A QUALITATIVE EVIDENCE SYNTHESIS OF REFUGEE PATIENTS' AND PROFESSIONALS' PERSPECTIVES ON MENTAL HEALTH SUPPORT

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To generate a more comprehensive understanding of mental health support for refugees, a qualitative evidence synthesis of studies examining professionals' and patients' perspectives was conducted. The aim was to identify what refugees and psycho-social professionals working with refugees perceived as positive/helpful and negative/hindering in the therapeutic process. Six electronic databases were searched, followed by citation tracking. Of the 711 studies found, 10 studies were selected for a thematic synthesis based on inclusion criteria such as being qualitative research reports published after 1998. From these studies, referring to 145 insider perspectives, descriptive themes were developed and subsequently synthesised into 13 analytical clusters. The results highlight the importance of a trusting therapeutic relationship, of the adaptation of therapeutic approaches to patients' needs and situation and of psycho-social support, of cultural sensitivity and external support structures for professionals. Negative or hindering aspects were identified as a lack of mental health care structures, the impact of the post-migrational situation on patients' well-being, cultural and language differences, and a context of mistrust and negative experiences. Finally, ambivalences were formulated regarding verbal therapies, trauma exposure, the benefit of mental health care, and the impacts of this work on professionals. Results are discussed in relation to flexible therapeutic boundaries. Suggestions are made for practice, such as using integrative approaches that focus on psychoeducation and transparency, and for future research, such as investigating psychotherapy with refugees in non-Western countries.

***Keywords**: refugees, transcultural psychology, systematic review, intercultural research, qualitative evidence synthesis*

1. Introduction

Currently, more than 79.5 million people around the globe are forcibly displaced trying to escape from wars, violence, and persecution (UNHCR, 2019). Certainly not all of these displaced people become mentally ill, and many show profound resilience (Papadopoulos, 2007) considering the challenges associated with dislocation. Nevertheless, augmented levels of psychological distress (De Anstiss et al., 2009; Lindert et al., 2009) are a common consequence of experiencing the "social dramas of war, violence, displacement" (Eastmond, 2000, p.72), and the difficulties faced in resettlement countries (Beiser, 2009; Fazel et al., 2005;

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Hassan et al., 2016; Murray et al., 2010; Sandhu et al., 2013). Especially high rates of post-traumatic stress disorder, sometimes reported to be up to 10 times higher than in the general population, as well as elevated rates of depression, anxiety, chronic pain and other somatic complaints, have been described among refugees (Fazel et al., 2005; Keyes, 2000; Kirmayer et al., 2011; Lindert et al., 2009; Steel et al., 2009). As untreated psychological suffering can lead to somatisation and a decrease in the chance of recovery (Schouler-Ocak, 2015), particular attention should be paid to provide adequate psychological support for refugees[1] resettling in new countries (Kluge, 2016; Kronsteiner, 2017; Ward et al., 2005).

In recent years, literature focusing on mental health support (MHS) for refugees has increased. For instance, the importance of cultural sensibility or humility (Kirmayer, 2012; Tervalon & Murray-Garcia, 1998) and of a recognition of the socio-political context of clients (Drožek, 2007; Metzl & Hansen, 2014; Watters, 2001) has been stressed. Some have argued that addressing refugees' complex needs in MHS through psycho-social and interdisciplinary work, advocacy and practical assistance is particularly helpful (Karageorge et al., 2017; Watters, 2001). Furthermore, the role of trust and the therapeutic relationship (Sandhu et al., 2013) have been emphasised as well as the high impact MHS can have on professionals' own mental health potentially leading to vicarious traumatisation or resilience (Barrington & Shakespeare-Finch, 2013). A number of qualitative studies have focused on the perspectives of "insiders" (Ahearn, 2000; Barrington & Shakespeare-Finch, 2013, 2014; Pugh & Vetere, 2009), i.e. of refugee patients and the psycho-social professionals[2] (PSPs) themselves (Karageorge et al., 2017; Kramer, 2005). Such research holds the potential to foster epistemological plurality in psychotherapy research in general (Castonguay, 2011) and, more specifically might help to overcome ethnocentric limitations (Patel, 2003a; Speight, 2012) and shed light on what is supporting refugee patients and their PSPs in the therapeutic process (Guregård & Seikkula, 2014; Kramer, 2005; Watters, 2001).

In qualitative health research, especially in the context of users' experiences, there has been a rising interest in qualitative evidence syntheses (QES; Barnett-Page & Thomas, 2009; Jensen & Allen, 1996; Karageorge et al., 2017; Paterson et al., 2001; Williams & Morrow, 2009). As a quantitative meta-analysis, QES can be a means to combine the knowledge of individual studies. In contrast to systematic reviews, they are more interpretative than aggregative (Paterson et al., 2001) and allow for going beyond the results of a single study (Thomas & Harden, 2008; Timulak, 2009).

To our knowledge, as of the writing of this article, only one paperhas systematically reviewed qualitative studies about the experiences of refugees and staff concerning MHS services (Karageorge et al., 2017). The authors analysed 11 studies and developed the core concepts: "Mutual understanding, addressing complex needs, discussing trauma, and cultural competence", which were each associated with enabler and barrier themes. For instance, "exploring clients' culture" and "practical interventions" were seen as enabling, whereas refugees having "more pressing concerns than talking" was considered a barrier to MHS. Furthermore, "discussing trauma" was an ambivalent topic among staff and clients – sometimes regarded as helpful in creating meaning, sometimes considered difficult and seen in relation to vicarious traumatisation in staff. Similar to Karageorge et al. (2017), the aim of the present study is a deeper understanding of MHS with refugees as experienced by staff and users. However, the focuses of this article are the helpful (positive) aspects as well as the hindering (negative) aspects that patients and PSPs face in the therapeutic process. Therefore, this research will synthesise qualitative interview studies that have been published in the last 10 years, investigating refugees' and PSPs' perspectives on the topic. To allow for an unconfounded comparison with the review by Karageorge et al. (2017) only studies that were not analysed by these authors will be included in the current QES. Also, in order to foster intercultural perspectives on such an intercultural topic (Britten et al., 2002), this QES will search for studies published in several languages and in varied international databases. The two

leading research questions are:
a) What do patients and PSPs perceive as positive/helpful aspects of MHS?
b) What do they perceive as negative/hindering aspects of MHS?

2. Method

2.1. Qualitative Evidence Synthesis (QES) approach

"Qualitative Evidence Synthesis" (QES) is an umbrella term suggested by Booth (2016), referring to the various methods that have been developed as tools to synthesise qualitative studies on a meta level. The approach of QES chosen here was orientated toward the meta-study method (Paterson et al., 2001), and thematic synthesis (Thomas & Harden, 2008). The meta-study method was selected for this study because it has a constructivist epistemology, posing the question of how participants construct their experience, researchers their results and meta-researcher the results of the results (Paterson et al., 2001). This is in line with the insiders' perspective in primary research, which focuses on the in-depth knowledge constructions of individuals. As the aim of this QES was to investigate the experience of PSPs or refugee patients, thus concentrating on primary studies following a constructivist insiders' perspectives approach, the use of the meta-study method allowed for a compatibility in epistemology and avoided violating the integrity or philosophical bases of the primary studies (Booth et al., 2016). Paterson et al.'s (2001) description of the method was taken as a practical guideline during the data collection process. Thematic synthesis guided the analysis process of this QES as it focuses on the inclusion of a narrow range of methodologies in primary studies (Booth, 2016). Thematic synthesis follows a critical realist epistemology and includes stages of coding secondary data from multiple studies, of generating and of interpreting the recurring themes. Both QES approaches go beyond summarising relevant studies with the aim of generating new results through the transference of themes across studies (Barnett-Page & Thomas, 2009; Jensen & Allen, 1996; Paterson et al., 2001).

2.2. Researchers' backgrounds

The primary researcher of this project is a German psychologist and PhD candidate fluent in all the languages that were included in the QES. She has experience working in the MHS of refugees in Germany and Brazil. The other researchers and co-authors who were involved in the selection of studies, coding, and theme development process are all German or Brazilian psychologists, and some have worked over 20 years in the MHS of refugees, mostly in Brazil, Canada and Germany.

2.3. Sampling

Between November 2017 and February 2018, six databases were searched for relevant research reports: *Web of Science, PsycINFO, EBSCO, Psyndex, Repère,* and *Redalyc.* The first three are mainly English language-based databases. *Psyndex* is a database used in German-speaking countries while *Repère* primarily presents articles from francophone countries and *Redalyc* articles from Ibero-America. The selection of databases was based on the intention to provide an internationally inclusive view on the topic. Nevertheless, we acknowledge that this selection might have led to firstly, a bias towards English-language articles and secondly, to the omission of some relevant articles. The keywords "refugee AND psychotherapy OR

counselling OR mental health service AND qualitative" were used in a full text search, as well as their German, French, Portuguese and Spanish equivalents. The sampling strategy was exhaustive in the sense that all studies that responded to key word search were considered for inclusion. During the selection process, the "Primary Research Appraisal Tool" (Paterson et al., 2001) was used to keep structured summaries of each study and to check the coherence and appropriateness of the primary studies' aims, methodology and interpretations (Paterson et al., 2001; Tong et al., 2012).

2.4. Inclusion criteria

The inclusion criteria for the primary studies were formulated according to the research questions. Articles had to be original qualitative research reports published in peer-reviewed journals (Timulak, 2009) after 1998 and written in English, German, French, Portuguese or Spanish. Only studies that investigated MHS as experienced by the PSPs or refugee patients were included. Therefore, study participants had to be either patients with a refugee background or PSPs working with refugees. Also, studies were considered exclusively if participants did not live in refugee camps, but instead had resettled or were living in communities in host countries. As the data retrieval yielded few primary studies investigating patients' experiences, we decided to include the perspectives of asylum seekers as well as those of officially recognised refugees, thus not considering people's official civil status in resettlement. In terms of methodology, this QES concerns itself solely with interview studies, following Jensen and Allen's (1996) suggestion to focus on primary studies with a single method. The authors argue that including diverse methods might lead to difficulties for comparability as methods are based on different ontologies and epistemologies (Jensen & Allen, 1996). Decisions on the inclusion of studies were discussed among the research team members.

2.5. Description of included studies and their participants

A total of 685 articles were found across the six databases (Portuguese keyword search yielded 65 articles, Spanish 114, German 54, English 303, and French 149). Additionally, another 26 English language articles could be identified from citation tracking. Of these 711 studies, 638 were excluded based on their titles being either not relevant to the research question (n=514) or duplicate records (n=124), and another 35 were excluded after examination of the abstracts (see Figure 1). A total of 38 studies were assessed for eligibility by reading the full text and using the "Primary Research Appraisal Tool" (PRAT, Paterson et al., 2001) as well as Thomas and Harden's (2008) 12 criteria for methodological quality assessment. The PRAT is a form that assists in coding and storing information on the primary studies related to their theoretical frame and methodological congruency such as by evaluating sampling, data analysis and interpretation procedures (see Paterson et al., 2001 for an example PRAT). The 12 criteria by Thomas and Harden (2008) evaluate three main aspects of quality: the adequate descriptions of the whole study (e.g. aims, methods, findings), the reliability and validity of methods of data collection and analysis, and finally, the appropriateness of the study's methods to guarantee that the data is based on participants' own perspectives. In the majority of excluded cases, the study participants were neither refugee patients nor PSPs or articles represented therapy guidelines.

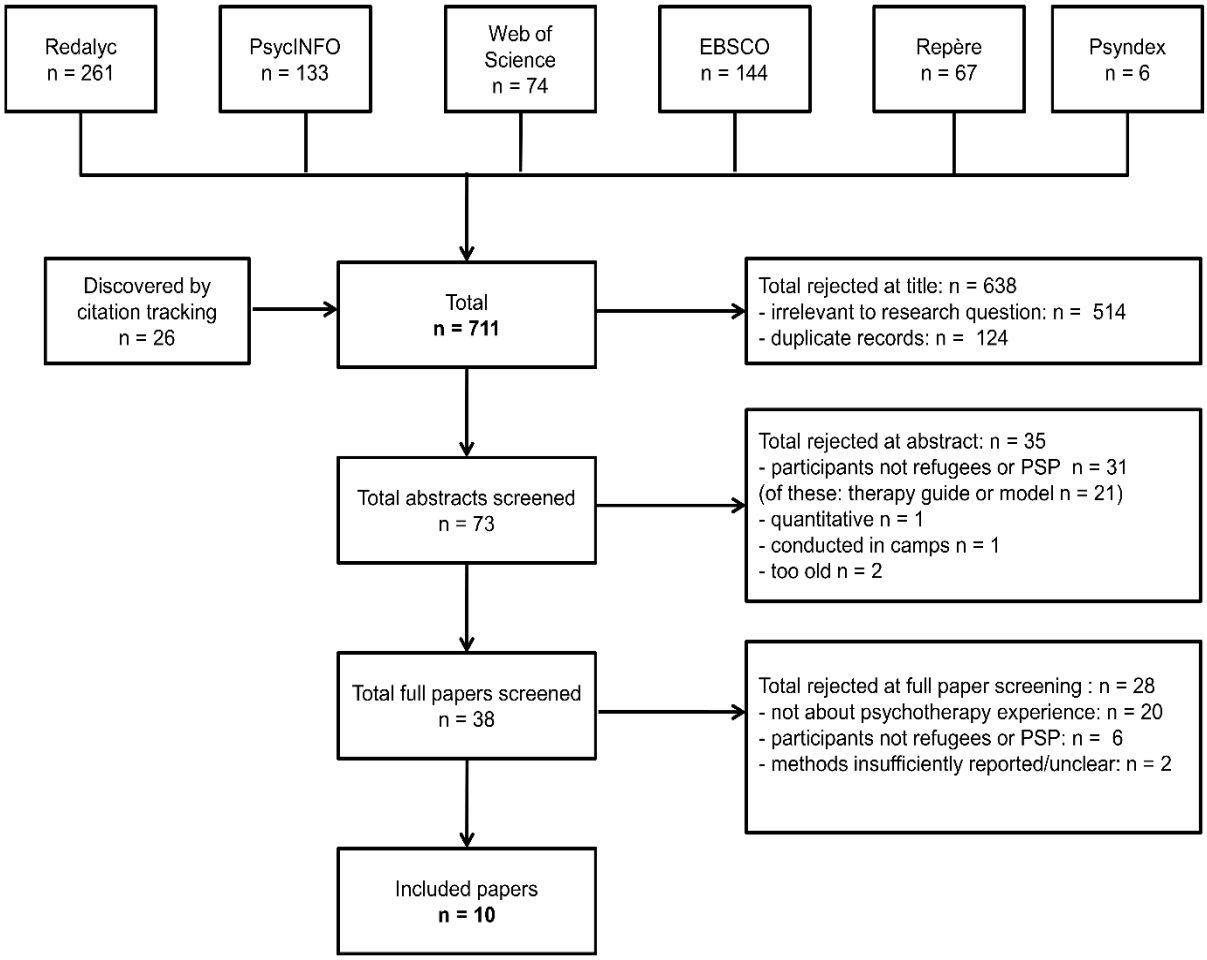

Figure 1. PRISMA flow diagram (adapted from Moher et al., 2010)

Two studies were excluded from analysis as they did not meet the quality criteria due to their methodology being reported with insufficient clarity. Finally, 10 studies remained for inclusion in the QES: All of them met the laid-out quality assessment criteria and differed from the ones chosen by Karageorge et al. (2017). Only one of the studies was a non-English language report. The details of the studies are summarised in Table 1, characteristics of the samples are provided in Table 2. This QES included 145 participants of 10 analysed studies in total, of which 68 were PSPs, 54 refugees with a granted asylum status in the host country and 23 asylum seekers. 15 of the participants were minors.

2.6. Data use and analysis

As suggested by Paterson et al. (2001) all information available in the results sections of the studies was used. As the first step of the analysis, the same data set, i.e. the results sections of the 10 studies were each coded line by line by the first author of this article and two other independent coders using MAXQDA 2018 (VERBI-Software, 2007). In the case of studies that involved the perspectives of other participants, such as interpreters, only the parts clearly attributable to patients or PSPs were coded. To approach the data inductively, the research questions were temporarily set aside (Thomas & Harden, 2008). The second step was the development of descriptive, data-driven themes. Coders independently grouped primary codes into hierarchical structures that distinguished between patients' and PSPs' perspectives.

Table 1. Characteristics of the studies included in the synthesis

Authors, Date	*Origin*	*Research Focus*	*Analysis*	*Sampling*	*MHS Strategy/Status*
Al-Roubaiy, Owen-Pugh, & Wheeler, 2017	Sweden	Ps' reasons for seeking therapy, perceptions of therapist, process & outcome.	IPA (Smith et al., 2009)[a]	purposeful homogeneous sampling	n.s.
Maier & Straub, 2011	Switzerland	Ps' concepts & attitudes about illness & appropriate treatment.	CA (Mayring, 1990)	maximum variation sampling	multimodal clinic; ≥10 sessions, still under treatment.
Majumder et al., 2015	UK	Unaccompanied minors' views on mental health & MHS.	TA (Boyatzis, 1998)	recruited through local authorities	specialist child & adolescent MHS, n.s.
Mirdal et al., 2012	Denmark	Ps' & PSPs' perceptions of curative & hindering factors in psychological therapy.	QPA (Girogi, 1985)	selective sample	short-term PDT existential & cognitive therapy; therapy terminated
Puvimanasinghe et al., 2015	Australia	PSPs' experiences of MHS, healthcare & resettlement when working with refugees.	TA (Braun & Clarke, 2006)	n.s.	5 working in healthcare, 11 in MHS, 10 in resettlement
Schweitzer et al., 2015	Australia	PSPs' conceptions & experiences of therapy with R	TA (Braun & Clarke, 2006)	snowball sampling	n.s.
Thöle et al., 2017	Germany	PSPs' perspectives of the difficulties in the psychotherapy with refugees.	GTA (Glaser & Strauss, 2010)	through governmental institutions & NGOs	independent practice, behavioural, PDT, PA, (12 additionally TT)
Valibhoy et al., 2017	Australia	Ps' experiences of access & process of Australian MHS.	TA (Braun & Clarke, 2006)	purposeful sampling; snowballing	multiple services, 8 under treatment, 8 former patients
Vincent et al., 2013	UK	Acceptability of TFCBT by exploring the experience of the therapy for asylum seekers with PTSD.	IPA (Smith & Osborn, 2003)	purposeful homogeneous sampling	TFCBT, ≥5 sessions in the last 6 months
Warr, 2010	UK	PSPs' perspectives of beneficial counselling approaches for refugees.	GTA (Strauss & Corbin, 1998)	convenience sample	counsellors & specialised care providers; n.s.

Note. CA = Content Analysis; GTA = Grounded Theory Analysis; IPA = Interpretative Phenomenological Analysis; MHS = Mental Health Support, n.s. = not specified; P = Patients; PA= Psycho-Analytic Therapy; PDT = Psycho-Dynamic Therapy; PSPs = Psycho-social Professionals; TA = Thematic Analysis; TFCBT = Trauma-Focused Cognitive Behavioural Therapy; TT = Trauma Therapy; QPA = Qualitative Phenomenological Analysis.

[a] All references refer to citations within the primary articles and will not be enlisted here.

[b] Only the results section related to the PSPs and patients were analysed in the study. Interpreters' parts were excluded from analysis.

Table 2. Characteristics of the participants in primary studies

Study	*Number of Participants*	*Nationalities*	*Gender*	*Age (years)*	*Asylum Status*	*Duration in host country (years)*
Al-Roubaiy et al., 2017	10 P	Iraq (10)	M: 10	Mean: 32 Range: 21-51	Refugees	Mean: 10.2 Range: 5-20
Maier & Straub, 2011	13 P	Afghanistan (2), Bosnia (2), Cameroon (1), Chechnya (1), Iran-Kurdish (2), Kosovo (2), Turkey (1), Turkey-Kurdish (1), Sudan (1)	W: 5 M: 8	Mean: 37 Range 22-35	Asylum seeker: 8 Refugee: 5	Mean: 5.1 Range: 1.5 to 17
Majumder et al., 2015	15 P	Afghanistan (11), Eritrea (1), Iran (2), Somalia (1)	W: 1 M: 14	Mean: 16.7 Range: 15-18	Asylum seeker: 8 Refugee: 7	n.s
Mirdal et al., 2012	16 P, 4 PSP, (8 interpreters)	PSP: Denmark (4) Refugees: Afghanistan (1), Bosnia (5), Iraq (6) Lebanon (1), Palestine (1), information missing (2)	PSP: 4 W Refugees: W: 9 M: 7	PSP: n.s. Refugees Mean: 39 Range: n.s.	Refugees	n.s
Puvimanasinghe et al., 2015	26 PSP	16 mainstream Australian, 5 Refugee Background (Asia, Europe, Middle East), 5 Immigrant Background (Asia, Europe, Middle East, South America)	W: 18 M: 8	n.s	Not applicable	Not applicable
Schweitzer et al., 2015	12 PSP	7 Australian born 5 born outside Australia	W: 10 M: 2	n.s	Not applicable	For not Australia born - Mean: 17 Range: 3-34
Thöle et al., 2017	20 PSP	4 with own immigration/flight experiences, n.s.	W: 15 M: 5	Mean: 54 Range: 42-70	Not applicable	Not applicable
Valibhoy et al., 2017	16 P	Afghanistan, Côte d'Ivoire, DR Congo, Ethiopia, Iraq, Iran, Pakistan, Sudan, Tanzania (no information of distribution)	W: 9 M: 7	Mean: n.s. Range: 18-25	Refugees	Mean: 5.2 years Range: 1.5- 12.3
Vincent et al., 2013	7 P	Afghanistan (1), Burundi (2), Iraq (1), Sudan (2), Zimbabwe (1)	W: 3 M: 4	Mean: 29 Range: 22-42	Asylum Seekers	Mean: 3.2 Range: 0.5-10
Warr, 2010	6 PSP	n.s.	n.s	n.s	Not applicable	Not applicable

Note. M = Men; n.s. = not specified; P = Patients, PSP = Psychosocial Professionals; W = Women.

The findings of this inductive part showed that several elements were not clearly positive or negative but rather experienced ambivalently by participants, which is why a third research question about "ambivalent aspects" was put into place. The third methodological step was organising the descriptive themes into analytical clusters that answered the QES questions. The descriptive themes of PSPs and refugees were compared and grouped together, ultimately forming a hierarchical analytical framework. The decision of bringing together the experiences of PSPs and refugees was based on the finding that experiences tended to overlap. Records were kept if the descriptive themes related to the accounts of patients, PSPs, or both (see Table 3). The coders worked independently in English on all steps and subsequently discussed their findings until consensus about the themes and their structures and labels was found (Braun et al., 2014; Hill et al., 2005; Paterson et al., 2001; Thomas & Harden, 2008). As a final step, the primary data were coded a second time, this time deductively by applying the previously developed analytical framework. A "miscellaneous" category was kept to avoid overlooking themes that might have been omitted in former steps. This last step was undertaken by two new independent coders and the first author of this article.

3. Results

3.1. Analytical clusters

Based on the 10 included studies referring to the perspectives of 68 PSPs and 77 refugee patients, five analytical theme clusters were synthesised to answer the first question (positive/helpful), four clusters to answer the second question (negative/hindering), and four clusters concerning ambivalent aspects. This third category was put into place because the inductive data analysis showed that several elements were repetitively discussed in an ambivalent way. The analytical clusters are depicted in Figure 2. Table 2 shows the descriptive themes organised into the analytical clusters. Only two clusters were based exclusively on the perspectives of PSPs (cluster C4) or patients (cluster B3). The relationships between analytical clusters are depicted in Figures 3a-e. The primary studies included a diversity of MHS professions, but when comparing the descriptive themes across the studies, no clear differences between psychotherapists' perspectives and other MHS professions were found. Furthermore, the patient samples of the primary studies were heterogenous within each study (see Table 2, the exception being Al-Roubaiy at al. (2017) who focused on male refugees from Iraq only) and across studies including refugees and asylum seekers of diverse origins, genders and age groups and suffering from different kinds of mental health problems. As most studies focused on commonalities among their participants, or stressed individual differences rather than differences related to asylum status, gender, origin or psychopathology, the present QES could not compare and contrast the data set in relation to these participants' characteristics. For similar reasons the QES did not compare and contrast among the different contexts in which primary studies were conducted. The following section presents the analytical clusters and descriptive themes. Quotation marks are used to indicate expressions obtained from primary studies.

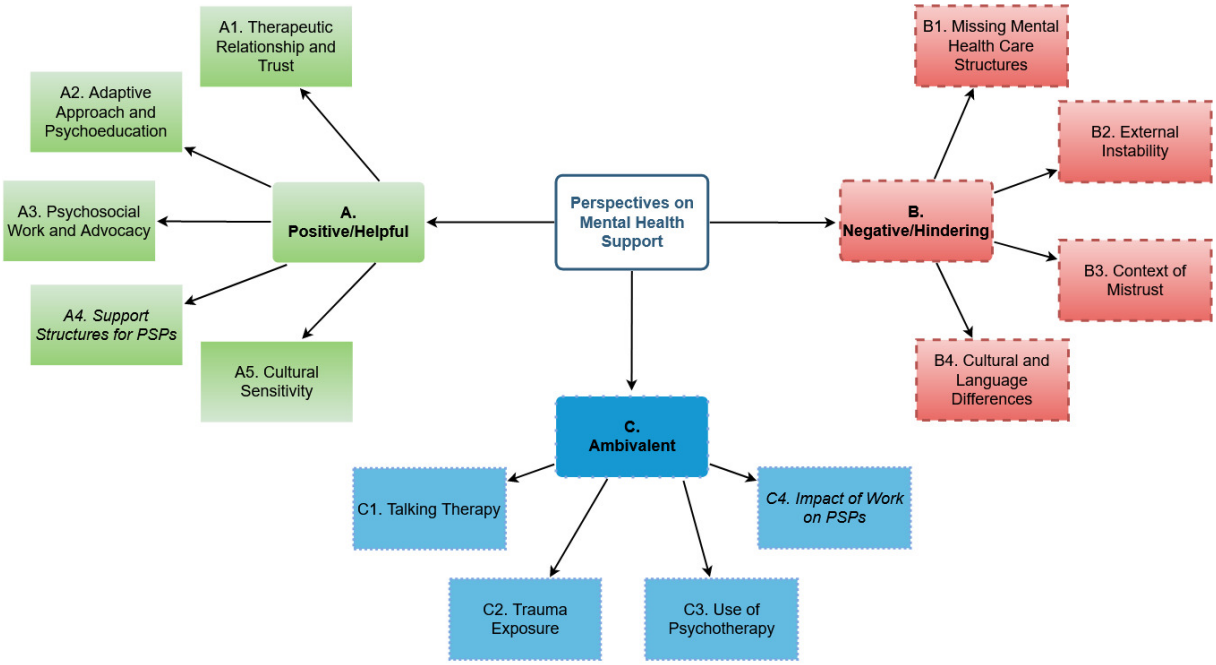

Figure 2. Analytical clusters grouped according to the research questions. Clusters only mentioned by PSPs are depicted in italic

Table 3. Analytical clusters, allocated descriptive themes and studies that contributed to each

A. What are positive/helpful aspects in the therapeutic process?

Cluster	*Descriptive Theme*	*Evidence in Studies*	*Patients or PSPs*
A1.	Relationship as key & therapeutic in itself	AR, MAI, MI, PU, SC, VA, VI, WA	Both
	Importance of trust	MAJ, MI, PU, SC, VA, WA	Both
	Relationship for safety	SC, WA	PSPs
	Empathy, warmth, care	MI, VA, VI	Both
	Solidarity, belief, becoming a witness	AR, MI, PU, VA, VI, WA	Both
	Support	MAI, MI, PU, VA, VI	Both
	Respect	MI, VA, VI	Both
	Flexible boundaries: Being like family or friends	MI, SC, VA, VI	Both
A2.	Psychoeducation - understanding one's problem & the therapeutic process	MAI, MAJ, MI, PU, SC, VI, WA	Both
	Focus on patient, situation & adapt the approach	MAI, MI, PU, SC, VA, WA	Both
	Mindfulness of the refugee situation	VA, WA	Patients
	Groups, especially for isolated patients	PU, WA	PSPs
	Develop coping strategies	MI, PU, WA	PSPs
	Integrative work	SC, WA	PSPs
	Strengths based	PU, SC	PSPs
A3.	Psycho-social Work	MI, SC, VA	Both
	Empowerment	PU, WA	PSPs
	PSP giving information on resettlement country & skill training	MI, PU, SC	PSPs
	Interdisciplinarity	MI	PSPs
	Practical help & advocacy	AR, MI, PU, SC, TH, VA, VI, WA	Both
	Direction and advice	MI, VA, VI	Patients
	Hierachy of needs: Context = fundamental feature of therapy	MI, SC, TH, VA, WA	Both

A4.	Importance of supervision	PU, SC	PSPs
	Importance of mentoring & networks	PU, TH	PSPs
	Personal strategies to avoid getting overwhelmed by patients' needs	PU, SC	PSPs
A5.	PSP having knowledge of & recognising the sociocultural environment of patients	VA, WA	Both
	PSP being curious & improving their cultural awareness	PU, SC, VA, WA	Both
	Working transculturally needs high sensitivity	PU, SC, VA, WA	Both
	Learning from patients and mediators	PU, SC, VA, WA	Both
	Work with mediators is helpful	TH, VA	Both
	Talking about differences	MI, PU, VA, WA	Both
	Reflecting on one's own culture	PU, TH, WA	PSPs

B. What are negative/hindering aspects in the therapeutic process?

Cluster	*Descriptive Theme*	*Evidence in Studies*	*PSP or Patients*
B1.	Difficult access to psychotherapy	MAI, SC, VA, WA	Both
	Not enough time for therapy	MI, TH	PSPs
	Lack of specialised supervision & networks	SC, TH	PSPs
	Confusing & missing funding responsibilities	SC, TH	PSPs
B2.	Post-migrational difficulties enter the psychotherapeutic space	MAI, MAJ, MI, PU, SC, TH, VA, VI, WA	Both
	External instability hinders working on past	SC, TH, VA, WA	Both
	Patients partly too dis-empowered to benefit from MHS	MAI, PU, SC, TH, VI, WA	Both
	PSPs feel overwhelmed & not competent due to patients' resettlement difficulties	PU, SC, WA	PSPs
	PSP identify with patients' hopelessness in their current situation	PU, SC, TH	PSPs
	PSP become frustrated & outraged by challenges patients face in resettlement	PU, SC, TH	PSPs
	Impacting: Separated families/isolation	MI, VA, VI, WA	Both
	Impacting: Living & housing	MAI, MI, VA, WA	Both
	Impacting: Job and economic situation	TH, VA, WA	Both
	Impacting: Insecure asylum status, fear of deportation & uncertainty of future	MAI, MAJ, MI, PU, SC, TH, VI, WA	Both
	Impacting: Situation in country of origin	MAI, MAJ, MI, SC, TH, VA	Both
	Impacting: Social exclusion & discrimination	AR, MAI, VA	Patients
B3.	Bad or limited MHS in country of origin	MAJ, VI	Patients
	Lack of information & transparency on MHS	AR, MAJ	Patients
	Mistrust in profession & competence	AR, MAJ, VA, VI	Patients
	MHS in a context of initial mistrust	MAJ, VA, VI	Patients
	Lack of respect or invasiveness of PSPs	AR, VA	Patients
	Stigma: "mentally ill" in some patients	MAI, MAJ, PU, VA, VI	Both
B4.	Cultural differences as difficulty	AR, MAJ, SC, TH, VA, VI, WA	Both
	Patients having different worldviews & concepts of mental health than PSP	MAI, MAJ, MI, VI, WA	Both
	Abstinence & neutrality do not work	SC	PSPs
	PSP feel incompetent when what they learnt does not work with other cultures	SC, TH	PSPs

	Perceiving PSP as insensible towards cultural differences & narrow minded	AR, VA	Patients
	Language differences = difficulty	PU, SC	PSPs
	PSPs perceive no synchrony with interpreters, under-/overinvolvement	MI, TH	PSPs
	Worry about incorrect translation	VA	Patients

C. What are ambivalent aspects in the therapeutic process?

Cluster	*Descriptive Theme*	*Evidence in Studies*	*Patients or PSPs*
C1.	Letting things out & catharsis	AR, MI, VA	Patients
	Structuring mental chaos through talking	MAI, MI	Both
	Linking words, feelings & bodily sensation	MI, VA	Both
	Reflecting on moral dilemmas	MI	PSPs
	Talking = implicit prerequisite MHS	MI, VA	PSPs
	Acting against cultural norms & customs when talking about intimate problems	VA, WA	Both
	Wanting to protect family by not talking	VA, WA	Both
	Needing practical advice/medication, not talking	MI	Patients
C2.	Negative consequences of accepting past traumas & potential re-traumatisation	VI, WA	Both
	Desire to avoid talking about past	VI	Patients
	Addressing trauma is inappropriate in instability	SC, TH, VA	Both
	Talking about trauma worsens pain	MAJ, VA, VI	Patients
	Being forced to remember things you want to forget by narrating trauma	MAJ, VA, VI	Patients
	Constructing meaning	MI, SC, VI	Both
	Creating continuity for fragmented memories & discontinuity of experience	MI, SC	PSPs
	Narrating & re-experiencing = part of the healing	MI	PSPs
C3.	No use of psychotherapy if context of patients remains difficult	MI, PU, SC, TH, VA, VI	Both
	Mixed experiences & thoughts about use	PU, VA, VI	Both
	Psychotherapy did, does or will not help	AR, MAI, MAJ, MI, VA, VI	Patients
	Experiencing symptom improvement	AR, MAI, MAJ, VA, VI	Patients
	Appraisal of use of MHS mostly changing from negative to positive	MAI, PU, VA, VI	Both
	Regaining hope through therapy	VA, VI	Patients
C4.	Loss and trauma as a major topics	MAJ, SC, TH, VA, VI, WA	Both
	Ongoing violence in country of origin is burdening for PSPs	TH	PSPs
	Not getting a break from the topic	PU	PSPs
	Heavy demands on PSP; feeling overwhelmed	PU, SC, TH	PSPs
	Personal alteration processes of PSP	SC	PSPs
	Vicarious traumatisation, burnout, worsening of worldview	PU, SC, TH	PSPs
	Adding meaning & awareness, mutual learning	PU, SC, WA	PSPs

Note. AR = Al-Roubaiy et al, 2017; MAI = Maier & Straub., 2011; MAJ = Majumber et al., 2015; MI = Mirdal et al., 2012; PU = Puvimanasinghe et al., 2015; SC= Schweitzer et al., 2015; TH = Thöle et al., 2017; VA = Valibhoy et al., 2017; VI = Vincent et al., 2013; WA = Warr, 2010.

A. What are positive/helpful aspects in the therapeutic process?

A.1. A healing therapeutic relationship of trust, solidarity, respect and flexible boundaries

> *"Therapists identified the therapeutic relationship as therapeutic in itself because an authentic, mutual relationship afforded traumatised clients the opportunity to experience a sense of safety within the relational dyad."* (Schweitzer et al., 2015, p. 112)

In most of the studies, PSPs and patients both described the therapeutic relationship as key to the experience of MHS and as being therapeutic in and of itself when it gave patients the feeling of being understood through PSPs' empathy, warmth, and care. Healing relationships involved, for patients and PSPs, a sense of solidarity and belief in patients' stories.

For PSPs in two studies, a healing therapeutic relationship included patients experiencing safety. Yet, patients rather stressed the feeling of being respected as important. Some PSPs and patients characterised positive relationships by a sense of "flexible boundaries": Patients considered PSPs to be relatives or friends. PSPs in two studies highlighted that classical boundaries of abstinence and distance were not appropriate when working with refugee patients, which they explained by cultural reasons and the demands of the post-migrational refugee situation. Instead, they reported that it was helpful to transcend relationship boundaries by following patients' invitations to events outside of therapy or by sharing personal information. This was considered a part of building trust and connecting across cultural differences with patients. Trust was perceived as an essential element of a helpful relationship in the majority of studies and by both, PSPs and patients. It was described to develop through engagement from the PSP, which sometimes involved expanding the professional role and advocating on behalf of patients (see Figure 3a).

A.2. An adaptive approach focusing on psychoeducation, coping and strengths

> *"You really had to adapt what you were providing to understand that people didn't come with one particular issue."* (Schweitzer et al., 2015, p. 113)

In six of the studies, PSPs and patients described that central to the therapy with refugees is the adaptation of the approach to the needs of the refugee patients. For patients, PSPs who listened to and assisted them with their practical needs were regarded as supportive, whereas PSPs who stuck to "classic" therapeutic methods were criticised as not mindful of their situation. In that regard, de-contextualised therapeutic advice, for example sleep related strategies, was considered inappropriate. Patients and PSPs found it helpful when the latter listened to what each individual patient brought into the therapeutic space and avoided "narrowness" and "pre-assumptions". PSPs in two studies found it beneficial to work integratively by drawing on multiple therapeutic perspectives. Also, a focus on the strengths of the patients was described as useful in two studies, emphasising patients' resilience regarding the obstacles they had overcome and were facing in resettlement. PSPs in three studies saw it as helpful to develop coping strategies with their patients, especially in group therapies. Creative therapies were also considered helpful as they offered alternatives to MHS purely based on verbal expression. Patients rarely described specific approaches. However, they highlighted how psychoeducation helped them to understand their own difficulties. PSPs in all but one study mentioned psychoeducation as a central pillar in the therapeutic process.

A.3. Context as a fundamental feature of psychotherapy highlighting the importance of psychosocial work, empowerment, and advocacy

> *"Many described the dual benefits of advocacy—both to empower clients and to build vital trust."* (Puvimanasinghe et al. , 2015, p. 13)

In half of the studies, patients and PSPs described a strong hierarchy of needs of refugees in resettlement, making context work an essential feature of the MHS. In two studies, PSPs explicitly stressed the concept of empowerment, which they saw as enabling refugees to overcome their contextual difficulties. In eight studies, context work meant that helpful therapy aspects included PSPs engaging in social work, advocating on behalf of their patients, and providing practical help to meet patients' resettlement needs. PSPs in one study described how this was facilitated by working in interdisciplinary teams and networks consisting of social workers, lawyers, etc. In this way, the diverse needs of patients could be addressed by various professions, the perceived responsibility load for PSPs was reduced, and the extent to which PSPs needed to leave their traditional professional role was limited.

A.4. Support structures and strategies for PSPs to avoid getting overwhelmed

> *"…many acknowledged the vital function of supervision and mentoring."* (Puvimanasinghe et al., 2015, p. 15)

This analytical cluster was only mentioned by and relevant to the PSPs. They described that supervision, through which PSPs could receive support to reflect upon their professional role and boundaries, as well as to mentoring, prevented them from getting overwhelmed by their patients' needs, resettlement difficulties, and traumatic stories. In two studies, PSPs referred to personal strategies to distance themselves emotionally from their patients' situations and stressed the importance ofreducing their caseloads.

A.5. Cultural sensitivity, mutual learning, and constant reflecting

> "*Participants wanted practitioners to be ready to learn about and accommodate nuances in ethnic and religious identities."* (Valibhoy et al., 2016, p. 8)

In the majority of studies, patients and PSPs regarded high sensitivity for cultural differences as essential (see Figure 3e), as the cultural background was seen to influence ideas about mental health, psychotherapy, Western health care systems and patients' self-images when seeking MHS. Both groups thought it helpful if the PSPs constantly aimed at increasing their cultural awareness, for instance by discussing differences with patients and interpreters. At the same time, rather than PSPs having solid "knowledge" about other cultural contexts, patients and PSPs stressed the importance of the PSP remaining open-minded, curious, and willing to learn from patients. PSPs in three studies pointed to the necessity of being conscious about the fact that their own cultural background, not only that of their patients, is brought into the therapeutic space. In three studies, providing information on the resettlement culture was considered useful to help patients adapt to their new environment.

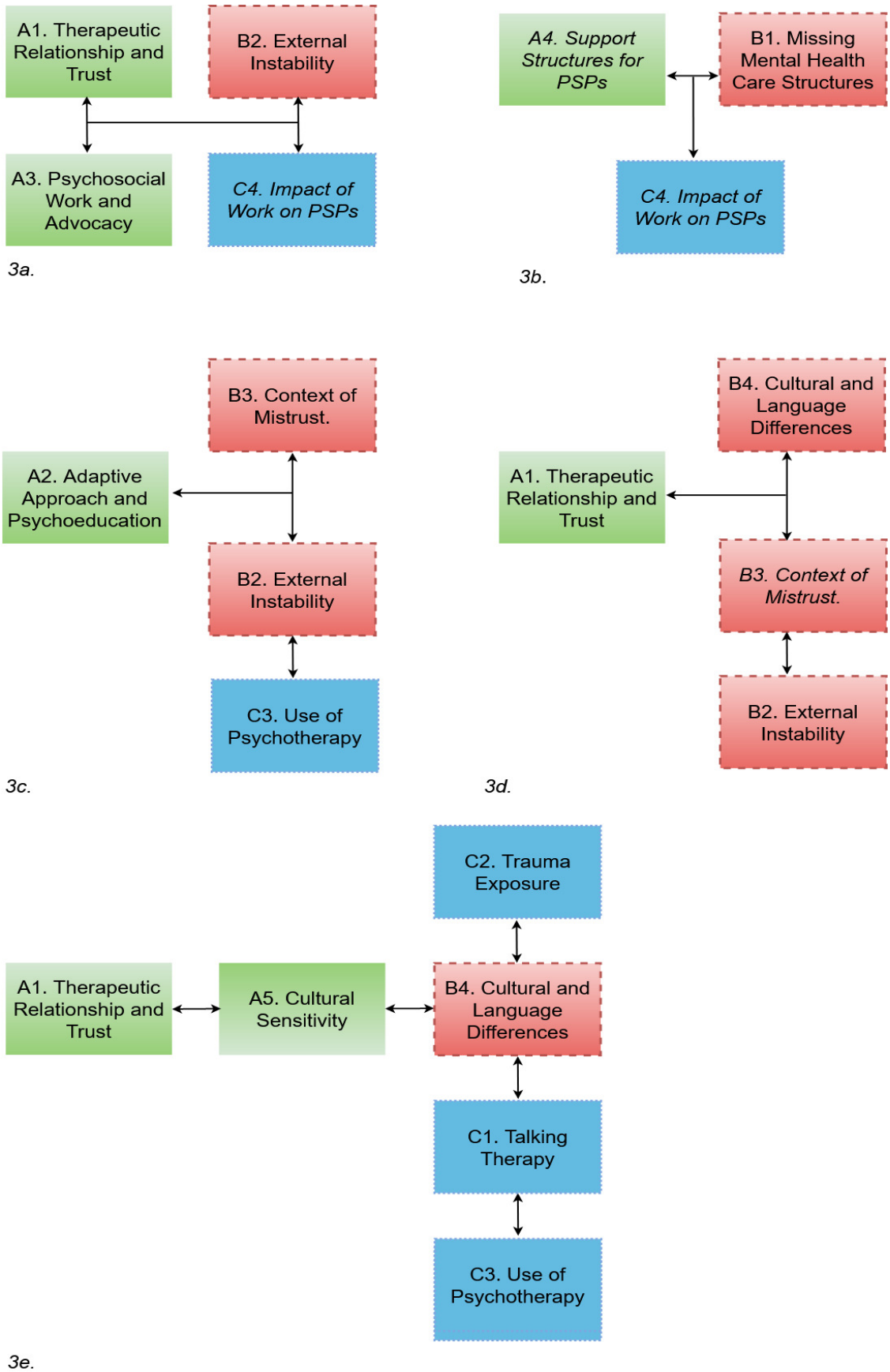

Figure 3a-e. Relations between analytical clusters. Clusters only mentioned by PSPs are depicted in italic

B) What are negative/hindering aspects in the therapeutic process?

B.1. A context of lacking mental health care structures and funding

> *"One weekly session is not enough. Persons who are so heavily affected need more…"* (Mirdal et al., 2012, p. 454)

Missing MHS structures were mentioned as a primary difficulty in six studies. Patients complained about waiting lists and the difficult access to MHS. PSPs additionally referred to tedious procedures to secure funding for the treatment of refugees or, in some cases, their non-existence. The financing of interpreters was reported to be especially difficult. PSPs described how cancelled appointments placed them in dilemmas, as there were no structures to cover their expenses. Furthermore, PSPs criticised the lack of appropriate supervision and networks of support, which negatively affected their own well-being (see Figure 3b).

B.2. The constant threat to the external and internal stability of patients

> *"… it's very difficult to start working with clients unless they have already been given refugee status because until the young person begins to feel secure and safe in their environment, it's difficult to start dealing with the issues."* (Warr, 2010, p. 272)

This cluster includes the highest number of descriptive themes and involved all primary studies. PSPs and patients depicted how the mental stability of patients is constantly threatened by two main aspects – the difficulties in resettlement and the current situation in the country of origin. These aspects seemed to enter the therapeutic space as a permanent source of worry for patients, influencing their well-being, making it often inappropriate to address past traumas. Concerning the first aspect, the difficulties in resettlement, a "hierarchy of needs" became apparent in which improvements in the resettlement context of refugee patients seemed more urgent for their well-being than psychotherapy. Resettlement stressors such as future insecurity, lack of a secure asylum status, unemployment, social exclusion, and separation from families burdened patients but also affected PSPs – the latter often did not feel competent to deal with the complexity of this situation or became frustrated or hopeless regarding the existential challenges their patients had to face. Patients saw it as a major difficulty when their PSPs were not aware of their refugee situation. In six studies, the ongoing violence in the country of origin were also referred to as impacting patients' well-being and the MHS, having the potential to undo what had been achieved in MHS at any time.

B.3. Mistrust in psychotherapy due to negative experiences, stigma and lacking transparency

> "*(...) the recurrent experience of clients not being informed of their therapists' educational backgrounds, orientation in therapy, and/or treatment structure: 'I did not know this idea that there are different methods used for different types of disturbances […] I actually learned afterwards towards the end of my counselling with her. But she did not explain any of this to me.'"* (Al-Roubaiy, 2017, p. 467)

This cluster exclusively related to the perspectives of patients. They saw the development of trust as particularly difficult as atrocious experiences in the past, having been victims of persecution, and inhuman treatment lead to the natural reaction of general distrust of other people

and particularly of those working in formal institutions (see Figure 3c). Current experiences in resettlement countries such as a lack of transparency and social exclusion also contributed to mistrust. Furthermore, patients in four studies reported mistrusting the whole profession of MHS, on the one hand due to negative stigma of psychotherapy and mental illness. On the other hand, the mistrust was also caused by a lack of information on MHS and insufficient transparency from PSPs concerning their work. Some patients reported mistrusting the competence of their practitioners, which was reinforced when the PSP appeared inquisitive or not mindful of their refugee situation.

B.4. Diverging cultural and language backgrounds

> *"…concerns were raised about interpreters omitting material, interpreting inaccurately, hampering interpersonal dynamics, inserting opinions, or passing judgment on the client…"* (Valibhoy et al., 2016, p. 8)

Building the therapeutic relationship was described as a challenge by patients and PSPs in general. This was explained by several factors, mainly language and cultural differences and negative prejudices against psychotherapy (see Figure 3d). The latter led some patients feeling like a failure due to their problems and finding it difficult to be open to receiving support. The diverging cultural backgrounds of patients and PSPs were also mentioned as a difficulty; PSPs framed this mostly as "cultural differences in general," which made bonding with patients more complex. Patients were particularly critical about, and sensitive toward, their PSP's position. In two studies, they felt PSPs were judgmental or disrespectful regarding cultural differences, forcing their own values upon them. They perceived PSPs as narrow-minded toward different ways of being and feeling.

In most cases, PSPs and patients spoke different languages, which made direct one-to-one communication impossible. Therefore, PSPs worked with the support of interpreters. However, sometimes PSPs and patients perceived a lack of synchrony between PSPs and interpreters or criticised interpreters' over-involvement (e.g., independently asking questions) or under-involvement (e.g., symbolising disinterest via body language). Also, PSPs were preoccupied with interpreters' well-being, especially when it came to trauma work. Patients were particularly worried about interpreters changing the content of what they said. These worries were described as impeding both the relationship building and the therapeutic process.

C) What are ambivalent aspects in the therapeutic process?

Some aspects of the MHS experience were found to be ambivalent either because the findings of the studies contradicted each other, participants differed in their opinions among each other, or participants experienced internal ambivalences regarding a particular aspect.

C.1. Talking: Acting against cultural norms vs. prerequisite of therapy

> *"What I need is physical therapy and massage. I do not need to talk…"* (Mirdal et al., 2012, p. 454)

Talking in general was an ambivalent aspect of MHS. On the one hand, a number of patients perceived it as helpful to "let things out," structuring mental chaos through verbal expression, and

having someone who listened. Many PSPs saw talking as an implicit prerequisite of MHS. On the other hand, patients in two studies felt that they were acting against cultural norms that made the verbal expression of personal emotions inappropriate (see Figure 3e). Others feared for the safety of their families and therefore felt uncomfortable when having to talk. In one study, participants also questioned the benefit of talking – they did not perceive it as useful and rather sought medication, physical therapy, or practical advice.

C.2. Trauma exposure: Creating continuity vs. suffering again

> *"Someone is forcing you to talk about them and you, you are trying to forget them [...] you are forced to remember, so you feel discouraged and you feel no happy, no happy. You feel angry at the time."* (Vincent et al., 2012, p. 584)

Trauma work was often discussed as an integral part of psychotherapy with refugees. However, the results also show that it was not seen as the most important aspect, and often considered appropriate only after patients' situational improvements. It was predominantly PSPs who considered narrating and re-experiencing traumatic memories as part of a healing process. Many referred to the importance of creating continuity for fragmented memories by talking. Some refugee patients perceived talking about traumas as helpful because it allowed them to give meaning to their experiences. However, in three studies, patients held the opinion that narrating the past might worsen the pain, they did not understand why they had to relive the suffering, or felt that it countered their desire to forget. PSPs in one study also mentioned that trauma exposure comes with the risk of re-traumatisation.

C.3. The use of psychotherapy: Regaining hope vs. not seeing its point

> *"What is the use of spending so much money on my treatment if I am going to stay unemployed? I never see anyone. I become ill if I don't work."* (Mirdal et al., 2012, p. 455)

Another ambivalent point was the attributed benefit of MHS in itself. Many patients and PSPs agreed that it was of no use if the resettlement situation remained difficult and characterised by a constant fear of deportation (see Figure 3c). In six studies, several patients held the opinion that MHS was unhelpful. However, for some patients, the uncertainty of their external situation increased the value of MHS: It provided a stable space with a person from the majority population listening to and supporting them. They appreciated being helped to deal with their stress and described how they regained hope, and experienced symptom improvements. If the latter was the case, in four studies, patients' appraisals of the use of MHS changed from negative to positive over time. PSPs also reported positive developments that made them see a usefulness in their work, although many highlighted that patients' basic needs had to be addressed first.

C.4. Impacts on PSPs: Adding meaning vs. vicarious traumatisation

> "*All of the participants described some awareness of personal changes that resulted from their work with refugee clients."* (Schweitzer, 2015, p. 114)

This final cluster exclusively concerns PSPs and their well-being. PSPs experienced the MHS with refugees as placing heavy demands on them. They described how the work with refugee

patients involves listening to many atrocious experiences, stories of trauma and loss –patients losing family, their home, and cultural frame of reference. Compounding this, patients' harsh experiences do not lie exclusively in the past but are rather ongoing due to the resettlement difficulties and the continuation of violence in the countries of origin. Consequently, some PSPs reported getting overwhelmed by patients' stories, and becoming frustrated with their own home country. In three studies, PSPs saw the worsening of one's world view, vicarious traumatisation, and burnout as consequences. The risk for such negative consequences was augmented by assuming excessive responsibility for patients' needs, by seemingly being the only significant person for the patient in the resettlement context or by keeping relationship boundaries flexible which yielded the potential of PSPs overly identifying with patients (see Figure 3a). However, PSPs' transformative experiences were not exclusively negative. Positive consequences were described in three studies such as becoming aware of their own privileges, being inspired by their patients' strength, and obtaining a sense of meaning from their work.

4. Discussion

The present article synthesised 10 qualitative studies investigating PSPs' and refugee patients' perspectives on MHS. We could confirm many of the findings by Karageorge et al. (2017), even though our analysis was based on entirely distinct primary studies. In the following section, the central findings will be linked to the scientific literature and their implications will be discussed.

Consistent with ample research, this QES shows that the external context of refugee patients highly influences the MHS, which relates to missing mental health care structures for refugee patients (De Anstiss et al., 2009; Kluge, 2016; Knobloch, 2015) and notably to the effect of the resettlement situation on patients' well-being (Beiser, 2009; Bhugra, 2004; Hassan et al., 2016). The latter might call the use of psychotherapy into question as long as patients remain in a situation characterised by disempowerment and unclear asylum status (Codrington et al., 2011; Savic et al., 2016; Summerfield, 1999; Watters, 2001). At the same time, the difficult resettlement context might increase the importance of MHS as a stabilising factor (Kronsteiner, 2017). Indeed, many refugee patients experienced the therapy as a valuable safe space amid the external instability, whereby engaging in psycho-social and interdisciplinary work, and advocacy seemed especially helpful (Goodkind et al., 2014; Hassan et al., 2016; Karageorge et al., 2017; Kramer, 2005). Interestingly, the latter came up in studies that included various MHS professions as well as in the ones that exclusively interviewed psychotherapists. Practical help and advocacy seem to be beneficial due to their direct consequences, but also in an indirect way by supporting the development of trust (Kronsteiner, 2017; Watters, 2001).

This aspect is of central importance, as a trusting therapeutic relationship was found to be a key to the MHS experience (Hassan et al., 2016; Sandhu et al., 2013). Karageorge et al. (2017) do not explicitly report on healing impacts of a therapeutic relationship in itself. However, the authors describe that "mutual understanding" is central, but hindered by mistrust. This is consistent with the finding of the present study as well as of others (Codrington et al., 2011; Sandhu et al., 2013; Turner, 1995) that establishing trust with refugee patients might take a long time, as negative past experiences, unfamiliarity with the resettlement country's health care system, negative preconceptions of psychotherapy, and the sometimes hostile attitudes of receiving communities are major barriers for the development of trust.

Alongside trust, this QES found a healing relationship to be characterised by empathy, respect, solidarity, and furthermore described as one of kin- or friendship and "flexible boundaries". Flexible boundaries remain a scientifically debated issue, and the present study supports the view that they constitute a balancing act for therapists; they can strengthen bonds and be appropriate especially for culturally competent practise (Speight, 2012; Zur, 2004). However, they might

counteract the goal of nurturing patients' independence (Codrington et al., 2011) and they come with the risk of PSPs overly identifying with patients (Kronsteiner, 2017).

In line with Karageorge et al. (2017), as well as Barrington and Shakespeare-Finch (2013, 2014), this QES found that working with refugees can have a deep impact on PSPs– positively by evoking inspiration and adding meaning, but also negatively by leading to frustration or vicarious traumatisation. Therefore, it becomes vitally important that PSPs develop personal strategies for distancing themselves and that they receive appropriate structural support, namely through supervision and mentoring (Barrington & Shakespeare-Finch, 2013, 2014).

In terms of therapeutic approaches, this study and others (Codrington et al., 2011; De Anstiss et al., 2009; Guregård & Seikkula, 2014; Savic et al., 2016) have found that the adaptation of methods according to patients' individual needs is central. Important pillars to such an adaptive approach seem to be psychoeducation and transparency. Known to be of importance for general patients as common factors across therapeutic schools (Wampold & Imel, 2015), these elements become crucial for refugee patients, as the latter often face a lack of transparency and information in resettlement countries (Davidson et al., 2008; De Anstiss et al., 2009; Sandhu et al., 2013). Psychoeducation and transparency as central pillars can provide ways to establish trust, counter disempowerment and stigma, and change patients' potentially negative self-views when attending therapy (Murray et al., 2010; Turner, 1995).

Cultural differences were described as a difficulty by patients and PSPs. At the same time, as reported by Chang & Berk (2009) and Karageorge et al. (2017), asking questions and talking about cultural differences were seen as ways to overcome the difficulties, as well as PSPs reflecting on their own culture (Kirmayer, 2012; Rober & De Haene, 2014) and involving interpreters (Martins-Borges & Pocreau, 2009; Pugh & Vetere, 2009). Similar to Karageorge et al. (2017), this QES found that, while PSP's culture-specific knowledge is evaluated positively by patients, of higher importance seems to be firstly, a willingness to learn from each other, and secondly, the recognition of the socio-political context of refugees (Goodkind et al., 2014; Kluge, 2016; Kramer, 2005; Murray et al., 2010).

Finally, the present QES as well as Karageorge et al. (2017) found ambivalent attitudes toward verbal therapies and narrating traumatic experiences which might also be due to the fact that in some cultural contexts, talking about individual problems is regarded as inappropriate (Ahearn, 2000; Patel, 2003b; Savic et al., 2016). These ambivalences call for a careful consideration of how appropriate trauma exposure approaches are for some patients, as people from different backgrounds might have different "functioning" strategies to overcome painful experiences (Becker, 2014; Reddemann & Sachsse, 1997). It remains open to debate whether a familiarisation of patients with talking about their emotions is a necessary condition for therapy, or whether alternatives could be taken into account such as empowering community-focused interventions (Goodkind et al., 2014; Westoby, 2008), or creative therapies (Koch & Weidinger-von-der-Recke, 2009).

4.1. Methodological considerations

There are several limitations to the present findings. Firstly, some might argue that qualitative findings are not generalisable but rather specific to a certain context (Thomas & Harden, 2008). Meanwhile, others state that qualitative research will reach its full contribution only if syntheses generalise across the increasing amount of individual studies (Britten et al., 2002). Certainly, the findings of this QES represent the interpretation of the primary studies from the perspective of the QES researchers. However, this study does not claim objectivity; it is rather an attempt at a *"subjective testimonial to other people's voices"* (Ahearn, 2000), p.15*)*. During the research

process, steps were undertaken to ensure its transparency and enable its repetition (Paterson et al., 2001; Tong et al., 2012).

Secondly, critiques may relate to the present QES' inclusion of studies with adult and adolescent patients, as well as the inclusion of a diversity of MHS professions rather than purely psychotherapists. Yet, as the qualitative literature on the topic from insider perspectives is sparse, our aggregation seemed appropriate to obtain a broader database. Meanwhile, attention was given to the potential impact of the difference in participants when analysing the material. Furthermore, the present study included the perspectives of 23 asylum seekers and 54 refugees, but the database did not allow for an investigation of differences in relation to asylum status. Asylum-seekers, unlike refugees, do not yet have a clear status in the host country, but rather still wait for their claim to be processed. Thus, their status is uncertain and temporal and they often fear deportation which has been described to highly influence their mental health (Momartin et al., 2006). This QES found that clients' insecurities about their future were stressed in most of the primary studies independently if the sample included asylum seekers and/or refugees, but due to the restricted information no clear conclusions could be drawn. Certainly, more studies are needed to understand in which way asylum status as well as other patients' characteristics might impact the therapeutic relationship and process. Similarly, limited contextual data provided in primary studies did not allow for a comparison among different contexts of resettlement and reception of patients, although these contexts play an important role for MHS and refugee mental health. Restricted information on participants and contexts provided by primary studies is an issue for qualitative evidence synthesis that has been noted critically by others (Paterson et al., 2001; Thomas & Harden, 2008).

Thirdly, including only primary studies with a single methodology in the synthesis might have been limiting as triangulation of diverse methods can help to counter the limitations of one method with the strength of another. However, there is a debate around the appropriateness of mixing different qualitative methodologies in a synthesis (Booth, 2016; Jensen & Allen, 1996), as problems in comparability might arise from incongruencies between the underlying epistemologies of methods (Jensen & Allen, 1996).

Finally, the synthesis did not achieve its initial goal of including studies from non-Western countries. Despite using Ibero-American and francophone databases, as well as key words in five different languages, the final selection of studies stems exclusively from Western countries. There are two likely explanations for this. Firstly, the selection criteria of the present QES might have given preference to a Western way of conducting research and not allowed different ways of generating knowledge to enter the analysis. Secondly, there seems to be little research on the topic of mental health support for refugees in non-Western countries (Teixeira et al., 2013).

4.2. Conclusion and recommendations for practice and future research

In terms of implications for practice, this QES suggests that the greatest emphasis in the MHS with refugees should be given to the development of a trusting relationship between the professional and the patient. The challenge for the PSP might be to remain open-minded and flexible in terms of relationship boundaries and in terms of adapting to patients' needs, increasing one's cultural sensibility and awareness of the refugee context. Working in interdisciplinary networks, using integrative therapy approaches, and receiving appropriate structural support might help to meet these challenges and encounter the risk of overly burdening PSPs. Furthermore, psychoeducation and transparency are important for enabling patients to make their own decisions and develop trusting relationships. Future research might investigate in more detail the development of trust. In doing so, particular attention should be paid to providing sufficient contextual information on participants, their asylum status as well as the policies of refugee

reception in the study's country of origin. Also, further studies investigating refugee patients' perspectives could shed more light on the meaning of trauma exposure approaches for those who experience them. In terms of policy development, the present study provides further evidence for the fact that context improvements are central to refugees' mental health. If the aim is to foster refugees' well-being, the first step should be to improve their life situation by facilitating asylum procedures and family unity and quickly providing work permits.

Footnotes

[1] This article uses the terms "displaced people" and "refugees" interchangeably and does not differentiate between people's official civil statuses in resettlement. The term "asylum seekers" is only used when the difference between already officially recognised refugees and asylum seekers, who are still waiting for their claim to be processed, is of importance.

[2] The term psycho-social professional (PSP) as used in this article does not follow any specific standardised definition. It was chosen here since studies investigating perspectives of MHS professionals on psychotherapy with refugees are still sparse and the unifying term "PSP" allows for an inclusion of a wide range of professional labels including "psychotherapist," "counsellor," and "psychologist." It also allows for a better integration of international studies, as more specific professional labels such as "psychotherapist" may have diverging conceptualisations and understandings across countries.

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