the language. I think I speak better Swedish as a result” (p17, line 596-600).

The extracts used above demonstrate how participants viewed establishing relationships with Swedes as difficult to achieve, and how the opportunity to interact with a Swede is experienced as a rare and valuable opportunity. Underneath the surface, there is this view of the Swedish therapist as being part of the elite in society and as some kind of gate keeper to entering Swedish society.

This view of the therapist being part of the elite in Swedish society seemed to give rise to a feeling of hostility towards the therapist because of his or her perceived belonging to this elite group. Also, in being marginalised and controlled by members of this elite group, participants expressed valuing this rare encounter in which they finally had some sense of control and influence in the relationship.

I got to talk about what was troubling me. I got to influence a relationship with a Swede. I got to experience some sense of power and status which I had not experienced in the last 12 years of my life here in Sweden. I finally got to say something without having to worry or fear the consequences. I could understand that this place was about my problems, this whole setting was about solving my problems, and she had to help me and treat me like a human being whether she liked it or not” (P16, line 402-407).

“I needed to talk to someone, and in talking to a Swedish man I thought I would somehow get closer to this society, understand them better. I mean to me he was my way in. Where else am I going to find a Swedish person who is willing to talk to me? Not that they are worth talking to. I mean the dialogue is a joke, it’s one-sided, it’s like talking to a wall, and I’m sure it’s not my language. I speak good enough Swedish considering the fact I’ve only been here for 7 years (P19, line 279-286).

Therapy as helpful

Participants experienced how and why therapy was helpful. Out of the ten participants, six expressed views and described experiences that demonstrated this theme.

“Psychotherapy for me has been about getting tools. I have received tools to better understand myself and solve my problems” (P11, line 362-364).

For some participants, counselling was experienced as helpful specifically in terms of symptom relief.

“I was getting much better. It felt like I was somehow more comfortable with some of the breathing difficulties” (P16, line 429-430).

“I suppose it was nice and helpful in that I’m not as angry as I was. I was angry almost the whole time” (P18, line 408-410).

For one participant, counselling was experienced as helpful specifically because the therapist had helped the client in applying for financial aid. This form of practical help was unique as it was the only example of advocacy-based counselling to be experienced by a participant in the study.

“She helped me with the financial situation [...] she took it upon herself to even guide me in that respect. And that meant a lot to me [...] she was simply there to help in any way possible” (P15, line 149-153).

C. Negative counselling experiences

Therapist microaggressions

Participants described what may be understood as racial microaggressions (verbal and nonverbal communications conveying insensitivity, neglect, and/or disrespect regarding their cultural heritage) from therapists. Out of the ten participants, six expressed views and described experiences that demonstrated this theme.

“all the time with my psychologist I kept trying to talk about specific issues, and for some reason she used to always somehow steer us back to the point of my relationship with my girlfriend, specifically fearing that I might end up hurting my girlfriend, or hitting her, or behaving violently towards her. And I could actually tell that she seemed to think that we are accustomed to hitting our women” (P14, line 88-92).

Although the psychologist, described in the above extract, seems to be simply concerned for the safety of the client’s girlfriend as a consequence of having understood that the client might have violent tendencies, the insistence on cautioning the client from acting in an aggressive or violent manner towards his girlfriend was interpreted by the client/participant as a form of racism.

For some participants, their experience of racial microaggressions from therapists was upsetting yet not due to the nature of the assault being racist, but rather that the racism implied in the microaggression was perceived as unjust – due to their belonging to a group

of Iraqis that did not deserve this negative stereotypical view. The implied message was that the other group of Iraqis deserved being viewed in this negative and stereotypical manner:

“asking if my mother had a veil on and if my mother and father were arguing in a way that always led to my mother being oppressed [...] I told him that you are asking me these things because you have seen the Shia Iraqis that you have here [...] I am a Sunni Muslim and I am actually from what Iraq used to be at one point in time, I am from the civilised Iraq” (P19, line 127-134).

For some participants, their experiences of racial microaggressions in therapy were in the form of clear racist views from therapists implied in their line of questioning:

“He had already lectured me about women and how they are liberated. He had already asked about my sisters and the liberties that they perhaps don’t have, or how oppressed my mother might have been. Mind you, all of this was in the form of questions, but his questions were more like he was telling me how my family was probably living in all likelihood, as if he already knew how we treated each other as a family” (P19, line 405-410).

In the above extract, the participant was initially lectured about women’s rights before being asked about the likelihood of his mother and sisters being oppressed in his family, displaying a blatantly racist view of the client and his cultural background. For other participants, the racial microaggression was arguably of a much more subtle nature:

“in exploring my war experiences and where I came from we could understand why I have such violent tendencies or why we who come from other countries that are war ridden might have this kind of capacity for violence [...] this is how she explained her line of questioning about war experiences and Iraq” (P20, line 62-65).

Client as political opponent

Participants experienced therapists as forcing their political ideologies on them in therapy. Out of the ten participants, six expressed views and described experiences that demonstrated this theme.

“he said I should forget my heritage, I should forget my norms and traditions from the Arab and Iraqi culture because we are here in Sweden and that this is where I should be and this is what I need to be taking on board basically. And to me it’s impossible to forget my childhood, my upbringing, the way I remember myself in Iraq. I mean it’s impossible to just simply forget and simply throw away this big part of who I am. I don’t want to do that, it’s impossible to do that” (P12, line 409-414).

“she didn’t acknowledge that these situations were indicators of racism or racist attitudes. She used to actually get upset and tense when I used to interpret these situations as a clear indication of racist attitudes. She would say that these situations were more about my inability to adapt and understand these Western and

European ways of behaving and interacting in society. She specifically said that the day I truly adapt and internalise these Swedish norms is the day when I will be met with respect in every situation” (P14, line 505-510).

The above two extracts demonstrate how therapists can pressure clients into taking on their political views, which in the above two extracts seem to suggest racist and xenophobic political views in which immigrants are pressured to assimilate into Swedish society rather than integrate. Other situations in which clients have been treated as political opponents seemed to revolve mainly around the issue of women’s rights and gender equality in Sweden.

“it was always about the woman, my girlfriend, other women, and this lecturing about women and men being the same and equal, and they have the same rights and the same freedoms in here [...] how was this relevant to what I was discussing [...] I had lived in Sweden for quite some time and understood these things. Why was I being lectured about these things?” (P14, line 435-441).

“the issues she wanted to cover were regarding women’s rights. I mean she spoke quite a bit about the rights that Swedish women have [...] whereas in Iraq the situation might not be the same [...] it is not really why I was there. My situation had not much to do with this. I mean we seemed to be talking, say for 15 minutes, about my actual problem and my situation, and somehow ended up talking for half an hour about women’s rights” (P20, line 176-189).

As demonstrated by the above two extracts, clients/participants experienced being lectured about women's rights and gender equality in Sweden as unnecessary and irrelevant to their present difficulties and reasons for seeking counselling. For some participants, being treated as political opponents by their therapists with regards to gender equality in Swedish society led to a clash of political ideologies in therapy, as demonstrated by one participant's account:

"I mean asking about my sisters and asking if I can accept Swedish women and their liberties and freedom and accept my proper place in society as a man, which I understand as simply being a castrated submissive man which he actually protested to and wanted to even lecture me about what equality truly means" (P19, line 177-182).

Client reluctance to disclose

Participants were reluctant to discuss issues pertaining to their ethnic minority status in therapy, believing that Swedish therapists would not understand or empathise. Out of the ten participants, eight expressed views and described experiences that demonstrated this theme.

"Since she was Swedish I had to know what to avoid basically. I mean I could not really tell her everything I was thinking" (P11, line 339-340).

"This psychologist was there to help me, to listen to my problems, but still I was

pretty careful not to express much of this. I did not really feel it was appropriate [...] Well think about it, how much can she really understand if I was to say that these issues upset me?” (P16, line 381-388).

“I did not talk about all the issues that were troubling me [...] even if I had the language skills to communicate these issues I’m not sure how much of these issues the psychologist would be able to understand as a Swede [...] I had to hold back. [...] there was continuously this distance that was obviously there. So I did not really talk about everything” (P14, line 113-122).

For some participants, it was their sense of the therapist harbouring racist attitudes towards them that specifically led them to avoid discussing issues pertaining to their ethnic minority status since therapists were seen as part of the problem, and therefore unlikely to empathise.

“I could tell that she viewed immigrants, probably specifically Muslims, as oppressive towards their women [...] I did not really talk about this with her but I could sense this view. [...] I specifically felt that she viewed Muslims as fundamentalists [...] it’s just something that I felt through the line of questioning she was using quite often in our sessions” (P14, line 216-223).

“I held back, specifically because I felt she would not understand. And if she did understand somehow, miraculously, she would not care” (P16, line 422-423).

Therapist as incompetent

Participants experienced their therapists as being incompetent. Out of the ten participants, six expressed views and described experiences that demonstrated this theme.

“I felt that perhaps as a psychologist she would be well prepared and probably good at her job with Swedish clients, but I did not feel that she could relate to me or understand me. [...] Perhaps an immigrant psychologist would have been able to attend to my problems as I experienced them” (P14, line 192-199).

“I noticed that she behaved towards me as if I was not being cooperative enough, or as if I wanted to somehow escape the issue or avoid talking about my problems. But I really believe she was missing the point” (P17, line 296-298).

“It was of such low quality I am convinced that he is not a very popular psychologist. I have a very difficult time believing that this is what psychology or counselling is about” (P19, line 75-77).

The above three extracts suggest a view of therapists as incapable of understanding their clients or relating to them. Even though part of the problem might lie in language and interpretation, even using interpreters has its share of problems as one participant explained:

“She actually used an interpreter for a few of our sessions, but I got really upset with him, he was a very strange and annoying little man and I really felt like doing

something about it. [...] I then asked to do it with my own limited Swedish language and I had my dictionary with me, and every time I wanted to say something I would look up the word in Swedish and point to it [...] it seemed to work for me because I got to say what I wanted to say. How much of what I had to say she understood or could relate to, that's something else" (P17, line 488-496).

For some participants this experience of not being understood by therapists was clearly linked to therapists' lack of cultural competency in that they did not seem capable of understanding, or even attempting to understand clients' difficulties with regards to cultural issues and ethnic minority status.

"she had made up her mind from the way we are usually shown on TV as Arab or Muslim men, as basically being female oppressors. [...] she did not really come across as someone who knew much about our culture, she just simply seemed to have this negative view" (P14, line 550-556).

"the whole time I was waiting for this magical intervention to come. I mean even with his horrible comments, I was actually waiting for his education to come through, I was waiting for his professional expertise to show somewhere. I could not believe that that was it, asking about Iraq or what I had experienced or what violence I might have seen" (P19, line 429-433).

Lack of therapist transparency

This theme refers to the recurrent experience of clients not being informed of their therapists' educational backgrounds, orientation in therapy, and/or treatment structure. All ten participants expressed views and described experiences that demonstrated this theme. In the following extract one participant describes not being collaboratively engaged in the process of therapy:

“he just simply asked his questions and when he did not get the answer that he wanted he simply actually asked the same question in a different manner [...] I could also see him just writing and asking, and I was not really part of this, I was not let in on what was happening” (P12, line 710-714).

Although this situation can be encountered by Western clients in different countries, it can be particularly disempowering for clients who are already at a disadvantage in being members of an ethnic minority group. Similarly, another participant describes having learned that counselling can be done by different professionals and using different methods, but not from his therapist and not while in therapy:

“I did not know much, but after a year of going to her I actually found out from other people that people who do counselling can have different professional categories, they can have different educational backgrounds. This idea about using different methods or approaches to different types of disturbances, I mean all of these things I actually learned afterwards towards the end of my counselling with her. But she did not explain any of this to me” (P14, line 287-292).

Therapy as unhelpful

Participants experienced not being helped by therapy. Out of the ten participants, five expressed views and described experiences that demonstrated this theme.

“Actually, if anything, this experience could have potentially harmed me and harmed my future, it could have destroyed me had I gone on to do more sessions with this person” (P12, line 462-464).

“I had hoped to get support, to get help, to get perhaps some solution to my problems and help maybe with this aggression or tension that I was feeling. But that did not really happen. I mean so I was truly let down, I mean I had big hopes for the counselling that I sought” (P14, line 105-108).

“I waited and waited for this magical intervention that never came. By session 19 or 20 I knew that it was not coming, it was never going to come, so I cut my losses and told him I would never come back” (P19, line 435-438)...“I am not sure there was a counselling process. I mean it is horrible, it would be astonishing to me if what we did was really counselling or therapy of any form. I believe this person is a fake, whatever he did with me was not counselling. If it is, then I believe this whole profession is a joke. I really doubt what he did was proper psychotherapy, because if it was there should be no psychotherapy, if what he did was really psychotherapy then perhaps these people should not be working with people in need, they should not be doing this” (P19, line 456-461).

Reflexive observations – Phase 2

In Phase 2, I came into contact with the Iraqi cultural stigmatisation of mental illness and counselling early on in the study. To start with, it was very difficult to recruit participants for this phase as the information sheet clearly described the research interest as being the counselling experiences of ex-clients who are also Iraqi refugee men who have lived in Sweden for at least five years. At first I thought that the my criteria were too specific for this phase in that I wanted the inclusion criteria to include all Phase 1 aspects in addition to having experienced some form of counselling. But as time went by, and I had an informal chat with one of the earliest founding members of the Iraqi cultural association in Malmo (where I recruited the Iraqi refugee men for Phase 1 and Phase 2), I came to the realisation that I had underestimated the level of stigma attached to this phase of my study. In Phase 1 there were no such concerns or difficulty in recruiting participants as the research interest was clearly on exploring the psychosocial experiences of Iraqi refugee men in the later stages of exile in Sweden and the helping systems available to them, with no mention of counselling or psychological therapy, or any other such term.

This cultural stigma was largely responsible for my eventual decision to recruit some participants for Phase 2 from the original sample in Phase 1 – from participants who described having been in counselling in discussing the help and support systems available to Iraqi refugee men in Sweden (3 people). I eventually recruited 7 new participants for Phase 2. In discussing the counselling experiences of adult male Iraqi refugee ex-counselling clients in Phase 2, the cultural stigma attached to mental illness and counselling in Iraqi culture was expressed by one participant (P16, line 80-84).

In further discussing the cultural stigma attached to mental illness and counselling in Iraqi culture, an interesting and novel view was expressed by this same participant as he described a new feature of this stigma not previously covered in literature that I had read or in accounts I recognised from my own personal and professional contact with Iraqi refugee men. Basically the view that among Iraqi men, someone who is labelled insane for seeking counselling is also perceived as weak and vulnerable, thereby becoming an easy target for ridicule (P16, line 185-201). Although this particular experience might be unique to this participant, it does touch on familiar notions of masculinity, Iraqi gender roles, and militarised Iraqi masculinity.

Similar accounts, in which masculine ways of dealing with distress and Iraqi gender role expectations came together, were expressed in some participants' trivialisation of pre-migration war and torture experiences (P17, line 179-182 and P18, line 161-164). This trivialisation was expressed in terms of pre-migration trauma symptoms being a natural and normal part of life which only Swedes tend to make an issue out of. Similarly, one participant used humour in reflecting on his experiences of war, imprisonment, and torture in Iraq – including seeing the humour in the manner he was beaten in prison (P17, line 158-168). This attitude was certainly something that I had often encountered in counselling Iraqi refugee men, and although it came up briefly in these two participants' accounts I was unsure about including it as a theme in the analysis. Ultimately, I did not due to my own indecisiveness as to whether such a theme would be reflective of alternative ways of coping and resilience, or limited emotional responsiveness and tolerance of violence.

Two other issues that came up in the interviews that I ultimately chose not to include as

separate themes in the analysis: therapists' views of how Iraqi men treat their women, and the use of interpreters. The Iraqi refugee male ex-counselling clients in Phase 2 repeatedly described encountering a view from their therapists that tended to reflect a stereotypical image of the Iraqi male client as a female oppressor. While this view is certainly relevant for understanding how Swedish therapists can view their Iraqi refugee clients, I felt that it would be more of an observation rather than a theme which can provide insight into how the Iraqi clients experienced encountering this view. Insight into the client experience of this view among Swedish therapists was, to me, best described as part of the experiences reported in the sub-ordinate themes of *Therapist microaggressions* and *'Client as political opponent'*.

As for the use of interpreters in therapy, the one account that did address the issue was expressed by a participant as part of the whole negative experience of counselling because he was upset with that particular interpreter (P17, line 488-496). While the issue of interpreters in counselling did come up in another participant account, it was more about not being offered the use of an interpreter even after having expressed the need for having one present (P13, line 30-39). Therefore, while the issue of using interpreters is obviously relevant to counselling Iraqi refugee clients, participant accounts in Phase 2 did not give much of an indication of whether this was necessarily a good or bad part of the counselling experience.

Super-ordinate themes for professionals in Phase 3

In Phase 3 five super-ordinate themes emerged from the analysis: **A. Client connection to Iraq and Iraqis** (refers to the professionals' experience of male Iraqi clients' need for contact with fellow Iraqi men and their need for maintaining links with Iraqi culture, yet at the same time noting a level of distrust in the manner of seeking and establishing these relationships); **B. Client experiences of exile** (refers to the professionals' experience of Iraqi male clients expressing distress in therapy due to exile-related stressors); **C. Therapist observations on client difficulties** (refers to the professionals' views regarding PTSD, somatisation of symptoms, and the use of metaphors being recurrent features in counselling Iraqi refugee men); **D. Therapist limitations** (refers to the limitations expressed and experienced by therapists in working with Iraqi refugee men); and **E. Client feedback regarding therapy** (refers to the professionals' conflicting experiences of Iraqi male clients on the one hand expressing the need for help with practical issues not just talk, while on the other hand expressing an appreciation for simply talking about their problems and finding it helpful).

Sub-ordinate themes for professionals in Phase 3

In '**Client connection to Iraq and Iraqis**' two themes described participants' experience of Iraqi clients' need to maintain connections to Iraq and fellow Iraqis: '***Social support versus distrust***' (refers to the professionals' experience of male Iraqi clients needing and valuing contact with fellow Iraqi men yet at the same time displaying considerable distrust) and '***Connection to Iraq***' (refers to the professionals' observation of Iraqi male clients' need for maintaining a sense of being Iraqi and being connected to Iraq). In '**Client**

experiences of exile' three themes described participants' experiences of Iraqi clients' expressed distress in reaction to exile-related stressors: ***'Loss of status'*** (refers to the professionals' experience of Iraqi male clients expressing distress in therapy due to having lost their status as men in Swedish society); ***'Integration difficulties'*** (refers to the professionals' observation of Iraqi male clients struggling with acculturation processes in Swedish society); and ***'Exile trauma not Iraqi trauma'*** (refers to the professionals' experience of Iraqi male clients' accounts of negative aspects of life in Sweden being more distressing than negative experiences from Iraq).

In ***'Therapist observations on client difficulties'*** three themes described participants' views regarding PTSD, somatisation of symptoms, and the use of metaphors being recurrent features in counselling Iraqi refugee men: ***'Emphasising pre-migration trauma'*** (refers to participants' view regarding PTSD and related negative pre-migration experiences being the main difficulties Iraqi refugee men bring to therapy); ***'Somatisation of symptoms'*** (refers to participants' experience of Iraqi male clients expressing their mental health difficulties as physical complaints); and ***'Using metaphor'*** (refers to participants' experience of Iraqi male clients using metaphors to describe their thoughts and feelings).

In ***'Therapist limitations'*** three themes described the limitations expressed and experienced by therapists in working with Iraqi refugee men: ***'Difficulty in relating to client's worldview'*** (refers to participants' experiences of difficulties in relating to Iraqi clients' world view); ***'Therapist discomfort'*** (refers to participants' experiences of discomfort in discussing certain issues with their Iraqi clients); and ***'Limited therapist***

transparency’ (refers to participants’ experiences of limitations to the applicability of therapist transparency with Iraqi clients in terms of educational background and theoretical orientation in therapy). In ‘**Client feedback regarding therapy**’ two themes described participants’ experiences of feedback expressed by Iraqi refugee male clients regarding their experience of therapy: ‘*Needing practical help*’ (refers to participants’ experience of Iraqi male clients expressing the need for help with practical issues and not just talk) and ‘*It helps to talk*’ (refers to participants’ experience of Iraqi male clients expressing finding talking about their problems in therapy to be helpful).

Schematic table of themes in Phase 3

Super-ordinate themes	Sub-ordinate themes	Frequency
A. Client connection to Iraq and Iraqis	<i>Social support versus distrust</i>	General
	<i>Connection to Iraq</i>	Variant
B. Client experiences of exile	<i>Loss of status</i>	General
	<i>Integration difficulties</i>	Typical
	<i>Exile trauma not Iraqi trauma</i>	Typical
C. Therapist observations on client difficulties	<i>Emphasising pre-migration trauma</i>	Typical
	<i>Somatisation of symptoms</i>	Typical
	<i>Using metaphor</i>	Variant

D. Therapist limitations	<i>Difficulty in relating to client's worldview</i>	Typical
	<i>Therapist discomfort</i>	Variant
	<i>Limited therapist transparency</i>	Variant
E. Client feedback regarding therapy	<i>Needing practical help</i>	Variant
	<i>It helps to talk</i>	Typical

Table 6: Structure of themes and frequency categories of the responses from the mental health professionals in Phase 3.

Analysis of professionals' responses in Phase 3

A. Client connection to Iraq and Iraqis

Social support versus distrust

The professionals experienced male Iraqi clients as needing and valuing contact with fellow Iraqi men yet at the same time displaying considerable distrust (there are similarities here to the Phase 1 theme of *'Iraqi social support'*). It should be noted that, although participants in both focus groups described their Iraqi refugee clients as needing and valuing social support from fellow Iraqis, Iraqis' distrust of one another was only expressed by participants in the first focus group. Out of the eight participants in the focus group interviews, four referred to the issue of distrust in addition to the need for social support (all were members of the first focus group, namely P21, P22, P23, and P24). Three described the valuing and needing of social support among Iraqi refugee men with no mention of distrust being part of this experience (members of the second focus group, P25, P26, and P27), and only one participant (P28) expressed none of these themes.

"Iraqi men seem to speak mostly about the relationships with their family, but when speaking about relationships outside of the family they seem to discuss or experience a certain difficulty in establishing relationships or making friends. There is specifically a type of mistrust of others, of other men, that Iraqi refugee men seem to display. And because of this, from the experiences I've had, Iraqi men express feeling a need of contact, specifically even from other Iraqis. And they actively seek this contact, yet with a certain level of anxious mistrust, or this kind of reserve, with the intention of simply trying to maintain relationships at a somewhat safe distance,

yet still needing these relationships with other Iraqi men” (P21, line 7-4).

“Clearly, relationships between Iraqi men in these groups that we have been working with demonstrate how this is important to them, but what is clear also is that there is a certain level of distance, a certain level of anxiety in the air, some kind of tension, and once this somehow fades away with getting to know each other, with getting a bit more intimate in the group sessions, they tend to express valuing these relationships” (P22, line 21-25).

“most of my Iraqi clients, Iraqi male clients, have expressed the value of maintaining social relationships, the importance of the social networks specifically with other Iraqis. I mean I often get a sense that most of my clients know all, or most of the other Iraqis living in Sweden, which is of course not realistic, but you do get the sense of this strong connection, that most know of each other or somehow have some links. And this is expressed in the manner they emphasise the value of maintaining relationships with each other” (P26, line 42-47).

“I also think it’s a question of having recently arrived, and in the early stages most Iraqi men do express this idealised picture of wanting to be part of society and being able to somehow function eventually. But after a while, once they do settle in more segregated heavily refugee populated areas like Rosengård, they do express feeling safer in being able to live closer to other Iraqis, the need for wanting to maintain this connection with fellow Iraqis” (P27, line 31-35).

Connection to Iraq

The professionals referred to their Iraqi male clients as needing to maintain a sense of being Iraqi and being connected to Iraq (there are similarities here to the Phase 1 theme of ***‘Maintaining Iraqi culture’***). Only three participants (P21, P26, and P27) expressed views and described experiences that demonstrated this theme.

“There’s a sense of pride that does come up when speaking of Iraqi culture and Iraq, and Iraqis do seem to express this with pride, that “we as Iraqis feel and think this way”, that Iraq has an ancient history and that clients are actually happy to even tell of this past ancient history of Iraq. Then again, the negative also comes up and the clients do tell of what it has been to live under the circumstances they’ve had to endure” (P21, line 96-101).

“I had an Iraqi male client who expressed the need to have to leave often to Iraq, to have to travel to Iraq to fill up somehow, to get this kind of charging of the batteries [...] for this client it seemed to be vital to his existence here in Sweden to have this opportunity to be able to travel often to Iraq. And in terms of getting something out of it in terms of culture or religion, it didn’t seem possible for this client to get these feelings here in Sweden. So the necessity of maintaining this connection with Iraq was a big part of what he brought to therapy. I mean the idea of maintaining his roots and getting this charge that will help him deal with all the possible issues that might arise in Sweden, this was definitely a big part of this client’s experience” (P26, line 90-99).

“It makes me think of this sense of being a pilgrim and being able to go to Mecca, kind of same experience of having this spiritual contact that clients do express in terms of how they view Iraq. But I mean I hope that this will not really hinder their ability to become more united with the rest of society, or more part, so as to say, that is my hope at least” (P27, line 106-110).

The above extract demonstrates how this participant understands the spiritual and religious value of maintaining a sense of connection to Iraq as expressed by his Iraqi refugee male clients in therapy, yet at the same time concern is expressed that their integration into Swedish society might be hindered by this maintained connection.

B. Client experiences of exile

Loss of status

The professionals referred to Iraqi male clients expressing distress in therapy due to losing their status as men in Swedish society (there are similarities here to the Phase 1 theme of **‘Emasculation’**). Out of the eight participants, seven expressed views and described experiences that demonstrated this theme.

“I have encountered this attitude, specifically this idea that there is a hierarchy in which women come first in society, in Swedish society, then children, then even cats and dogs, and the man feels that he comes in as the lowest in the hierarchy. I mean Iraqi refugee clients seem to express not wanting to be in this kind of a position and

experiencing that. For Swedish men perhaps this is acceptable, but coming from Iraq this is experienced as distressing” (P21, line 261-266).

“this affects many Iraqi men, that this role is not reality here in Sweden, does not exist here.[...] when the children become more fluent in Swedish and speak the language and can communicate, even further making the father almost feel like he’s not capable of contributing. I mean generally a difficult process for many men” (P23, line 300-307).

“For the majority of Iraqi men that I have worked with, this sense of being exploited, this sense of being underestimated in terms of contacts with certain agencies such as the Job Centre, and going from place to place to be able to get a job, and then all the time working as trainees and never really ending up in employment [...] I can say that for Iraqi men it does seem to be distressing, specifically compared to what kind of status they once had in Iraq” (P25, line 292-298).

“one observation in working with the Iraqi refugee male clients is that they have lost their sense of status and identity in Sweden. Even in terms of their position and status in their family or their relationship with their children, this loss or decline in position seems to be so overwhelming” (P28, line 276-279).

Integration difficulties

The professionals observed Iraqi male clients struggling with acculturation processes in Swedish society. Although this theme was expressed using milder terms it does resemble the Phase 1 theme of ***‘Exclusion and marginalisation’***. This theme also resembles the Phase 2 theme of ***‘Exile not Iraq’*** in terms of the distress that marginalisation can induce in Iraqi refugee men in Swedish society. This theme was expressed in different ways and by different participants in all three phases of this study, highlighting its significance. Out of the eight participants, six expressed views and described experiences that demonstrated this theme.

“I have encountered clients who express difficulties in integrating into society, and not surprisingly having gone through what they have gone through in Iraq, they will have these difficulties, and most will probably not be able to establish contacts in Swedish society or get work” (P21, line 405-407).

“In coming to Sweden in the early stages of exile and trying to adapt and integrate into society, many of them do experience difficulties. And most of them, or perhaps some of them that do, tend to feel the need to gather and live in the residential areas that are very unlikely to enable them to establish contacts with ethnic Swedes. It does contribute to their integration difficulties. And many of these clients who do end up in this situation have a lot to say about integration, and most of it is negative. I mean they mostly experience the situation in a negative manner. But these negative views of Swedish society sometimes seem to come about through contacts with other Iraqis who have been in the situation where they have felt

difficulties in integration, so they kind of pass on to each other these negative attitudes in certain cases” (P23, line 237-246).

It is interesting to note that the therapist/participant in the above extract is aware of the difficulties in integration that Iraqi refugees say they face, yet chooses to emphasise Iraqi refugees’ responsibility for spreading these negative attitudes about Swedish society among themselves.

In both focus groups participants generally avoided highlighting discrimination in Swedish society as relevant to Iraqi men’s difficulties in integrating into Swedish society. The only exception was participant 25, who was also the only Iraqi male among the Phase 3 participants. Participant 25 argued that employment was not a route to integration, as other participants suggested, since he had been in employment for many years but still did not feel fully integrated into Swedish society:

“Most of the Iraqi men I’ve had this discussion with seem to express an interest in wanting to move out into less segregated areas and want to be integrated into Swedish society, and to them, in being able to live in less segregated areas perhaps they will be considered as integrated. And quite often I will give the example that I am in employment personally, yet I do not feel integrated into Swedish society. I mean I do pay taxes, I do share quite a bit of the contributions and responsibilities of most ethnic Swedes, yet I do not feel that I am part of Swedish society” (P25, line 21-27)...“there is something specific for Sweden in terms of being promised that employment equals integration. But for me, integration as a feeling, as how I feel

inside, as I mentioned earlier I am in employment but I'm not integrated. I mean if you ask me how I feel, I do have some friends, but still it's not the same as when for example I lived in other countries. I lived in the former Yugoslavia, I lived in Russia, and for these periods I felt that I was part of society. I don't know how to explain it, but this feeling I could never really experience here in Sweden" (P25, line 398-404).

Exile trauma not Iraqi trauma

The professionals viewed Iraqi male clients' negative experiences of Sweden as more distressing than their negative experiences of Iraq (there are similarities here to the Phase 1 theme of ***'Exile worse than pre-migration'*** and the Phase 2 theme of ***'Exile not Iraq'***). This theme was expressed by different participants and in different ways in all three phases of this study, highlighting its significance. Out of the eight participants, five expressed views and described experiences that demonstrated this theme.

"many clients do express feeling that Sweden is a kind of prison, or even that they see some of the same treatment they've seen in Iraq happen to them again here in Sweden. Some of them even express living in Sweden as a form of torture, and understandably when they express these kinds of views for certain government employees, say as a social worker, and express feeling that this social worker resembles Saddam, or that they are similar, obviously they will not go so far and they will have trouble" (P21, line 426-431).

“their main concern is not being part of Swedish society [...] being excluded and not being able to integrate. To them this is the most distressing aspect of their experience. [...] they often do reply and tell me that ‘I do not want to go there and keep talking about the same subject for a whole year, what happened in Iraq and what I experienced. This is not what I need’. For me as an Iraqi, I have to admit that I feel the same way” (P25, line 187-194).

“I can think of something a client said that I specifically remember with regards to this feeling of being oppressed by certain aspects in Swedish society [...] he said that in Sweden I am dying a slow death, whereas in Iraq I would have received a much more tolerable, swift and fast death” (P27, line 309-313).

In addition to describing exile-related stressors as more distressing, this participant also explains that negative and potentially traumatic experiences in Iraq are considered by Iraqi refugee men to have some sense and meaning, whereas being discriminated against and excluded by Swedish society is more difficult to relate to:

“Many of my Iraqi male clients express feeling that their distress and their oppression in Iraq seemed to make sense, that it was understandable, but the truly difficult aspect for them to comprehend or accept, is being treated badly here in Sweden. They often say that ‘it’s understandable in Iraq, because Iraq is not a democratic country, it’s a dictatorship, but here in Sweden I am in a democratic country so why am I being treated in this manner?’ I have heard this many times” (P25, line 435-440).

C. Therapist observations on client difficulties

Emphasising pre-migration trauma

Professionals viewed PTSD and related negative pre-migration experiences as the main difficulties that Iraqi refugee men brought to therapy. Out of the eight participants, six expressed views and described experiences that demonstrated this theme.

“One thing I do want to emphasise is that being traumatised, being able to understand the world, or having a sound world view, is not easy when someone has been traumatised, especially with regards to trauma through unnatural causes such as the war and the torture and the difficult unnatural experiences that many Iraqi men bring to therapy. [...] everything that they bring in terms of world view or relating to each other is not safe from the effects of the trauma. [...] trauma that is probably seen in every aspect of the way they express their needs and whatever they bring to therapy” (P22, line 183-190).

“the war experiences that most Iraqis have experienced seem to have even made changes to the original culture [...] so many wars and so many difficult experiences that might have changed whatever we call today culture” (P23, line 177-179).

“the actual experiences, mostly of, for example, having to hold a weapon or a rifle by the age of 10, having to do this, having to observe certain rapes and other types of assaults. And in their manner of telling these stories and experiences, one can sense the suffering, one can sense the distress” (P28, line 460-463).

Somatisation of symptoms

The professionals experienced Iraqi male clients as expressing their mental health difficulties in the form of physical complaints. Out of the eight participants, five expressed views and described experiences that demonstrated this theme.

“However, one issue of difficulty is trying to understand that, if not getting something as medicine, or an injection, or something physical, so how can these discomforts go away, which are sometimes formulated in a somatised manner, a somatisation of symptoms does come up. But then again this might be even true for some other groups, or even some other cultures, where there is a question mark regarding the talking therapies” (P21, line 198-203).

“clients will often express their difficulties in a practical and physical manner in terms of having a headache, or in terms of being tired, and they will not use words such as “anxiety” or even “worry”, or these ways of relating to direct feelings or thoughts, but rather more of physical and practical nature” (P26, line 478-481).

“I have experienced that Iraqi men do tend to want to go along with talking if it is connected to seeing a medical doctor and getting medication. I mean just talking is not desirable from what I’ve experienced in working with this client group, not initially at least. And some of them are so traumatised by what they’ve experienced that they actually do exhibit quite a bit of physical ailments” (P28, line 144-148).

Using metaphor

Some professionals also experienced Iraqi male clients as using metaphors to describe their thoughts and feelings in therapy. Out of the eight participants, only two expressed views and described experiences that demonstrated this theme. Even so, it appears to capture an important observation relevant to successful communication with Iraqi clients.

“clients who seem to sleep throughout the day, and even parents who do not use their day in a way that is considered ideal, simply because they tell me that they do not have much to do in the day because they can’t go anywhere, they don’t have jobs to go to, and they end up sleeping in the day and perhaps staying up late at night watching TV, or watching Arabic channels or...and this idea of not living a normal life here in Sweden. So they will often say that my evening is day, and my day is evening” (P25, line 495-500).

“mostly in terms of metaphor, they tend to use descriptions of being oppressed, specifically in relation to being treated as an animal. I mean it is a very strong way of saying one feels humiliated” (P27, line 488-490).

D. Therapist limitations

Difficulty in relating to client's worldview

The professionals had difficulties in relating to their Iraqi clients' world view, such as difficulty in understanding why Iraqi men choose to have many children even in light of limited resources, and the difficulty in relating to the Iraqi belief in the supernatural causes of problems. Out of the eight participants, five expressed views and described experiences that demonstrated this theme.

“this belief in fate, the belief in destiny, specifically using the phrase “inshallah”, meaning “God willing”, that it’s all in the hands of God. This I do find a bit difficult to relate to because this strong belief in fate and destiny externalises quite a bit of the clients’ problems and I do find myself struggling with this [...] I do find this aspect a bit difficult for me personally to understand or appreciate this kind of externalising of what’s happening, or why my situation is this way” (P21, line 104-111)...Another aspect of this externalisation and not taking personal responsibility for the situation is the belief in black magic, these traditional beliefs in external supernatural forces somehow being responsible for the client’s difficulties, this I specially also struggle with accepting or relating to” (P21, line 118-136).

“When some of my clients do start talking of possession and even devils and what the demons can do and these types of things, and to me this is difficult because it’s such a far and distant world from the perspective that I’m trying to work through. And this is not easy because I cannot really get close to this way of relating, and

I'm not sure how much benefit I will be doing in getting too close or trying to see this much from the client's perspective. [...] it's one of these things that does feel unsettling" (P24, line 150-157).

One participant goes on to describe how she might communicate to a client in therapy that she does not approve of his reasoning, a prime example of this inability to relate to the client's worldview:

"One of the most difficult issues for me to understand or accept is when Iraqi men seem to have a tendency of wanting to have more children, and bring children to life and not really be able to take care of them. I mean fathering children beyond one's means, I could never really understand or accept this, and I suppose this is one example of when I cannot help but imply that I am not too accepting or understanding" (P 21, line 356-360).

Therapist discomfort

The professionals experienced discomfort in discussing culturally sensitive issues and intense traumatising pre-migration experiences with their Iraqi clients. Out of the eight participants, only three expressed views and described experiences that demonstrated this theme.

"I did not really feel comfortable going into his religious beliefs or his perceived right of being able to get married to another woman, or having a sort of temporary

marriage to fulfil his needs, and this was not something I could even attend to. I could only remain within the constraints of the practical issues in terms of wanting to get married to another woman and how that might impact on the family and children. Other than that I could not go further or deeper” (P24, line 316-321).

“I haven’t always dared approach these cultural issues. I mean I can say that before I was more afraid, more Swedish in my way of talking and relating to clients, [...] I was just discussing this with a trainee psychologist I am supervising, and she has an Iraqi client as well, and I was just talking with her regarding our inability to approach these issues because we are afraid, this avoidance that we have of cultural issues [...] I’ve noticed that it’s better to get the client talking and explaining, as opposed to what I previously used to do, which was simply going from my own perspective” (P26, line 215-229).

In the above extract, the participant reflects on her initial discomfort in addressing culturally sensitive material for fear of contributing to social segregation and stereotypical ideas, and describes the difference she noticed upon transcending this initial fear by engaging and asking rather than using her own cultural norms to deduce what the client might be thinking and feeling. For other participants, the discomfort was more about fearing being unable to handle the pre-migration war and/or torture experiences that some Iraqi refugees can describe in therapy; as demonstrated in the below extract:

“having to observe certain rapes and other types of assaults. And in their manner of telling these stories and experiences one can sense the suffering, one can sense the

distress. And I try my best not to collapse myself upon hearing their stories, and in trying to sit still in my chair and allow for this space, to allow for them to express these difficult experiences, they do eventually comment that it was helpful to let this out” (P28, line 461-466).

Limited therapist transparency

Some professionals acknowledged that they were not open with their Iraqi clients about their training and theoretical orientation (there are similarities here to the Phase 2 theme of ‘lack *of therapist transparency*’). However, these participants generally attempted to involve clients by explaining the structure and goals of therapy. Out of the eight participants, only three expressed views and described experiences that demonstrated this theme.

“I do make clear the goals and structure of therapy. But even that is difficult, I mean trying to set up goals and maintaining a certain level of structure, it’s difficult” (P 24, line 490-492).

“I’ve noticed that for many Iraqi clients, they will either not care for the details or structure, or will even express in my experience a fear of signing a document” (P25, line 614-615).

“I don’t include all the facts, and I don’t include all of my methods, but then again I will go through what it simply means” (P26, line 650-651).

E. Client feedback regarding therapy

Needing practical help

The professionals experienced Iraqi refugee male clients as needing help with practical issues (e.g. employment), implying the need for advocacy-based interventions. Out of the eight participants, four expressed views and described experiences that demonstrated this theme.

“expectations that are not in line with what talking therapies are about. Quite often I do hear of comments of not really being happy, or even being let down by the fact that the Red Cross does not offer help in practical issues or in employment or other government agencies. The fact that therapists do not have more influence has been expressed by clients as not so helpful. I mean comments like “you should be able to help me with this government agency or with that agency” and that “you should be able to tell them how it is with me” and these kind of comments often are expressed” (P21, line 522-528).

“even though they’ve had contact with several places offering counselling, they will actually say that they did not maintain this contact. And when I ask my clients “why do you no longer have contact with these places” they will tell me that these places, people working there, just talk, it’s just babble, they say the same things again and again and again. And what they truly need is practical help, what they tell me they want is practical help. And when I ask “exactly what is practical help” they will often tell me that either medication, which is seen as practical and legit, or

employment, “help me find a job”. They often tell me that they are not helped by this babble” (P25, line 177-184).

“many Iraqi male clients want more practical solutions, more practical help, as opposed to talking, which might seem to them as more passive, or even as accepting the current situation. I mean I see this need of wanting to talk about what they have done, actively done, which places they have been to, and this need to “want to do” is quite apparent in this need for practical help” (P28, line 279-283).

For two participants, this observed need for practical help was viewed as a common, or recognisable, feature of masculine behaviour and not necessarily specific to Iraqi culture:

“I have encountered this attitude amongst Swedish men as well” (P28, line 255).

“I just thought of the actual experience of Iraqi refugee men of talking therapies as being basically babbling, and what you just mentioned made me think of this as a part of a man culture, it’s more of a masculine issue that I seem to be able to recognise, even in some of my Swedish male clients. I mean I have encountered this resistance or reluctance to engage in counselling and heard expressions of not seeing this as beneficial or not necessarily macho” (P27, line 245-250).

Irrespective of how much this expressed need for practical help is culture-specific or gender-specific, it was still noted as important for Iraqi clients according to the therapists. Although most did not explain whether they attempted to fulfil this need or not, one

therapist in particular displayed a narrow, anti-advocacy line of thinking:

“we have to be clear, we have to explain what we can do and what we can’t do. I mean there are limitations to what we can be helpful in, and there is this need for establishing trust early on. But addressing practical issues, I feel, is not within the realm of what we do” (P21, line 537-540).

The accounts expressed in this theme indirectly give voice to the Iraqi clients concerned; thus highlighting the need for therapists to be, at the very least, open to advocacy-based counselling approaches.

It helps to talk

The professionals believed that Iraqi male clients did find it helpful to talk about their problems in therapy (there are similarities here with the Phase 2 theme of ***‘getting things off my chest’***). Out of the eight participants, five expressed views and described experiences that demonstrated this theme.

“In my experience, clients do express feeling happy about establishing a contact, just simply having somewhere to go to and talk. And eventually they do express feeling good about leaving this session and expressing having benefited somehow by talking simply. But of course it does get more difficult and demanding with the more traumatised clients” (P22, line 500-503).

“hearing their stories, and in trying to sit still in my chair and allow for this space, to allow for them to express these difficult experiences, they do eventually comment that it was helpful to let this out” (P28, line 464-466).

In the first of these extracts, the therapist notes the expressed benefit and value of talking, referring to feedback from male Iraqi refugee clients. However, it is acknowledged that simply talking about one’s problems might not be enough for Iraqi clients with more severe traumatic experiences and symptoms. For one therapist, this need to talk and tell one’s story was perceived to be especially apparent among Iraqi asylum seekers and typical of Iraqi men in the early stages of exile:

“I think quite a bit of my work at the refugee centre, specifically with the asylum seekers. Just recently this week an Iraqi man, an asylum seeker, seemed to want to talk extensively about his experiences, and without really holding back. And he even cried during the session and wanted to really, as soon as possible, book another session, and was very in need of this type of help. And this man, like other Iraqi asylum seekers, have expressed to me that they need to talk about what they have experienced, they need to be heard in this manner. And of course this is to me related to the stage of exile because they are asylum seekers, they have recently only arrived, and to them this need is more apparent than perhaps other stages” (P27, line 158-165).

What makes the above extract particularly interesting is that it was the only time a therapist in Phase 3 observed a link between refugee clients’ counselling needs and their stage of

exile. This observation was so thought provoking for one other participant (the only Iraqi refugee therapist in Phase 3) that he drew a comparison between it and his own observation of Iraqi refugee men in later stages of exile who expressed distress over exile-related stressors:

“to me it’s interesting that you mention this asylum seeker who wanted to talk in this manner, because for most of my clients who have their residence permit, they do not express this need, I don’t see that they need to try and talk about residence permit or other issues, but rather that their main concern is not being part of Swedish society, in being outside, in being excluded and not being able to integrate. To them this is the most distressing aspect of their experience” (P25, line 184-189).

Besides demonstrating the therapists’ belief in the cathartic benefit of talking, these quotations suggest that Iraqi refugees in later stages of exile may experience social exclusion, marginalisation, and discrimination as more central features of their distress, while those in the early stages of exile experience a primary need to tell their stories.

Reflexive observations – Phase 3

In Phase 3, dialogue and interaction between participants in the second focus group gave rise to a clear clash of understanding marginalisation and exclusion in Swedish society as the only Iraqi mental health professional (P25) in Phase 3 described his view of the limited possibilities of integration into Swedish society which was in direct contradiction to the views expressed by the Swedish mental health professionals (P25, P27, and P28, line 368-403). The Iraqi mental health professional challenged the simplistic and possibly naive view of integration that was expressed by the other Swedish professionals.

In recruiting this certified counsellor who shared my Iraqi refugee background, I knew I was going to open up new avenues for dialogue that would otherwise not come about had I only interviewed ethnic Swedes, but I was not prepared for the passion that he displayed in talking about how truly difficult it is to transcend the feeling of marginalisation and exclusion in interacting with Swedish society as an Iraqi refugee man. I was particularly moved by his later contribution in the same focus group interview, in which he emphasised the responsibility of the host society in facilitating or even allowing integration to occur (P25, line 413-417).

Although the Iraqi counsellor did not explicitly discuss the impact of racism and discrimination on integration possibilities, I believe he still managed to imply this in expressing his view that integration into Swedish society is practically impossible. Although I was particularly mindful of maintaining my role as a moderator in the focus group interviews and not as an active participant, I could not maintain myself upon

concluding the focus group interview when I thanked all of my participants including the Iraqi counsellor in Swedish, only to thank him again in Arabic as the other participants were leaving the interview room.

As I reflected on my own role as a moderator in the second focus group, particularly during this encounter between the Iraqi counsellor and other professionals, I noticed that I was struggling to hold back my own views on the issue of integration into Swedish society. I am not sure how much of my body language and facial expressions might have shown my support for what the Iraqi counsellor was saying, but I believe to some degree it made the ethnic Swedes in the second focus group avoid further discussion of the subject. So, while I was pleased that on some level this clash of ideologies and indeed politics did make its way into the interview and subsequent analysis – I believe that the issue could have been explored further had it not been for the sense of tension and unease that suddenly took over the atmosphere.

The way that the Swedish professionals froze up as the Iraqi counsellor described how he was not integrated into Swedish society neither through speaking the language nor through employment – as advocated by Swedish government integration policies and indeed by the therapists in the group – was very much similar to the discomfort and avoidance of cultural issues that the therapists described in the Phase 3 subordinate theme of '*Therapist discomfort*'. This observation confirmed to me the extent of this discomfort that seems to transcend cultural and language differences between Swedish therapists and Iraqi clients since it was just as comfortable for the Swedish therapist to discuss these issues with me and the Iraqi counsellor – professional colleagues who speak fluent Swedish.

Final reflexive observations

Throughout this three-phase study, I was set on exploring the experiences of post-migration stress among Iraqi refugee men, much like I had often done in my own counselling practice with this client group (discussed in Chapter 1 under the heading of ‘My experiences as a psychologist working with refugees’). Difficulties in integration were acknowledged in different ways and by different participants in all three phases of the study (Phase 1 theme of *‘Exclusion and marginalisation’*, Phase 2 theme of *‘Exile not Iraq’*, and Phase 3 theme of *‘Integration difficulties’*), confirming the reality of exclusion and marginalisation among Iraqi refugee men in Sweden. Similarly, the experience of exile as worse than pre-migration trauma was also acknowledged in all three phases of the study (Phase 1 theme of *‘Exile worse than pre-migration’*, Phase 2 theme of *‘Exile not Iraq’*, and Phase 3 theme of *‘Exile trauma not Iraqi trauma’*), thereby highlighting the impact of post-migration stress among Iraqi refugee men in Sweden.

Although the overarching theme was that exile was experienced as more distressing than pre-migration experiences, I had encountered Iraqi refugee participants who were haunted by memories of prison and torture in Iraq even after 20 years in exile, leading me to question the relevance of my research focus (discussed in Chapter 4 under the heading of ‘Reflexive observations – Phase 1’). I realised that my own mild pre-migration experiences and intense post-migration stress (explored in Chapter 1 under the heading of ‘My experiences as an Iraqi refugee’) had desensitised me to some degree to the Iraqi refugee men’s pre-migration trauma. Conversely, the counselling professionals in Phase 3 were desensitised to the effects of exile-related stressors among their Iraqi refugee clients as most expressed

viewing pre-migration trauma as the main source of their clients' distress (Phase 3 sub-ordinate theme of '*Emphasising pre-migration trauma*') – when in fact most of what their Iraqi refugee clients were describing as distressing revolved around issues pertaining to their ethnic minority status and experiences of marginalisation and discrimination (Phase 3 sub-ordinate themes of '*Loss of status*', '*Integration difficulties*', and '*Exile trauma not Iraqi trauma*').

While the analysis of all three phases of the study confirmed the need for addressing post-migration stress, it also made me aware of how counselling professionals like the participants in Phase 3 and like me (not as a researcher but as a practitioner) can be desensitised to what the client is bringing to therapy even when we claim, and perhaps believe, that we are guided by the client. I now wonder if my own distress, in reaction to post-migration issues, might have contaminated my counselling work with Iraqi refugee clients in ways that might have shifted the focus from addressing pre-migration trauma to exile-related stress – at times when clients might have been better served to stay within pre-migration issues.

This observation made me aware of the need to re-emphasise at this point that the main source of distress experienced by Iraqi refugee men in later stages of exile should always be what the individual client says it is. The need for locating the individual client perspective at the heart of all theorising and interventions has become even clearer to me as a consequence of this reflexive engagement. What this study aims to offer is insight into one possible aspect of Iraqi refugee men's distress, and an exploration of how counselling can be used to address it – when the client expresses the need to do so.

Chapter 5: Discussion

The present study was informed by the idea that “different things are likely to help different people at different points in time” (Cooper & McLeod, 2011, p. 6). In line with this idea, I attempted to explore how counselling and psychotherapy can address the experiences of a specific client group, at a specific stage in their lives, and for a specific issue – Iraqi refugee men, in later stages of exile, struggling with post-migration stress. I designed and carried out this three-phase study in order to explore how Iraqi refugee men can experience post-migration stress in later stages of exile in Sweden, and how counselling can address this experience if, or when, it is expressed by this client group in therapy.

Phase 1 entailed asking ten Iraqi refugee men about their experiences of post-migration stress and the help/support systems available to them in later stages of exile in Sweden. Phase 2 involved asking ten adult male Iraqi refugee ex-counselling clients, in later stages of exile, about their counselling experiences in Sweden. Phase 3 was designed to elicit responses from two groups of mental health professionals regarding their experiences of counselling Iraqi refugee men – with specific emphasis on issues identified as relevant for the experience of post-migration stress. This three-phase study was inspired by a pluralistic approach to psychotherapy research – that is “consumer-based research...engaged in ongoing dialogue and debate with counselling and psychotherapy professional groups” (Cooper & McLeod, 2011, p.119). Phase 1 and Phase 2 represented the ‘consumer-based’ emphasis which reflects the centrality of the client perspective in this study. Phase 3 represented the ‘dialogue and debate with counselling and psychotherapy professional groups’.

Main Findings

The Iraqi refugee men expressed feeling disempowered and racially discriminated against in Swedish society (Phase 1 sub-ordinate themes of *‘Emasculation’* and *‘Primitive and inferior’*). This finding is in line with research that has documented the prevalence of racism and discrimination in Sweden (e.g. Hübinette & Lundström, 2011; Kamali, 2009; Khosravi, 2012; Pringle, 2010). Coupled with the experience of societal racism, Iraqi refugee men expressed feeling generally excluded from, and marginalised by, Swedish society (Phase 1 sub-ordinate theme of *‘Exclusion and marginalisation’*). Similarly, the mental health professionals also described observing their Iraqi male clients’ experiences of marginalisation in Swedish society (Phase 3 sub-ordinate theme of *‘Integration difficulties’*). These findings are in line with the literature on immigrant acculturation difficulties in Sweden (e.g. Kamali, 1997; Khosravi, 2012; Hübinette & Lundström, 2011).

Hübinette and Lundström (2011, p. 45) claim that “Sweden stands out among other Western countries as having perhaps the most extreme pattern of racial segregation”. While it is suggested that integration is the healthiest acculturation strategy (Berry & Sam, 2006) the emphasis on formulating integration as a choice, approach, and strategy in the literature (e.g. Berry & Sam, 2006; Colic-Peisker & Walker, 2003; Davidson, Murray, & Schweitzer, 2008; Rostila, 2010) consistently overestimates the control and power that the individual immigrant/refugee has over the acculturation process.

Acculturation theories run the risk of blaming the individual immigrant/refugee for the unsuccessful integration, undermine the efforts exerted by the individual to integrate into

the host society, and ignore the responsibility of the dominant and majority groups in the host societies for the oppressive societal practices that counteract integration. Oppression can be defined as “a system of domination that denies individuals dignity, human rights, social resources and power” (Dominelli, 2008, p.10). Therefore, power issues and oppressive attitudes in society seem to be more relevant than acculturation theories for understanding the experiences of the Iraq refugee men (Phase 1 sub-ordinate themes of *‘Emasculation’*, *‘Primitive and inferior’*, and *‘Exclusion and marginalisation’*).

Marginalisation and exclusion have obvious implications for socioeconomic status and wellbeing. Allen and Britt (1983, p.149) observed that “the correlation between social class and prevalence of symptoms of psychological disorder is one of the most thoroughly documented relationships in epidemiological research”. Out of the ten Iraqi refugee men in Phase 1, five were unemployed, five were university graduates, and nine had below average incomes. Out of the seven Iraqi refugee ex-counselling clients in Phase 2, five were unemployed, none had a university degree, and all had below average incomes. Iraqi refugee men in both samples had below average incomes (with the exception of one), suggesting lower socioeconomic status among all the Iraqi refugee men in the study.

It might be interesting to note that the first sample of Iraqi refugee men (Phase 1) had a higher proportion of university graduates and above average incomes (half of the sample), while the second sample of Iraqi refugee men (Phase 2) had no university graduates and all but one participants had below average incomes. The Iraqi refugee men who were ex-counselling clients were more disadvantaged in terms of socioeconomic status than the Iraqi refugee men who had not tried counselling. Perhaps having had somewhat higher

socioeconomic status might have protected the Phase 1 Iraqi refugee men from the distress of low income and unemployment that marked the Iraqi refugee ex-counselling male clients in Phase 2. It is worth noting that the average monthly income that was used as the cut-off point in the study was 16 583 SEK per month – which corresponds roughly to an annual income of 198 996 SEK. This figure is the median annual income in Sweden for foreign born men (20 years old and above) for the year 2010 (Statistics Sweden, 2011). Swedish born citizens have for years statistically earned more money than foreign born men and women of the same age (Statistics Sweden, 2009).

The APA Task Force on SES (2006) defined “three understandings of socioeconomic status and social class-related inequalities” (p. 17), one of which offers clear direction for an examination of social class within a social justice perspective. These three categories were described as 1) ‘materialist approaches’, or those that correlate differences in SES with differential access to resources; 2) ‘gradient approaches’, or those in which socioeconomic status is conceptualised as a continuum along relative differences in class position; and 3) ‘reproduction of power and privilege’, or approaches that treat class inequity as a form of socio-political oppression by the dominant groups in society.

It might be argued that the Iraqi refugee men were marginalised and excluded because they were not in employment, which consequently explains why they had below average incomes. But the fact that half of the Iraqi refugee participants in Phase 1 were employed and earning above average incomes, yet still reported the same marginalisation and exclusion (all ten participants expressed the Phase 1 sub-ordinate theme of ***‘Exclusion and marginalisation’***) makes such an argument less valid. Similarly, the only mental health

professional in Phase 3 who was also an Iraqi refugee man (P25), described how his employment and income did not make him feel like part of Swedish society and that he also felt marginalised much like many of his Iraqi clients. Therefore, the ‘reproduction of power and privilege’ seems to be the most relevant approach to understanding socioeconomic status and its influence on Iraqi refugee men’s experience of marginalisation in Swedish society – especially after having lived in Sweden for so many years (length of residence in Sweden ranged from five to twenty one years for the Iraqi refugee men in both Phase 1 and Phase 2).

The Iraqi refugee men also expressed valuing social support from fellow Iraqis, and described maintaining links to Iraq and Iraqi culture as helpful strategies in dealing with post-migration stress (Phase 1 sub-ordinate themes of *‘Iraqi social support’* and *‘Maintaining Iraqi culture’*). Similarly, the mental health professionals also noted the tendency among their male Iraqi refugee clients to want to establish and maintain connections to Iraq and fellow Iraqi refugees, even in light of the trauma-induced distrust that traumatised individuals tend to experience (Phase 3 sub-ordinate theme of *‘Social support versus distrust’* and *‘Connection to Iraq’*). These findings are in line with the literature confirming the value of social support. Gorst-Unsworth and Goldenberg (1998), for example, found that social support in a sample of Iraqi refugees in Britain was important in determining the severity of both post-traumatic stress disorder and depressive reactions. Similarly, Taloyan et al. (2011) found the need to contribute to Kurdish culture and Kurdish language to be a shared positive experience and a major way of coping for Kurdish men living in Sweden.

Social support was described as an important and valuable resource by Iraqi refugee men in later stages of exile, yet it was only available to participants from other Iraqis not from Swedish society as a whole (Phase 1 sub-ordinate theme of *'Iraqi social support'*). It has been suggested that relationships with both co-nationals and host-society members are the most adaptive to acculturation (Sam & Berry, 2006). However, Iraqi refugee men's experiences of racism and marginalisation (Phase 1 sub-ordinate themes of *'Emasculation'*, *'Primitive and inferior'*, and *'Exclusion and marginalisation'*) suggest a limitation in social support. It is worth noting that the literature on social support (e.g. Brewin, Andrews, & Valentine, 2000; Lindström, Sundquist, & Östergren, 2001) does not clarify whether individuals, who receive social support from one group in society but not from another, are said to have or lack social support.

Iraqi men's need to maintain links with Iraq, and Iraqi culture, has been expressed as a helpful strategy in this study (Phase 1 sub-ordinate theme of *'Maintaining Iraqi culture'* and phase 3 sub-ordinate theme of *'Connection to Iraq'*), but it may be contributing to their acculturation difficulties. Sam and Berry (2006) refer to the degree to which an immigrant's culture differs from that of the host society as 'cultural distance'. Iraqi culture tends to differ from Swedish culture, therefore maintaining certain Iraqi cultural norms (e.g. patriarchy) might lead to a clash of cultures, tension, and/or conflict when certain Swedish norms (e.g. feminism) are in direct contradiction to the Iraqi ones. Sam and Berry (2006, p.50) argue that "The general and consistent finding is that the greater the cultural differences, the less positive is the adaption".

The Iraqi refugee men in the study reported feeling specifically disempowered by certain dominant laws and norms in Swedish society (Phase 1 sub-ordinate theme of '*Emasculation*'). Similarly, the mental health professionals described the loss of status experienced by their Iraqi refugee male clients as a significant source of exile-related distress (Phase 3 sub-ordinate theme of '*Loss of status*'). Although the cultural distance between patriarchal Iraqi culture (Al-Ali, 2005, 2007) and feminist Swedish society (Stetson & Mazur, 1995; Holmgren & Hearn, 2009) is likely to have contributed to this overwhelming experience of disempowerment and emasculation, other explanations do exist. Sweden's gender equality politics has been criticised for leaving little space for conflict themes related to racism (Pringle 2010). Similarly, Hübinette and Lundström (2011, p. 48) argue that Sweden's "state-sanctioned and institutionalized gender equality discourse carries with it a sense of national identity which is intimately intertwined with whiteness and racial hierarchies and which excludes migrants".

Hübinette and Lundström (2011, p. 5), who describe themselves as "post-colonial feminists and anti-racists", argue that some voices in the Swedish media and even in the Swedish academic community have been repeatedly promoting a white feminist understanding of gender equality which tends to exclude non-white and non-Western migrants. Hübinette and Lundström (2011, p. 42) describe the promotion of such ideas in light of the September 2010 elections in Sweden in which "the racist party, the Sweden Democrats (sverigedemokraterna) has entered the national parliament with almost 6% of the electorate".

This disempowerment and loss of status that Iraqi refugee men experience in Swedish society can pose a problem for counselling professionals who attempt to incorporate multicultural thinking in their practice with this client group. Specifically, it has been argued that while multiculturalism and feminism share many common ideas, they are not always compatible (Okin, 1999). Reid (2002, p.107), for example, argues that “there are instances when cultural practices and familial roles may threaten, endanger, and grievously disadvantage women. Can therapists, counselors, or educators risk girls and women to protect a cultural tradition?” This line of thinking can have obvious implications for counselling Iraqi refugee men, especially considering the patriarchal nature of Iraqi culture (Ismael & Ismael, 2000).

Conversely, as a result of the depiction of Arab and Muslim men as female oppressors in some sources of Western media (Shaheen, 2009; Kamali, 2009), a Western therapist might stereotypically view an Iraqi male client as insensitive to women’s rights and communicate this intentionally or unintentionally to the client - who is likely to experience this as a form of racial microaggression. Such an encounter can negatively influence the process and outcome of therapy due to the potentially harmful effects that the experience of racial microaggressions can have on the working alliance (Constantine, 2007; Owen et al., 2011).

However, it is important to note that the notion of multiculturalism being in conflict with gender equality (as it is argued by the anti-immigration lobby) is not in line with deconstructivist multiculturalism which challenges this form of cultural essentialism (e.g. Narayan & Harding, 2000). Similarly, multiracial feminism “stresses the importance of race as a power system that interacts with other structured inequalities” (Zajicek, 2002, p.

157) suggesting the need for looking beyond culture and race in attempting to protect women from the oppression that this naive and hostile view of multiculturalism brings. Furthermore, “when feminism is opposed to multiculturalism, racism quickly pervades what becomes efforts to save non-Western women from their cultures” (Bassel, 2012, p. 4).

When asked about the help and support systems available to them in Sweden, the Iraqi refugee men in Phase 1 generally expressed an avoidance of help-seeking outside the context of family and/or fellow Iraqi social support (Phase 1 sub-ordinate theme of *‘Barriers to help seeking’*). While social support is acknowledged as positive and adaptive for the most part (e.g. Gorst-Unsworth & Goldenberg, 1998), it has been argued that men tend to use having family and friends as a form of avoidance to considering counselling, in addition to generally having a negative view of the profession (White, 2009).

Also, while Levant (1998, p.37) suggests that some men’s emotional inexpressiveness makes it “less likely that such men will benefit from psychotherapy”, others (e.g. Garde, 2003; Wheeler, 2003) have highlighted the general incompatibility of masculinity with psychotherapy. Along the same lines, Shill and Lumley (2002) reported that females were more psychologically minded than males, which can be considered as further evidence of some masculine traits being incompatible with psychotherapy. Similarly, Griffiths (2001, p. 306) notes that “male refugees may be bound by socialized gender roles which restrict their emotionality and ability to self-disclose”.

However, Iraqi refugee men’s resilience and coping strategies were apparent in some participants’ accounts of dealing with pre-migration trauma through humour and with some

degree of emotional irresponsiveness. As suggested by Levant (1998) and other researchers, these are masculine traits. Many researchers seem to view masculine traits as incompatible with psychotherapy, but considering the need to empower clients to use the resources available to them poses the question of whether masculine traits are an obstacle to therapeutic change, or one of few resources available to Iraqi refugee men in dealing with their pre-migration and post-migration stress.

In addition to being men, most participants in Phase 1 were Muslim and some studies suggest that Muslims tend to underutilise mental health services (e.g. Inayat, 2005; Patel et al., 2000). The fact that 97% of Iraqis are of the Muslim faith (Nydell, 2006) partially accounts for participants' reluctance to seek counselling (Phase 1 sub-ordinate theme of *'Barriers to help seeking'*). Yet another possible reason for not considering counselling is the stigma attached to mental illness in Iraqi culture (Shoeb, Weinstein, & Mollica, 2007). These different gender and cultural dimensions explain some Iraqi men's reluctance to seeking counselling. However, it is important to note that reluctance to seek counselling might not necessarily imply a barrier to help seeking if the Iraqi men were indeed asking for, and/or getting, the type of help that they need in gender-specific and/or culture-specific ways that do not match the expectations of Western counselling theorists and practitioners. This observation ultimately led to the exclusion of the Phase 1 sub-ordinate theme of *'Barriers to help seeking'* when Phase 1 was published as a stand alone study (Al-Roubaiy, Owen-Pugh, & Wheeler, 2013).

The Iraqi refugee men felt that negative pre-migration experiences were more tolerable than exile (Phase 1 sub-ordinate theme of *'Exile worse than pre-migration'*). Similarly, the

Iraqi ex-counselling male clients reported seeking counselling for exile-related difficulties, not for pre-migration experiences (Phase 2 sub-ordinate theme of *'Exile not Iraq'*). The mental health professionals also noted this same experience of exile being more distressing than negative pre-migration experiences among their Iraqi refugee male clients (Phase 3 sub-ordinate theme of *'Exile trauma not Iraqi trauma'*). These findings suggests that post-migration stress can be experienced as more distressing than some of the potentially traumatic experiences that Iraqi refugees might have faced in Iraq.

This observation has been explored in previous studies. For example, when Jamil et al. (2010) examined the distribution of mental health disorders among Iraqi refugees as compared to non-refugee Arab immigrants in the U.S. they found no significant differences between the refugees and non-refugees in terms of major psychiatric disorders. Differences in psychotic disorders were not accounted for but there was a category labelled 'other' to emphasise limiting the comparison to depression and anxiety-related disorders. Jamil et al. (2010, p. 440) concluded that: "Perhaps both refugees and nonrefugees are at equal risk to develop depression and anxiety due to the various psychosocial stressors that accompany assimilation into a new culture".

Similarly, in reflecting on her clinical experience of working with refugees Tribe (1999, p.234) uses the phrase "the trauma of exile" to emphasise the potentially traumatic experiences that refugees face in the UK. Along the same lines, Griffiths (2001, p. 307-308) comments on Kurdish refugee men's experience of the later stages of exile in the UK by noting that "In the context of their political struggle their trauma had meaning, and was perhaps more manageable. However, disappointed expectations in the new cultures could

be experienced as deeply traumatic”.

In yet another example demonstrating exile-related stressors to be more distressing than potentially traumatic pre-migration experiences, Taloyan et al. (2011) came across one participant’s account of comparing his physical torture in Turkey to the psychological torture of social discrimination and exclusion in Sweden, only to arrive at the conclusion that the psychological torture in Sweden is worse. These studies suggest that exile-related stressors and their negative impact on mental health warrant specific attention from counselling researchers and practitioners as their impact seems to be potentially traumatic (e.g. Griffiths, 2001; Jamil et al., 2010; Tribe, 1999) and appears to extend to refugees as well as non-refugees (Jamil et al., 2010).

Pre-migration trauma should not be underestimated when working with refugee clients, but at the same time it should not desensitise practitioners to the exile-related difficulties that refugee clients can bring to therapy. The counselling practitioners described pre-migration trauma in their Iraqi refugee male clients as the main source of distress (Phase 3 subordinate theme of *‘Emphasising pre-migration trauma’*). However, the same counselling practitioners revealed that much of what their Iraqi refugee clients were describing as distress actually revolved around exile-related issues pertaining to their ethnic minority status and experiences of marginalisation and discrimination in Swedish society (Phase 3 sub-ordinate themes of *‘Loss of status’*, *‘Integration difficulties’*, and *‘Exile trauma not Iraqi trauma’*).

One possible explanation for professionals' emphasis on pre-migration trauma might be the abundance of literature on pre-migration trauma and availability of structured therapies to specifically alleviate PTSD symptoms (CBT, EMDR, etc.). Post-migration stress, on the other hand, can be somewhat abstract as it entails psychosocial and socio-political dimensions. While neither of these possible explanations was apparent in participants' accounts, other explanations were (Phase 2 sub-ordinate theme of '*Client reluctance to disclose*'; Phase 3 sub-ordinate themes of '*Difficulty in relating to client's worldview*' and '*Therapist discomfort*').

The adult male Iraqi refugee ex-counselling clients described feeling that Swedish mental health professionals could not appreciate how their ethnic minority status and experiences of discrimination impacted on their psychological wellbeing, and that this perception led them to avoid discussing their experiences of societal racism and discrimination out of concern that their therapists would be incapable of understanding and unwilling to empathise (Phase 2 sub-ordinate theme of '*Client reluctance to disclose*'). This reluctance makes it less likely that therapists will know how much of their Iraqi refugee clients' distress is due to post-migration stress since clients were reluctant to disclose this material. This reluctance by ethnic minority clients to disclose issues pertaining to their ethnic minority status with white therapists has been noted in previous studies (e.g. Cardemil & Battle, 2003; Chang & Yoon, 2011).

Interestingly, the mental health professionals in Phase 3 expressed views that suggest the likelihood of the anticipated lack of therapist understanding and empathy expressed by Iraqi refugee ex-counselling clients in Phase 2. Specifically, the professionals described

feeling discomfort in discussing cultural issues with Iraqi refugee male clients and difficulties in relating to Iraqi refugee male clients' worldviews (Phase 3 sub-ordinate themes of *'Difficulty in relating to client's worldview'* and *'Therapist discomfort'*). It is worth noting that the professionals in Phase 3 were for the most part White Swedish women (5 out of 8 participants) whereas only three were men (1 ethnic Swede and 2 Middle Eastern men). Research has documented the discomfort that white therapists can display in cross-racial interactions and their subsequent avoidance of racial and cultural material in therapy (Turner & Armstrong, 1981; Utsey, Gernat, & Hammar, 2005; Vasquez, 2007). These defensive reactions have been shown to adversely impact on communication and the ability to collaborate effectively with culturally and ethnically diverse clients (Dovidio et al., 2002; Norton et al., 2006).

Another reason for professionals' lack of response to their clients' distress in reaction to exile-related stress might be a lack of empathy and insensitivity to the refugee client's post-migration situation. To a large extent, pre-migration experiences have nothing to do with the counselling professional as a person and are likely to only evoke empathy and understanding. Post-migration stress on the other hand has implications for the counselling professional as a person and member of the host society – bringing into the therapeutic encounter political ideologies and the potential for conflict of interest.

In discussing their counselling experiences, the Iraqi refugee men repeatedly described statements and attitudes communicated to them by therapists that were experienced as highly culturally insensitive and even racist at times (Phase 2 sub-ordinate themes of *'Client as political opponent'* and *'Therapist microaggressions'*). Racial microaggressions

include a wide range of verbal and nonverbal communications that convey insensitivity and/or disrespect regarding some aspect of another person's cultural heritage. Constantine (2007) found, among other things, a negative relationship between clients' perceptions of racial microaggressions and working alliance. Similarly, Owen et al. (2011) found that clients' ratings of racial microaggressions were negatively associated with their psychological wellbeing and that this effect was mediated by clients' ratings of working alliance, highlighting the negative impact of racial microaggressions on the working alliance.

The Iraqi refugee male ex-counselling clients also frequently expressed viewing their therapists as incompetent as a consequence of missing the point or being culturally unaware (Phase 2 sub-ordinate theme of '*Therapist as incompetent*'). This view of the incompetent therapist seemed to often come up when participants experienced situations in which the therapist was imposing his/her political ideology on them as clients (Phase 2 sub-ordinate theme of '*Client as political opponent*') or as a result of culturally insensitive or racist attitudes being conveyed by the therapist (Phase 2 sub-ordinate theme of '*Therapist microaggressions*').

Three Phase 2 sub-ordinate themes ('*Client as political opponent*', '*Therapist microaggressions*' and '*Therapist as incompetent*') in addition to two other Phase 3 sub-ordinate themes ('*Difficulty in relating to client's worldview*' and '*Therapist discomfort*') suggest a lack of cultural competency awareness and an incapability of relating to clients' worldviews among some counselling practitioners in Sweden, thereby adversely impacting on the therapeutic relationship. As Kim, Ng, and Ahn (2005, p. 73) note:

“having a shared worldview among clients and counselors, at least in terms of agreeing on the cause of the problem, is important in establishing a good working relationship and helping clients feel understood by the counselors”.

Similarly, therapists should be aware of the fact that viewing clients as political opponents can be experienced by clients as a form of racial microaggression, especially when the therapist tries to impose his or her ideologies on the client in therapy.

The need for raising awareness of the value of cultural competency among mental health professionals involved in counselling ethnic minority clients is of vital importance for promoting sound and effective psychotherapy practice with all culturally diverse client groups. Neglecting cultural competency can potentially harm the working alliance which in turn can adversely impact on both the process and outcome of psychotherapy. Constantine (2007) found negative relationships between clients’ perceptions of microaggressions and working alliance and both general and multicultural competences of therapists. Conversely, Fuertes et al. (2006) found that practitioners who were rated highly by ethnic minority clients on therapeutic alliance and empathy were also rated higher in cultural competency. These two studies demonstrate that cultural competency is an important requirement for therapists who wish to maintain a strong working alliance with their ethnic minority clients – which seems to be a missing component in most of the therapists that worked with the Iraqi refugee men in phase two of this study.

Most therapists understand the value and importance of establishing and maintaining a strong working alliance with their clients for both the process and outcome of therapy as many studies emphasise this (Horvath & Luborsky, 1993; Hubble, Duncan, & Miller, 1999; Ogles et al., 1999; Safran & Muran, 2000; Wampold, 2001; Yalom, 2001). Therefore if therapists were made aware of how important cultural competency is for maintaining a strong working alliance (e.g. Constantine, 2007; Fuertes et al., 2006; Owen et al., 2011) then perhaps they will prioritise cultural competency as a vital skill in working with culturally diverse and ethnic minority clients such as Iraqi refugee men in exile. Understanding the importance of cultural competency in maintaining a strong working alliance will also serve to challenge the perception of cultural competency being motivated mainly by political correctness and not evidence, as Satel and Forster (1999) have argued.

However, the feeling of discomfort in discussing cultural issues with Iraqi refugee male clients and the difficulties in relating to Iraqi refugee male clients' worldviews that the professionals described (Phase 3 sub-ordinate themes of ***'Difficulty in relating to client's worldview'*** and ***'Therapist discomfort'***) might be also reflective of a certain degree of insensitivity to the plight of Iraqi refugee men in terms of post-migration stress. While this attitude was not expressed by the professionals beyond struggling with accepting the Iraqi client's worldview and discomfort in discussing cultural issues, it was possibly implied in their overemphasis on the effects of pre-migration trauma (Phase 3 subordinate theme ***'Emphasising pre-migration trauma'***) even in light of the feedback they got from their Iraqi refugee male clients (Phase 3 sub-ordinate themes of ***'Loss of status'***, ***'Integration difficulties'***, and ***'Exile trauma not Iraqi trauma'***).

If this is the case, then counselling professionals who fail to take into account their refugee clients' culture and ethnic minority status might simply be doing so as a consequence of viewing the client as a political opponent or as a foreign threat to their society, reflecting anti-refugee sentiment and 'fear of the other'. While this was not expressed by the professionals in Phase 3, it was certainly a recurrent experience among most of the Iraqi refugee ex-counselling clients (Phase 2 sub-ordinate themes of '*Client as political opponent*' and '*Therapist microaggressions*'). This is precisely why culturally sensitive counselling and multicultural competence cannot be achieved without a commitment to social justice. The social justice counselling paradigm "uses social advocacy and activism as a means to address inequitable social, political, and economic conditions that impede the academic, career, and personal/social development of individuals, families, and communities" (Ratts, 2009, p. 160).

Although admirable in theory, applying social justice in counselling is not as straightforward as proponents of this model might want to believe. Critics of the social justice movement in counselling (e.g. Hunsaker, 2011) argue that adherents to this paradigm lack empirical evidence for their claims and exclude counselling professionals who might not share their political views. In addition to being associated with left-wing politics, social justice counselling interventions such as advocacy might be inappropriate in some contexts (e.g. in violation of agency/government rules) or incompatible with the professional's therapeutic approach (e.g. breaching boundaries in therapy).

Additionally, the social justice movement in counselling emphasises anti-racism and anti-oppression philosophies which although well-meaning can, as Corneau and Stergiopoulos

(2012, p. 275) suggest:

“run the risk of perpetuating a stereotype that racialized groups are powerless victims on whom action must be taken, rather than promoting a strengths-based approach that places equal emphasis on people’s strengths and ways of coping”

However, in terms of empirical evidence, the oppression, exclusion, and marginalisation in the accounts of Iraqi refugee men in later stages of exile (Al-Roubaiy, Owen-Pugh, & Wheeler, 2013) can only be addressed by counselling interventions that are associated with the social justice movement – specifically empowerment and advocacy. Similarly, the existence of anti-refugee sentiments and potentially oppressive attitudes among counselling theorists and practitioners should be taken as evidence of the desperate need for the social justice counselling paradigm. In the following four pages, I will discuss some literature which specifically highlights the insensitivity, or lack of awareness, which some counsellors have of refugee clients’ social realities of discrimination and marginalisation.

To start with, here is an example taken from an article on refugee group psychotherapy:

“there is the unconscious transmission of trauma of refugees to their descendents, such as children of political refugees living in peaceful tolerant communities perceiving their environments as constantly hostile and persecutory...an essential task of therapy is to make increasingly conscious the factual social reality of the trauma as it has been transmitted to the next generation...” (Tucker, 2011, p. 70).

The insensitivity, or lack of awareness, in the above observation lies partly in the fact that the author does not go on to address the possibility that such clients can indeed be living in “hostile and persecutory” environments. Similarly, in stating that “an essential task of therapy is to make increasingly conscious the factual social reality of the trauma” (Tucker, 2011, p. 70), the author implies that she has access to the actual social reality of the refugee clients who are bringing to therapy their experiences of being in hostile and persecutory communities, which the author/therapist dismisses as reality and interprets as a consequence of the trauma transmitted from refugee parents to their descendents. Now, the genuine insensitivity in this rationale is not only inherent in the stigmatising and disempowering notion of ‘the ever lasting trauma of refugees’, but also in the immense feeling of injustice and invalidation that the client would feel if this therapist is wrong.

The above mentioned example can also be interpreted as a possible lack of awareness or understanding of the reality of discrimination and racism that all minority groups experience in most countries. Such lack of awareness, or insensitivity, can easily explain why some counsellors might question and distrust refugee clients and consequently refuse to help with practical matters, or even feel used or betrayed in response to such requests. For example, in their study on counsellors’ experiences of working with refugees in the UK, Century et al. (2007, p. 33) observed that:

“While all counsellors appreciated that practical issues such as obtaining adequate family housing, welfare benefits and legal status were very important for these clients, they had varying and often strong views about how much they should get

involved in such matters”.

The interesting words in the above extract are “strong views”, because they imply an emotional reaction that is probably more intense than trying to preserve boundaries. For example, Century et al. (2007, p. 34) describe this interaction between a young female refugee client and a counsellor:

“at the end of the allotted sessions, the girl beseeched the counsellor to come to her house as she was ill and needed help. On arrival at the house the counsellor was asked by the girl if she would sign a Home Office form to enable her mother to stay in the country. She felt ‘tricked’ and deeply upset”

In the above mentioned example, the counsellor’s strong reactions of feeling tricked and being upset do not make sense to me as her refugee client had only made this request “at the end of the allotted sessions”, not before or midway; thereby guaranteeing no loss of time or money for the counsellor and suggesting no indication of deception or fraud. As for the reason the counsellor was asked home, well wanting your mother to stay with you, as opposed to leaving you alone in exile and going off to a conflict-ridden country to face an uncertain destiny is more than justification for the refugee girl to claim that “she was ill and needed help”. Similarly, Century et al. (2007, p. 36) note that:

“most counsellors raised serious difficulties relating to the maintenance of client-counsellor boundaries, some of which appeared to be profound and perhaps disturbing. These difficulties were reported as extremely difficult to disclose and

counsellors had spent considerable time on their own or in supervision grappling with the issues these raised. Thus, some counsellors describe how their usual and established client boundaries seem to be threatened, and sometimes lowered, in the work with refugees” (Century et al., 2007, p. 36).

Again, the key words to note in the above mentioned extract are “profound and perhaps disturbing” in reaction to “difficulties relating to the maintenance of client-counsellor boundaries”, an exaggerated emotional response when one considers the lack of clearly defined boundaries in theory and practice (e.g. Gutheil & Brodsky, 2008).

For example, in discussing how the concrete can intrude into the therapeutic space of psychotherapy groups for refugees and asylum seekers, Tucker (2011, p. 69) notes:

“When the concrete intrudes into these groups it can be thought of as an attack on the symbolic therapeutic space. Certainly, at times, these sorts of attack have felt like violent bombardments in which my sense of meaning as the group psychotherapist and my sense of the purpose of the therapeutic space have been severely compromised”.

The issue of boundaries in clinical practice is not as clear cut as some counsellors seem to suggest, and quite often what constitutes a breach of boundaries in one context might not do so in another (Gutheil & Brodsky, 2008). In reviewing Gutheil’s and Brodsky’s book on preventing boundary violations in clinical practice, Owen-Pugh (2010a, p. 131) concludes that the authors’ message is that “there are no simple answers to the question of what

constitutes a boundary crossing or violation”.

So if it is not the boundary breaches that are upsetting some counsellors in response to requests for practical help from refugee clients, then what is? Perhaps it is the feeling that this refugee client is not trustworthy and therefore undeserving of my help. As Century et al. (2007, p.33) note:

“counsellors stress the need to ‘give witness’, ‘acceptance’ or ‘offer validation’ to the refugee experience, such counselling values are rarely provided without a consideration that the counsellor or the ‘system’ may be prey to manipulation by the refugee”

This attitude would certainly explain why some counsellors would refuse and get upset by requests for practical help from refugee clients. As Century et al. (2007, p. 38) note:

“more concerning is the background perception or anxiety of refugee clients as manipulative and the sense of when the counsellors feel that the sessions are being used for ulterior purposes”.

In his psychodynamic approach, Blackwell (2005b) emphasises the importance of addressing the practical and social problems that refugee clients might bring to counselling, even if some of these problems seem beyond the scope of therapy. Others suggest that refugee “clients present with contemporary concrete problems, which can only call for concrete solutions and in this way intrude into the therapeutic space” (Tucker, 2011, p. 75).

The Phase 3 sub-ordinate theme of '*Needing practical help*' suggests the need for counselling practitioners to engage in advocacy with or on behalf of their Iraqi refugee clients – which can complement the talking therapy being used as both are experienced by Iraqi male refugee clients to be helpful (Phase 2 sub-ordinate theme of '*getting things off my chest*' and Phase 3 sub-ordinate theme of '*It helps to talk*'). Considering the vagueness of boundaries, why are some therapists willing to offer refugee clients practical help when others are not? While some mental health professionals might be unaware of advocacy as a legitimate branch in counselling, others might simply be restricted by their training, theoretical orientation, or profession.

In this study, the mental health professionals in Phase 3 were made up of five psychologists, two counsellors/social workers, and one psychotherapist – with theoretical orientation in CBT, psychodynamic, and a variety of integrative approaches. As discussed in Chapter 1 under the heading of 'Counselling and psychotherapy', the term 'psychotherapy' is the more dominant term in clinical and academic settings in Sweden, while the term 'counselling' is often avoided. A primary example of this avoidance is the fact that in Sweden psychologists can specialise in many fields, such as clinical or educational psychology, but counselling psychology simply does not exist (Al-Roubaiy, 2012a). One possible explanation for the view among the professionals in the study regarding the inappropriateness of responding to requests for practical help from their clients (Phase 3 subordinate theme of '*Needing practical help*') might be the consequence of not having 'counselling psychology' as a field of study and practice in Sweden.

When one reads journals such as *The Counseling Psychologist*, *Journal of Counseling Psychology*, *Counselling Psychology Quarterly*, and *Counselling Psychology Review*, it becomes apparent how often terms such as ‘social justice’, ‘advocacy’, and ‘empowerment’ come up. In a theoretical article on the need for the Swedish Psychological Association to include counselling psychology in the training and practice of Swedish psychologists, I (Al-Roubaiy, 2012a) argued that we as a profession are missing out on social justice, advocacy, and empowerment thinking due to this gap in Swedish psychology.

Perhaps the lack of multicultural competence, socio-political inattentiveness, and disregard for clients’ requests for practical help that the professionals displayed (Phase 3 sub-ordinate themes of *‘Difficulty in relating to client’s worldview’*, *‘Therapist discomfort’*, and *‘Needing practical help’*) are evidence for the consequences of this gap in Swedish psychology. Similarly, the experiences of the Iraqi refugee ex-counselling clients that demonstrate a similar view of Swedish mental health professionals (Phase 2 sub-ordinate themes of *‘Client as political opponent’* and *‘Therapist microaggressions’*) might further support this theory.

However it is important to note that the difficulty described by professionals in Phase 3 in terms of discussing cultural issues and relating to the client’s worldview does not necessarily imply a lack of empathy or insensitivity as admitting to struggling with such issues is understandable. The experiences of ex-counselling clients in Phase 2 were generally reflective of a lack of empathy from the therapists the participants had seen. It is therefore crucial to emphasise that the therapists in Phase 3 were not the therapists that the Iraqi refugee men saw as clients (unless coincidently so). Additionally the experiences

described by the participants in Phase 2 were simply reflective of how each participant experienced his therapist and therapeutic process – not necessarily a reflection of reality.

It is also crucial to note that although the findings suggest the need to adopt a social justice paradigm in working with Iraqi refugee men, all clients can benefit from such an approach because power imbalances and oppression are part of client realities across a range of different genders, ethnicities, and class backgrounds. As Crethar, Rivera, & Nash (2008, p. 272-273) argue:

“From a multicultural/feminist/social justice counseling perspective, the rights of women need not be perceived as competing with the rights of people of color...multicultural/feminist/social justice oriented counselors strive to foster the empowerment of all people while placing a particular emphasis on those persons in positions of less relative power and privilege”.

Another Phase 2 sub-ordinate theme to emerge from participants’ accounts of their counselling experiences which further demonstrates the need for empowerment and advocacy-based thinking is that of ***‘Lack of therapist transparency’***, which refers to the recurrent experience of Iraqi refugee male clients not being informed of therapists’ education, orientation in therapy, and treatment structure and goals. Similarly, some mental health professionals described certain limitations in transparently involving their Iraqi refugee male clients in the theory and structure of therapy (Phase 3 sub-ordinate theme of ***‘Limited therapist transparency’***). However, it should be noted that for the most part, the

professionals in Phase 3 described attempts to involve clients by explaining the structure and goals of therapy.

Transparently engaging clients in therapy through sharing with clients information about the therapist's education, profession, theoretical orientation, in addition to the structure and goals of therapy ought to be a priority for all therapists – especially when working with ethnic minority clients. As Dass-Brailsford (2012, p. 41) notes:

“Transparency is an important ingredient in the therapeutic encounter since it plays a significant role in balancing the power inherent in the therapeutic relationship; reducing this by being clear about the process is important”.

Not only is therapist transparency important for balancing the power in the therapeutic relationship, but it is vital for establishing the working alliance as agreement on goals and assignment of tasks are essential components of the working alliance across therapies (Bordin, 1979; Duff & Bedi, 2010; Wampold, 2001). Again, it should be noted that therapists' limited transparency – as expressed by professionals in Phase 3 – might simply reflect a difficulty in communicating effectively with the client due to cultural and language barriers. The professionals in Phase 3 were all genuine in their attempts to communicate effectively and transparently with their Iraqi refugee clients – as evidenced by their willingness to take part in this study in the hopes of shedding more light on the subject. In being open about their difficulties in working with this client group, the professionals in Phase 3 contributed considerably to achieving the aims of this study.

Contribution to knowledge

Post-migration stress among Iraqi refugee men in later stages of exile encompasses psychosocial and socio-political dimensions that revolve around the experience of several forms of oppression. Iraqi refugee men who, after living in Sweden for many years, realise that they are still not part of the host society are confronted with an array of dilemmas. They have invested many years of their lives in Sweden and can no longer go back to Iraq because *their* Iraq simply no longer exists. Their attempts at maintaining links with Iraq and Iraqi culture can never equate to being there and experiencing or contributing to the changes that have occurred in Iraqi society during all those years they were living in Sweden. Also, the changes that have occurred in them as a result of interacting with Swedish society further isolate them in that only other Iraqi refugees who have lived long enough in Sweden can comprehend the cultural distance between Iraqi and Swedish culture. Furthermore, the fantasies about civilisation, democracy, and freedom – that are ingrained in the minds of many Iraqi refugees that come to the West – can become an intense source of distress when the reality of poverty, racial discrimination, and marginalisation shatters these fantasies and hopes.

Counselling professionals who attempt to work with this client group should be aware of the fact that assessing such clients' level of acculturation or world view is far more complex than the literature on these subjects suggests because Iraqi refugee men in later stages of exile can struggle with their own conflicting identities as any person who lives in a society for many years is bound to be influenced by its peoples' culture. Acknowledging or even recognising that we, as Iraqi refugee men who have lived in Sweden for many

years, can think, feel, and behave in Swedish ways is not an easy thing to appreciate for an outsider to this experience. Our traditional patriarchal Iraqi culture and the varying degrees of militarised masculinity that we have been brought up on for generations in Iraq causes considerable tension when parts of our psyche might be more in tune with, or at least aware of, the conflicting Swedish counterparts to these Iraqi cultural norms. This tension and internal conflict becomes even more distressing when Iraqi refugee men attempt to accept their partially Swedish personalities only to be reminded by Swedish society that they are not Swedish. These reminders come in many forms, but for the most part through the systematic and institutional racism and discrimination that Iraqi refugee men described in this study.

In my REBT approach to working with Iraqi refugee exile-related stress, I address the psychosocial components of these stressors and help clients *adapt to* (not accept) the distress that comes from encountering these psychosocial stressors. While I briefly introduced my REBT approach in Chapter 1 under the heading of ‘My experiences as a psychologist working with refugees’, I did not discuss my REBT conceptualisation of these stressors or the strategies that I have employed in addressing them. Since the findings of this study revolved mainly around the oppression that Iraqi refugee men experienced as a consequence of societal racism, I will only discuss this aspect of my REBT approach to exile-related stress.

“In societal racism, the activating events (A) were often racist attacks and subtle institutional racism. The cognitive consequences (C) were thoughts about being discriminated against and treated as less worthy. The emotional consequences (C)

were often feelings of inferiority, cultural shame, and anger. The irrational beliefs held about the societal racial discrimination were mainly: “I cannot handle being discriminated against, so I must hide my refugee and Iraqi background” and “all Swedes are civilised and all Iraqis are primitive, so I must prove to Swedes that I am as civilised as they are and prove to Iraqis that I am not as primitive as they are”. Disputing (D) those irrational beliefs often led to the new and effective (E) rational beliefs being: “I can handle being discriminated against and I do not need to hide my refugee and Iraqi background” and “not all Swedes are civilised and not all Iraqis are primitive, and I do not have to prove being civilised neither to Swedes nor to Iraqis” (Al-Roubaiy, 2012b, p. 46-47).

Of course this REBT approach to societal racism is only empowering in terms of accepting clients’ experiences of social cues as oppressive and racist no matter how subtle or unclear to therapists. The danger in using such an approach when a therapist does not share the Iraqi refugee client’s ethnic minority status is that it might be suggestive of an acceptance of societal discrimination and inequality. As Ellis and Carlson (2009, p.226) state:

“as a result of their own discomfort, counselors may too quickly focus therapeutic goals on helping the client adjust to inequities or to develop coping strategies to get along in mainstream culture. ‘Adjustment’ that perpetuates injustice, however, is not an appropriate goal, particularly when inequality and discrimination are social norms”.

However, as an Iraqi refugee man who had lived for so many years in Sweden, I have first hand experience in the distress that accompanies refusing to adjust at some level to the societal racial discrimination that we live with in Sweden. Challenging societal racism can place a huge burden on the ethnic minority person. At some level, we need to function in society while we are attempting to change some of its unjust values – otherwise every day will be a battle against injustice which is not as positive as it sounds if you had to actually live it. The other option, which is at the extreme opposite of always battling the injustice of racism is internalising it. Although I detected some possible hints of internalised racism in this study among two Iraqi refugee men, it was considerably milder than what I have come to encounter in my own counselling practice with this client group. Therefore, a balanced approach is more feasible than a strictly politically correct one. The three REBT techniques that I have found to be the most helpful with this client group are: ‘disputing strategies’; ‘semantic precision’; and ‘shame-attacking exercises’.

“Using disputing strategies, I challenged clients’ irrational beliefs by highlighting the faulty reasoning in the absolute demands that they were making about themselves, others, and their environment (e.g. “I must never be discriminated against”). Using semantic precision, I encouraged clients to not use language carelessly and to try to be as precise as possible, especially with self-talk, which can perpetuate irrational beliefs (e.g. using words such as ‘horrible’ and ‘impossible’ when they actually meant ‘unfortunate’ and ‘difficult’). Using shame-attacking exercises, I encouraged clients to carry out certain behaviours in public that they considered shameful (e.g. speaking Arabic in a Swedish restaurant) so that they could experience the discomfort and learn that they can tolerate it and accept

themselves even when they receive disapproval from others. In adapting the new rational beliefs, and as a consequence of understanding and implementing the idea that ‘A’ does not cause ‘C’ and that ‘B’ is the target for change in order to elicit the healthy types of ‘C’, many of my clients reported feeling the healthy alternatives to their original unhealthy emotions; mainly concern instead of anxiety, sadness instead of depression, disappointment instead of shame, and annoyance instead of anger” (Al-Roubaiy, 2012b, p. 47).

Therefore, Western therapists working with Iraqi refugee male clients should be aware of this spectrum of responses to societal racism and at the very least not contribute to the problem by conveying racist or culturally insensitive attitudes to their clients in therapy. Multicultural counselling competencies can be especially valuable for professionals who want to work with this client group because they foster awareness of therapists’ own biases, thereby reducing the risk of a client being discriminated against by the therapist. However, this should not equate to pressuring clients into standing up for their rights and fighting for equality at all costs, as some counselling professionals do under the guise of empowerment – unless they are willing to help themselves. Only then can it be considered an empowerment intervention.

White and Western therapists working from a multicultural perspective with this client group should aim for a balanced approach in addressing societal racism – in other words, do not send out your clients on a quest to change society while you sit and observe from a safe distance. Oppression can occur at three levels: individual (e.g. discrimination); social/cultural (e.g. societal norms); and institutional levels (e.g. policies) (Hardiman &

Jackson's, 1982). While my REBT approach addresses the psychosocial aspect of societal racism, it does not address the socio-political dimension of oppression and racism in society. When Iraqi refugee clients ask for my help in writing a letter to a government agency or to translate a letter, I do not hesitate. The need for practical help among Iraqi refugee men who have lived in Sweden for many years often reflects societal injustices and oppressive treatment by the dominant members in society. This can only be addressed when therapists adopt a socio-politically responsible approach to working with their clients.

“Sociopolitical awareness and cultural sensitivity can only go so far in terms of addressing the oppression that refugee clients can experience in exile. While multicultural theory can foster an anti-racist attitude between an ethnic minority client and his or her therapist, it offers little in addressing racism in society. Similarly, a socio-politically aware approach to counselling refugee clients might foster understanding and empathy but this empathy does not necessarily translate into action. A counselling and psychotherapy professional who is socio-politically aware is in tune with the injustices a refugee client can encounter in society - a socio-politically responsible one is willing to act on this awareness either with or on behalf of clients when necessary” (Al-Roubaiy, Owen-Pugh, & Wheeler, 2013, p. 65).

Contribution to theory

The findings of the study suggest the need for adopting a social justice perspective in counselling Iraqi refugee men in later stages of exile as participant accounts revolved mainly around their experiences of various forms of oppression in Swedish society – including racial microaggressions from therapists. Similarly, mental health professionals described difficulty in relating to this client group’s worldview. This gap in relational empathy can be addressed when therapists attempt to emphasise the therapeutic relationship in working with this client group in a particular way. Specifically, the anti-refugee sentiment among counselling practitioners in the literature discussed in Chapter 5 under the heading of ‘Main Findings’, suggest a gap in empathy and compassion.

Rogers (1957, p.99) described empathy as a therapist’s ability “to sense a client’s private world as if it were your own”. A similar concept to empathy is that of ‘compassion’, which Vivino et al. (2009) view as similar to, yet different from, empathy. Vivino et al. (2009) investigated how therapists conceptualise and use compassion in psychotherapy and found that fourteen therapists, who were nominated by peers as compassionate, defined compassion in psychotherapy as connecting with the client’s suffering and promoting change through action. It is the *action* component of compassion that seems to differentiate it the most from empathy.

As Vivino et al. (2009, p. 161) note, “compassion goes beyond the Western notion of empathy and implies the necessity of taking action...going beyond traditional boundaries when necessary”. If taking action on behalf of clients is part of being a compassionate

therapist as Vivino et al. (2009) suggest, then advocacy-based counselling interventions which promote the same idea should surely be viewed as part of, or in support of, facilitating compassion in psychotherapy. Vivino et al. (2009, p.161) also found that compassionate therapists described compassion as an inner experience of “feeling loving kindness, being nonjudgmental and accepting of the client, and being genuine and open”.

This nonjudgmental and accepting attitude greatly resembles Rogers’ unconditional positive regard, and being genuine and open can easily be interpreted as Rogers’ congruence. Clearly compassionate therapists must share some of the ideas of person-centered therapists, at the very least the belief that the core conditions of congruence, unconditional positive regard, and empathy are important (as opposed to being both necessary and sufficient according to person-centred therapists) in bringing about therapeutic change. Vivino et al. (2009) also found that even compassionate therapists had difficulty feeling compassion for some clients at times, and that they employed strategies (e.g. supervision, consultation, resolving external issues, etc.) in order to regain their compassionate stance when this occurred.

Therefore counselling professionals who find themselves struggling with experiencing and conveying Rogers’ (1957) core conditions and compassion as conceptualised by Vivino et al. (2009), should either work at attaining and maintaining these values when working with this client group, or refer them to counselling professionals who can or want to live up to this high relational standard.

Contributions to practice and policy

When I attempt to bring together my findings, I find myself arriving at a model which I propose therapists utilise, or at least consider, when counselling Iraqi refugee men in later stages of exile in Sweden, and perhaps other Western countries. The model is based on Cooper and McLeod's (2007, 2011) pluralistic approach to psychotherapy. The structure of the model is simple - therapists and clients are encouraged to work on "the formation and maintenance of a collaborative therapeutic alliance, emphasising dialogue around the goals, tasks, and methods of therapy" (Cooper & McLeod, 2011, p. 9). Goals are meant to fluidly represent what clients want from life ('life goals') and from therapy ('therapeutic goals'), while tasks are meant to represent the macro-level strategies by which clients can achieve these goals. Similarly, the term 'methods' is meant to represent the micro-level activities that both clients and therapists undertake in helping the client achieve the desired goals.

The main principle behind this pluralistic approach to addressing post-migration stress among this client group is that it should be used only when the individual client expresses the need for formulating goals that revolve around issues similar to the experiences identified in the study. Additionally, therapists are advised to structure the methods of achieving these goals with clients in a highly collaborative manner. Metacommunication and the use of feedback are emphasised in this model in order to address ruptures in the working alliance, clash of political ideologies, racial microaggressions, and clients' reluctance to disclose issues pertaining to their ethnic minority status in good time before such situations impact on the process of therapy beyond reconciliation.

In the present study ex-counselling clients experienced racial microaggressions and felt like they were treated as political opponents, while therapists described their discomfort in discussing cultural material and their inability to relate to Iraqi male clients' worldview. Therefore, another major component of my pluralistic model is cultural sensitivity which includes the three MCC competency domains (Sue et al. 1992, 1998) of: 1) counsellor awareness of own cultural values and biases; 2) counsellor awareness of the client's worldview; and 3) culturally appropriate intervention strategies – in addition to the skill of 'dynamic-sizing' (Sue, 1998) which refers to the counselling practitioner's ability to know when to generalise and when to individualise.

I also propose an emphasis on the therapeutic relationship from the therapist's perspective, where compassion (as different from Carl Rogers' empathy) in addition to Rogers' core conditions of empathy, congruence, and unconditional positive regard are central. For client-centered and other humanistic therapists, this last component in my proposed pluralistic model is already at the heart of much of their practice and theory with all clients. Compassion can help white therapists connect with their Iraqi refugee clients' suffering in reaction to exile-related issues, thereby encouraging clients to disclose material they would otherwise consider withholding from white therapists who are generally seen to be incapable of, or unwilling to, empathise with ethnic minority issues.

Additionally, by adopting Rogers' core conditions, therapists working with Iraqi refugee men can benefit themselves and clients in several ways. Empathy equates to understanding which is likely to lead to culturally and socio-politically aware therapists. Unconditional positive regard can help therapists identify potential prejudice against clients and can allow

for a more genuine attempt at relating to the client's worldview. Congruence is also valuable in that it can aid therapists in deciding whether or not their political ideologies allow for the experience of compassion for Iraqi refugee male clients or not. In cases where a therapist might find himself or herself questioning the integrity and motives of their refugee clients without evidence, then a congruent stance would encourage such a therapist to either work on attaining and maintaining (e.g. through supervision) a compassionate and respectful view of their client (i.e. giving them the benefit of the doubt) or referring them to someone else.

Last but not least, my pluralistic model includes a social justice element in which therapists are encouraged to promote the ideas of equality and diversity and help counteract oppressive social attitudes such as anti-refugee sentiment and racial discrimination. One of the most effective and structured ways of attempting this is through the utilisation of the Advocacy Competencies framework (Lewis, Arnold, House, & Toporek, 2002). The Advocacy Competencies include three levels of advocacy: 1) client; 2) community; and 3) public arena. Each level of advocacy contains two domains that stress advocacy with, and advocacy on behalf of the client. The client level entails empowering individuals and advocating on their behalf if the need arises. The community level involves collaboration with organisations to bring about change. The public arena level is concerned with shaping public policy and informing the public about systemic barriers that affect human development.

It is precisely through the public arena level of advocacy that policy can be shaped in order to address the issues explored in this study. When counselling professionals emphasise the

nature of oppression and anti-refugee sentiment in Western societies, they allow for a genuine discussion on how policy can be influenced to address these societal inequalities. While not all mental health professionals can, or want to, engage in social advocacy and political activism, raising awareness through training, supervision, practice, and research regarding some of the elements described in my pluralistic model (e.g. MCC) can ultimately benefit a wide range of clients from ethnic minority groups in Sweden. Additionally, introducing counselling psychology into the training and practice of Swedish psychologists is well overdue, especially considering the cultural diversity and continuous flow of refugees that the country has experienced in recent years – a fact which clinical, educational, and occupational psychology does not address.

Ideally, I hope to influence policy specifically by promoting my pluralistic model to working with Iraqi refugee men who might be struggling with post-migration stress in the later stages of exile in Sweden, and perhaps other Western countries. The true strength of this pluralistic model lies in the pluralistic philosophy of situating the client experience at the heart of all theorising and interventions. Therapists working with this client group need to approach each client's individual experience as both linked to, and separate from, other Iraqi refugee men. Even when the Iraqi refugee male client expresses distress in reaction to post-migration stress in later stages of exile, my pluralistic model is only meant to highlight possible pathways in interacting with, and helping, such a client.

Contribution to method

McLeod (2001) proposed the concept of ‘critical reflexivity’ which emphasises both the researcher’s personal experiences in relation to the research, and the wider social and cultural context in which the research is conducted. In the present study, I attempted to approach my analysis through the use of ‘critical reflexivity’ as much as possible – especially considering the fact that my experiences of Iraqi refugee post-migration stress are a reflection of personal and social influences which have ultimately collectively shaped this research project. Throughout the analysis, I tried to reflect on how my background and understanding of the Iraqi refugee experience were influencing the process and outcome of this study. I was not only influenced by my experiences as an Iraqi refugee but also by my theoretical approach to counselling Iraqi refugees. McLeod (2001) argues that a researcher’s theoretical orientation in counselling can also influence the research process and outcome.

I started out my research from an REBT background, thinking that the practical help and political activism that marked some of my counselling practice with Iraqi refugee clients was more of an overflow of my personal issues into my practice. However, in the few years that I have spent working on this study I experienced a shift in understanding that led me to where I am today in terms of professional identity. I now see myself as a social justice counselling practitioner and researcher. I believe that in truly adopting this type of reflexive approach, new understandings and experiences are possible even with subject matter that one might believe to be all too familiar. This study can serve as a novel example of how critical reflexivity can be approached and how powerful its effects can be on the researcher.

Limitations of the research

Reid (2002, p. 105) argues that “Given the task of putting gender in multicultural studies, it is difficult to focus exclusively on one group or another”. This was certainly a limitation in the current study as some findings were difficult to attribute to either culture or gender. For example, the barriers to help seeking that were partly apparent in Iraqi men’s reluctance to seek counselling were possibly attributable to both masculine traits and cultural stigmatisation of mental illness. Another limitation was the use of three participants from Phase 1 in Phase 2, as opposed to recruiting a totally new sample. This entailed a limitation because it further limited the number of Iraqi refugee participants who were already few.

Another limitation was the somewhat essentialist construction of ‘Iraqi culture’ and ‘white Swedish therapist culture’ which came about as a result of the data indicating such polarised positions. A more nuanced positioning of both groups would have been more in tune with non-essentialist constructions of culture (e.g. Bassel, 2012) and possibly more accurate in terms of generalisation. Similarly, the fact that some Iraqi refugee men might have overlapping worldviews with ethnic Swedes was not explored as the data suggested a strong tendency among the Iraqi refugee men to become even more traditional in their thinking as a result of the exclusion and marginalisation they experienced.

Not being able to generalise due to the small samples involved was another limitation, but in considering the philosophy behind the method of analysis perhaps this becomes of less relevance. As most IPA studies do, the present study emphasised thinking “in terms of theoretical transferability rather than empirical generalizability” (Smith, Flowers, & Larkin,

2009, p. 51). Transferability makes less forceful claims that the findings will be true to all or most situations, instead suggesting that the reader may be able to find some useful ideas and information from the findings (Dallos & Vetere, 2005, p. 23-24).

One other possible limitation in this study might be reliability. The impact of having a shared history, gender, culture, and language with the Iraqi refugee participants in Phase 1 and Phase 2 makes it unlikely that another researcher would be able to duplicate the findings unless he happened to share these same characteristics with participants. Having said that, reliability might not be an issue in terms of duplicating the findings from Phase 3 since being a counselling professional suggests having a shared platform with other counselling professionals, to varying degrees, in terms of counselling and psychotherapy training and clinical experience. However, Willig (2001, p. 17) notes that “there is disagreement among qualitative researchers about the extent to which reliability ought to be a concern for qualitative research”.

In terms of strengths, the present study can be considered to have high external validity as participant accounts were explored through semi-structured interviews, thereby allowing for spontaneous and flexible answers to emerge in a relatively naturalistic setting. Reflexivity and the use of external analysis represent further strengths as both strategies enhanced validity by highlighting the researcher’s prior assumptions and controlling for potential biases.

Conclusion

The findings suggest the need for promoting social justice thinking among professionals engaged in counselling this client group. In addition to incorporating empowerment and advocacy-based counselling, the results of the present study also suggest the need for counselling practitioners to convey their interest and comfort in discussing culturally sensitive material with their ethnic minority clients – in culturally competent ways that can help avoid unnecessary ruptures in the working alliance due to racial microaggressions and/or due to a lack of transparency from therapists. Furthermore, the findings suggest the need for raising awareness among researchers of the reality and true nature of racism and marginalisation that refugees face in host countries – especially considering the fact that insensitivity to these issues can even be found among some counselling practitioners.

In terms of future research, the following issues tend to resonate with me the most:

- The experiences of Iraqi refugee women in the early and later stages of exile.
- The experience of Iraqi asylum seekers in the early stages of exile.
- The countertransference of counselling professionals working with Iraqi refugees.
- The political ideologies of counselling professionals working with Iraqi refugees.
- The argument for and against introducing counselling psychology in Sweden.
- The views of counselling professionals regarding the ethics behind advocacy.

In terms of recommendations, my proposed pluralistic model to working with this client group and for this set of issues can be considered my main recommendation. Additionally, counselling professionals working with this client group should consider the following points:

- Iraqi refugees can face several post-migration stressors in Western host countries which can add to, or interact with, pre-migration trauma in giving rise to the observed psychological distress among refugee clients.
- The subjective experience of what the client experiences as trauma should always be the focus of the counselling work done with the refugee client as research suggests a variety of different reactions to potentially traumatic experiences.
- Empowerment and advocacy-based counselling approaches seem to have the most relevance for addressing Iraqi refugee men's experience of post-migration stress in later stages of exile.
- Counselling professionals who find themselves struggling with experiencing and conveying Rogers' (1957) core conditions and compassion as conceptualised by Vivino et al. (2009), should either work at attaining and maintaining these values when working with this client group, or refer them to counselling professionals who can or want to live up to this high relational standard.

Appendices

Appendix 1: Information sheet for Phase 1 in English

Dear fellow Iraqis,

I came to Sweden in 1993 as an Iraqi refugee and I am today working as a psychologist in Malmo. I am currently working on a research study that is going to form a major part of my PhD degree in counselling and psychotherapy from the University of Leicester. This study has two major aims: 1) The exploration of the positive as well as the negative social and psychological aspects of life in Sweden. 2) The exploration of the various support and help systems available to Iraqi refugees in Sweden.

The participants needed for this study are ten adult male Iraqi refugees who have lived in Sweden for a minimum of five years. This study aims to inform mental health professionals of the psychosocial realities of life in Sweden as experienced by adult male Iraqi refugees who have lived in Sweden for longer periods of time. This study has the potential to improve counselling services offered to Iraqi refugees living in Sweden and perhaps other similar western countries.

Participation will involve an individual interview with the researcher that should last roughly an hour. The interview will be held in a room here (the Iraqi cultural association in Malmo). The interview will be audio taped to be later translated and transcribed by the researcher. Participant names will not be used in the audio recordings nor will they be used in the transcripts. Instead numbers will be assigned to each participant to preserve

anonymity. The audio recordings and transcripts will only be available to the researcher and his supervisor to ensure the highest levels of confidentiality. The transcripts will be kept until they are no longer necessary for potential publication purposes while the interview tapes will be destroyed upon successful completion of the PhD course.

You have the right to withdraw from the study at any point during or after the interview; as long as it is before data analysis. Should you be disturbed by any of the issues discussed during the interview, the researcher can provide you with names and contact numbers to appropriate counselling agencies if you ask for them. This study is subject to the University of Leicester's Research Ethics Code of Practice and is fully supervised; therefore if you feel that you were treated badly during the interview process and the researcher was incapable of addressing the issue, you can make a direct complaint to the research supervisor, Dr. Valerie Owen-Pugh (vap4@leicester.ac.uk).

I would be very grateful if you could contact me on the details provided at the end of this information sheet if you are interested in participating.

With thanks and regards,

Najwan Al-Roubaiy

Tel: 0707231284

najwanuk@yahoo.co.uk

Appendix 2: Information sheet for Phase 1 in Arabic

اعزائي و اخواني العراقيين

اتيبت الى السويد عام 1993 كلاجئ من العراق، و انا اليوم اعمل كأخصائي نفسي في مدينة مالمو. اعمل حالياً على دراسة علمية تشكل جزءاً رئيسياً من رسالة الدكتوراه في العلاج النفسي من جامعة ليستر البريطانية. الدراسة لها هدفان: الاول هو استكشاف الجوانب الاجتماعية و النفسية، الايجابية منها و السلبية، في الحياة بالسويد. الثاني هو إيجاد مصادر الدعم و المساعدة المتوفرة لمساندة اللاجئين العراقيين في السويد.

المتطوعون المطلوبون للمشاركة هم عشرة رجال عراقيين من اللذين جاؤا الى السويد كلاجئين، و عاشوا فيها لمدة لا تقل عن خمس سنوات. تهدف هذه الدراسة لتوعية الاخصائيين النفسيين بالحقائق النفسية و الاجتماعية التي تواجه الرجل العراقي المقيم في السويد لفترات طويلة من الزمن. هذه الدراسة قد تؤدي الى تطوير اساليب تقديم العلاج النفسي للاجئين العراقيين في السويد، و ربما بدول اخرى مشابهة لها.

المشاركة تتضمن مقابلة فردية مع الباحث لمدة ساعة تقريباً. المقابلة ستجرى في غرفة (بالجمعية الثقافية العراقية في مالمو)، وسوف تسجل صوتياً ثم تترجم و تحلل من قبل الباحث. اسماء المشاركين لن تستعمل في التسجيلات الصوتية و لا في الكتابة. وبدلاً عن الاسماء سيرمز برقم لكل مشترك للمحافظة على سرية هويته. التسجيلات و التحاليل المكتوبة سوف تكون فقط في حوزة الباحث و المشرف على البحث لضمان اكبر درجة من الخصوصية. التحليلات المكتوبة سوف تحفظ الى حين عدم الحاجة اليها لاسباب النشر. اما التسجيلات الصوتية فستستمر حتى اتمام متطلبات رسالة الدكتوراه.

للمتشارك الحق في الانسحاب من الدراسة في اي وقت اثناء او بعد المقابلة شرط ان يكون ذلك قبل تحليل النتائج. اذا استاء المشارك بسبب اي موضوع يناقش اثناء المقابلة، يستطيع الباحث توفير اسماء و ارقام الاماكن المختصة بالعلاج النفسي المناسب اذا طلب المتشارك منه ذلك. هذه الدراسة تخضع الى قواعد جامعة ليستر في ممارسة الابحاث بشكل اخلاقي، و يتم الاشراف عليها بشكل كامل. لذلك اذا شعر المشارك بانه لم يعامل بشكل لائق اثناء المقابلة، و لم يستطع الباحث علاج الموضوع بنفسه، يمكن للمشارك ان يتقدم بشكوى للمشرفة على البحث:

Dr. Valerie Owen Pugh (vap4@leicester.ac.uk).

اكون شاكراً لو يتم الاتصال بي من قبل الاخوة الراغبين في التطوع على الرقم و العنوان البريد التالي:

نجوان الربيعي

0707231284

najwanuk@yahoo.co.uk

Appendix 3: Consent form for Phase 1, Phase 2, and Phase 3 in English

I, -----, have read the information sheet and I understand its contents and thereby consent to being interviewed and having my interview audio recorded. I understand that my identity will be protected and that my participation will be treated with the utmost anonymity and confidentiality. I also understand that I have the right to withdraw from the study at any point in time during or after the interview as long as it is before data analysis. I have also been informed of how to make a complaint should I choose to do so.

Date: -----

Signature: -----

Contact number: -----

Email: -----

Appendix 4: Consent form for Phase 1 and Phase 2 in Arabic

انا.....قد قرأت ورقة المعلومات، و فهمت مضمونها، و لذلك اعطي الحق بمقابلتي و تسجيل المقابلة صوتيا. انا على بينة من ان هويتي سوف تحفظ، و ان مشاركتي سوف يتم التعامل معها بأتم السرية و الخصوصية. انا ايضا على علم بأنه لدي الحق بالانسحاب من الدراسة في اي وقت اثناء او بعد المقابلة، شرط ان يكون ذلك قبل تحليل النتائج. لقد تم اعلامي ايضا بكيفية تقديم الشكوى في حال اردت ذلك.

التاريخ:

التوقيع:

رقم الهاتف:

العنوان البريدي:

Appendix 5: Socio-demographic information for Phase 1 and Phase 2

Socio-demographic information for participant number:

- a) Age:
- b) Level of education:
- c) Employment:
- d) Income:
- e) Religion:
- f) Family in Iraq:
- g) Family in Sweden:
- h) Length of stay in Sweden:
- i) Negative experiences from Iraq:

War:

Political oppression:

Witnessed acts of violence:

Experienced personally acts of violence:

Imprisonment:

Torture:

Appendix 6: Interview questions for Phase 1

Five main areas will be explored: 1) experiences of social support; 2) acculturation and related aspects; 3) experiences of racial discrimination; 4) negative experiences from Iraq compared to negative experiences in exile; and 5) the help and support systems available to Iraqi refugee men in Sweden.

- 1) What are your experiences of social support from Swedes, fellow Iraqis, and other social and ethnical groups in Sweden?
- 2) How has your time in Sweden impacted on your Iraqi cultural identity (i.e. cultural norms and traditions, language, and religion)?
- 3) On a scale of 0-10, how Swedish do you think you have become throughout the years and in what ways?
- 4) How do you think Swedes generally perceive and treat you?
- 5) On a scale of 0-10, how much do you think the issues we discussed today affect you in your current everyday life, and in what ways?
- 6) On a scale of 0-10, how much do you think your experiences from Iraq affect you in your current everyday life, and in what ways?

- 7) Have you ever sought any form of help for any of the issues that we have discussed today, and if not then why?
- 8) If you have, then what kind of help did you seek and why did you choose that form of help?
- 9) How successful was the form of help that you sought?
- 10) Is there anything else that you would like to say regarding the issues that we have discussed today?
- 11) Would you be interested in participating in any future research that I might be engaged in?

Appendix 7: Ethical approval for Phase 1

To: **NAJWAN SAAED AL-ROUBAIY**

Subject: Ethical Application Ref: **ns260-7493**

(Please quote this ref on all correspondence)

25/02/2011 11:22:13

Institute of Lifelong Learning

Project Title: **Counselling and psychotherapy with Iraqi refugees: The psychosocial stressors of life in later stages of exile**

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with

Appendix 8: Information sheet for Phase 2 in English

Dear fellow Iraqis,

I came to Sweden in 1993 as an Iraqi refugee and I am today working as a psychologist in Malmo. I am currently working on a research study that is going to form a major part of my PhD degree in counselling and psychotherapy from the University of Leicester. Some of you may already know about my research since I had used a similar information sheet to this one to recruit participants in an earlier study. This current study aims to explore the counselling experiences of Iraqi refugee men who have lived in Sweden for longer periods of time and have had some form of counselling or psychotherapy during their time in Sweden.

The participants needed for this study are ten adult male Iraqi refugees who have lived in Sweden for a minimum of five years and have had some form of counselling during their stay in Sweden as the only method of mental health intervention or as part of a combined treatment utilising both counselling and medication. However the focus will be only on experiences of counselling not medication. This study has the potential to improve counselling practice with Iraqi refugees who have lived in exile for longer periods of time in Sweden and perhaps similar western countries.

Participation will involve an individual interview with the researcher that should last roughly an hour. The interview will be held in a room here (the Iraqi cultural association in Malmo). The interview will be audio taped to be later translated and transcribed by the researcher. Participant names will not be used in the audio recordings nor will they be used

in the transcripts. Instead numbers will be assigned to each participant to preserve anonymity. The audio recordings and transcripts will only be available to the researcher and his supervisor to ensure the highest levels of confidentiality. The transcripts will be kept until they are no longer necessary for potential publication purposes while the interview tapes will be destroyed upon successful completion of the PhD course.

You have the right to withdraw from the study at any point during or after the interview; as long as it is before data analysis. Should you be disturbed by any of the issues discussed during the interview, the researcher can provide you with names and contact numbers to appropriate counselling agencies if you ask for them. This study is subject to the University of Leicester's Research Ethics Code of Practice and is fully supervised; therefore if you feel that you were treated badly during the interview process and the researcher was incapable of addressing the issue, you can make a direct complaint to the research supervisor, Dr. Valerie Owen-Pugh (vap4@leicester.ac.uk).

I would be very grateful if you could contact me on the details provided at the end of this information sheet if you are interested in participating.

With thanks and regards,

Najwan Al-Roubaiy

Tel: 070-7231284

najwanuk@yahoo.co.uk

Appendix 9: Information sheet for Phase 2 in Arabic

اعزائي و اخواني العراقيين

اتيبت الى السويد عام 1993 كلاجئ من العراق، و انا اليوم اعمل كأخصائي نفسي في مدينة مالمو. اعمل حالياً على دراسة علمية تشكل جزءاً رئيسياً من رسالة الدكتوراه في العلاج النفسي من جامعة ليستر البريطانية. البعض منكم قد يعرف عن بحثي من خلال استعمالي لورقة معلومات مشابهة لهذه في دراسة أخرى. هذه الدراسة تهدف لاستكشاف تجارب الرجال العراقيين المقيمين في السويد لفترات طويلة من الزمن و كانت لهم تجربة في العلاج النفسي أثناء اقامتهم بالسويد.

المتطوعون المطلوبون للمشاركة هم عشرة رجال عراقيين من اللذين جاؤا الى السويد كلاجئين، و عاشوا فيها لمدة لا تقل عن خمس سنوات و كانت لهم تجربة باستعمال العلاج النفسي بالكلام فقط او بالاضافة الى ادوية لمعالجة المشاكل النفسية. لكن هذه الدراسة سوف تركز على تجارب العلاج النفسي بالكلام فقط و لن تتعمق في تجارب العلاج بالادوية. هذه الدراسة قد تؤدي الى تطوير اساليب تقديم العلاج النفسي للاجئين العراقيين في السويد، و ربما بدول اخرى مشابهة لها.

المشاركة تتضمن مقابلة فردية مع الباحث لمدة ساعة تقريباً. المقابلة ستجرى في غرفة (بالجمعية الثقافية العراقية في مالمو)، وسوف تسجل صوتياً ثم تترجم و تحلل من قبل الباحث. اسماء المشاركين لن تستعمل في التسجيلات الصوتية و لا في الكتابة. وبدلاً عن الاسماء سيرمز برقم لكل مشترك للمحافظة على سرية هويته. التسجيلات و التحليلات المكتوبة سوف تكون فقط في حوزة الباحث و المشرف على البحث لضمان اكبر درجة من الخصوصية. التحليلات المكتوبة سوف تحفظ الى حين عدم الحاجة اليها لاسباب النشر. اما التسجيلات الصوتية فستستمر حتى اتمام متطلبات رسالة

الدكتوراه.

للمتشارك الحق في الانسحاب من الدراسة في اي وقت اثناء او بعد المقابلة شرط ان يكون ذلك قبل تحليل النتائج. اذا استاء المشارك بسبب اي موضوع يناقش اثناء المقابلة، يستطيع الباحث توفير اسماء و ارقام الاماكن المختصة بالعلاج النفسي المناسب اذا طلب المتشارك منه ذلك. هذه الدراسة تخضع الى قواعد جامعة ليستر في ممارسة الابحاث بشكل اخلاقي، و يتم الاشراف عليها بشكل كامل. لذلك اذا شعر المشارك بانه لم يعامل بشكل لائق اثناء المقابلة، و لم يستطع الباحث علاج الموضوع بنفسه، يمكن للمشارك ان يتقدم بشكوى للمشفرة على البحث:

Dr. Valerie Owen Pugh (vap4@leicester.ac.uk).

اكون شاكراً لو يتم الاتصال بي من قبل الاخوة الراغبين في التطوع على الرقم و العنوان البريدي التالي:

نجوان الربيعي

0707231284

najwanuk@yahoo.co.uk

Appendix 10: Interview questions for Phase 2

Three main areas will be explored: 1) client perceptions of self in therapy; 2) client perceptions of the mental health professional; and 3) client perceptions of the counselling process and outcome. Participants will be encouraged to talk about all of their counselling experiences if they had more than one.

- 1) How (e.g. referral or sought yourself) and why did you seek counselling?
- 2) How did you see yourself before, during, and after the counselling process?
- 3) Did your Iraqi cultural background affect your choice of seeking counselling, and if so then in what ways?
- 4) Did living in Sweden for so many years affect your choice of seeking counselling, and if so then in what ways?
- 5) What were your perceptions of the mental health professional who offered you counselling before, during, and after the counselling process?
- 6) What was the mental health professional's educational background and theoretical orientation in counselling and what did these aspects mean to you?

- 7) What was the mental health professional's gender and ethnical background and what did these factors mean to you?
- 8) How do you think the mental health professional thought and felt about you and how was this apparent to you in your relationship with him or her?
- 9) How did you view counselling practice in general before, during, and after you tried it?
- 10) Has counselling helped you with the problems you sought help for, and if so then how?
- 11) Has counselling been helpful in ways you had not anticipated prior to the counselling process, and if so then in what ways?
- 12) Has counselling been unhelpful or distressful in ways you had not anticipated prior to the counselling process?
- 13) Do you have anything else to say about the issues we discussed today?

Appendix 11: Ethical approval for Phase 2

To: **NAJWAN SAAED AL-ROUBAIY**

Subject: Ethical Application Ref: **ns260-6cf4**

(Please quote this ref on all correspondence)

23/09/2011 09:30:47

Institute of LifeLong Learning

Project Title: **Counselling and psychotherapy with Iraqi refugee men: The psychosocial stressors of life in later stages of exile**

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with.

Appendix 12: Information sheet for Phase 3 in English

Dear colleagues,

I came to Sweden in 1993 as an Iraqi refugee with my family. Today I work as a psychologist in Malmo and I am also engaged in research about Iraqi refugees and their counselling and psychotherapy needs. I am currently working on a study that is going to form a major part of my PhD degree in counselling and psychotherapy from the University of Leicester. This study aims to explore how counsellors, psychologists, and/or psychotherapists, from different backgrounds and theoretical orientations, experience working with Iraqi refugee men in Sweden.

The participants needed for this study should belong to one or more of the professional categories mentioned above, and should have experience in working with adult male Iraqi refugee clients in counselling/psychotherapeutic contexts. The participants will be interviewed in two groups of four to five people using a focus group approach. The researcher will conduct each interview (lasting approximately an hour) using questions that revolve around issues of importance to Iraqi refugee men; based on findings from previous research conducted by the researcher with this client group. The researcher will function as a moderator in the two interviews, while participants are encouraged to share their experiences and reflections regarding working with this client group.

Participation can be valuable for both researcher and participants. This study can potentially help the researcher identify limitations and flaws as well as possibilities and strengths in working with this client group through professional perspectives. The

interviews will probably also enrich participants' knowledge about this client group through the exchange and sharing of reflections and experiences among colleagues. The interviews will be audio taped to be later translated and transcribed by the researcher. Participant names will not be used in the audio recordings nor will they be used in the transcripts. Instead numbers will be assigned to each participant to preserve anonymity. The audio recordings and transcripts will only be available to the researcher and his supervisor to ensure the highest levels of confidentiality. The transcripts will be kept for a maximum period of five years for potential publication purposes, while the interview audiotapes will be destroyed upon successful completion of the PhD course.

As a participant, you have the right to withdraw from the study at any point during or after the interview; as long as it is before data analysis. This study is subject to the University of Leicester's Research Ethics Code of Practice and is fully supervised; therefore if you feel that you were treated badly during the interview process and the researcher was incapable of addressing the issue, you can make a direct complaint to the research supervisor, Dr. Valerie Owen-Pugh (vap4@leicester.ac.uk). I would be very grateful if you could contact me on the details provided at the end of this information sheet if you are interested in participating.

Kind regards,

Najwan S. Al-Roubaiy

Tel: 0707231284

najwanuk@yahoo.co.uk

Appendix 13: Information sheet for Phase 3 in Swedish

Kära kollegor,

Jag kom till Sverige 1993 som flykting från Irak med min familj. Idag arbetar jag som psykolog och forskar på deltid om Irakiska flyktingar och deras behov av counselling och psykoterapi. Just nu arbetar jag på en studie som kommer att forma en del av min PhD i counselling och psykoterapi vid University of Leicester. Studien syftar till att ta reda på hur kuratorer, psykologer, och/eller psykoterapeuter från olika bakgrund och med olika teoretiska orienteringar upplever arbetet med Irakiska män med flykting bakgrund i Sverige.

Deltagarna som behövs för denna studie bör tillhöra en, eller flera, av de yrkeskategorier nämnda ovanpå och ska ha arbetat med Irakiska män som klienter i något counselling och/eller psykoterapeutiskt sammanhang. Deltagarna kommer att intervjuas i två grupper av fyra till fem personer utifrån en 'focus group' design. Forskaren kommer att leda intervjun (ungefär en timme) utifrån frågor som berör Irakiska män baserad på egen forskning om denna klient grupp. Forskaren kommer att fungera som moderator under intervjun, medan deltagarna kommer att ägna sig åt ett utbyte av erfarenheter och reflektioner kring arbetet med denna klient grupp.

Medverkan kan vara värdefull för både forskaren och deltagarna. Denna studie kan eventuellt hjälpa forskaren att identifiera begränsningar och brister samt möjligheter och styrkor i arbetet med denna klient group ur det professionella perspektivet. Intervjuerna kan också berika deltagarnas kunskap om denna klient grupp genom utbytet av reflektioner och

erfarenheter bland kollegorna. Intervjuerna kommer att ljudinspelas för att senare översättas och transkriberas till engelska av forskaren. Deltagarnas namn kommer inte att användas varken i ljudinspelningarna eller i avskrifterna; istället kommer varje deltagare att tilldelas ett nummer. Ljudinspelningarna och avskrifterna kommer enbart att vara tillgängliga för forskaren och handledaren för att på bästa sätt bevara tillit och anonymitet. Avskrifterna kommer att bevaras i max fem år för möjlig publicering medan ljudinspelningarna kommer att förstöras i samband med avslutningen av PhD kursen.

Som deltagare har du rätt att dra dig ur studien när som helst under eller efter intervjun; så länge detta sker innan data analys fasen. Denna studie regleras av 'University of Leicester's Research Ethics Code of Practice' och utförs under handledning. Deltagaren kan vända sig direkt till handledaren med klagomål om han eller hon upplever kränkning under intervjuprocessen som forskaren själv inte kunde bemöta eller åtgärda; handledaren är: Dr. Valerie Owen-Pugh (vap4@leicester.ac.uk). Jag är jätte tacksam för er medverkan och skulle verkligen uppskatta det om ni kontaktade mig på uppgifterna längst ner för att ordna deltagandet.

Med vänliga hälsningar

Najwan S. Al-Roubaiy

Tel: 0707231284

najwanuk@yahoo.co.uk

Appendix 14: Consent form for Phase 3 in Swedish

Jag, _____, har läst informationsskriften och förstått innehållet, och jag ger mitt medgivande till att bli intervjuad och att få intervjun ljudinspelad. Jag förstår att min identitet kommer att skyddas och att mitt deltagande kommer att behandlas med högsta möjliga anonymitet och tillit. Jag förstår också att jag som deltagare har rätt att dra mig ur studien när som helst under eller efter intervjun; så länge detta sker innan data analys fasen. Jag har också blivit informerad om hur jag kan göra ett klagomål om jag skulle välja att göra det.

Datum: _____

Signatur: _____

Kontakt nummer: _____

E-post: _____

Appendix 15: Socio-demographic information for Phase 3 in English

Socio-demographic information for participant number:

Ethnicity/cultural background:

Gender:

Age:

Profession:

Number of years in counselling/psychotherapy practice:

Theoretical orientation (e.g. CBT, psychoanalytic, integrative, etc.):

Level of experience in working with Iraqi refugee men:

Less than five clients:

Five to ten clients:

Eleven to fifteen clients:

Twenty or more clients:

Appendix 16: Socio-demographic information for Phase 3 in Swedish

Sociodemografisk information för deltagare nummer:

Etnicitet/Kulturell bakgrund:

Kön:

Ålder:

Yrke:

Antal år arbetat med counselling/psykoterapi:

Teoretisk orientering (ex. KBT, psykoanalytisk, integrativ, osv.):

Erfarenhet av arbete med Irakiska män med flyktingbakgrund:

Mindre än fem klienter:

Fem till tio klienter:

Elva till femton klienter:

Tjugo eller mer klienter:

Appendix 17: Interview questions for Phase 3

Each interview question in phase three was designed to explore the professionals' experiences and views on each of the sub-ordinate themes (in brackets) that emerged from phase one and phase two of this study.

- 1) Have the Iraqi men which you have worked with ever discussed their social relationships with other Iraqis, and if so then in what ways; and how did you address the issue? (Iraqi social support)
- 2) Has Iraqi culture ever been discussed with you by your clients and if so then in what ways; and how did you address the issue? (Maintaining Iraqi culture)
- 3) Have you ever experienced difficulties in engaging Iraqi men in therapy and if you have then in what ways; and how did you address the issue? (Barriers to help seeking)
- 4) Have your Iraqi male clients ever expressed distress in reaction to some Swedish cultural norms and if they have then in what ways; and how did you address the issue? (Emasculation & Primitive and inferior)

- 5) Have your clients ever discussed their experiences of integration into Swedish society and if they have then in what ways; and how did you address the issue?
(Exclusion and marginalisation)
- 6) Have your clients ever compared their negative experiences from Iraq to their negative experiences in Sweden and if they have then in what ways; and how did you address the issue? (Exile worse than pre-migration & Exile not Iraq)
- 7) What were the mental health problems of your Iraqi refugee male clients and how did you try to address them in therapy? (Presenting issues)
- 8) Have your clients ever expressed what they found helpful in therapy and if they have then what did they say? (Getting things off my chest, Counteracting marginalisation, & Therapy as helpful)
- 9) Have you ever found it difficult to understand, or relate to, your Iraqi male clients' culture or world view, and if you have then in what ways; and how did you address the issue? (Therapist microaggressions & Client as political opponent)
- 10) Have you ever experienced reluctance from your client to discuss certain issues and if you have then what issues; and how did you address this reluctance? (Client reluctance to disclose)

- 11) How much of your educational background, theoretical orientation, and structure and goals in therapy do you generally manage to share with your clients? (Lack of therapist transparency)
- 12) Have your clients ever expressed what they found unhelpful in therapy and if they have then what did they say; and how did you address their grievances? (Therapist as incompetent & Therapy as unhelpful)

Appendix 18: Ethical approval for Phase 3

To: **NAJWAN SAAED AL-ROUBAIY**

Subject: Ethical Application Ref: **ns260-f908**

(Please quote this ref on all correspondence)

21/03/2012 12:23:25

Institute of LifeLong Learning

Project Title: **Counselling and psychotherapy with Iraqi refugee men: The psychosocial stressors of life in later stages of exile.**

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with.

Appendix 19: Master table of themes across Phase 1 transcripts

A. Support systems	Line Number
<i>Iraqi social support</i>	
P1: have always been very, very deep and very solid with Iraqis	15-16
P1: I always try to seek my fellow Iraqis, try to maintain relationships	362-363
P2: collective thinking exceeds the family	23-31
P2: warm relationships with fellow Iraqis	96-98
P3: these relationships felt almost like a gift	46-48
P4: it's all about the large extended family	316-322
P5: to help protect myself from all of these issues	423-428
P6: in Iraq neighbours are considered family	77-83
P7: As far as Iraqis go I have very good relationships	8
P8: I can always count on my fellow Iraqi friends to be there for me	10-11
P9: No	
P10: No	
<i>Maintaining Iraqi culture</i>	
P1: every time I think of Iraq I feel like my heart is breaking	312-313
P1: it has always been my country and always will be my country	323-325
P2: This is something that lives with me	110-114
P2: my Iraqi-ness has remained intact	223-226
P2: I think that in itself defines my Iraqi-ness	231-235

P3: make me feel this side of my personality	488-490
P4: in many ways become much more traditional	128-135
P4: my own cultural norms have been unchanged	167-168
P5: my heritage, my traditions	354-355
P6: my cultural heritage	129-130
P7: I choose to maintain my Iraqi culture	44-48
P8: I haven't changed any of my traditions	90-94
P9: No	
P10: No	
<i>Barriers to help seeking</i>	
P1: I am active in many social events	362-363
P2: No	
P3: No	
P4: No	
P5: I saw it had no effect	393-399
P6: No	
P7: No	
P8: I go to my friends	318-319
P9: in Iraqi culture we tend to view these things negatively	672
P10: I haven't accepted the counselling part	356
B. Disempowerment	
<i>Emasculation</i>	
P1: Iraqi men have lost their status as men here in Sweden	182-183

P2: No	
P3: No	
P4: it feels like feminism and racism somehow belong together	530-542
P5: taking my children away from me	158-166
P6: strip me of my role as a man	145-148
P6: sorry for us as Iraqi men	163-166
P6: force on us as Iraqi men	183-190
P7: In Iraq I was something else	203-206
P8: In Iraq my fellow Iraqi knows my status	52-54
P9: becoming more tolerant with women	128-134
P9: the Iraqi man has lost his value	201-208
P10: I am not even sure there is equality	138-140
<i>Primitive and inferior</i>	
P1: Iraqi men, with relative ease, apply violence	190-202
P2: No	
P3: expected to be beneath them	195-198
P4: makes me understand that I am beneath him or her	235-237
P5: No	
P6: I do feel inferior	93-96
P7: here I am simply a refugee with housing problems	205-206
P8: we are primitive savages	99
P9: in tune with the concept of cheating	8-12
P10: dirty looks	176-179

C. Exile stressors	
<i>Exclusion and marginalisation</i>	
P1: outside social settings	26-31
P2: the isolation, the loneliness	157-159
P3: they're upset by my being there	210-213
P4: I am still isolated, I am still socially rejected	292-297
P5: always met with rejection	39-43
P5: I am not really one of them	346-348
P6: pressured to stay in my flat	98-101
P7: I was isolated	79-81
P8: become part of Swedish society	94-96
P8: I am often told off	221-224
P9: avoid even greeting me	60-65
P10: being treated well	107-110
<i>Exile worse than pre-migration</i>	
P1: No	
P2: No	
P3: what I came to experience later on	369-372
P3: instead of treating his wounds	377-378
P4: I truly regret leaving Iraq	307-310
P4: I was simply psychologically destroyed here	455-472
P5: even more dangerous	332-336
P5: much milder	343-344

P6: dying a very slow death	264-266
P6: horrible loneliness and isolation	373-376
P7: social reality in Sweden	193-197
P8: true suffering is life in Sweden	284-288
P9: In Sweden I die many deaths	643-648
P10: No	

Appendix 20: Master table of themes across Phase 2 transcripts

A. Seeking counselling	Line Number
<i>Exile not Iraq</i>	
P11: No	
P12: in here	3-4
P13: No	
P14: having lived in Sweden	3-6
P14: I mean the depression	55-60
P15: No	
P16: sometimes Iraqi, sometimes Swedish	108-111
P17: struggling with now in Sweden	282-285
P18: the money was not enough	67-71
P19: not in Iraq, my problems were here	107-108
P19: what I have come to experience	481-484
P20: I had a problem at the school	3-9
P20: what I have come to experience	481-484
<i>Presenting issues</i>	
P11: I was psychologically disturbed	3
P12: exhausted and desperate	3-4
P13: psychologically under stress and was not really coping	4
P14: being chocked somehow	40-50

P15: sustained injury	6
P16: big object lying on my chest	8-9
P17: remember the bombing	3-8
P18: wasn't really able to make ends meet	67-71
P19: help me make sense	40-41
P20: a physical fight	4
B. Positive counselling experiences	
<i>Getting things off my chest</i>	
P11: I need to talk to someone	395-397
P12: No	
P13: No	
P14: these things off my chest	49-50
P14: get them off my chest	111-114
P14: talking about my thoughts	606-609
P15: possible just through talking	309-313
P16: got to express myself	297-298
P16: got to talk	402-403
P17: these things off my chest	582-584
P18: No	
P19: No	
P20: No	
<i>Counteracting marginalisation</i>	
P11: being Swedish made it important	276-279

P12: No	
P13: No	
P14: find someone to talk to	607-611
P15: No	
P16: had to sit there and listen to me	294-300
P16: first relationship with a Swede	378-381
P16: relationship with a Swede	409-407
P17: to have somewhere to go to	207-210
P17: practice my Swedish	596-600
P18: nice to have someone to talk to	101-102
P19: he was my way in	279-286
P20: No	
<i>Therapy as helpful</i>	
P11: to better understand myself	362-364
P11: that is what I gained	383-389
P12: No	
P13: No	
P14: relieved in talking	123-125
P14: some benefit out of these sessions	592-600
P15: not just there to help me talk	149-153
P15: has really helped me	158-159
P16: I was getting much better	429-431
P17: helpful in some aspects	582-583

P18: it was nice and helpful	408-410
P19: No	
P20: No	
C. Negative counselling experiences	
<i>Therapist microaggressions</i>	
P11: No	
P12: talking to a savage	338-339
P13: No	
P14: I did not really understand	77-82
P14: all the time	88-92
P15: No	
P16: I could see the tension that she was feeling	347-354
P17: as if I am some kind of simple creature	382-386
P18: No	
P19: asking if my mother had a veil on	127-134
P19: He had already lectured me	405-410
P20: this kind of capacity for violence	62-65
<i>Client as political opponent</i>	
P11: No	
P12: he said I should forget my heritage	409-414
P13: Swedish society is well known	582-588
P14: it was always about the woman	435-441
P14: she didn't acknowledge	505-510

P15: No	
P16: you should be grateful	449-455
P17: No	
P18: No	
P19: what equality truly means	177-182
P20: regarding women's rights	176-189
<i>Client reluctance to disclose</i>	
P11: I could not really tell her everything	339-340
P12: I actually avoided going into that	433-442
P13: No	
P14: I did not say everything	113-122
P14: I could tell	216-223
P15: certain aspects that I chose to keep from her	259-261
P16: careful not to express much of this	381-388
P16: I held back	422-423
P17: I had to hold back and not talk	525-528
P18: No	
P19: I never brought up this much	321-323
P19: I did not say anything	385-389
P20: would not really understand or empathise	327-350
<i>Therapist as incompetent</i>	
P11: No	
P12: someone who lacks experience	292-294

P13: I said that I cannot understand	33-39
P13: too hectic	234-237
P14: well prepared and good at her job	192-199
P14: it was clear to me	550-556
P15: No	
P16: No	
P17: she was missing the point	296-298
P17: just looking at her face	488-496
P17: my problem was, and still is	611-616
P18: No	
P19: It was of such low quality	75-77
P19: he would actually stare in my face	249-250
P19: waiting for his professional expertise to show	429-433
P20: the counsellor kept on wanting to talk	55-58
P20: could not really make sense of what she wanted	95-97
<i>Lack of therapist transparency</i>	
P11: some form of training. I'm not sure what	65-66
P12: I'm not entirely sure	260-275
P12: I was not let in on what was happening	710-714
P13: not exactly a real doctor, I'm not sure what she was	11-13
P14: I actually found out from other people	283-292
P15: never really did talk about her theoretical orientation	168-169
P16: never did describe what she was	246-248

P17: she never mentioned any of that	348-350
P18: I don't really understand	340-349
P19: had a few degrees on the wall	448-450
P20: No nothing, nothing of this sort	155-167
<i>Therapy as unhelpful</i>	
P11: No	
P12: it could have destroyed me	462-464
P13: Not much has changed	91-95
P14: I had hoped to get support	105-108
P14: distant from what my actual problems were	308-313
P15: No	
P16: No	
P17: No	
P18: No	
P19: I waited and waited for this magical intervention	435-438
P19: I am not sure there was a counselling process	456-461
P20: this counselling that I have had	366-374
P20: nothing helpful about these sessions	379-385

Appendix 21: Master table of themes across Phase 3 transcripts

A. Client connection to Iraq and Iraqis	Line Number
<i>Social support versus distrust</i>	
P21: Iraqi men	7-14
P22: this is important to them	21-25
P23: valuing relationships with other Iraqi men	28-30
P24: getting social support from each other	32-37
P25: express a feeling of safety	21-29
P25: safer in being able to live closer	34-35
P26: most of my Iraqi clients	42-47
P27: connection with fellow Iraqis	31-35
P28: No	
<i>Connection to Iraq</i>	
P21: speaking of Iraqi culture and Iraq	96-101
P22: No	
P23: No	
P24: No	
P25: No	
P26: to travel to Iraq	90-99
P27: it makes me think	106-110
P28: No	

B. Client experiences of exile	
<i>Loss of status</i>	
P21: I have encountered this attitude	261-266
P22: having lost their status	466-468
P23: this affects many Iraqi men	300-307
P24: frustration regarding the role and status of men	256-259
P25: status they once had in Iraq	292-298
P26: this loss of status	319-323
P27: No	
P28: lost their sense of status	276-279
<i>Integration difficulties</i>	
P21: difficulties in integrating into society	405-407
P22: No	
P23: trying to adapt and integrate	237-246
P24: integration as quite difficult	386-391
P25: to be integrated into Swedish society	21-27
P25: employment equals integration	398-404
P26: No	
P27: difficult to be integrated into Swedish society	358-361
P28: they do struggle with trying to adapt	113-116
<i>Exile trauma not Iraqi trauma</i>	
P21: Sweden is a kind of prison	426-431
P22: Sweden is worse than Iraq	443-445

P23: No	
P24: worse than what he had come to experience	434-441
P25: not being part of Swedish society	187-194
P25: many of my Iraqi clients	435-440
P26: No	
P27: more tolerable, swift, and fast death	309-313
P28: No	
C. Therapist observations on client difficulties	
<i>Emphasising pre-migration trauma</i>	
P21: horrible traumatic experiences	196-198
P22: being traumatised	183-190
P23: the war, the war experiences	177-179
P24: traumatised populations	206-209
P25: No	
P26: in considering the trauma they've experienced	213-214
P27: No	
P28: having to hold a weapon or a rifle	460-463
<i>Somatisation of symptoms</i>	
P21: one issue of difficulty	198-203
P22: No	
P23: No	
P24: No	
P25: the description of being tired	492-494

P26: in a practical and physical manner	478-481
P27: the use of the word tired	472-474
P28: physical ailments	144-148
<i>Using metaphor</i>	
P21: No	
P22: No	
P23: No	
P24: No	
P25: my day is evening	495-500
P26: No	
P27: mostly in terms of metaphor	488-490
P28: No	
D. Therapist limitations	
<i>Difficulty in relating to client's worldview</i>	
P21: this belief in fate	104-111
P21: this externalisation	118-136
P21: to understand or accept	356-360
P22: I try to put in my own values	339-342
P23: No	
P24: when some of my clients start	150-157
P25: No	
P26: No	
P27: the ones that have jobs	368-374

P28: not being let in	349-356
<i>Therapist discomfort</i>	
P21: No	
P22: No	
P23: No	
P24: I did not really feel comfortable	316-321
P25: No	
P26: haven't always dared approach these cultural issues	215-229
P27: No	
P28: not to collapse myself upon hearing their stories	461-466
<i>Limited therapist transparency</i>	
P21: No	
P22: No	
P23: No	
P24: educational background, or even orientation	488-493
P25: not care for the details or structure	611-619
P26: I don't include all the facts	650-653
P27: No	
P28: No	
E. Client feedback regarding therapy	
<i>Needing practical help</i>	
P21: what talking therapies are about	522-540
P22: No	

P23: No	
P24: No	
P25: what they truly need is practical help	177-184
P26: No	
P27: talking therapies as being basically babbling	245-250
P28: more practical help	279-283
<i>It helps to talk</i>	
P21: do give positive feedback	516-519
P22: expressing having benefited somehow by talking	500-503
P23: No	
P24: does seem to be helpful	513-514
P25: No	
P26: No	
P27: in need of this type of help	158-165
P28: it was helpful to let this out	464-466

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