



Stelikou, Viktoria (2026) *A cognitive interview study exploring a culturally adapted version of the Dissociative Experiences Measure Oxford (DEMO) in Persian and a systematic review and thematic synthesis of asylum seekers and refugees' experiences of accessing mental health services in the UK.* D Clin Psy thesis.

<https://theses.gla.ac.uk/85879/>

Copyright and moral rights for this work are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This work cannot be reproduced or quoted extensively from without first obtaining permission from the author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Enlighten: Theses

<https://theses.gla.ac.uk>

research-enlighten@glasgow.ac.uk



A cognitive interview study exploring a culturally adapted version of the Dissociative Experiences Measure Oxford (DEMO) in Persian and a systematic review and thematic synthesis of asylum seekers and refugees' experiences of accessing mental health services in the UK

Viktoria Stelikou, BSc (Hons), MSc

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

School of Health and Wellbeing

College of Medical, Veterinary and Life Sciences

University of Glasgow

January 2026

Table of Contents

List of Tables	4
List of Figures	5
Acknowledgements	6
Chapter 1: Systematic Review	7
Abstract.....	8
Introduction	9
Methods.....	11
Results.....	18
Discussion	50
Conclusion	56
References	57
Chapter 2: Major Research Project.....	64
Plain Language Summary.....	65
Abstract.....	67
Introduction	68
Methods.....	71
Results.....	81
Discussion	95
Conclusions	104
References	105
Appendices	114
Appendix 1.1: Prisma Checklist.....	114
Appendix 1.2: ENTREQ Checklist	117
Appendix 1.3: Search Terms and Search History (Conducted 26 th June 2025)	119
Appendix 1.4: CASP Checklist	146
Appendix 1.5: Extract of reflexive journal entry / Bracketing (SR)	147
Appendix 1.6. Recurrence of Themes.....	148
Appendix 1.7. Supplementary Detailed Version of Critical Appraisal	150
Appendix 2.1: Ethical Approval Letter	151
Appendix 2.2: Managerial Approval	153
Appendix 2.3: Final approved MRP proposal	155
Appendix 2.4: Study Documentation.....	156
Appendix 2.5: CORE-Q	157

Appendix 2.6: DEMO.....	159
Appendix 2.7: Extract reflective notes.....	162
Appendix 2.8: Topic Guide.....	164
Appendix 2.9: Data Availability Statement.....	165
Appendix 2.10: Codebook.....	166
Appendix 2.11: Item-by-Item review.....	167

List of Tables

Table 1. Eligibility Criteria for the Systematic Review	13
Table 2. Thematic Synthesis stages by Thomas & Harden (2008)	16
Table 3. Study Characteristics.....	23
Table 4. Critical Appraisal Skills Programme UK (CASP) Ratings.....	35
Table 5. Participant Characteristics	77
Table 6. Comprehension and problem summary for Persian DEMO items across participants	82

List of Figures

Figure 1. PRISMA Diagram	20
Figure 2. Thematic Map	37
Figure 3. Translation and cross-cultural adaptation process	74

Acknowledgements

First and foremost, I want to thank my wonderful participants. It was a privilege to meet you all, and I am deeply grateful for your time and trust. I would also like to thank Farhad Bavarsad, the main interpreter who supported the interviews. Farhad, your warm presence and kind nature elevated this project, and it was genuinely moving to witness the safe and supportive relationships you have with participants.

My deepest gratitude also goes to Dr Asieh Yousefnejad Shomali, my Iranian collaborator, who supported this project with her linguistic, cultural, personal, and academic expertise and made it possible. Your contribution has been invaluable.

Prof Andrew Gumley - thank you for your emotional, practical, and unwavering support through a journey that was anything but linear, and often very stressful. Your reminders to hold the bigger picture in mind, and your gentle, compassionate redirection towards the goal, helped make this possible. I am grateful for our time together over the last almost three and a half years of supervision, and for your constructive and kind feedback. I particularly valued the moments when we took a few minutes to speak about the unfair state of the world and how this inevitably shapes our work as clinicians and researchers, especially in the context of this project. Those conversations genuinely helped my sanity! A huge thank you also to my field supervisor, Dr Alison Hauenstein-Swan, for supporting this research with our Iranian participants, from interpreter logistics, to tracking down participants when recruitment was challenging, to liaising with services, and for offering much-needed perspectives on trauma and dissociation. You were a steady, supportive, and encouraging presence throughout. It really was a journey for all of us. I would also like to thank my initial field supervisor, Dr Kirsten Atherton, whose idea and support helped launch this project. Thank you as well to the Glasgow Psychological Trauma Service, both for the practical support and for welcoming me when I was there in person for interviews.

I'm grateful to Paul Cannon and Chris O'Malley (UHI) for their support with my search strategy and systematic review, and to Melissa for taking the time to act as my second reviewer, even though she had already graduated by the time we reached that stage. A special thank you goes to Deborah, my study skills tutor. I could not have completed what often felt like an impossible task without your support.

Mum and Dad, over these last three months finishing my research back home, your support has been invaluable, from dropping off food at the co-working space, to calling to check I'd eaten! Thank you for checking-in from a distance during what was often a lonely journey in the UK, and for believing in me. I know you are proud of me.

To the friends I made along the way - DClin friends and otherwise - thank you for sticking around and support me in different ways. Special thanks to M, who travelled to Inverness to look after me and get me out of the house while I was juggling the intensity of placement and thesis. I felt so lucky and loved. R, thank you for listening to all my vents and for your steady support.

Finally, thanks to myself for not giving up, even in moments when it felt like the only option, and for making it to the end of this journey despite the challenges. I think it is fitting to end this with Persian mystic poet Rumi: *"I know you're tired but come, this is the way."*

Chapter 1: Systematic Review

**Refugees and asylum seekers experiences of accessing mental health services in the UK - A
systematic review and thematic synthesis of qualitative research**

Prepared in accordance with the author requirements for Frontiers in

Psychology (Psychology for Clinical Settings) for Systematic Review

(<https://www.frontiersin.org/about/author-guidelines>)

Abstract

This review aimed to systematically review and synthesise qualitative data related to the lived experiences of asylum seekers and refugees (ASRs) and their access to mental health services in the UK. A pre-planned systematic search with no date restrictions was conducted on 26th June 2025. Studies were screened by title and abstract, followed by full text. Included studies were appraised using the Critical Appraisal Skills Programme UK (CASP) Qualitative Studies Checklist. A thematic synthesis of 11 studies revealed three overarching themes which related to different aspects of ASRs accessing and using mental health services in the UK: structures and systems that produce both distress and inaccessibility, negotiating distress and help-seeking within cultural, religious and social worlds and conditions under which care feels safe, trustworthy and genuinely helpful. The experiences of accessing mental health support for ASRs are discussed. Key areas for service development and improvement are highlighted, particularly around language support, safety, trust and the need for holistic care. Finally, recommendations are made for clinicians, service leaders and policymakers to improve access, acceptability and engagement in mental health services for ASRs.

Keywords: refugees; thematic synthesis; systematic review; mental health care; United Kingdom

Introduction

Over the past decade, and particularly in recent months, ongoing conflict, violence, and persecution have driven more global displacement (UNHCR, 2024). By the end of 2024, 123.2 million people were forcibly displaced worldwide (UNHCR, 2024). Refugees are individuals *"who flee their country due to war, violence, natural disasters or persecution, with a well-founded fear of being persecuted for reasons such as race, religion, or political views"* (United Nations, 1951). Asylum seekers remain in a more uncertain legal position while awaiting a decision and protections linked to refugee status (Hynie, 2018). In the UK, substantial numbers of people are seeking asylum and refugee protection, and the asylum caseload remains high (House of Commons, 2025).

It is established that asylum seekers and refugees (ASR) face a high risk of psychological distress often associated with the three stages of the migratory process (pre-migratory, peri-migratory, and post-migratory) and these stages are linked with trauma that ASRs face (Katsampa et al., 2025). Upon arrival in host countries, mental health can deteriorate due to post-migration stressors and socio-political factors, including the asylum process, racism and xenophobia, poor living conditions, limited access to healthcare, and socio-economic difficulties (Demirli Yıldız & Strohmeier, 2024; Morrice et al., 2021). These cumulative stressors increase the risk of enduring mental health difficulties, with ASR more likely than the general population to have long-term psychological needs (Santambrogio et al., 2024; Katsampa et al., 2025). Recent reviews indicated high prevalence of depression and PTSD among ASR living in high-income countries (HICs) and these symptoms can persist for years post-displacement and resettlement (Blackmore et al, 2020; Henkelmann et al., 2020).

Host countries have responsibilities to ensure access to health care, including for people seeking protection (UNCES, 2000). However, research suggests ASR have disproportionately higher rates of unmet mental health needs (Dumke et al., 2024). Reviews have highlighted a gap between ASR's mental health needs and treatment provision in high-income countries, barriers related to differences in cultural conceptualisations of distress, limited availability of specialist services, and issues around therapeutic and cultural "competence" (Dumke et al., 2024; Satinsky et al., 2019).

In the UK, policy and public discourse are relevant to mental health and help-seeking. The “hostile environment” has been described as damaging, creating a climate of fear and contributing to harmful portrayals of ASR, with impacts linked to racism, islamophobia and xenophobia (Essex et al., 2022; Trueba et al., 2023). Jannesari et al. (2019) described how ASRs experienced this as “diplomatic torture”, contributing to re-traumatisation and dehumanisation. Essex et al. (2022) further highlighted that fear of detention or deportation discouraged people from seeking care. It is also important to note that ASRs’ experiences may not be uniform and vary depending on how people are racialised and positioned within policy. Some groups have been represented as more “deserving” of support than others (Reynolds et al., 2024). Griffiths & Yeo (2021) critiqued the hostile environment as an ideological stance rather than an evidence-based policy approach. These contexts sit alongside broader NHS pressures and widening inequalities (Institute of Government, 2024), which compound barriers for marginalised groups (Lowther-Payne et al., 2023; Alam et al., 2024).

Although there is growing recognition of the complex mental health needs of ASRs in the UK, access to appropriate support remains inconsistent and influenced by intersecting structural, cultural and institutional barriers. Byrow et al. (2020) identified barriers to service use including transport difficulty, insecure housing, appointment scheduling difficulty or delay, immigration status, continuity of care, and stigma around mental health. While international and European-wide reviews provide important evidence (Byrow et al., 2020; Dumke et al., 2024), there remains a lack of systematic qualitative work focused specifically on the UK’s legal, mental healthcare, and policy landscape for ASRs.

Pollard and Howard’s (2021) scoping review highlighted a gap in UK-wide evaluations of mental healthcare access for ASRs and called for context-specific, culturally sensitive and responsive service designs, but did not conduct a formal synthesis of qualitative findings. Other reviews (Hanwell et al., 2025; Harrington et al., 2022; Due et al., 2020) explored barriers within primary care or general healthcare settings. Alam et al. (2024) and Bansal et al. (2022) addressed racialised experiences more broadly, often without focusing specifically on the asylum process or on ASRs’ experiences of accessing mental health services. More recently, Koja et al. (2025) published a UK-focused systematic review of adult refugees’ perceptions of accessing mental health services; however, it excluded asylum seekers and under-18s/over-65s and synthesised evidence across quantitative, qualitative and mixed-methods designs.

A UK-wide, qualitative-led synthesis centring asylum seekers and refugees lived experiences of accessing and engaging with mental health services (across ages and UK nations) remains a

gap. Recent protocols (PROSPERO CRD42024540071, 2024; PROSPERO CRD42024597069, 2024) have similar aims but are limited by scope (geography, availability-focused questions) or are still in progress. Furthermore, existing reviews often prioritise identifying barriers over exploring the meaning and experience of help-seeking. By focusing on the UK context and centring the voices of ASRs, this review aims to provide a comprehensive, thematically synthesised understanding of ASRs' experiences of mental health service access and use, to inform policy, practice, and service design aligned with principles of equity, social justice, trauma-informed care, and cultural responsiveness.

The overall aim of the review is to systematically review and synthesise the perspectives and lived experiences of ASRs who are seeking mental health care and living in the UK. It aims to provide an understanding of how ASR access and use mental health services in the UK, including features that may improve access and engagement, and those that act as barriers.

Methods

Registration

In accordance with PRISMA guidelines (Page et al., 2021), this systematic review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 7th of August 2025 (CRD420251115664) and reported in line with PRISMA guidelines (Appendix 1.1). The Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) guidelines (Tong et al., 2012) were also followed to ensure transparency of reporting (Appendix 1.2).

Search Strategy

A pre-planned systematic search with no date restrictions was conducted on 26 June 2025. Five databases were identified and included OVID Interface (MEDLINE and EMBASE), EBSCO (CINAHL and PsychInfo) and Web of Science Core Collection (Science Citation Index Expanded (SCI-EXPANDED), Social Sciences Citation Index (SSCI), Emerging Sources Citation Index (ESCI).

Search terms were formulated using the SPIDER framework (Cooke et al., 2012). The search strategy was developed in consultation with a specialist librarian to ensure specificity and sensitivity, amended as appropriate per database. A detailed account of search terms and the full electronic search strategy) can be found in Appendices (1.3). The following key concepts were searched:

1. Key word searches related to main subject terms:

Studies conducted in the UK: UK geographic filter (Ayiku et al., 2017)

Refugees and Asylum Seekers: Refugee* OR asylum seeker* OR forced migrant*
OR displaced persons

Mental Health Services: Community Mental Health Service* OR Psychiatric
Rehabilitation OR Therapeutics OR Psychological Therap* or Counselling or IAPT
OR Mental Health Care Utilisation

Qualitative Research: qualitative OR ethnograph* OR grounded theory OR
naturalistic OR IPA OR phenomenolog OR experience* OR perception* OR
narrative OR interview* OR content analysis OR focus group* OR questionnaire
OR survey OR thematic analysis

2. The use of MeSH/Subject Headings to map articles to main subject terms.
3. The use of the OR Boolean Operator to combine search lines for each main subject.

Study Selection

This review included qualitative studies and the qualitative components of mixed-methods studies that reported on the experiences of ASRs accessing mental health services in the UK. Qualitative, in-depth data were understood as accounts of people's experiences, stories, beliefs, feelings, or thoughts about accessing and using MH services in the UK, generated through structured or unstructured methods such as interviews and focus groups.

An initial search of PROSPERO identified existing and planned reviews, many of which focused on quantitative evidence or on healthcare more broadly. To avoid duplication and to add to the literature, this review concentrated on qualitative evidence with a primary focus on ASRs' experiences of accessing MH services in the UK. Inclusion and exclusion criteria are presented in Table 1.

Table 1. Eligibility Criteria for the Systematic Review

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> • Qualitative research studies exploring asylum seekers and/or refugees' (ASRs) experiences accessing and using mental health services in the UK. • Studies with their primary aim focusing on access and use of mental health services/support/care in the UK. • Studies must look at experiences and qualitative accounts reported from the defined population of those accessing and using mental health services services/input (barriers, facilitators, perceptions, stigma, etc.). The sample needs to constitute at least 50% of the sample amongst a study sample, for example, inclusion of studies where there was an approximate 1:1 ratio of patient: stakeholders' perspectives. • Any qualitative research design, including mixed methods with a clinical or non-clinical sample (people with or without mental health difficulties) that explored 	<ul style="list-style-type: none"> • Studies conducted outside of the UK. • Studies using only a sample of migrants (as there is not an internationally agreed legal definition of 'a migrant', for the purpose of this study 'a migrant' is considered to be an individual residing outside of their country of origin, who is not a refugee or asylum seeker). • Studies focusing on physical health support or medication. • Studies with their primary aim as access to healthcare more generally with a focus on broader conceptions of health services such as infections, cardiovascular, primary healthcare etc. • Studies focusing on cultural adaptation of specific treatments for ASRs (e.g. art therapy, CBT, ACT, etc). • Studies that are focusing on family experience (family as a unit rather than individual accounts).

<p>ASRs experiences of accessing and using mental health services.</p> <ul style="list-style-type: none"> • Studies must be published in a peer-reviewed journal 	<ul style="list-style-type: none"> • Studies not published in full in the English Language. • Unpublished, non-peer reviewed articles. • Studies that only include quantitative data.
---	--

Review Process

Study Screening

Database searches were conducted by the lead researcher, and all citations were managed in EndNote and Rayyan (Ouzzani et al., 2016). Titles and abstracts were screened against the inclusion and exclusion criteria, and where eligibility was unclear, the full text was retrieved. Full texts for all potentially relevant studies were uploaded to Rayyan and read in detail to determine inclusion/exclusion criteria; irrelevant papers were excluded. Reasons for all full-text exclusions were recorded in line with PRISMA guidance. All included full-text articles were then independently checked by a second reviewer in Rayyan to confirm that they met the inclusion criteria.

Data Extraction

Data were extracted from full-text papers by the author into a pre-defined table populated with variables of interest. Data extracted from the included papers were: Author, Year, location/setting, sample and participant characteristics, contact with mental health services, data collection method, data analysis, qualitative key and sub themes. For studies including both ASRs and staff participants/other stakeholders, we reported both the total sample size (with group breakdown) and the relevant ASRs subsample. This ensured transparency regarding the study context while highlighting the proportion of data directly relevant to the review question. Where possible, it was also noted whether quotations and themes were presented separately for each group or where combined. All text was extracted from the

"results"/"findings" section of the included studies to a word document. The accuracy of the extracted data was verified by a second reviewer for five of the included studies.

Quality Appraisal

The Critical Appraisal Skills Programme UK (CASP) Qualitative Studies Checklist tool (Appendix 1.4) was used to critically appraise included papers for methodological quality and risk of bias, including strengths and limitations of the included papers (CASP, 2023). Quality appraisal was not used as a basis for exclusion, as research suggests that excluding studies due to low quality has little impact on the findings of qualitative syntheses, and existing appraisal tools may not adequately capture the depth or significance of such findings to justify exclusion (Sattar et al., 2021). This is in accordance with Cochrane Qualitative guidelines for conducting systematic reviews (Noyes et al., 2018). Although, the CASP tool does not provide cut offs for determining quality, the studies were rated against each question, and then allocated to a score of low (0-4), moderate (5-7) and high quality (8-10) that corresponded to the overall critical appraisal (Milner et al., 2020). Quality appraisal findings were therefore used to categorise studies by quality and to structure the subsequent thematic synthesis (Long et al., 2020).

Although CASP tool has been criticised as a less sensitive measure of methodological quality compared to other tools such as the Joanna Briggs Institute (JBI) tool (Hannes et al., 2010), it is the most commonly used tool for quality appraisal in health and social care qualitative evidence synthesis, is recommended for novice qualitative researchers (Long et al., 2020) and is approved by Cochrane for use in qualitative synthesis (Hannes, 2009).

All included studies were initially appraised by the first author, with a random 64% sample (n = 7) independently co-rated by a second reviewer to check reliability and ensure coverage across quality levels. Agreement on the overall CASP quality band (low/moderate/high) was substantial (weighted Cohen's $\kappa = 0.84$), with one category difference (moderate vs high). At the item level, discrepancies related to whether ethical approval had been reported, the adequacy of the recruitment strategy, and the appropriateness of the qualitative methodology.

Method of Synthesis

The synthesis was guided by an interpretive intent, in line with Booth's (2016) definition of meta-synthesis as an *"attempt to integrate results from different but inter-related qualitative studies with interpretive, rather than aggregating intent"*. This was informed by a critical

realist stance, acknowledging how underlying social mechanisms and structures shape participants' experiences (Fletcher, 2017). Thematic synthesis was used (Thomas & Harden, 2008) to inductively develop descriptive and analytical themes across studies and produce a comprehensive narrative. Synthesis and interpretation followed the three-stage approach (Table 2).

Table 2. Thematic Synthesis stages by Thomas & Harden (2008)

Level	Process
Stage 1	Familiarisation with qualitative findings and code data line-by-line.
Stage 2	To develop inductive <i>descriptive themes</i> based on the initial codes by grouping and synthesising them together.
Stage 3	To develop <i>analytical themes</i> that move beyond description, extending the primary studies' findings to generate additional concepts and understanding.

Given the dataset included both under-18s and adults, themes were synthesised together where patterns were similar. Study quality was considered during theme development, with more weight placed on higher-quality studies and confidence in findings interpreted accordingly. In line with guidance for thematic synthesis (Thomas & Harden, 2008) all text labelled as "results" or "findings" in the included studies was treated as data for analysis. However, to ensure the synthesis remained centred on lived experience, quotations attributed directly to ASRs were treated as primary data, while authors' interpretations were treated as secondary data. The first author prioritised primary data during the initial phase of coding to ensure that the emergent themes were grounded directly in the participants' voices. Subsequently, a second pass was conducted to integrate secondary data, with the aim to complement the primary data and allow for a comparison of similarities and differences across the studies in order to begin grouping and synthesising them together which followed by the development of analytical themes. Where studies included ASRs and other stakeholders, only ASR data (and the authors' interpretation of these accounts) were extracted; stakeholder-only quotations were not included, except in Fish and Fakoussa (2018), where attribution by role was often ambiguous. In this case, ASR accounts were prioritised and, following clarification from the authors that staff contributions were minimal and largely based on what ASRs had shared, blended interpretations were retained but confidence in

relevance was considered accordingly. Although the primary focus was mental health service access and use, accounts of informal and self-help were coded where they were described as ways of managing psychological distress, as part of the broader context shaping engagement with mental health care.

Reflexivity Statement

The researcher is an ethnic minority female Trainee Clinical Psychologist and first-generation immigrant to the UK with a skin tone allowing proximity to whiteness. The researcher's motivation to conduct this review is both personal and professional. Their experiences of working as a trainee within an unaccompanied asylum-seeking children (UASC) service, alongside previous roles with refugees and asylum seekers in third sector organisations, have shaped a strong interest in understanding how refugees and asylum seekers experience accessing and using mental health services. These roles fostered a commitment to improving the quality of support and challenging systemic inequalities that often perpetuate their difficulties. Conversations with refugees and asylum seekers have been central in shaping the researcher's values, political stance and understanding of structural injustice. In addition, the researcher is a second-generation internally displaced person (IDP) in their home country; their family was displaced following the war and relocated to an IDP resettlement village, where they still reside. The researcher's political views and exposure to anti-immigration narratives, together with these personal and professional histories, provide important context for this study.

The researcher was aware that these experiences might influence their approach to the review, particularly in relation to the selection of studies, the interpretation of findings, and the language and frameworks used. They recognise that they hold critical views of wider UK systems and have prior clinical, personal and academic knowledge of how structural violence and oppression can operate within the "hostile environment". This carries a risk of privileging studies and interpretations that align with their own observations and beliefs. At the same time, as a trainee clinical psychologist educated and trained within a Western institution, the researcher acknowledges the importance of critically examining their own assumptions about mental health and the structures and institutions of the UK. They recognise the importance of remaining open to diverse conceptualisations of distress and care, avoiding the homogenisation of refugees' and asylum seekers' experiences of mental health services.

To address these potential influences, explicit and transparent inclusion criteria were developed, and an independent reviewer was involved to ensure that included studies met these criteria. The researcher kept a reflexive journal (bracketing) throughout the review to document decisions, dilemmas and emerging thoughts (Appendix 1.5), and engaged in regular supervision to examine assumptions, generalisations and possible biases. Supervision was also used to support a balanced interpretation of the data that attends both to participants' accounts and to structural and political contexts. The researcher aimed to use language that is honest about their political commitments while inviting readers to engage critically with the analysis. Questions about whether the framing is "critical enough" or "too critical," and about who gets to define acceptable critique within academia and psychology, were actively reflected on and are encouraged by readers.

Given the researcher's experiences, values and interest in understanding refugees' and asylum seekers' perspectives on accessing mental health services in the UK with the aim of improving the quality of care, their epistemological stance in this review is most closely aligned with a "critical realist" perspective (Fletcher, 2017).

Results

4,096 articles across the five databases, all database results were imported into EndNote, grouped by source, and exported to Rayyan for processing (Ouzzani et al., 2016). Web of Science required multiple export batches due to platform limits but were grouped together under the relevant source. Rayyan's deduplication tool identified 1,344 possible duplicates, these were manually reviewed for inclusion/exclusion by the author, leaving 3,319 articles for screening.

The remaining articles were screened by title and abstract, according to inclusion/exclusion criteria. The author screened all records, while a second independent reviewer (MA) screened blindly a random 10% sample to assess consistency. During title and abstract screening, reviewers showed high agreement, with only 3 disagreements from 300 papers.

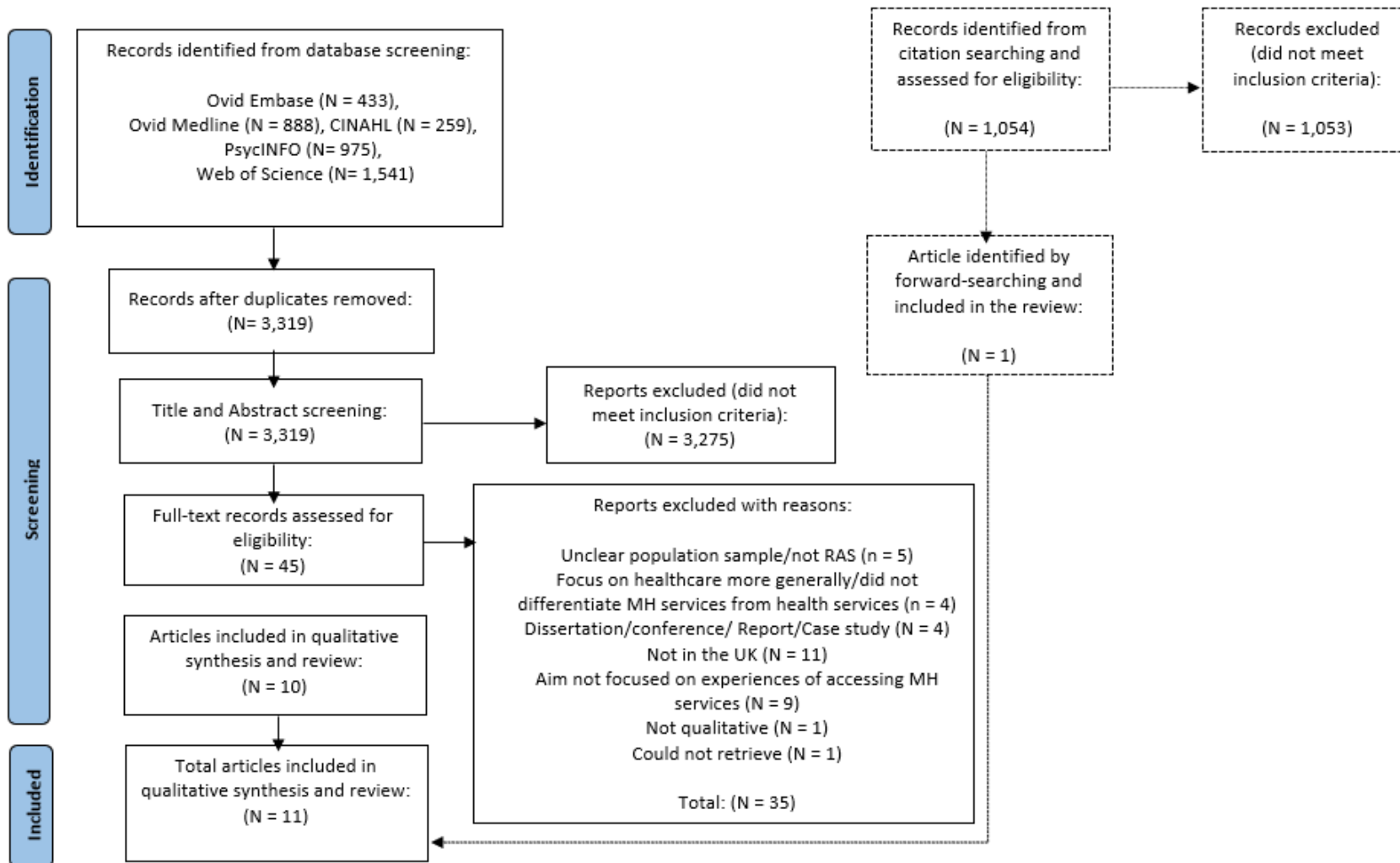
Disagreements were resolved through discussion, and full consensus achieved. This left forty-five full text papers, which were retrieved and reviewed by the first author. The full text for 1 article was unavailable, despite contacting authors. Thirty-five full text articles were excluded and reported in sufficient detail, leaving ten articles to be included in the qualitative synthesis.

To check adherence to the inclusion and exclusion criteria, the second reviewer (MA) independently reviewed a random selection of approximately 23% of the full text articles

(n=10). There was strong inter-rater agreement, with the two reviewers agreeing on 9 out of 10 papers, resulting in a 90% inter-rater percentage agreement with discrepancies discussed until an agreement was reached. Cohen's Kappa was 0.74, indicating substantial agreement (McHugh, 2012).

Backward and forward citation search was completed for the remaining ten articles, and 1 additional article that met the eligibility criteria was found after 1,053 were hand searched. Following full-text screening of forty-five records, as well as forward and backward citation searches, 11 studies met the inclusion criteria for the thematic synthesis. A PRISMA (2020) diagram details this process within Figure 1 in Results.

Figure 1: PRISMA Diagram



Study characteristics

The papers were published between 2006 and 2024 and were all conducted in the UK, predominantly in England, with some recruiting across multiple UK nations (Fazel et al., 2016; Ziyachi & Castellani, 2024). Across the studies, 168 asylum seekers and refugees (ASRs) contributed data relevant to this review. The overall sample was predominantly male (n=96 versus female n=52), while two studies did not report participants' gender and did not provide a rationale for this (Fish & Fakoussa, 2018; Misra, 2006). Although the two Majumder et al. (2019; 2014) papers did not explicitly state that they drew on the same sample since they addressed different research aims and questions, the study location and reported demographic characteristics were identical, suggesting a high likelihood of sample overlap. For this reason, both papers were retained in the synthesis because they focused on different issues and their findings addressed different research questions, but participant numbers were only counted once when calculating the overall sample size. Samples ranged from 7 to 40 participants and included both adults and adolescents, with several studies focusing specifically on unaccompanied minors or young people engaged with Child and Adolescent Mental Health Services (CAMHS) (Fazel et al., 2016; Majumder et al., 2019, 2014). Where reported, ages across the combined sample ranged from 15 to 79 years, spanning unaccompanied minors (15 to 18 years) to older adults (up to 79 years; Fazel et al., 2016; Majumder et al., 2019; Paudyal et al., 2021). Most studies reported age, length of time in the UK and immigration status in varying detail, although some provided limited demographic information or aggregated characteristics at group level (e.g. refugee community leaders or mixed ASR/staff samples; Fish & Fakoussa, 2018; Misra et al., 2006).

Participants originated from a wide range of countries and regions, including Afghanistan, Iran, Iraq, Kurdish regions of Iraq and Turkey, Syria, Somalia, Sudan, Eritrea, Ethiopia, Rwanda, Palestine, Albania, Bosnia, Kosovo, Azerbaijan, Russia, Ukraine, Colombia and Cyprus (Greek and Turkish Cypriot). Fazel et al. (2016) reported countries of origin by mostly world region (Europe, Africa, Asia and South America) with few exceptions, noting that its sample alone included young people from 20 different countries, including five from Albania, four from Somalia and three from Sudan. Fazel et al. (2016) contributed almost one quarter of all participants, however, in line with qualitative synthesis principles, studies were treated as equal units of analysis and themes were not weighted by sample size.

The majority of studies included participants from Afghanistan (n = 5; Majumder et al., 2014; Majumder et al., 2019; Misra et al., 2006; Trueba et al., 2023; Ziyachi & Castellani, 2024),

Kosovo (n = 2; Misra et al., 2006; Palmer & Ward, 2007), Iran (n = 4; Majumder et al., 2014; Majumder et al., 2019; Palmer & Ward, 2007; Ziyachi & Castellani, 2024), Iraq (n = 3; Fazel et al., 2016; Misra et al., 2006; Palmer & Ward, 2007), Somalia (n = 6; Majumder et al., 2014; Majumder et al., 2019; Misra et al., 2006; Palmer, 2006; Palmer & Ward, 2007; Ziyachi & Castellani, 2024), Sudan (n = 3; Fazel et al., 2016; Trueba et al., 2023; Ziyachi & Castellani, 2024), Syria (n = 3; Paudyal et al., 2021; Trueba et al., 2023; Ziyachi & Castellani, 2024), Albania (n = 3; Fazel et al., 2016; Misra et al., 2006), and Turkey (n = 2; Leavey et al., 2007; Misra et al., 2006). This pattern reflects both the over-representation of certain groups (for example, Afghan and Somali participants) and gaps in the literature regarding other cultures and nationalities. However, not all studies specified which quotes were from which participant and their country of origin. Most participants had direct contact with formal or informal mental health provision, including child and adolescent mental health services (CAMHS), secondary mental health services, school-based mental health support, community mental health services, primary care and specialist refugee or asylum support organisations that provide mental health support. Across studies that reported it, length of stay in the UK varied widely with some participants being newly arrived (a few months since arrival), while others had been in the UK for up to 10 to 12 years (Paudyal et al., 2021; Palmer & Ward, 2007). Several samples clustered around 1 to 5 years since arrival (e.g. Ziyachi & Castellani, 2024; Trueba et al., 2023), and one study of Turkish-speaking participants reported a mean residence of 9 years (Leavey et al., 2007).

All included papers reported qualitative analyses. Data were generated primarily through individual semi-structured interviews with ASRs, with one study relying on mixed ASR/staff focus groups rather than individual interviews (Fish & Fakoussa, 2018). Analytic approaches were predominantly thematic (n=8) studies using thematic or framework-based thematic analysis (Ziyachi & Castellani, 2024; Fazel et al., 2016; Majumder et al., 2014, 2019; Palmer, 2006; Palmer & Ward, 2007; Fish & Fakoussa, 2018; Trueba et al., 2023). 1 used thematic content analysis following Burnard's method (Paudyal et al., 2021), 1 drew on grounded theory within a broader needs-assessment framework (Misra et al., 2006), and 1 adopted a narrative, case-based approach to analysing illness accounts and pathways to care (Leavey et al., 2007). Purposive and snowballing sampling were the most used recruitment techniques, and the recruitment was facilitated often via NHS or third-sector services supporting ASRs, with some studies explicitly combining purposive and snowball approaches (Paudyal et al., 2021; Trueba et al., 2023). Table 3 synthesises the aims and characteristics of the papers and participants, the study design, the reported findings and a brief critical appraisal.

Table 3. Study Characteristics

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
<p>Ziyachi & Castellani (2024)</p> <p>Northeast England and Northern Ireland</p>	<p>To propose a new conceptual approach to psychotherapy for migrants*, utilizing a 'cultural models' framework to analyse their experiences with mental health care in the UK</p>	<p>Total N = 35 (20 female, 15 male)*; Relevant N = 25 (14 female, 11 male)</p> <p>Most interviewees were from Iran, but some were from Afghanistan, Palestine, Somalia, Sudan and Syria</p> <p>Age range: 20-56</p> <p>Educational level: Varied from primary school to PhD, with most having high school diploma or an undergraduate degree</p> <p>Participants had been living in the UK for between one and four years</p> <p>All participants were refugees and asylum seekers.</p>	<p>Participants had between 6-24 sessions of talking therapy in the UK</p>	<p>Qualitative study with an ethnographic approach</p> <p>Thematic Analysis (Two levels of analysis were carried out, p.8)</p> <p>Purposeful (purposive sampling strategy for recruitment)</p> <p>Individual semi-structured interviews (online)</p> <p>Interviews were conducted in English, Farsi or Arabic</p>	<p>Participants' evaluations of talking therapy ranged from satisfaction to dissatisfaction. Interviews revealed frequent mismatches between clients' expectations of therapy and the services received. Adopting a 'cultural models' approach could offer an innovative way to improve mental health treatment by exploring clients' underlying schemas and personal meanings of their experiences.</p>

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
<p>Trueba et al (2023)</p> <p>England: Brighton and Hove</p>	<p>To understand whether current mental health support meets ASR needs, to identify ways to strengthen available support, and to explore how these needs are perceived by ASRs and those providing support</p>	<p>Total N = 15 (9 ASR, 6 support workers); Relevant N = 9 ASR (3 female, 6 male)</p> <p>Participants were from Syria, Sudan and Afghanistan</p> <p>Age range: 17-30</p> <p>Participants had to have proficiency in English</p> <p>77.8% had achieved refugee status</p> <p>Participants had been living in the UK for between one and five years</p>	<p>The Clinical Director of Brighton Exile/ Refugee Trauma Service (BERTS) acted as initial gatekeeper.</p> <p>16 publicly advertised organisations providing mental health support to ASR were approached for recruitment purposes – participants were receiving support from them</p>	<p>Qualitative study</p> <p>Thematic Analysis (Data saturation was not fully achieved)</p> <p>Purposive and snowballing sampling strategy for recruitment</p> <p>Individual Semi-structured interviews (Face-to-face)</p> <p>Interviews were conducted in English</p>	<p>The mental health needs of ASR are complex and multifaceted, negatively impacted by the hostile UK asylum process, precarious living, and socio-economic isolation. Urgent improvements are needed and that includes more resourcing, better coordination across services and transparency of existing services.</p>

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
Paudyal et al (2021) Southeast of England	To explore mental well-being of Syrian refugees and the barriers they face in accessing mental health care services, their coping mechanisms and pathways towards integration in their new communities	Total N = 12 (3 women, 9 men) Participants were from Syria Age range: 18-79 (Majority N = 9 over 45) Education level: Five participants were university graduates, six had school-level education and one was illiterate. Relationship status: Most participants were married, with one separated and two single. Participants had been living in the UK for between zero to ten years	Recruitment targeted individuals that were knowledgeable or have experienced the studied phenomenon.	Qualitative study Thematic content analysis following Burnard's method (Burnard, 1991) Purposive and snowballing sampling strategy for recruitment Semi-structured interviews (Face-to-face) All interviews were conducted in Arabic	Participants reported ongoing challenges to integration, with psychological distress linked to bereavement, separation, and nostalgia for their homeland. Cultural differences and fragile migrant communities hindered connectedness, while stigma, taboos, and language barriers limited access to mental health care. Many relied instead on faith, ritual, nature, and self-reliance for healing.

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
<p>Majumder et al (2019)</p> <p>Two local authorities in England</p>	<p>"To understand the perceptions of unaccompanied refugee minors and their carers regarding the barriers to utilising mental health services and exploring issues perceived to be related to poor engagement with services" (p. 1)</p>	<p>Total N = 30 (15 unaccompanied minors, 15 carers); Relevant N = 15 (1 female, 14 male)</p> <p>Participants were from Afghanistan, Eritrea, Iran and Somalia</p> <p>Age range: 15 to 18</p> <p>Mental health problems reported: depression, self-harm, PTSD, anxiety, adjustment reaction, substance misuse, dissociative disorder, psychosis, learning difficulties, impaired sleep</p>	<p>Involvement with Child and Adolescent Mental Health Services (CAMHS)</p>	<p>Qualitative study</p> <p>The method suggests a targeted approach to access participants with relevant experiences, but the paper does not explicitly name the sampling strategy (e.g. purposive, convenience), although it is indicative of purposive sample.</p> <p>Thematic analysis (Data saturation was reached)</p> <p>Individual Semi-structured interviews</p>	<p>Participants reported mixed experiences of mental health care, shaped by factors such as passive treatment engagement, therapeutic relationship, clinician characteristics, challenges with talk therapy, differing cultural beliefs and preference for medication due to beliefs of treatment. The paper highlighted that service development for unaccompanied minors should take these factors into account when developing services.</p>

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
Fish & Fakoussa (2018) England: Plymouth	To expand Western-centric understandings of helpful mental health and support by exploring ASR views in Plymouth, broadening professional understanding of culturally diverse perspectives, and developing service user-led approaches to strengthening mental health support.	Total N = 18 (10 ASR, 8 staff members) Participants' country of origin was unspecified, but mention was made of diverse cultural backgrounds Relevant N = 10 (5 female, 5 male); drawn from mixed focus groups where staff and ASR were combined. Two staff were also refugees Immigration status: 9 refugees, 1 asylum seeker All received support from the following agencies: ASR team , START (Students and Refugees together), Red Cross, REC (The Racial Equality Council)	Recruitment targeted service users accessing the various relevant support services in Plymouth	Qualitative study Collaboratively conducted thematic analysis with service users (one participant agreed to take part) Researchers consulted with staff from support agencies before producing an invitation to service users and staff Focus groups with mixed staff/ASR (ASR team: 2 ASR; START: 4 refugees, 1 staff; Red Cross group: 2 service users; 3 staff (2 refugee staff; REC: 2 ASR, 4 staff)	The findings identified nine themes that hinder, and nine themes that support, ASRs' mental health and well-being. The themes were then conceptualised into a model of N = 10 "Holes of Hindrance" and N = 9 "Strands of Support". Recommendations were made for services and future planning and the findings contributed to successful funding for a peer-led support project in Plymouth.

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
Fazel et al (2016) England: Oxford Wales: Cardiff Scotland: Glasgow	To address the lack of data on young adolescent refugees' experiences accessing school-based mental health services	Total N = 40 (11 female, 29 male) Participants were originated from 20 countries: Europe: 9 (including 5 from Albania); Africa: 13 (including 4 from Somalia and 3 from Sudan); Iran, Iraq, Afghanistan: 9; Other Asia: 7; South America: 2 Age range: 15–24 years Median length of time in the UK: 2.5 years	All participants had been seen by a school-based mental health service and were discharged within 8 months of their interview.	Qualitative study with purposive sample Framework analysis with a thematic analysis of content Individual Semi-structured interviews with a topic guide	Most young people preferred to be seen within the school mental health services and school is a helpful point for integrating services for adolescent refugees. Most young people felt that their problems had been helped. Pre-migration and post-migration factors were identified as affecting them to an equal extent, with post-migration factors playing a particularly negative role in their lives and the asylum process was one of the main stressors making it difficult to concentrate at school or to everyday life.

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
Majumder et al (2014) Central England	To explore and understand the views and perceptions of unaccompanied minors about mental health services	Total N = 15 (1 female; 14 male) Participants were from Afghanistan, Somalia, Iran and Eritrea Mental health problems reported: depression, self-harm, PTSD, anxiety, adjustment reaction, substance misuse, dissociative disorder, psychosis, learning difficulties, impaired sleep	Involvement with Child and Adolescent Mental Health Services (CAMHS) – looked after children service	Qualitative design Thematic analysis and interviewing continued until data saturation was reached Face-to-face semi-structured interviews	Many of the young people had negative attitudes toward mental health and spoke about mistrust in services. The explanation of this varied with explanations from their home country experiences of psychiatric care, their experiences of being a ASR and/or cultural differences.
Palmer & Ward (2007) England: London	The aim of this study was to explore mental health and prioritise the experiences of service users as perceived by	Total N = 21 (10 female; 11 male) living in the UK for between 18 months and 12 years Participants were named by nationality: Azeri, Bosnian, Colombian, Congolese, Ethiopian (N=3), Iranian (N=3), Iraqi, Kosovan, Kurdish (Iraqi), Russian,	N = 15 were accessing mental health services provided by the NHS and third sector organisations	Thematic analysis according to the framework method and used constant comparative process to define themes	The stressors and difficulties across all stages of the migration process, particularly difficult post-migration social conditions, contribute to psychological distress and physical health problems. The mental health care for this population should adopt a more integrated, holistic approach, with a shift towards a social model of care.

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
Palmer & Ward (2007)	refuges and asylum seekers	Rwandan, Somali (N=5), Ukrainian Age range: 21 to 65	N = 6 were not accessing mental health services		
Leavey et al (2007) England: Northeast London – Haringey	To explore the possible interconnection of health beliefs and pathways into care among Turkish-Speaking patients with a history of psychosis	Total N = 9 (1 female; 8 male) Participants were from Turkey (Kurdish) and Cyprus (N=1) N = 7 were refugees or asylum seekers Age range: 19 to 41 Mean length of time in the UK: 9 years	Participants were discharged from their services and were identified through a family intervention study for people with first episode of psychosis	Qualitative approach to elicit narratives of illness Researchers read each interview and wrote a synopsis with subheadings and agreed a final version which followed by more detailed and complex coding Face-to-face transcribed Interview	The study highlights fragmented explanatory models of illness and complex, non-linear pathways to psychiatric care. The findings suggest that help-seeking is often shaped by family and wider social networks rather than by the individual alone, particularly in more traditional or non-Western families.

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
<p>Misra et al (2006)</p> <p>England: London</p>	<p>To undertake a needs assessment of mental health services for asylum seekers and refugees, estimate numbers of ASR who need mental health support, to understand their perspective on mental health services and needs and to develop a service model for ASR mental health needs in Haringey</p>	<p>Total N = 10</p> <p>Participants were from Afghanistan, Albania, Cypriot (Turkish Cypriot and Greek Cypriot), Iraq, Kosovo, Kurdistan, Somalia, Turkey</p> <p>Adults of working age (not specified range)</p> <p>Participants were community representatives/leaders of the main refugee groups in Haringey</p>	<p>Users of mental health services</p>	<p>Needs assessment framework using both epidemiological and corporate approaches (for the purposes of this study, the focus is on the qualitative element)</p> <p>Purposive sampling strategy for recruitment</p> <p>Grounded Theory</p> <p>Individual Semi-structured interviews (Face-to-face and telephone interviews)</p>	<p>The findings concluded that effective services for this group must be broad-based, involve multidisciplinary approaches, and be community-driven, addressing significant language and cultural barriers, and prioritising practical and social support alongside clinical interventions and specialised mental health services.</p> <p>This paper gave a representation of the participant quotes in a way that highlighted the theme of the discussion under one topic area rather having specific themes.</p>

Study authors (year) and location	Aims	Relevant Study population and Participant Characteristics	Contact with mental health services	Data Collection Method and Analysis	Summary of Findings and Main Themes (and sub-themes were applicable)
Palmer (2006) England: London, Camden Borough	To explore the Somali community's perception of mental illness and the barriers in accessing and using services in Camden	Total N = 7 (4 female; 3 male) Participants were from Somalia Mean age: 34 years old N = 3 had a mental health diagnosis	All participants were service users of the St Pancras ASR Refugee centre which supports people with mental, physical and social problems	Multi-method approach (triangulation) Qualitative elements were analysed using the framework method In-depth semi-structured interviews	The initiatives between public, private and community groups have proven to be the most beneficial for the Somali community. Somali service users were reported to use mental health services considerably less, influenced by cultural understandings of illness and concerns about the post-migration stressors they face in the UK

*= Ziyachi & Castellani (2024) use migrant as an umbrella term for refugees and asylum seekers. The interviews included a total of 35 participants; however, the study's analysis focused on 25 interviews with refugees and asylum seekers. The remaining 5 participants were non-refugee immigrants and were not included in the original and reported analysis.

Quality appraisal

Most studies were rated high or medium quality, with two rated low (Misra, 2006; Palmer, 2006) (Table 4, Appendix 1.7). The lowest-rated papers were also the oldest, which may reflect wider advances in qualitative research practice and reporting over time. All studies provided a thorough literature review and clear aims, and most used an appropriate design. Misra (2006) was rated 'no' for qualitative design appropriateness because it relied on interviews with community representatives rather than service users (SU), which did not fully align with the stated aim of capturing ASRs' own experiences of mental health and services, and risked homogenising narratives and filtering them through gatekeepers (albeit refugees themselves and potentially SUs).

All high and medium-quality papers were rated as having a clear statement of findings. Most researchers collaborated with local refugee organisations acting as gatekeepers (e.g. refugee centres, community groups, charities, NGOs) (Misra, 2006; Palmer, 2006; Palmer & Ward, 2007; Ziyachi & Castellani, 2024; Paudyal et al., 2021; Trueba et al., 2023; Fish & Fakoussa, 2018). Three recruited through CAMHS (Fazel et al., 2016; Majumder et al., 2019;2014), and one (Leavey et al., 2007) recruited from a previous family intervention study. The recruitment approaches likely facilitated trust and engagement with ASRs (Fish & Fakoussa, 2018; Palmer & Ward, 2006; Paudyal et al., 2021). However, recruiting exclusively through established organisations may have excluded those not linked to services, limiting applicability to findings other refugee populations, particularly those who have "fallen through the cracks".

Research with marginalised groups (such as ASRs) requires careful attention to ethical considerations and its methodology, particularly researcher-participant power imbalance (Hearn et al., 2022; Solie, 2024). Ethical and inclusive qualitative guidance emphasises ongoing reflexivity (Ratnam & Drozdowski, 2022; Shaw et al., 2020) as researchers' social, political and professional positions inevitably shape the project and interpretations (Solie, 2024). A key limitation across almost all included studies was the lack of an explicit reflexivity section addressing researcher positionality, assumptions, or relationships with participants. Only Paudyal et al. (2021) provided a dedicated, detailed account of the research team's positionality and reflexive considerations. Palmer and Ward (2007) described in some detail the safeguards they put in place to minimise coercion, protect vulnerable participants and manage the emotional risks of discussing mental health, drawing on their pre-existing relationships with a refugee centre. However, this approach is open to criticism given concerns that labelling refugees as "vulnerable" may contribute to disempowerment and loss

of agency (Ludwig, 2016; Solie, 2024). Fish and Fakoussa (2018) used a collaborative approach (working with refugee organisations, involving a service user in analysis, and aiming to avoid an expert stance), and Ziyachi and Castellani (2024) shared linguistic and cultural commonalities with participants that shaped recruitment. However, across these three studies, these practices were framed primarily as ethical or practical decisions rather than as an explicit reflexive examination of researcher power, standpoint, or influence on knowledge production, and were therefore unclear evidence of reflexivity. Word limits in journal papers may have constrained reporting of reflexive processes. As such, gaps in reflexivity and analytic rigour may reflect write-up constraints rather than the absence of these practices (Sattar et al., 2021).

Beyond reflexivity, several additional limitations emerged from the CASP appraisal, particularly among the older and lower-quality studies. In a small number of papers, recruitment strategies were described briefly, making it difficult to judge how appropriate or inclusive the sampling was (Majumder et al., 2014; 2019; Palmer, 2006). Some provided limited detail on data collection procedures or topic guides, reducing transparency about how accounts were generated (Leavey et al., 2007; Misra, 2006). Reporting of ethical considerations was uneven, with occasional uncertainty about formal ethical approval and/or safeguarding measures for potentially traumatised participants (Misra, 2006; Fish & Fakoussa, 2018; Majumder et al., 2014; Palmer, 2006). Finally, several older studies offered minimal description of their analytic processes and were less explicit about the implications or value of their findings (Leavey et al., 2007; Misra, 2006; Palmer, 2006), limiting assessment of rigour and contribution of the work. Despite these limitations, the studies offered important insights into ASRs' experiences of accessing mental health services and support, reasons preventing access, and help-seeking mechanisms.

Table 4. Critical Appraisal Skills Programme UK (CASP) Ratings

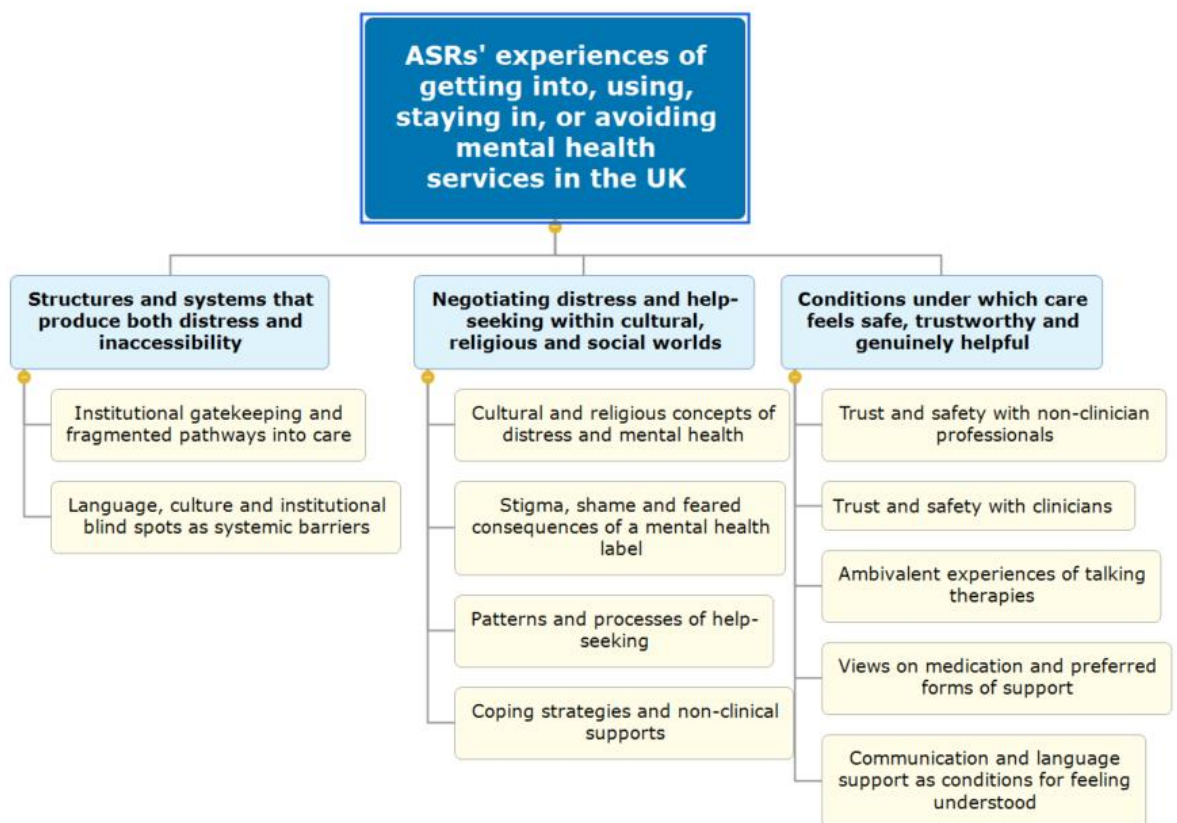
Authors (Year)	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Rating
Majumder et al (2014)*	Y	Y	Y	Y	Y	N	?	?	Y	Y	Moderate 7/10
Palmer & Ward (2007)*	Y	Y	Y	Y	Y	N	Y	N	Y	?	Moderate 7/10
Leavey et al (2007)	Y	Y	Y	Y	N	N	Y	N	Y	N	Moderate 6/10
Misra et al (2006)*	Y	Y	N	N	?	N	N	N	?	?	Low 2/10
Palmer (2006)	Y	Y	Y	?	Y	N	?	?	?	?	Low 4/10

Abbreviations: Y = Yes ? = Unclear; N = No; Q1 = Clear statement of aims; Q2 = Appropriate qualitative methodology; Q3 = Appropriateness of research design; Q4 = Appropriateness of recruitment strategy; Q5 = Adequacy of data collection; Q6 = Consideration of relationship between researcher and participants; Q7 = Ethical considerations; Q8 = Rigor of data analysis; Q9 = Clear statement of findings; Q10 = Overall value of research. * = Articles that have been co-rated by an independent reviewer. The studies were rated against each question and then allocated to a score of low (0-4), moderate (5-7) and high quality (8-10) that corresponded to the overall critical appraisal (Milner et al., 2020).

Thematic synthesis

Three main themes with 11 subthemes were created following the thematic synthesis (Figure 2). Supplementary materials include the recurrence of subthemes across studies (Appendix 1.6). We present each theme and subtheme in turn, illustrating them with participant quotations and, where relevant, authors' interpretations. Sentences and/or words in italics signify direct participant quotes. The three themes were: (1) Structures and systems that produce both distress and inaccessibility, (2) Negotiating distress and help-seeking within cultural, religious and social worlds, (3) Conditions under which care feels safe, trustworthy and genuinely helpful. A thematic map describing the themes and subthemes can be found in Fig.2.

Figure 2. Thematic Map



Structures and systems that produce both distress and inaccessibility

This theme captures how institutions, including the asylum, welfare system and mental health services, shape what is possible in terms of care and access. It captures how wider systems such as asylum processes, primary care, and service procedures act as gatekeepers; determining who receives mental health support, when, and on what conditions. The theme comprises two subthemes: (1) Institutional gatekeeping and fragmented pathways into care and (2) Language, culture and institutional blind spots as systemic barriers.

Institutional gatekeeping and fragmented pathways into care

Across studies, access to specialist mental health care was shaped by positioning within asylum, welfare and primary care systems, rather than clinical need alone (Fish & Fakoussa, 2018; Palmer, 2006; Palmer & Ward, 2007; Paudyal et al., 2021; Trueba et al., 2023). In Fish and Fakoussa's (2018), the UK asylum process was described as "*a killer*" that left people feeling "*crushed*" by "*too many blocks and discrimination*" (p. 369). One participant reflected they would likely never have reached a specialist ASR team without disclosing torture in their asylum claim, adding "*there are people who don't know about mental health support, and would not think to explore this as an option*" (Fish & Fakoussa, 2018, p. 369). This positions the asylum system as a gatekeeper to specialist MH support as support deemed conditional, without guidance on how to be accessed and reinforced unclear pathways. Paudyal et al. (2021) similarly reported that if family reunion rules had allowed their child to join them, "*we probably would not need a psychiatric doctor*", implying that immigration policy was generating distress later framed as psychiatric need.

Primary care often functioned as the first, and sometimes only, point of contact, yet brief, medication-focused consultations and limited understanding of asylum-related distress meant GPs could feel like an "*imperfect prescription*" for complex social, legal and psychological problems (Misra, 2006; Palmer, 2006; Palmer & Ward, 2007). Participants also described inconsistent referral rules, duplicated referrals, long waits, limited information about the system, and practical barriers such as unaffordable transport; voluntary-sector "*drop-in*" services could be more accessible but were often patchy and time-limited (Trueba et al., 2023; Misra, 2006; Palmer & Ward, 2007). Even after entry into services, support could remain unstable:

" I used to see her [counsellor] but I don't know if she's too busy now, or if she's doing something else... but now there's no one..." (Trueba et al., 2023; Zemar, 19-year-old refugee,

pp.3176). These accounts reflect structural powerlessness that, for some, compounded a sense of lost agency.

In contrast, school-based routes sometimes provided more direct access for young ASRs, with teachers recognising difficulties and mediating contact with mental health services (Fazel et al., 2016). This also suggests greater barriers for older ASRs who do not benefit from school pathways towards MH support and may face additional obstacles (e.g., unaffordable transport), whereas younger ASRs may be supported by youth travel provision (Trueba et al., 2023). Overall, this subtheme shows how institutional rules and resource constraints shape whether, when and how ASRs reach care.

Language, culture and institutional blind spots as systemic barriers

Across studies, language functioned as a structural filter shaping who could access services and how far support could be used. Information about available services and referral pathways was often only provided in English, leaving some unaware that mental health support existed or how to reach it (Fish & Fakoussa, 2018; Misra et al., 2006; Palmer & Ward, 2007; Trueba et al., 2023). Once in services, institutional rules around interpreters could act as barriers rather than facilitators; as one participant noted, *“people with mental health problems need counsellors who speak their own language... if you go through an interpreter, it’s very hard to tell your true feelings”* (Misra, 2006). In Ziyachi and Castellani’s (2024), one participant described being required to use an interpreter despite preferring to speak directly in English, suggesting reduced comfort and agency in sessions:

“In my first therapy, I had an interpreter. After the first session, I told my therapist that I didn’t feel comfortable with the interpreter... But my therapist said no, and the interpreter must be in the session. I told her that now I am speaking English with you. But she said no, there may be some terms that you don’t know their meanings. I said I would check those terms in my phone’s translator, but she didn’t accept it....but she insisted that I should have an interpreter and I had to censor myself.” (Ziyachi & Castellani, 2024, Participant B, pp. 14–15)

Elsewhere, participants reported that no interpreter was provided at appointments, or that psychological terminology remained difficult to understand even with interpretation (Majumder et al., 2019; Misra et al., 2006; Paudyal et al., 2021; Trueba et al., 2023):

“That’s the biggest thing, the language, because medical terminologies you know are very difficult, especially psychological ones.” (Paudyal et al., 2021, Participant 7, p. 5)

Across studies, institutional blind spots, particularly misunderstandings of culture and religion, also shaped access and care. Participants and authors suggested services often lacked cultural and religious training and at times treated ASRs as a homogeneous group, influencing how language support and clinical care were organised and how far they aligned with people's linguistic and cultural realities (Fish & Fakoussa, 2018; Palmer & Ward, 2007; Ziyachi & Castellani, 2024). As one focus group contributor put it:

“Mental health workers lack cultural and religious training and have limited understanding of the asylum-seeking system and pressures people face.” (Fish & Fakoussa, 2018, Focus group 3, Red Cross, p. 372)

Some participants described avoiding or limiting contact with clinicians, particularly “English” or British doctors, because they expected their culture, religion or experiences would not be understood. In Leavey et al. (2007), one participant said he would not discuss spiritual beliefs around hallucinations with English doctors because “they would not understand these terms and spiritual beliefs” and were “*only interested in symptoms*” (p. 264), leading him to visit *Hocas*, rather than specialised psychosis services; others similarly opposed consulting native British doctors for fear of being misunderstood (Paudyal et al., 2021). This reluctance was framed not as an individual issue, but as a consequence of limited cultural and religious understanding and the institutional blind spots within which professionals operate (Fish & Fakoussa, 2018; Leavey et al., 2007; Majumder et al., 2014; Palmer & Ward, 2007; Paudyal et al., 2021; Ziyachi & Castellani, 2024).

Negotiating distress and help-seeking within cultural, religious and social worlds

This theme comprises four subthemes and captures how ASRs make sense of distress and decide whether, where, and how to seek help through their cultural, religious, and social worlds. It brings together how people name and explain difficulties, the stigma and feared consequences attached to mental health labels, the routes they use (or avoid) when seeking help, and the everyday, non-clinical ways they cope such as faith, family, community, and creative activities, alongside or instead of formal services. The subthemes were: (1) cultural and religious concepts of distress and mental health, (2) stigma, shame, and feared consequences of a mental health label, (3) patterns and processes of help-seeking, and (4) coping strategies and non-clinical supports.

Cultural and religious concepts of distress and health

This subtheme centres on the meanings and explanatory models participants used to name, understand and locate suffering, rather than subsequent help-seeking. Across studies, participants drew on cultural and religious concepts that did not map neatly onto Western psychiatric categories. Distress was often understood in binary terms; “normal” versus “mad/crazy”, with local terms carrying strong moral and derogatory meanings (Fish & Fakoussa, 2018; Misra et al., 2006; Palmer & Ward, 2007; Paudyal et al., 2021). In some communities there were “no words” for depression or stress, meaning these experiences were not always recognised as MH problems; instead, difficulties were described somatically and viewed as a matter for a medical doctor when they involved the body, while distress linked to thoughts and feelings was more likely to be managed through prayer (Fish & Fakoussa, 2018; Leavey et al., 2007; Misra et al., 2006; Palmer, 2006; Majumder et al., 2014). As one Somali man explained, *“Inside Somalia people are crazy but they don’t have depression. They (Somali community) didn’t know about depression (...). Depression doesn’t mean anything in Somalia.”* (Palmer & Ward, 2007, pp.205).

Explanations for suffering commonly drew on spiritual and religious frameworks, with variation within and between groups, underscoring that ASRs are not a homogeneous population. Problems were attributed to curses, jinn, the evil eye, God’s or Allah’s will, moral problems, or the social realities of exile and unemployment (Fish & Fakoussa, 2018; Leavey et al., 2007; Palmer, 2006; Palmer & Ward, 2007; Paudyal et al., 2021; Ziyachi & Castellani, 2024), as captured in the account: *“One hoca told him that a Cin (or Jin, a spirit) inside his body might be responsible for his problems”* (Leavey et al., 2007, p. 266). Within these frameworks, prayer, reciting holy texts and maintaining religious practice were described not only as alternatives to formal treatment but as ways to clear the mind, keep the spirit alive, and provide comfort and strength in adversity (Fish & Fakoussa, 2018; Misra et al., 2006; Paudyal et al., 2021; Ziyachi & Castellani, 2024):

“No one would understand what we went through and the situation like you would...who did not witness it won’t sympathise, yes, so it’s hard for me to go and explain my mental status to a doctor, it’s better to explain to God” (Paudyal et al., 2021, p. 5).

Some participants reflected on the boundary between spiritual and medical understandings, questioning when religious coping was sufficient and when “medical help” was needed (Fish & Fakoussa, 2018; Paudyal et al., 2021; Misra, 2006), and stressing that psychological care erases religion: *“Psychological therapy takes out religion, but you need something to believe to keep*

your spirit alive" (Misra et al., 2006, p. 245). This highlights a mismatch between assumptions embedded in Western models and participants' own concepts of mental health.

Stigma, shame, and feared consequences of a MH label

Stigma, shame and the feared consequences of a mental health label were reported across all studies, shaping access through beliefs about mental illness, the shame of disclosure, and anticipated outcomes such as community ostracisation, being labelled "crazy", or harm to future employment. "Mental ill health" was often equated with being "crazy" or "mad", with local terms carrying derogatory connotations and inviting prejudice from family and community, who sometimes struggled to accept mental health difficulties (Fish & Fakoussa, 2018; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Paudyal et al., 2021; Majumder et al., 2014). In Leavey et al. (2007), one participant described her family's reaction:

"Then, my family all gathered. I told them all that they did not understand me that I was in trouble. Then everyone got upset... They did not want to accept it."

Fears about gossip, "signs", and being reduced to a stigmatised identity were common. Somali participants described how community members would "make signs" and say others were "mad" if they sought help (Palmer & Ward, 2007). For some, it felt safer to talk to God than a psychiatrist, or avoid services altogether, because seeing a "mental doctor" implied something fundamentally wrong with their brain (Paudyal et al., 2021; Majumder et al., 2014). Others described a culture of denial, for example *"the Kurdish community has a term for mental illness – 'sakat', which has derogatory connotations, and invites prejudice"* (Misra, 2006; Community representative 2, pp. 245).

Stigma was also linked to feared material consequences, particularly immigration status. Participants and workers reported warnings that having a mental health problem "on your records" could damage job prospects or count against an asylum claim, contributing to fear of speaking up or engaging with services (Fish & Fakoussa, 2018; Trueba et al., 2023; Fazel et al., 2016). Cultural norms around shame and silence, especially regarding sexual violence or family trauma, also meant ASRs often avoided disclosure even when in contact with services (Misra, 2006; Majumder et al., 2019; Majumder et al., 2014; Leavey et al., 2007). Stigma attached to settings too, with hospitals and psychiatry described as places *"for the mentals"*, and some preferring support through schools or community contexts (Paudyal et al., 2021; Majumder et al., 2014; Fazel et al., 2016; Palmer & Ward, 2007; Palmer, 2006).

Patterns and processes of help-seeking

This subtheme focuses on how ASRs move (or do not move) from recognising distress to seeking support, and who is involved in that process. Across studies, help-seeking was rarely a straightforward decision to “go to a mental health service”, but a delayed and negotiated process shaped by norms of self-reliance, gendered expectations, and fears of misunderstanding or mislabelling by professionals (Fish & Fakoussa, 2018; Misra et al., 2006; Paudyal et al., 2021; Ziyachi & Castellani, 2024). Participants often spoke about “becoming their own doctor”, drawing on personal strength and faith before seeking help:

“The person is his own doctor. Whatever happens to you, support or help, if you were not helping yourself from the inside, you won’t be able to succeed” (Paudyal et al., 2021, p. 4).

Others challenged the idea that seeking help implies failure, noting that *“there is a sense that you have to feel ‘I can handle it’, but reaching out for support doesn’t mean you’ve failed”* (Fish & Fakoussa, 2018, p. 371). For some Syrian refugees this tension supported spiritual coping over professional care: *“it’s hard for me to go and explain my mental status to a doctor, it’s better to explain to God”* (Paudyal et al., 2021, p. 5), while others reframed psychiatry as *“a normal thing and healthy”* that people *“must resort to... whenever [they] feel the need to speak to someone”* (Paudyal et al., 2021, p. 6), underscoring diverse beliefs about help-seeking. Prior experiences of mental health care in countries of origin also shaped avoidance of hospital-based services in the UK. Afghan adolescents recalled psychiatric hospitals *“like a prison... inside the cage”*, and Turkish-speaking families described free state hospitals in Turkey as low-quality and *“for the poorest citizens”*, preferring paid private, Turkish doctors, patterns that continued to influence help-seeking after resettlement (Leavey et al., 2007; Majumder et al., 2014; Fazel et al., 2016)

Informal routes through family, friends, religious leaders and community organisations were commonly used before statutory services, and in some contexts family members or elders, rather than the individual, decided if and when to contact traditional healers, GPs or psychiatrists (Leavey et al., 2007; Misra et al., 2006; Palmer, 2006; Palmer & Ward, 2007). Help was often sought only when difficulties reached a critical stage (Leavey et al., 2007; Palmer, 2006). Leavey et al. (2007) noted participants had *“very little sense of their own power and value”*, framing helplessness as a response to having their destiny in accessing services *“controlled by family and other structural forces”*.

Gendered expectations also shaped pathways. Men were often described as most reluctant to seek help, with studies linking male pride, loss of status and silence about feelings to severe

distress and, at times, suicidality: *“Most are men. They feel helpless. They don’t know the way or speak the same language, I think that about 10 or 12 have committed suicide”* (Palmer & Ward, 2007, p. 203; see also Fish & Fakoussa, 2018; Misra et al., 2006; Palmer, 2006). Women were generally described as more open to counselling but faced constraints, including preferences or requirements to see female professionals, cultural norms of silence around sexual and gender-based violence, and patriarchal family structures limiting autonomy over when and how to seek help (Fish & Fakoussa, 2018; Leavey et al., 2007; Misra et al., 2006; Ziyachi & Castellani, 2024). For children and adolescents, access to CAMHS or school-based services was often initiated by adults (e.g. teachers, social workers or carers) rather than young people themselves. In Fazel et al. (2016) and Majumder et al. (2019; 2014), many were already in contact with services yet did not see themselves as having a mental health problem, indicating limited agency in help-seeking. Overall, help-seeking appears as a relational and gendered process shaped by family, community and institutional actors, intertwined with stigma, cultural and religious meanings, and wider systems.

Coping strategies and non-clinical supports

Participants drew on a wide range of coping strategies and non-clinical supports alongside, or instead of, formal mental health care. Religious practices such as prayer, reciting the Qur’an and consulting priests were described as clearing the mind, keeping the spirit alive and offering comfort when formal care felt distant or culturally unsafe (Fish & Fakoussa, 2018; Leavey et al., 2007; Misra et al., 2006; Paudyal et al., 2021). As one Syrian man put it, *“My mental state is better when I recite the Quran... this is honestly a comfort for me”* (Paudyal et al., 2021, p. 5). People also relied heavily on relationships and connections such as family, friends, refugee centres and community groups, with *“being with people with whom you feel loved from, this helps the person a lot to heal or to get out from the situation that he is in”* described as central to healing (Paudyal et al., 2021, p. 4; Palmer & Ward, 2007; Trueba et al., 2023). Others spoke about “becoming their own doctor” through self-reliance, time in nature, connecting mind and body health, and activity-based or practical supports such as sewing groups, volunteering, learning English, work, and help with housing and employment, which distracted from distress and restored a sense of purpose and agency with a strong emphasis on practical and holistic support (Fish & Fakoussa, 2018; Palmer, 2006; Palmer & Ward, 2007; Ziyachi & Castellani, 2024):

“In Islam, the mind-body are considered as one unit, with two divisions, but you can’t separate mind from body – if you’re depressed, diet and sleep are disrupted too. The opposite is true too, if you’re sick, you can’t think properly” (Fish & Fakoussa, 2018, p. 372).

Conditions under which care feels safe, trustworthy and genuinely helpful

This theme constructed how mental health services feel safe, trustworthy and genuinely helpful for participants, and when it felt unsafe, exposing or ineffective. It comprises five subthemes: (1) trust and safety with non-clinician professionals, (2) trust and safety with clinicians, (3) ambivalent experiences of talking therapies, (4) views on medication and preferred forms of support, and (5) communication and language support as conditions for feeling understood. Safety was described less in terms of service type and more in terms of how support was offered, whether professionals were trustworthy and consistent, responsive to practical needs, and attuned to cultural, religious, gendered and social concerns.

Trust and safety with non-clinician professionals

Trust and safety were often first established with non-clinician professionals (teachers, support workers, NGO staff and refugee-centre workers), rather than with mental health specialists. For young people, teachers who noticed concentration or behaviour changes and actively facilitated contact with services helped school-based support felt safer than hospital settings *“these teachers won’t harm you, they won’t abuse me. Yeah, [the teacher] he wanted to help me.... He made it really easy for me, you know and he find a nice room for us [for therapy in school]”* (Fazel et al., 2016). Adults described refugee centres and support workers as emotional and practical anchors; staff who helped with housing, benefits, or access to phone, data and transport were experienced as caring and protective amid instability (Palmer & Ward, 2007; Trueba et al., 2023; Ziyachi & Castellani, 2024). However, some questioned whether NGO or charity staff *“are really here to help us or are they just being paid to be supportive”* (Fish & Fakoussa, 2018, p. 373), a doubt that could extend to other professionals. Gender-sensitive arrangements, women-only services, female professionals and female drivers, were described as essential for women (Fish & Fakoussa, 2018). For some, safety also depended on access to trusted bilingual staff or interpreters, linking this subtheme to communication and language support.

Trust and safety with clinicians

Trust was a recurring concern and safety with clinicians appeared fragile rather than assumed. Many participants described doctors, psychologists and psychiatrists as embedded within the same hostile systems controlling immigration status, making disclosure and attendance feel risky, shaping decisions accessing services. Authors in adolescent and adult studies noted that some ASRs avoided appointments even after referral due to concerns about how clinicians' notes might affect asylum applications or their future in the UK ("these patients had deep concerns about their asylum applications and non-Turkish doctors may not have been trusted or considered sympathetic"; Leavey et al., 2007, p. 271; see also Majumder et al., 2014; Trueba et al., 2023). Young people described clinicians as unsafe: "*This doctor, I not trust him, I'm not safe*" and "*I didn't tell it to anybody... because I don't trust anybody*" (Majumder et al., 2014, p. 132).

Trust was also undermined when people felt culturally misread or dismissed. Several accounts suggested that "English people and doctor people" or native British doctors would not understand their experiences; Turkish-speaking Kurdish, Somali and Syrian participants described avoiding clinicians outside their cultural background (perceived as focused only on "symptoms"), preferring those who shared their language and background, or avoiding professionals from their own communities due to fears about gossip and stigma (Leavey et al., 2007; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Paudyal et al., 2021). There were also racialised preferences, including one young person who said they trusted English people but not Asian people in the UK, illustrating how personal histories and wider prejudice shape who feels safe to approach (Majumder et al., 2019). For some women, safety depended as much on gender as on language or culture, with women-only spaces and female counsellors described as conditions for attending and disclosing at all (Fish & Fakoussa, 2018; Misra et al., 2006).

ASRs described situations where clinicians appeared to treat them as a homogeneous group, lacked cultural humility, or normalised harmful practices, for example, a therapist describing FGM as "*normal in Somalia*", or offering strategies experienced as irrelevant: "*she just asked me to... dream that I was on a beach... I would rather get back to my religion instead*", which likely contributed to the participant "*not believe*" in therapists (Ziyachi & Castellani, 2024). However, clinical relationships were not uniformly negative. Some ASR named psychiatrists and counsellors as key sources of emotional support, and expressed appreciation for attentive, reliable care and follow-up: "*their health care system [in the UK] is excellent!*", when they felt listened to and taken seriously (Palmer & Ward, 2007; Paudyal et al., 2021). Taken

together, these accounts suggest trust in clinicians cannot be assumed and is easily disrupted when asylum processes, culture, religion, gender and power are not acknowledged within the therapeutic relationship.

Ambivalent experiences of talking therapies

Talking therapies were described ambivalently. For some, having a clinician to talk to felt life-saving and containing: "*[the therapist] saved my life... I talk to her about everything. She helps me focus, think about breathing and to take control when I have nightmares*" (Palmer & Ward, 2007, p. 208). Some young people similarly found it relieving: "*She talked to me about it [therapist], and I think it was kind of helpful, because sometimes when you talk to people, you know, everything's coming out...and you feel a bit better*" (Fazel et al., 2016, p. 373) with others describing feeling free inside after unloading past experiences (Majumder et al., 2019, pp. 376). However, some young people appeared to take a passive role, simply following practitioners' instructions, or found talking uncomfortable, patterns also reflected in adult studies (Majumder et al., 2019; Misra et al., 2006; Palmer & Ward, 2007; Ziyachi & Castellani, 2024). Others experienced repeated focus on the past as intrusive or actively harmful:

"I went to the counsellor but I feel even worse when I leave because he makes me talk and remember...They ask me about things that happened in my childhood but I don't know the use of that...Talking just reminds me more and more. I want more community activities and social activities." (Palmer & Ward, 2007; Kurdish female, pp. 208).

Similar concerns were reported elsewhere (Misra et al., 2006; Palmer & Ward, 2007; Majumder et al., 2019; 2014). Some participants felt "annoyed" by clinicians who "*keep talking to you*" or asked for their story before trust had been established, particularly women and young people (Majumder et al., 2019, pp. 375; Ziyachi & Castellani, 2024, p. 15). Therapy could be experienced as asymmetrical, with some describing reduced agency over their stories or feeling treated "*like a baby*" (Majumder et al., 2019; Ziyachi & Castellani, 2024).

Some participants emphasised that regular opportunities to speak with someone were vital for coping, while others criticised therapies they experienced as non-expert, overly conversational, or focused on revisiting trauma without offering solutions, leading some to stop attending (Fish & Fakoussa, 2018; Majumder et al., 2014; Ziyachi & Castellani, 2024). Others highlighted that therapy felt helpful when clinicians took time and offered practical support:

"He is a perfect counsellor. He supports me a lot. For example, my accommodation's window was broken, and the water came down to my room when raining. I talked to him and showed him a picture of it. He called my case worker and Migrant Help. The next day they came and fixed the window" (Ziyachi & Castellani, 2024, pp. 13)

Overall, talking therapies were neither uniformly rejected nor embraced; helpfulness depended on whether talking felt safe, paced and purposeful, and whether it was paired with concrete coping tools and practical support.

Views on medication and preferred forms of support

Participants often viewed medication as more acceptable than talking therapies, particularly when distress was understood in physical terms or when a quick, less exposing route to feeling *"back to normal"* was preferred (Majumder et al., 2014, p. 134; Majumder et al., 2019; Palmer & Ward, 2007; Leavey et al., 2007). Several young people asked for tablets and described antidepressants as *"keeping my mood up"*, contrasting with talking therapies experienced as re-traumatising or unhelpful (Fish & Fakoussa, 2018; Majumder et al., 2014, 2019; Misra, 2006). However, medication was not unproblematic: some Turkish-speaking participants reported feeling numb or uncomfortable on pills, and in other contexts being offered tablets was read as confirmation of being *"crazy"*, reinforcing stigma and deterring help-seeking (Fish & Fakoussa, 2018; Leavey et al., 2007; Palmer & Ward, 2007). When asked what support they wanted, ASRs consistently prioritised practical, holistic and social help, secure housing, immigration and welfare advice, language and vocational courses, opportunities to work or study, community groups, and religious or meaningful activities, over medication or intensive psychological treatment alone (Fish & Fakoussa, 2018; Misra et al., 2006; Palmer & Ward, 2007; Paudyal et al., 2021; Trueba et al., 2023; Ziyachi & Castellani, 2024). Where psychological treatment was accessed, participants also emphasised integrating it with practical, problem-oriented support (Ziyachi & Castellani, 2024).

Communication and language support as conditions for feeling understood

Language and communication were core conditions for whether care felt containing or alienating once people reached services. Participants described interpreters with ambivalence: they enabled access, yet often made it harder to say *"personal things... straight from your heart"* (Paudyal et al., 2021, p. 5). Having an interpreter present could make disclosure feel unsafe and uncomfortable, particularly in relation to confidentiality (Palmer & Ward, 2007; Palmer, 2006; Paudyal et al., 2021; Leavey et al., 2007) and some experienced

interpreters as a relational barrier that slowed sessions and felt "boring" (Ziyachi & Castellani, 2024). Concerns about interpreters "*talking too much in the community*" (Palmer & Ward, 2007, pp. 206) and dialect differences, further highlighted within-language/culture heterogeneity:

"Sometimes because my language Arabic [is] different from country to country, I think sometimes they [interpreters] can't understand me... Maybe I am better, I can understand them but they can't understand me... I think a Syrian interpreter its better" (Trueba et al., 2023, Jaliyah, 27-year-old refugee, p. 3174).

In some studies, participants reported inaccurate translations, limited mutual understanding or emotional nuances being lost, leading some to use interpreters only for Home Office interviews or to avoid them altogether (Palmer & Ward, 2007; Trueba et al., 2023). ASRs often preferred counsellors who spoke their language, noting that going through an interpreter made it difficult to share true feelings, particularly if were of the opposite gender (Ziyachi & Castellani, 2024). Others felt native English doctors could not understand them at all, reinforcing a sense of being fundamentally misunderstood and limiting engagement with treatment (Leavey et al., 2007; Majumder et al., 2014; Misra et al., 2006; Paudyal et al., 2021).

At the same time, communication could be repaired when clinicians worked flexibly with language: checking meanings, slowing down, explaining terms, using the same interpreter, allowing phone translators instead of formal interpreters, and avoiding overly sophisticated psychological terms, which helped participants feel that "*my counsellor could understand me*" (Ziyachi & Castellani, 2024; pp.14) and supported a more equal, empowering, collaborative relationship: "*The sessions went on according to my will. She paid attention to whatever I wanted*" (Fish & Fakoussa, 2018; Palmer & Ward, 2007; Ziyachi & Castellani, 2024, pp.15). Language therefore operated as a cross-cutting mechanism both at the system level (e.g., information only in English, lack of funded interpreters) and at the relational level, shaping whether interactions felt safe and trusting and whether therapy could continue without ongoing barriers.

Discussion

This systematic review adds to the limited qualitative evidence on ASRs' experiences of accessing and using mental health services in the UK. Using thematic synthesis, we constructed three themes and 11 subthemes showing how access and non-access are shaped by factors spanning structural systems through to cultural, social and individual contexts. Across diverse services and communities, decisions about whether, when and how to seek support were influenced not only by symptoms and individual beliefs, but by an interplay of structural conditions, culturally grounded meanings of distress, stigma, and relational experiences of safety or mistrust with services and clinicians.

The findings align with existing literature on intersecting barriers to ASR mental healthcare, including structural inequalities, limited awareness of services, stigma, non-Western explanatory models, and the importance of language and trust (Byrow et al., 2020; Alam et al., 2024; Dumke et al., 2024; Koja et al., 2025). However, this review adds nuance by centring UK-based ASRs' accounts and showing how these influences operate as linked mechanisms, rather than discrete "barriers". Two points appeared particularly salient. First, whether distress was recognised and legitimised as a MH concern within participants' cultural, social and religious frameworks (often within families/communities), alongside worries about social and legal consequences. Second, whether contact with services felt safe and meaningful, shaped by trust in clinicians and interpreters, confidentiality concerns, the perceived relevance of talking-based interventions, and structural conditions limiting choice, control and continuity of care.

Across studies, participants emphasised that distress was shaped as much by post-migration conditions, particularly the asylum and welfare system, housing insecurity and practical instability, as by pre-migration experiences. Consistent with evidence on post-migration stressors, these were associated with anxiety, depression and PTSD, but in this synthesis they also constrained the routes through which help became possible (Blackmore et al., 2020; Katsampa et al., 2025; Dumke et al., 2024). Pathways into specialist support were often experienced as fragmented and conditional, shaped by institutional gatekeeping (including primary care constraints) rather than clinical need alone (Fish & Fakoussa, 2018; Paudyal et al., 2021), echoing UK evidence on racialised barriers to mental health support (Alam et al., 2024). Therefore, the distress generated through policy, welfare and asylum conditions (Pollard & Howard, 2021), arrives with services "downstream" as mental health deteriorates.

Even when ASRs accessed services, “mental health support” was commonly framed as needing to extend beyond symptom-focused or purely “talking” approaches to include practical help and attention to the wider political, cultural and social conditions shaping distress. Helpfulness was closely tied to whether care felt safe, trustworthy, responsive to material realities, and able to accommodate preferences (including around language and interpreters). Trust was therefore central: its absence limits disclosure, undermine engagement, or contribute to withdrawal. However, trust was not straightforwardly increased by shared language or cultural background; in some interpreter contexts, there were fears about confidentiality and stigma, whereas in others cultural and religious recognition could facilitate feeling understood, supporting the value of holistic care (Ziyachi & Castellani, 2024). This pattern is consistent with evidence that repeated interpersonal and organised violence erodes trust. ASRs experience concerns about confidentiality, authority figures and public organisations, including healthcare, shaped by persecution histories and fear of being reported (Byrow et al., 2020; Dumke et al 2024; Nickerson et al., 2014). While some participants were hesitant about talking therapies, medication was often described as more acceptable, contrasting with DeSa et al. (2022) who found greater hesitancy around medication. Across studies, talking therapies were described ambivalently. Some experienced them as “life-saving”, while others found revisiting the past re-traumatising leaving them feeling worse.

Participants frequently asked for community and social activities and prioritised practical support alongside emotional care. This complicates assumptions in UK service models that prioritise talking therapies for trauma, as several participants did not find these approaches helpful in isolation. Instead, valued care was collaborative and empowering, grounded in being listened to, trust, and attention to wider material needs (Majumder et al., 2019; Ziyachi & Castellani, 2024).

Language and communication were repeatedly described as major barriers to accessing and using support (Paudyal et al., 2021). At a system level, information about services and referral pathways was often available only in English, limiting awareness and increasing reliance on others to navigate care (Trueba et al., 2023). In clinical settings, interpreter arrangements could restrict agency (e.g. being required to use an interpreter despite preferring English), or support could be undermined by lack of interpreters, difficulty with psychological terminology, confidentiality concerns, and dialect/accents mismatches (Paudyal et al., 2021; Palmer & Ward,

2007; Trueba et al., 2023). Koja et al (2025) corroborated these patterns and suggested bilingual professionals with cultural and mental health understanding may better meet needs.

The review also shows how explanatory models of distress and stigma shape help-seeking from formal services, particularly where Western frameworks did not align with participants' meanings and expectations (Ziyachi & Castellani, 2024). This helps explain preferences for religious leaders and spiritual healers when participants anticipated not being understood, consistent with wider ASR literature (Byrow et al., 2020; Dumke et al., 2024). At the same time, accounts were not uniform: participants held varied views about when spiritual coping was sufficient and when professional help was appropriate, cautioning against treating culture or religion as fixed "barriers". These findings reinforce that ASRs should not be treated as a homogeneous group.

Participants described both overlapping and divergent understandings of mental health and expectations of support. Implications for services include avoiding cultural essentialism (Ziyachi & Castellani, 2024) and adopting a holistic, person-centred approach grounded in the individual needs and preferences. In practice, this may involve negotiating interpreter use, recognising practical and psychosocial support are often inseparable, strengthening cultural humility, understanding of varied meanings of distress and remaining open to sociocultural, political, or religious frameworks where these are meaningful. Holistic approaches that move beyond fixed, "one-size-fits-all" assumptions, often shaped by Western service models, may help reduce barriers to engagement and support more trusting therapeutic relationships (Koja et al., 2025; Ziyachi & Castellani, 2024). More critically, the findings point to UK-specific systemic gaps beyond individual services, including limitations in health commissioning for ASRs (Pollard & Howard, 2021), the constraining effects of hostile environment policies on both access and mental health need, and the importance of clinicians recognising these barriers and adopting advocacy roles to support change at service and policy levels.

Strength and limitations

This review synthesised ASRs perspectives in way that goes beyond simply documenting the difficulties. Adopting a critical realist stance, it treats participants' accounts as lived experience while also examining the social, legal, and political conditions that shape what care is possible. A key strength is that it links structural, cultural, and relational processes into an explanatory account rather than treating barriers as isolated problems. Including studies with

adults and young people also allows comparison of how pathways into care differ by age and setting.

The evidence base spans UK regions, age groups, and multiple countries of origin. Despite this diversity, recurring patterns emerged, suggesting that many challenges are embedded in wider systems and service arrangements rather than specific services. Although most studies were conducted in England, asylum policy is not devolved to nations. This matters because one of the most consistent patterns concerned the asylum system and its impacts. While devolved health and social care systems may shape service development and delivery, the asylum-related pressures described by participants are likely to affect all UK nations. The design does not support strong conclusions about change over time, but similar difficulties appearing across studies published over many years suggests these problems are persistent.

Some groups (notably participants from Afghanistan and Somalia) were over-represented, likely reflecting migration patterns at the time particular studies were conducted; to mitigate this, we drew across studies and communities so no single group dominated the narrative. Most participants were recruited via third-sector organisations, refugee centres, community groups, or statutory services, meaning the experiences of those who are most isolated, disengaged, or least visible to research are likely underrepresented. As the synthesis is UK-focused, caution is needed when applying findings elsewhere; similar patterns may appear in other high-income contexts, but different welfare, immigration, and healthcare systems can produce different routes into care and help-seeking. Our scope also shaped what could be captured; excluding grey literature may have limited access to rich narratives in theses, evaluations, and reports, and excluding broader healthcare studies where mental health was not the main focus strengthened conceptual clarity but reduced breadth and may have increased publication bias.

A further limitation concerns how primary studies treated “ASR.” Many papers did not clearly distinguish refugees from asylum seekers when presenting quotes and findings. While both groups share experiences that differ from the wider migrant population, they also differ in legal status and in the degree of uncertainty shaping daily life. The dataset contained explicit references to insecurity and fear linked to asylum processes, suggesting asylum-related uncertainty was well represented, but findings should be interpreted cautiously where legal status was unclear or mixed.

Although the included studies aimed to explore ASR experiences, in Trueba et al. (2023) participant accounts were sometimes less represented in favour of staff or stakeholder perspectives. We did not code stakeholder-only quotations; however, the prominence of non-ASR voices in parts of the evidence base highlights a broader problem whereby “experience” is filtered through professional interpretation, raising questions about whose voice is prioritised and how power imbalances may be reproduced when stakeholders speak “about” or “for” ASRs. Where first-person data were thinner, the synthesis inevitably relied more on author interpretation, weakening support for some subthemes and lowering confidence in those claims. Women’s voices were also less represented across most studies, limiting what can be said about gendered experiences of safety, disclosure, and service preferences, though we were able to report some gendered perspectives (particularly around help-seeking).

Finally, we did not conduct a GRADE-CERQual appraisal (Lewin et al., 2018), so we cannot provide formal confidence ratings for each finding. Nonetheless, we strengthened transparency and rigour through structured quality assessment, explicit consideration of study limitations in interpretation, and caution where participant voices were rare, mixed with stakeholder accounts, or where themes relied on limited data and heavier author interpretation. We also documented the recurrence of subthemes across studies to support judgements about coherence and adequacy and aimed to demonstrate variation within and between communities rather than presenting culture or religion as a single “barrier.” Older studies tended to show more methodological weaknesses than recent papers, so their contributions should be treated with additional caution.

Implications for practice, policy and future research

Several implications for practice and policy follow from this review. First, services need a workforce able to provide trauma-informed and culturally responsive care, including greater access to clinicians with relevant language and cultural knowledge, alongside training in cultural humility and different models of distress (Dumke et al., 2024). This also applies to interpreting. Commissioners should prioritise trained mental health interpreters with clear standards for confidentiality, consistency, and psychological terminology, and arrangements that reduce community-based confidentiality concerns while remaining culturally sensitive (Koja et al., 2025; Krystallidou et al., 2024). Training is also needed across all points of contact; from reception and GP practices to specialist teams, to avoid cultural stereotyping and recognise that ASRs are not a uniform group, even within the same country or language background. Services should make routes into care clearer through multilingual information

(including self-referral where possible) and reduce reliance on GP gatekeeping alone; where interpreters are used, choice and continuity matter, including options around gender and dialect/accents and the ability to work with the same interpreter when preferred (BPS, 2017).

The review highlights the mental health impact of the asylum process itself, indicating a need for proactive, accessible and ongoing psychosocial support for people living with asylum-related uncertainty. At a policy level, this strengthens the case for reducing avoidable distress generated by asylum and welfare conditions (e.g., prolonged uncertainty, poor housing, barriers to work and stability) and ensuring timely access that is not dependent on crisis or specific disclosures (Katsampa et al., 2025). Regular opportunities for supportive contact, including counselling where appropriate, may be particularly valuable for those living with ongoing instability linked to the asylum system.

Findings also raise questions about the fit of narrowly applied Western service models. Rather than assuming “talking therapies” are universally acceptable or sufficient, services should offer holistic, integrated approaches that acknowledge how distress is shaped by material realities (housing, finances, legal insecurity, isolation) and combine psychological input with practical problem-solving and advocacy. Care should be flexible and paced, offering stabilisation and community-based options where needed rather than defaulting to trauma-focused talking therapy as a first step. This aligns with community-oriented and liberatory approaches that attend to power dynamics, structural determinants and the social context of suffering, including a “cultural models” approach (Fish & Fakoussa, 2018; Ziyachi & Castellani, 2024). Co-production with ASRs and community stakeholders can strengthen service design, outreach and intervention acceptability, including decisions about language, setting and pace of therapeutic work (Fish & Fakoussa, 2018).

Finally, services should prioritise trust-building and safety as core conditions for engagement. This includes clear communication about confidentiality, options around interpreter use, and culturally safe spaces for disclosure. Gender-sensitive provision should be routine, including women-only spaces and access to female clinicians and interpreters where needed.

Partnerships with schools, refugee centres, NGOs and organisations working with racialised and marginalised groups can support culturally informed outreach and education in neutral community settings where stigma is reduced, and sociocultural and religious understandings of distress can be acknowledged rather than dismissed.

In terms of research implications, future qualitative studies should prioritise ASR-led and ASR-centred methods that protect participant voice from being diluted by stakeholder accounts. Researchers should clearly separate ASR quotations from staff or service opinions and justify mixed-sample designs to reduce the risk of filtering lived experience through professional interpretation. More work is needed with ASRs who are not connected to services or non-profit organisations, as this group may be underrepresented and face particular challenges related to isolation, mistrust, language barriers and lack of information.

More research should also attend to gender and age and across different UK nations such as Scotland. Women's views were often underrepresented despite providing important insights on safety, disclosure and gender-related barriers. Future studies should intentionally include ASR women and explore their experiences of accessing mental health services in the UK. Similarly, studies should compare young people's and adults' experiences more explicitly, including the roles of schools, caregivers and other non-clinical gatekeepers, and how agency and consent are understood in these contexts. Finally, intervention and implementation research should test holistic models that integrate psychological support with practical problem-solving and advocacy, rather than evaluating trauma-focused talking therapies in isolation. This should include co-produced and community-based approaches, with outcomes reflecting ASRs' priorities beyond symptom change. Where possible, future evidence syntheses should strengthen confidence in findings using approaches such as GRADE-CERQual and specify how adequacy, coherence and relevance of ASR quotations vary across themes.

Conclusion

This review shows that ASRs' involvement with mental health services in the UK is shaped by an interplay of structural, service-level, and sociocultural factors instead of just individual willingness to seek help. Barriers to access and engagement result from systemic uncertainty, restrictive policies, differing conceptualisations on distress and help-seeking, and mismatches between service models and lived experiences. To tackle these challenges, we need responses that go beyond focusing on individual engagement. We should embrace trauma-informed, culturally sensitive, and structurally aware methods at clinical, service, and policy levels. Without these changes, existing gaps in access to mental health care for ASRs will likely continue. These findings call for urgent policy action to eliminate hostile-environment barriers. We also need targeted funding for accessible, trauma-informed, and culturally responsive mental health services to ensure that equitable care for ASRs is a system requirement rather than an individual responsibility.

References

Alam, S., O'Halloran, S., & Fowke, A. (2024). What are the barriers to mental health support for racially-minoritised people within the UK? A systematic review and thematic synthesis. *The Cognitive Behaviour Therapist*, 17, e10, Article e10.

<https://doi.org/10.1017/S1754470X24000084>

Ayiku, L., Levay, P., Hudson, T., Craven, J., Barrett, E., Finnegan, A., & Adams, R. (2017). The medline UK filter: development and validation of a geographic search filter to retrieve research about the UK from OVID medline. *Health Information & Libraries Journal*, 34(3), 200-216. <https://doi.org/https://doi.org/10.1111/hir.12187>

Bansal, N., Karlsen, S., Sashidharan, S. P., Cohen, R., Chew-Graham, C. A., & Malpass, A. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta-ethnography. *PLOS Medicine*, 19(12), e1004139. <https://doi.org/10.1371/journal.pmed.1004139>

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS Med*, 17(9), e1003337.

<https://doi.org/10.1371/journal.pmed.1003337>

Booth, A. (2016). Searching for qualitative research for inclusion in systematic reviews: a structured methodological review. *Systematic Reviews*, 5(1), 74.

<https://doi.org/10.1186/s13643-016-0249-x>

British Psychological Society (2017). Working with interpreters: Guidelines for psychologists

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clin Psychol Rev*, 75, 101812. <https://doi.org/10.1016/j.cpr.2019.101812>

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qual Health Res*, 22(10), 1435-1443. <https://doi.org/10.1177/1049732312452938>

Critical Appraisal Skills Programme (2023) CASP (Qualitative Studies Checklist). [online].

<https://casp-uk.net/casp-tools-checklists/qualitative-studies-checklist/>.

Demirli Yıldız, A., & Strohmeier, D. (2024). The Role of Post-Traumatic Stress Symptoms and Post Migration Life Difficulties for Future Aspirations of Iraqi and Syrian Asylum Seekers. *SAGE Open*, 14(2), 21582440241244698. <https://doi.org/10.1177/21582440241244698>

DeSa, S., Gebremeskel, A. T., Omonaiye, O., & Yaya, S. (2022). Barriers and facilitators to access mental health services among refugee women in high-income countries: a systematic review. *Systematic reviews*, 11(1), 62. <https://doi.org/10.1186/s13643-022-01936-1>

Due, C., Green, E., & Ziersch, A. (2020). Psychological trauma and access to primary healthcare for people from refugee and asylum-seeker backgrounds: a mixed methods systematic review. *International Journal of Mental Health Systems*, 14(1), 71. <https://doi.org/10.1186/s13033-020-00404-4>

Dumke, L., Wilker, S., Hecker, T., & Neuner, F. (2024). Barriers to accessing mental health care for refugees and asylum seekers in high-income countries: A scoping review of reviews mapping demand and supply-side factors onto a conceptual framework. *Clin Psychol Rev*, 113, 102491. <https://doi.org/10.1016/j.cpr.2024.102491>

Essex, R., Riaz, A., Casalotti, S., Worthing, K., Issa, R., Skinner, J., & Yule, A. (2022). A decade of the hostile environment and its impact on health. *Journal of the Royal Society of Medicine*, 115(3), 87-90. <https://doi.org/10.1177/01410768221078327>

Fazel M, Garcia J, Stein A. The right location? Experiences of refugee adolescents seen by school-based mental health services. *Clinical Child Psychology and Psychiatry*. 2016;21(3):368-380. doi:10.1177/1359104516631606

Fish, Matt & Fakoussa, Olivia. (2018). Towards culturally inclusive mental health: learning from focus groups with those with refugee and asylum seeker status in Plymouth. *International Journal of Migration, Health and Social Care*. 14. 10.1108/IJMHS-12-2017-0050.

Fletcher, A. J. (2017). Applying critical realism in qualitative research: methodology meets method. *International journal of social research methodology*, 20(2), 181-194. <https://doi.org/10.1080/13645579.2016.1144401>

Griffiths, M., & Yeo, C. (2021). The UK's hostile environment: Deputising immigration control. *Critical Social Policy*, 41(4), 521-544. <https://doi.org/10.1177/0261018320980653>

Hannes, K. (2009). Chapter 4-Critical appraisal of qualitative research Key points.

Hannes, K., Lockwood, C., & Pearson, A. (2010). A Comparative Analysis of Three Online Appraisal Instruments' Ability to Assess Validity in Qualitative Research. *Qualitative Health Research*, 20(12), 1736-1743. <https://doi.org/10.1177/1049732310378656>

Hanwell, K., Finnerty, F., & Richardson, D. (2025). Asylum seekers' and refugees' experiences of violence and accessing healthcare in the UK: a systematic review. *J Public Health (Oxf)*, 47(2), 207-216. <https://doi.org/10.1093/pubmed/fdaf005>

Harrington, S., Sornalingam, S., Evenden, R., Singh, N., & Paudyal, P. Barriers to primary care access for asylum seekers and refugees in the UK: a systematic review (2022). LID - ckac131.509. (1101-1262 (Print)).

Hearn, F., Biggs, L., Brown, S., Tran, L., Shwe, S., Noe, T., Toke, S., Alqas Alias, M., Essa, M., Hydari, S., Szwarc, J., & Riggs, E. (2022). Having a Say in Research Directions: The Role of Community Researchers in Participatory Research with Communities of Refugee and Migrant Background. *International Journal of Environmental Research and Public Health*, 19(8), 4844. <https://doi.org/10.3390/ijerph19084844>

Henkelmann, J. R., de Best, S., Deckers, C., Jensen, K., Shahab, M., Elzinga, B., & Molendijk, M. (2020). Anxiety, depression and post-traumatic stress disorder in refugees resettling in high-income countries: systematic review and meta-analysis. *BJPsych Open*, 6(4), e68. <https://doi.org/10.1192/bjo.2020.54>

House of Commons (2025). Asylum statistics (Research Briefing). House of Commons Library. <https://commonslibrary.parliament.uk/research-briefings/sn01403/> House of Commons Library

Hynie, M. (2018). The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *Can J Psychiatry*, 63(5), 297-303. <https://doi.org/10.1177/0706743717746666>

Institute for Government. (2024). The precarious state of the state: Public services. <https://www.instituteforgovernment.org.uk/publication/general-election-2024-precarious-state/public-services> instituteforgovernment.org.uk

Jannesari, S., Emma, M., & Lawrence, V. (2022). What affects the mental health of people seeking asylum in the UK? A narrative analysis of migration stories. *Qualitative Research in Psychology*, 19(2), 295-315. <https://doi.org/10.1080/14780887.2019.1581311>

Katsampa, D., Spira, J., Stamatopoulou, V., & Chapman, D. (2025). 'I'm facing everything by myself': Post-migration Difficulties and Barriers to Integration Among Refugees. *Journal of international migration and integration*. <https://doi.org/10.1007/s12134-025-01269-7>

Koja, R., Oliver, D., & Forrester-Jones, R. (2025). Factors That Affect Refugees' Perceptions of Mental Health Services in the UK: A Systematic Review. *Social Sciences*, 14(11), 635.

Krystallidou, D., Temizöz, Ö., Wang, F., de Looper, M., Di Maria, E., Gattiglia, N., Giani, S., Hieke, G., Morganti, W., Pace, C. S., Schouten, B., & Braun, S. (2024). Communication in refugee and migrant mental healthcare: A systematic rapid review on the needs, barriers and strategies of seekers and providers of mental health services. *Health Policy*, 139, 104949. <https://doi.org/10.1016/j.healthpol.2023.104949>

Leavey, G., Guvenir, T., Haase-Casanovas, S., & Dein, S. (2007). Finding help: Turkish-speaking refugees and migrants with a history of psychosis. *Transcultural psychiatry*, 44(2), 258–274. <https://doi.org/10.1177/1363461507077725>

Lewin, S., Booth, A., Glenton, C., Munthe-Kaas, H., Rashidian, A., Wainwright, M., Bohren, M. A., Tunçalp, Ö., Colvin, C. J., Garside, R., Carlsen, B., Langlois, E. V., & Noyes, J. (2018). Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implementation Science*, 13(1), 2. <https://doi.org/10.1186/s13012-017-0688-3>

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, 1(1), 31-42. <https://doi.org/10.1177/2632084320947559>

Lowther-Payne, H. J., Ushakova, A., Beckwith, A., Liberty, C., Edge, R., & Lobban, F. (2023). Understanding inequalities in access to adult mental health services in the UK: a systematic mapping review. *BMC Health Services Research*, 23(1), 1042. <https://doi.org/10.1186/s12913-023-10030-8>

Ludwig, B. (2016). "Wiping the Refugee Dust from My Feet": Advantages and Burdens of Refugee Status and the Refugee Label. *International migration*, 54(1), 5-18. <https://doi.org/https://doi.org/10.1111/imig.12111>

Majumder P, O'Reilly M, Karim K, Vostanis P. 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents.

International Journal of Social Psychiatry. 2014;61(2):129-136.

doi:10.1177/0020764014537236

Majumder P. (2019). Exploring stigma and its effect on access to mental health services in unaccompanied refugee children. *BJPsych bulletin*, 43(6), 275–281.

<https://doi.org/10.1192/bjb.2019.35>

McHugh, M. L. (2012). Interrater reliability: the kappa statistic. *Biochem Med (Zagreb)*, 22(3), 276-282.

Milner, K., Crawford, P., Edgley, A., Hare-Duke, L., & Slade, M. (2020). The experiences of spirituality among adults with mental health difficulties: a qualitative systematic review. *Epidemiology and Psychiatric Sciences*, 29, e34, Article e34.

<https://doi.org/10.1017/S2045796019000234>

Misra, T., Connolly, A. M., & Majeed, A. (2006). Addressing mental health needs of asylum seekers and refugees in a London Borough: epidemiological and user perspectives. *Primary Health Care Research & Development*, 7(3), 241–248. doi:10.1191/1463423606pc293oa

Morrice, L., Tip, L. K., Collyer, M., & Brown, R. (2021). 'You can't have a good integration when you don't have a good communication': English-language Learning Among Resettled Refugees in England. *Journal of Refugee Studies*, 34(1), 681-699. <https://doi.org/10.1093/jrs/fez023>

Noyes, J., Booth, A., Flemming, K., Garside, R., Harden, A., Lewin, S., Pantoja, T., Hannes, K., Cargo, M., & Thomas, J. (2018). Cochrane Qualitative and Implementation Methods Group guidance series-paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *J Clin Epidemiol*, 97, 49-58.

<https://doi.org/10.1016/j.jclinepi.2017.06.020>

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—a web and mobile app for systematic reviews. *Systematic Reviews*, 5(1), 210.

<https://doi.org/10.1186/s13643-016-0384-4>

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S.,...Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews.

BMJ, 372, n71. <https://doi.org/10.1136/bmj.n71>

Palmer, D., & Ward, K. (2007). 'Lost': listening to the voices and mental health needs of forced migrants in London. *Medicine, conflict, and survival*, 23(3), 198–212.

<https://doi.org/10.1080/13623690701417345>

Palmer, David. (2006). Imperfect prescription: Mental health perceptions, experiences and challenges faced by the Somali community in the London Borough of Camden and service responses to them. *Primary Care Mental Health*. 4. 45-56.

Paudyal, P., Tattan, M., & Cooper, M. J. F. (2021). Qualitative study on mental health and well-being of Syrian refugees and their coping mechanisms towards integration in the UK. *BMJ open*, 11(8), e046065. <https://doi.org/10.1136/bmjopen-2020-046065>

Pollard, T., & Howard, N. (2021). Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. *Int J Ment Health Syst*, 15(1), 60. <https://doi.org/10.1186/s13033-021-00473-z>

Reynolds, t., Erel, u., & O'neill, m. (2024). Editorial introduction: Racialised migrants navigating the UK's hostile environment policies. *Critical Social Policy*, 44(2), 165-177.

<https://doi.org/10.1177/02610183231223947>

Santambrogio, J., Cimminiello, N., Wisidagamage Don, P., Leon, E., Miragliotta, E., Capuzzi, E., Colmegna, F., & Clerici, M. (2024). Influence of post-migration living difficulties on mental health among refugees and asylum seekers: A scoping-review on clinical tools. *Int J Soc Psychiatry*, 70(7), 1191-1201. <https://doi.org/10.1177/00207640241251748>

Satinsky, E., Fuhr, D. C., Woodward, A., Sondorp, E., & Roberts, B. (2019). Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. *Health Policy*, 123(9), 851-863.

<https://doi.org/https://doi.org/10.1016/j.healthpol.2019.02.007>

Sattar R, Lawton R, Panagioti M, et al. (2021) Meta-ethnography in healthcare research: a guide to using a meta-ethnographic approach for literature synthesis. *BMC health services research* 21(1): 50

Solie, T. (2024). Reflexivity in research: addressing power dynamics in researching Syrian refugees in the UK. *Language and Intercultural Communication*, 24(5), 511–526.

<https://doi.org/10.1080/14708477.2024.2392264>

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8(1), 45.

<https://doi.org/10.1186/1471-2288-8-45>

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Med Res Methodol*, 12, 181.

<https://doi.org/10.1186/1471-2288-12-181>

Trueba, M. L., Tessa, A., & and Ayeb-Karlsson, S. (2023). Are asylum seekers and refugees provided with appropriate mental health support in the United Kingdom? *Journal of Ethnic and Migration Studies*, 49(13), 3163-3183. <https://doi.org/10.1080/1369183X.2023.2181126>

UNCES (2000). General comment No. 14: The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (E/C.12/2000/4). United Nations Digital Library.

<https://digitallibrary.un.org/record/425041?ln=en&v=pdf> OHCHR+1

United Nations (1951). Convention relating to the Status of Refugees. Retrieved December 16, 2025, from https://treaties.un.org/pages/ViewDetailsII.aspx?src=TREATY&mtdsg_no=V-2&chapter=5&Temp=mtdsg2&clang=en

United Nations High Commissioner for Refugees [UNHCR]. (2024). Global Appeal 2025 [Report]. <https://www.unhcr.org/publications/global-appeal-2025>

Ziyachi, M., & Castellani, B. (2024). A 'Cultural Models' Approach to Psychotherapy for Refugees and Asylum Seekers: A Case Study from the UK. *International journal of environmental research and public health*, 21(5), 650. <https://doi.org/10.3390/ijerph21050650>

Chapter 2: Major Research Project

**Exploring the Dissociative Experiences Measure Oxford (DEMO) in Iranian Persian: A
cognitive interviewing study**

Prepared in accordance with the author requirements for Frontiers in
Psychology (Psychology for Clinical Settings) for Original Research
(<https://www.frontiersin.org/about/author-guidelines>)

Plain Language Summary

Title: Exploring the Dissociative Experiences Measure Oxford (DEMO) in Iranian Persian: A cognitive interviewing study

Background: Refugees may experience multiple traumatic events arising in the context of war, forced displacement and torture. Given high rates of trauma, the experience of dissociation is common. Dissociation is one way that the mind copes with excess stress. People with dissociation may feel disconnected from memories, thoughts, feelings and the world around them. An important aspect of treatment is using appropriate measures to assess dissociation. The Dissociative Experiences Measure Oxford (DEMO) has been recently developed in collaboration with people with expertise by experience. However, this measure has not been explored in a clinical sample with Iranian refugees.

Aims: To explore the experiences of Iranian refugees when interacting with the DEMO, and to examine how their perspectives can inform future adaptations of DEMO to improve clinical and patient outcomes, as well as contribute to a deeper understanding of dissociation within this population.

Methods: Five Iranian participants from a refugee background were recruited from NHS Greater Glasgow and Clyde mental health services. The DEMO was translated according to good practice guidelines. One-to-one cognitive interviews were recorded and then transcribed, asking participants about the items of the DEMO, including how they understood the items and whether the questionnaire was easily understandable. Cognitive interviewing was used to explore and analyse participants' responses, alongside thematic analysis to allow flexible interpretation of the data.

Findings: There were significant difficulties in all parts of the Iranian Persian version of the DEMO, mainly relating to questions about "unreality" and "memory blanks". Participants' answers showed that some questions were hard to understand, insufficiently specific, or open to interpretation. In some cases, the Persian wording did not match the original English meaning, and there were also a few grammatical issues. Some groups of questions (reliving memories/flashbacks and "zoning out"), worked better overall, but even these still raised some concerns about word and idiom choice and how well the translation matched the intended meaning

Conclusions: This study used cognitive interviews with Iranian refugees in the UK to test how well the Persian DEMO works and found significant difficulties, especially in the Unreality and Memory Blanks subscales. Most difficulties came from unclear and ambiguous wording, poor matches between the English and Persian meanings, and translation issues, which meant that people's interpretations did not match the intended meaning behind the questions. These findings show that gold-standard translation alone is not enough, and that dissociation questionnaires need cognitive interviewing and close collaboration with bilingual stakeholders to make sure they are conceptually and linguistically suitable across cultures.

Abstract

Background: There is little empirical evidence on the translation and cultural validity of dissociation measures, particularly for diverse and marginalised groups such as refugees and asylum seekers in clinical settings. The Dissociative Experiences Measure, Oxford (DEMO) is an updated and comprehensive instrument that addresses several criticisms of existing dissociation measures; however, its sample was largely homogeneous. Further research is therefore needed to examine the DEMO's validity in diverse clinical populations and to assess whether it meets criteria for cross-cultural content and face validity.

Aims: This study aimed to explore how Iranian refugees using NHS Greater Glasgow and Clyde mental health services interact with and understand the items of the Persian-translated version of the DEMO.

Methods: A qualitative, descriptive design was adopted using cognitive interviewing. The DEMO was translated into Iranian Persian following good practice guidelines before data collection. Five Iranian refugees took part in individual, semi-structured cognitive interviews. Participants first completed the DEMO, followed by a verbal probing-only cognitive interviewing approach. Interviews were audio-recorded, transcribed and analysed using a hybrid analytic cognitive interview approach alongside thematic analysis to allow flexible interpretation. Analysis included item-by-item summaries, top-down coding, cross-participant comparisons and the development of a results matrix.

Results: The analysis revealed significant problems across all domains of the Persian DEMO, with particularly pronounced difficulties in the Unreality and Memory Blanks domains. Participants' responses highlighted recurring issues with comprehension, lack of clarity and specificity, ambiguity, semantic non-equivalence and grammatical issues. Some items, especially within the Vivid Internal World and Zoned Out domains, showed better functioning but still raised some concerns around wording, idioms and semantic equivalence.

Conclusion: Findings suggest that the current Persian adaptation of the DEMO does not consistently reflect the intended constructs for Iranian refugees in this clinical context and cannot be assumed to have cross-cultural content or face validity in its present form. Revision of problematic items, followed by additional cognitive interviewing and psychometric evaluation, is required.

Introduction

Dissociation occurs across various conditions, including post-traumatic stress disorder (PTSD), complex PTSD (CPTSD) (Wolf et al., 2012), psychosis (Longden et al., 2020) and panic disorder (American Psychiatric Association, p.208 [APA], 2013). Dissociation has a strong, causal link with trauma (Lynn et al., 2019), and there is emerging research demonstrating dissociation is a transdiagnostic construct (Ellickson-Larew et al., 2020). Dissociation is also a distinct category in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and involves *'distribution of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behaviour'* (APA, p. 291, 2013). Furthermore, dissociation has been associated with poorer treatment outcomes across various mental health problems including PTSD (Bae et al., 2016), panic disorder and OCD (Spitzer et al., 2007) and thus can impact the effectiveness of psychotherapeutic interventions.

Refugees, who are among the most marginalised groups globally face high risk of mental ill health and extreme distress (Richter et al., 2018). They are frequently exposed to inescapable and repeated trauma, including war, torture and childhood abuse (Jowett et al., 2021), conditions under which dissociation is thought to be particularly likely to develop (Schauer & Elbert, 2010; Boyer et al., 2022). Studies with war-affected children and adolescents, such as Palestinian youth in Gaza and resettled refugee adolescents in Sweden, have reported high levels of peritraumatic and ongoing dissociative experiences (Ghannam & Thabet, 2014; Qouta et al., 2012; Gušić et al., 2017, 2018), highlighting the relevance of dissociation in this population and the importance of situating it within wider socio-cultural and political contexts. However, prevalence data remain limited, making it difficult to inform healthcare priorities and treatment assessment (Harder, 2014).

Given that dissociation appears to be an important predictor in treatment outcomes for many mental health conditions (Lyssenko et al., 2018) and presents across diverse populations, dissociation outcome measures are needed to monitor the quality and effectiveness of psychotherapeutic interventions. The most common existing dissociation measures are the Dissociative Experiences Scale (DES and DESII) (Bernstein & Putnam, 1986; Carlson & Pytnam, 1993), the Wessex Dissociation Scale (WDS) (Kennedy et al., 2004), the Multiscale Dissociation Inventory (MDI) (Briere et al., 2005) and the Dissociative Symptoms Scale (DSS) (Carlson et al., 2018). Most of these instruments have received considerable criticism; significant limitations

include omitting to incorporate updated understandings of dissociation and questions relating to the measure's validity (Carlson et al., 2018, Cernis et al., 2018; Saggino et al., 2020). Existing measures are time-consuming for clinicians and service users (SU) and some fail to address the nuances of dissociation by not breaking down symptoms by subtypes (Cernis, et al., 2018). Cernis et al. (2018) developed the Dissociative Experiences Measure, Oxford (DEMO), which aimed to address the limitations of previous measures and attempts to take a more comprehensive approach reflecting newer developments relating to dissociation and incorporating the experiences of SU with dissociation. Although DEMO has demonstrated strengths, including high internal consistency, good discriminant, convergent and divergent validity, this bottom-up data-driven method, which included involving those with lived experience in the DEMO's development, its validity cannot be extrapolated to everyone with dissociation. The DEMO pool sample was mainly young women and 90% were from the Global North, illustrating the limited research into cross-cultural instrument validation and development.

Hosseini et al. (2025) highlighted the need for psychometric measures that are comprehensive, reliable, and valid, and reflect current conceptualisations of dissociative experiences across research and clinical domains. To address this, they examined the psychometric properties of the DEMO in an Iranian general population sample using confirmatory factor analysis (CFA) and reported good reliability and validity. While the translation procedures adopted by Hosseini et al. (2025) were rigorous, their pilot testing process was described only briefly, noting that the revised Persian version was piloted for clarity and cultural appropriateness without specifying how participants' understanding of items was evaluated or whether they followed a pre-testing protocol. This represents a common limitation in the adaptation of psychological measures, despite the consistently recommended use of qualitative methods such as focus groups or cognitive interviews to elicit respondents' interpretations and reactions to each item as a form of pre-testing (Morgado et al., 2018; Terwee et al., 2017). Factor-analytic approaches such as CFA are most suitable when constructs are well understood and prior validity evidence exists in comparable contexts (Knekta et al., 2019), yet they provide limited insight into how individuals interpret or interact with items. Moreover, self-report questionnaires administered online in non-clinical samples, such as in Hosseini et al. (2025) are inherently vulnerable to response biases, social desirability, and situational factors (Morgado et al., 2018; Mahudin et al., 2012; Pan et al., 2013), all of which may influence measurement accuracy.

These methodological considerations highlight the importance of supplementing quantitative validation with in-depth qualitative pre-testing among the target population to enhance conceptual clarity and cross-cultural equivalence (Morgado et al., 2018). Cognitive Interviewing (CI) is an evidence-based qualitative methodology commonly used to discern how participants interpret and answer questions that form part of a questionnaire. CI helps researchers to identify necessary adaptations in order to enhance the accessibility and validity of the instrument items by enabling them to anticipate potential difficulties that participants may experience when interpreting questions (Collins, 2015). Additionally, CI is commonly used as a qualitative method to evidence the content and face validity of a measure (Egger-Rainer, 2019; Willis, 2015a). Content validity concerns the extent to which an instrument adequately represents the construct of interest and ensures that its items are comprehensible (Terwee et al., 2017), whereas face validity refers to whether responders of the target language perceive the items as relevant and appropriate for their respective contexts (Connel et al., 2018).

Using semi-structured interviews and CI with participants from the target population, allows identification of questionnaire design problems (Egger-Rainer, 2019) and invites suggestions on how to make the measure accurate, understandable, acceptable and relevant to the target population (Singh et al, 2021). The application of cross-cultural cognitive interviewing (CCCI) has been considered a natural extension of standard CI, given the recognised and increasing need to evaluate surveys across different cultures and languages (Willis, 2015b). CCCI examines how the CI process operates outside the Western settings in which a questionnaire was developed, requiring researchers to reflect on the suitability of CI for the target questionnaire and its applicability to the intended participants and target language (Willis, 2015b). Moreover, when adapting a measure into a target language, items must undergo linguistic and cultural modification to ensure equivalence with the original version. This process usually involves forward and backward translation, review by an expert panel, cognitive interviewing, and final proofreading (Jia et al., 2022). Although there are some differences in the approach between CCCI and CI, the objective is aligned to the one of standard CI process; to pretest a survey to identify potential participant difficulties in answering. Although, it is typical in CI to take a reparative approach to problems identified, the option for a descriptive approach also exists (Willis, 2015a). The descriptive approach focuses on describing how an item operates based on the construct measured. Rather than focusing on "repairing" items, descriptive CI is used when the aim is to understand how a question functions as a measure of a particular concept, and to make explicit the implicit issues involved in a given wording (Willis, 2015).

Given that dissociation has been a widely present symptom in refugees, there is clearly insufficient literature discussing comprehensive, user-friendly measures for dissociation that are culturally adapted. Culturally adapted measures vitally enable the planning and delivery of appropriate interventions for this vulnerable population. There is evidence to suggest that cultural adaptation can improve the effectiveness of psychological interventions and instruments (Arafat et al., 2016; Harper Shehadeh et al., 2016; Singh et al., 2021). Building on this evidence, the present study employs CI with Persian-speaking individuals with clinical experiences of dissociation who are currently accessing psychological support in the UK, to explore how they understand the DEMO items of this current adaptation. This approach allows for the exploration of comprehension, clarity, and relevance of DEMO items within a clinical and cross-cultural context, offering insights into how individuals from Iranian backgrounds interpret dissociative experiences in migration and service-use settings where cultural and linguistic incongruences may affect assessment, treatment, evaluation and communication.

Aims

The study aims to further explore the DEMO's cross-cultural content and face validity. It assesses the experiences of Iranian refugee SU interactions with the DEMO exploring how they understand, respond to and make sense of DEMO items. Exploring how one group of SU interact with the instrument can deepen understandings of how cultural adaptation may improve the acceptability and effectiveness of psychological assessment and, consequently, intervention (Heim et al., 2019). The study intends to afford greater insight into whether DEMO effectively assesses/measures/captures how Iranian refugees experience dissociation.

Research questions:

1. To explore potential issues of the Persian-adapted version of DEMO when it comes to face and content validity including issues with item comprehension of the items.
2. To examine the semantic equivalence and cultural relevance of the Persian-adapted DEMO, exploring how participants comprehend and make sense of the items and identifying any difficulties encountered during responding and scoring.

Methods

Ethics

Ethical approval was obtained from the North of Scotland (2) NHS Research Ethics Committee on 7th November 2024, ref: 24/NS/0112; management approval was obtained from NHS GG&C Research and Innovation department on 14th November 2024, ref: UGN24MH201 (Appendix 2.1; 2.2). Three non-substantial amendments, including for the final MRP proposal (Appendix 2.3) were submitted and accepted on the 26th February, 6th June and 29th October 2025.

Following consent to contact, participants received Persian translations of the Participant Information Sheet and the Privacy Notice. They had the opportunity to ask questions before providing informed consent with an interpreter. They were informed of their right to withdraw at any time. Data handling was compliant with GDPR (2018) guidelines. Personal data were stored electronically in encrypted, password-protected files on secured NHS Scotland computer, accessible only to the primary investigator (PI) (VS). The written transcripts were stored in a password protected device and were accessible only to the research team. Anonymised data with pseudonyms were used for analysis to ensure confidentiality. To minimise potential risks, no questions were asked about participants' traumatic experiences.

Materials

The PIS and Privacy Notice, participant information leaflet (PIL), consent forms and the adapted Persian version of the DEMO were all translated in Persian (Appendix 2.4). A PPI panel comprised by two experts-by-experience who were Persian SU and now professionals were also recruited to review the participant-facing documents and proposed interview schedule to ensure that questions and explanations were relevant and sensitive.

Design

The study aimed to explore how participants understand the items of the Persian adaptation of the DEMO through a descriptive cognitive interview study. Qualitative semi-structured interviews were conducted by the PI using cognitive interviewing. The study is reported in accordance with the criteria for qualitative studies (COREQ) (Tong et al., 2007) to ensure standardised reporting (Appendix 2.5). The study included two phases, the translation of the instrument phase and the cognitive interviews.

Assessment Measure – DEMO measure

The DEMO (Cernis et al., 2018) scale used for the purposes of this study is an adapted version translated in Persian (Appendix 2.6). The original DEMO was designed to offer an updated and comprehensive measure of dissociative experiences and address the limitations of existing dissociation measures. The purpose of the instrument is to assess the frequency and the intensity of dissociative experiences. The scale consists of 30 items and has 5 subscales: “Unreality”, “Numb and Disconnected”, “Memory Blanks”, “Zoned Out”, and “Vivid Internal World”. The definitions for each subscale were used to guide the comprehension of each item as cited in Cernis et al. (2018). The scale used a five-point Likert scale from 1-5 asking if they had experienced the item in the last two weeks (never, rarely, sometimes, often, all the time). DEMO may be described as a valid measure due to good correlation with other measures of dissociation, and good psychometric properties (Cernis et al., 2018).

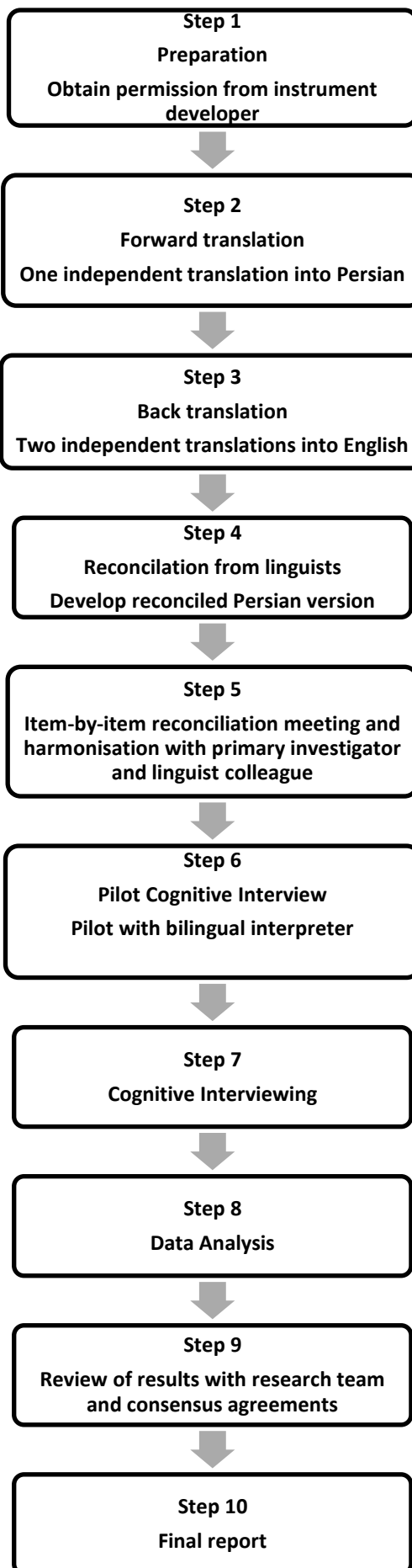
Translation of the scale

Semantic equivalence

The first author of the original paper (Cernis et al., 2018) granted permission to use the DEMO for the purposes of this study. While Hosseini et al (2025) recently adapted the DEMO into Persian, their version was unavailable at the outset of this research. The adaptation process and procedures for the current study were already underway prior to their publication. The study followed published guidelines for translation and cross-cultural adaptation (Figure 3: Jia et al., 2022). Despite lack of consensus regarding methodological approaches to processes of translation, adaptation and cross-cultural validation (Cruchinho et al., 2024; Wild et al., 2005), guidelines share some commonalities, and these were used in the present study with the exemption of quantitative validation. To ensure semantic equivalence (Herdman et al., 1997), the study followed established guidelines for translation and cultural adaptation of measurement instruments (Cruchinho et al., 2024). The translation agency contracted by NHS Greater Glasgow and Clyde (NHS GGC) assisted by sourcing a bilingual translator (SR), who produced a forward translation of the English items. Next, two additional bilingual Persian linguists on both the source and target languages who were uninvolved in the forward step (YM and FA) independently generated blind back-translations into English and provided written notes on discrepancies in which they provide their own reconciled version of the instrument. A bilingual colleague from the research team (AYS) then led an item-by-item reconciliation meeting with the principal investigator (VS) to review discrepancies between the source and final translation from the linguists, reaching consensus on wording, mostly on grammar, and correcting any errors identified by AYS. VS then undertook a pilot with a

bilingual interpreter to rehearse the topic guide and the cognitive interviewing procedure. Finally, the refined Persian version underwent cognitive interviewing with the study participants.

Figure 31. Translation and cross-cultural adaptation process



Participants

To maintain a relatively homogeneous sample, we included only Iranian individuals who have navigated the UK asylum system and/or self-identify as refugees (UNHCR, 2014), have experienced symptoms of dissociation and were seen by NHSGGC specialist Glasgow Psychological Trauma Service (GTPS), and NHSGGC Community Mental Health Teams (CMHTs). Although migration journeys differ, this shared position reduces variability from long-settled UK bilingual citizens, who are likely more familiar with English phrasing, which could shape how they interpret Persian-adapted items. Participants were recruited via their respective clinicians within the mental health teams. This group was chosen as, during discussion with GTPS clinicians, it emerged there was a high proportion of Iranian patients using NHS mental health services who experience dissociation and are survivors of torture, therefore, a purposive sample was recruited. This study adopts a more inclusive definition of 'refugee' to encompass both those officially conferred, and those applying for, this status.

Participants were required to meet the following inclusion criteria:

- 16 or over to comply with the requirements of the Age of Legal Capacity (Scotland) Act 1991.
- Are Iranian and speak Persian as their mother tongue
- Have had dissociative experiences
- Can provide informed consent
- Identify as a refugee or a person seeking asylum.

Participants were offered reimbursement for their participation in the form of a £20 Love2Shop voucher to compensate for their participation. In addition, their travel expenses were also covered. A total of five participants were recruited, and they were all men. All but one participant required interpreters as he was a bilingual speaker. All but one of the interpreters attended the interview in person alongside with the participant; for one participant the interpreter was included via MS Teams and via telephone. Table 5 provides details about the participants. To ensure anonymity pseudonyms have been used (participants had the option to choose their preferable pseudonym) as well as the age range.

Table 5. Participant Characteristics

Pseudonym	Interpreter	Mode of Interpreter	Age Range	Status
Arash	Yes	F2F	30 - 40	Asylum Seeker
Darius	Yes	F2F	40 - 50	Asylum Seeker
Cookie	No	N/A	30 - 40	Refugee Status
George	Yes	Ms Teams	30 - 40	Refugee Status
Ahmad	Yes	F2F	50 - 60	Refugee Status

Sample Size

Although Willis (2015a) suggests at least 7 to 10 interviews are needed to confirm item comprehensibility, this was not achievable in the present study due to resource and time constraints. COSMIN guidance indicates that a sample of approximately 4–6 participants is adequate for assessing content validity via cognitive interviews and qualitative methods; therefore, this study aimed to recruit at least four (Terwee et al., 2017). Further, the concept of data saturation has been widely criticised (Braun & Clarke, 2021; Malterud et al., 2015) on the basis that meaning in qualitative research is produced through the researcher's interpretation of the data rather than being inherent in the data. Consequently, decisions about when to stop collecting data are highly subjective (Braun & Clarke, 2021). In line with this guidance, the present study adopts an information power perspective such as recruiting of participants with highly specific characteristics, focusing on the quality of the transcripts and dialogue, and in-depth analysis of participants' narratives (Malterud et al., 2015), while recognising that qualitative sample sizes are determined pragmatically (Kaushik & Walsh, 2019), often in light of constraints such as time and resources.

Procedures

Recruitment was coordinated with the GPTS and the Consultant Clinical Psychologists from NHSGGC CMHTs. After clinicians identified potential participants, they informed them about the study using a translated Participant Information Leaflet (PIL). If interested, individuals provided consent to contact so the clinician could pass their details to the PI. The PI then sent the PIS and Privacy Notice by post and email. An initial phone call with the PI was arranged a minimum 24 hours after the materials were sent; during this call, the PI answered any study-related questions, confirmed willingness to participate, and scheduled the interviews,

including interpreter preferences. Personal data were used solely for contacting the participant and were not retained thereafter. A written consent form was completed on the day of the interview.

Study interviews were conducted either in person at participants' local NHS clinic or online via video call and with an interpreter, according to participant preference, and lasted approximately 90–120 minutes. All interviews were audio-recorded (with a backup device), transcribed verbatim and transcripts were verified against the recordings to ensure accuracy by VS. She also made brief reflective notes after each interview and during transcription to capture initial thoughts. No repeat interviews were carried out. Due to time constraints and lack of translation resources transcripts were not returned to participants for comment.

A semi-structured topic guide was developed using verbal probing (VP) methodology (Willis, 2015a), piloted with a bilingual interpreter, was used to invite participants to give their initial response to each item and then answer a series of standardised (anticipated) and/or free-form (emergent) probes exploring how they understood the wording, how they arrived at their answers and how relevant the item felt to their experiences, including their thought processes while reflecting on the item and offering a response (Willis, 2015a). A VP-only approach was chosen because it is suitable for diverse cultural and language groups and avoids the additional cognitive load associated with think-aloud techniques for marginalised participants (Willis, 2015b).

Demographic information (age range, gender, rough estimate how long they've been in the UK and status) was collected verbally. The interview style prioritised rapport, transparency and collaboration with participants and interpreters, with unnecessary probing avoided to support trust and openness (Miller, 2004). Bilingual samples can help separate language from acculturation effects, yet studies with monolinguals show that they experience substantial difficulties completing items (Willis, 2015b). This study adopted an inclusive approach, with no exclusion on any speaker whose mother tongue is Persian.

Although CCI ideally researchers with fluency in the target language (Willis, 2015b), this was not feasible for the present study. Due to this limitation, the following measures were taken. In line with guidance that interviewers should possess expertise in translation, cognitive/qualitative interviewing, and survey methodology (Sha & Pan, 2013), the interviewing team met these requirements. Moreover, to mitigate the absence of a target language fluent CI interviewer, interviews were conducted with trained interpreters and close

collaboration with bilingual speaker as part of the research team. It was not possible for interpreters to conduct the interviews on their own, as they were not trained in research methods. However, the same interpreter was used with the exception of one interview, to ensure consistency in relation to communication and interpreting responses.

While interpreters facilitate metaphoric or figurative communication to accurately translate clinical terms into the relevant cultural context (Bramberg & Dahlberg, 2013; Wand et al., 2019), their involvement can introduce sources of bias (Hlavac, 2017). This was mitigated by using NHS interpreters practiced in dealing with upsetting topics and BPS Guidelines was followed (BPS, 2017). VS met with the interpreter in advance of the interview to discuss the interview schedule, their role was within the interview itself (Bramberg & Dahlberg, 2013) and how the CI approach works. They were instructed to use first person present tense and to interpret directly without summarising and explaining cultural terms as necessary. After the interview, the interpreter was debriefed by the researcher to capture any necessary reflections about the three-way communication.

Analysis Plan

Analysis was conducted using NVivo 14. The primary analytic approach was descriptive cognitive interviewing, focusing on how each DEMO item functioned for participants at an item-by-item level. A secondary, supportive layer of analysis drew on principles of inductive thematic analysis to organise recurrent types of problems and interpretations across items and participants.

Guided by Willis (2015a), the study adopted a hybrid descriptive CI approach that integrated elements from different cognitive analysis testing models (i.e. text summaries, question-feature coding, theme coding, pattern coding) and focused on identifying item-level problems when these were evident in participants' responses. In line with Knafl et al. (2007), VS independently analysed the transcripts in depth, both within and across participants, drawing on a combination of top-down problem codes and data-driven insights.

A first pass of coding was conducted to apply codes for comprehension (yes, no, unsure), clarity, semantic equivalence and ambiguity. All comprehension and top-down coding ratings were decided through consensus coding. Discrepancies were resolved during consensus meetings between VS and a second coder (AG), where line-by-line data and participant explanations were reviewed to ensure consistent interpretation and application of the coding criteria. This was undertaken transcript by transcript. VS and the supervisor were involved in

all stages of the analysis, including coding. An item-by-item review (Miller et al., 2014) was also undertaken to explore participants' comprehension of each DEMO item, using a top-down coding scheme primarily informed by Willis and Lessler's (1999) Question Appraisal System. Consistent with Willis's (2015a) emphasis on measure-specific issues, an additional coding framework was developed to capture problems specific to the DEMO and aligned with the study's aims (Appendix 2.10).

In a second stage of analysis, principles of inductive thematic analysis (Braun & Clarke, 2006) were used to organise the CI findings. This phase involved grouping the item-level problem codes and participants' explanations into broader, descriptive patterns. These patterns were then developed into themes that summarised how participants interacted and made sense of the DEMO items.

Findings were summarised and cross-referenced across participants in an item-level results matrix, consistent with the descriptive CI focus of the study. For each item and participant, comprehension judgements (yes, no, unsure) were recorded and colour-coded (green = yes, red = no, orange = unsure). Additional columns listed the types of problems identified (e.g. clarity, ambiguity, semantic equivalence, translation error). VS and the supervisor met to discuss and resolve coding discrepancies and to agree on the final categorisation.

Transparency and Reflexivity

The researcher is a female a trainee clinical psychologist and came from an ethnic minority background. She has experience working with refugees and people seeking asylum and working with interpreters, particularly Persian-speaking interpreters, and patients in both the NHS and third-sector organisations. As part of her role, she is experienced in delivering and interpreting psychometric measures, particularly in the context of trauma and dissociation. Nevertheless, the researcher has awareness of the power dynamics involved within both the clinical and research worlds particularly for people with insecure asylum status and who experience dissociation. The researcher is a non-Iranian, non-Persian-speaking immigrant to the UK, with an accent and cultural similarities to the target group. This produced an ambivalent insider/outsider position (Bukamal, 2022) and asymmetrical power relations around language, citizenship and professional status, which inevitably shaped how the data were generated and interpreted. The researcher relied on professional interpreters during data collection and on translated transcripts for analysis, and there is a risk that some nuances were lost or transformed at each stage. To mitigate this, the researcher worked closely with

an Iranian colleague throughout the initial translation and adaptation process and discussed problematic items and emerging interpretations following data analysis. Nonetheless, the analysis reflects the researcher's own interpretive lens as an ethnic minority trainee clinical psychologist working and trained in a UK setting and should be read as one situated account rather than a definitive description of Iranian concepts of dissociation.

Results

During the cognitive interviews, several problems were identified with administering the scale and these are presented in Table 6. Table 6 presents an item-level results matrix showing each DEMO item by participant, with comprehension judgements colour-coded (green = yes, red = no, amber = unsure) and an additional column summarising other problems identified. The results are presented in two parts: 1) summaries and analysis of each DEMO factor domain (subscales), including problems identified through the top-down framework, and (2) additional themes generated through inductive coding. Detailed descriptions of item-by-item problems are provided in the appendices (2.11). The themes include: 1) Clarity and Specificity Issues, 2) Translation issues and 3) Broader reflections on the questionnaire and its relevance to lived experience.

Table 6. Comprehension and problem summary for Persian DEMO items across participants

Item	Arash	Darius	Cookie	George	Ahmad	Problems Identified
1. I have the feeling that other people, other things and the world surrounding me are not real	Red	Red	Green	Red	Red	Comprehension, clarity, ambiguity
2. I have the feeling that everything is unreal	Orange	Orange	Red	Green	Orange	Comprehension, clarity
3. I feel as if I don't exist, am not real	Green	Red	Red	Orange	Red	Comprehension, clarity, ambiguity
4. I feel like I am in a parallel world	Red	Red	Red	Red	Red	Comprehension, clarity, ambiguity
5. The world around me feels detached or unreal, as if there were an invisible barrier between me and the outside world	Red	Red	Green	Red	Red	Comprehension, translation errors, semantic equivalence, clarity, ambiguity
6. I feel like the external world is not real, a joke, a lie	Red	Orange	Red	Red	Red	Comprehension, ambiguity, clarity and semantic equivalence
7. I feel emotionally numb	Red	Red	Green	Green	Green	Mixed comprehension
8. I just feel numb and empty inside	Green	Green	Green	Red	Green	Clarity, semantic equivalence, specificity
9. I feel I can't make a proper connection with anyone around me	Green	Green	Green	Green	Green	N/A
10. I do not seem to feel anything at all	Red	Red	Green	Red	Green	Comprehension, clarity, specificity, ambiguity
11. I feel like I'm 'just existing'	Green	Green	Green	Red	Green	Translation error
12. I turn inwards, trying to work out why I feel so disconnected	Green	Green	Green	Red	Red	Mixed comprehension, clarity

Item	Arash	Darius	Cookie	George	Ahmad	Problems Identified
13. I find myself in situations or places with no memory of how I got there	Red	Green	Red	Orange	Red	Comprehension, clarity, ambiguity
14. I suddenly notice that I find myself in a place that is unknown to me without knowing how I got there	Green	Green	Green	Red	Red	Mixed comprehension, clarity
15. I find evidence of something I've done recently (e.g. through finding notes or drawings) but I don't remember doing it	Green	Red	Orange	Red	Green	Mixed comprehension, clarity, ambiguity, specificity
16. I find new articles among my things without being able to remember ever having purchased them	Green	Green	Red	Red	Red	Comprehension, semantic equivalence, translation error, clarity
17. I find myself somewhere and do not remember how I got there	Green	Green	Green	Green	Green	N/A
18. I have big gaps in my memory for recent things in my life	Red	Green	Red	Red	Green	Comprehension, clarity, semantic equivalence
19. I stare aimlessly without thinking about anything	Green	Green	Green	Green	Green	N/A
20. I 'zone out' and don't see or hear what's going on around me	Green	Green	Green	Green	Green	No issues with comprehension but issues with semantic equivalence and clarity were evidenced
21. I sometimes sit staring off into space, thinking of nothing, and am not aware of the passage of time (or	Red	Green	Green	Green	Green	Minor issues with comprehension but notable issues with clarity and semantic equivalence

Item	Arash	Darius	Cookie	George	Ahmad	Problems Identified
other people tell me that I do this)	Red	Green	Green	Green	Green	
22. I often think about nothing	Green	Green	Red	Green	Green	Clarity
23. Sometimes my mind is absolutely blank	Green	Green	Green	Green	Green	No issues with comprehension but significant issues with clarity, specificity, and semantic equivalence
24. My mind just goes empty	Red	Green	Green	Red	Red	Mixed comprehension, clarity, semantic equivalence
25. I can remember something that happened before so vividly that it's like a video playing in my head	Green	Green	Green	Green	Green	N/A
26. Unwanted images from my past come into my head	Green	Green	Green	Green	Green	N/A
27. I am surprised by or don't expect some of the thoughts or images that happen in my head	Green	Red	Green	Green	Green	Clarity
28. I experience past memories as if they are happening here and now	Green	Green	Green	Green	Green	N/A
29. I can get so involved in fantasies or daydreaming that it seems to be really happening and I lose touch with what is happening in the real world at that moment	Red	Green	Green	Green	Green	Clarity, semantic equivalence
30. I hear someone talking when no-one nearby has actually said anything	Green	Green	Green	Green	Green	N/A

Note. Cells are colour-coded to indicate comprehension judgements for each item and participant: green = comprehension "yes", red = comprehension "no", and orange = comprehension "unsure".

DEMO Factor Domains

Across DEMO domains, Unreality and Memory Blanks showed the most substantial and consistent problems with comprehension, clarity, ambiguity and semantic equivalence. Numb and Disconnected and Zoned Out showed mixed performance, with some items working reasonably well and others affected by vagueness, length and idiom. Vivid Internal World performed best overall, with most items understood as intended and only minor wording issues.

Unreality Domain

Unreality domain showed consistent and substantial problems with comprehension, clarity, ambiguity and semantic equivalence across all six items and across all participants. It seemed the hardest domain to comprehend overall.

Across items, participants struggled with the meaning of “not real”, “unreal”, “not existing”, “parallel world”, “external world is a joke” and “outside world”. These terms were repeatedly understood in concrete, literal or idiosyncratic ways that did not match the intended dissociation construct of unreality or not understood at all. Participants’ interpretations in relation to the above words, referenced dream states, pretending or acting, grief, existential worry, hypervigilance, religiosity, the afterlife, distrust of people as a way to protect oneself, and a general sense that the world could have been a much better place due to unfairness and it being “a joke” in a literal sense.

Phrases such as “parallel world”, “detached”, “the world is a joke, a lie”, “invisible barrier” and “external/outside world” also showed issues with semantic equivalence. Participants and interpreters reported that these words or expressions are not natural in Persian, or that in some cases they carried unintended religious, philosophical or scientific meanings which indicated ambiguity of the meaning. These semantic issues, combined with the ambiguity of the construct, meant that participants’ chosen response options often reflected unrelated constructs (e.g. hallucinations for “feeling that everything is unreal”, existential concerns, social withdrawal, a sense of unfairness, afterlife, etc.) rather than dissociative unreality based on Cernis et al.’s (2018) definition. Overall, the unreality domain showed poor comprehensibility across participants, with only isolated and inconsistent instances of comprehension. These findings indicate that the current Persian translation of the unreality

items does not reflect the intended construct and further investigation is needed to explore a reparative approach.

Numb and Disconnected Domain

This domain showed significant variability with comprehension and clarity. Across the six items within this domain, participants showed mixed understanding. Some items were consistently understood (such as Item 9), while others showed much more variation (Items 7, 8, 10 and 12). The items with greater variation in comprehensibility were partially understood by some participants but also highlighted recurring issues with clarity, semantic equivalence and lack of specificity even from participants who did understand the items. For Items 7 and 8, most participants demonstrated adequate comprehension; however, some struggled to interpret these items and gave examples that reflected social disconnection or other unrelated experiences, rather than this sense of emotional numbness.

Participant feedback also indicated that some of the Persian terms used in these items were not semantically equivalent. For example, although participants broadly understood what Item 8 was trying to ask, participants commented that the phrase “feeling empty inside” did not fully capture the intended meaning and was confusing. A spontaneous repair of the item was offered with a proposed alternative term (“پوچی (puchi)”) which felt it was more closely aligned with the intended construct culturally and linguistically and better conveyed emotional emptiness.

Item 10 showed the poorest comprehension within this factor, with three participants interpreting the item in ways that did not align with the intended construct. Difficulties were largely related to lack of specificity. Participants questioned what “not feeling anything” referred to, noting that there were many possible interpretations. The wording was described as too general, vague, and even meaningless or “too open”, which appeared to contribute to inconsistent interpretations across participants. Item 12 also showed mixed comprehension, with difficulties becoming evident when participants interpreted only one component of this two-part question. They typically understood the “turning inwards” element but did not recognise that this was meant to be specifically linked to feeling disconnected.

Overall, this factor demonstrated mixed comprehensibility, with Items 9 and 11 performing more strongly, and Items 7, 8, 10 and 12 showing recurring problems with clarity, specificity and semantic equivalence. The better-performing items tended to be straightforward, relatively brief, contained only one component, and tapped into a concept that did not leave

much room for ambiguity. In contrast, problems were more obvious when items used concepts that were understood as too broad or generic in Persian, contained multiple components, or relied on terminology that did not closely match the intended meaning of the original English items.

Memory Blanks Domain

The Memory Blanks domain also showed variation and substantial problems with comprehension, clarity, ambiguity and semantic equivalence. Across the six items within this domain, participants showed mixed comprehensibility, and their responses and examples seemed to reflect cognitive problems related to attention, distractibility or forgetfulness more often than dissociative experiences in relation to memory blanks. Item 17 was an exception to this pattern, with all participants describing it as very clear and easy to understand. Ahmad noted that its shorter length and simpler vocabulary made it easier to process than the earlier, similar items. By contrast, Items 13, 14, 15 and 18 all showed recurring comprehension problems with clarity, ambiguity and semantic equivalence. For Item 13, most participants either did not understand the question or gave examples that did not seem relevant to dissociative experiences, instead focusing on ordinary distraction such as going somewhere and forgetting why. Item 14 was somewhat clearer, with several participants able to paraphrase or relate to it, but others still struggled, and one participant only understood it after a more concrete, day-to-day example and then offered an alternative, shorter phrasing in Persian that he felt would be clearer. Item 15 also showed mixed comprehension, with some participants interpreting it as temporarily not remembering something until they double-checked, indicating an understanding related to distraction and short-term memory and more than one plausible reading of the item. One participant understood the item but commented that the sentence was far too long, which made it harder to follow, highlighting issues with clarity and how, due to memory problems (retention/recall), shorter questions are easier for him to understand. Item 16 demonstrated clear issues with semantic equivalence, as the word “articles” had been translated literally and was understood as written articles or journals in Persian, leading most participants to say they did not understand the question at all until it was explained. Item 18 showed mixed comprehension, with the main issue being that the Persian word for “gap” was too unclear, closer to “space” than to a break in memory. Taken together, these findings suggest that, within this domain, participants often grounded their understanding in attentional lapses and short-term memory difficulties, and that several

items were experienced as too vague or unclear, too long, or semantically mismatched in Persian to reliably capture the intended dissociative construct.

"Zoned Out" Domain

This domain performed better than the previous three, but it still showed some issues with clarity, ambiguity and semantic equivalence. Item 19 was the strongest performing item, with all participants describing it as very clear and easy to understand. Item 20 was also broadly well understood, but participants highlighted that the English idiom “zone out” does not exist in Persian and instead explained it using phrases closer to “losing focus or concentration” or “not being mentally present”, which indicates issues with semantic equivalence and relatively acceptable comprehension. Item 21 demonstrated good comprehension, but there were issues of clarity and semantic equivalence, with the word used for “space” reported as being understood as “outer space” or “sky” in Persian, which did not change the conceptual meaning of the phrase but highlighted a semantic equivalence issue. Item 22 was understood by everyone with the exemption of the bilingual speaker. The consensus meeting also raised questions about the phrasing “I often...”, given that frequency is already captured in the response options, which potentially highlights issues of clarity. Items 23 and 24, which focus on the mind being “blank” or “empty”, showed the clearest problems with semantic equivalence and clarity. Although all participants appeared to comprehend Item 23, several reported that the phrasing was confusing and unnatural in Persian, noting that it is not possible to say that the brain is “empty”, or “empty of what”, and that the question would be easier if it specified that the mind is blank of; one participant offered a spontaneous repair using a Persian expression meaning “the brain hangs”, as more linguistically and culturally relevant. Item 24 showed the poorest comprehension in this domain, with three participants stating that the question “doesn’t have a meaning” in Persian unless it is rephrased and grammatically rearranged, with one participant highlighting similar issues with Item 23. Taken together, the “zoned out” domain demonstrated relatively good comprehensibility for items describing staring or drifting out of awareness, but items relying on metaphors of the mind being “blank” or “empty”, and on specific English idioms, showed clear problems with clarity and semantic equivalence in Persian.

Vivid Internal World Domain

This domain performed the best overall showing good comprehensibility and mapping closely onto the intended construct. Items 25 and 26 were clearly understood by all participants, who

offered relevant examples and described them as easy to answer. One participant commented that Item 26 felt easier than some of the previous questions because Item 25 already provided a built-in example (“like a film or video”), whereas Item 26 comes “like a picture”, suggesting that the use of concrete imagery may support understanding. Item 28 and Item 30 were also well comprehended by all participants and were described as straightforward. For Item 30, one participant did note that the current phrasing makes it sound as if the person “has an illness” and is not entirely clear about what is being asked, which may point to a minor issue with clarity, but this did not appear to affect comprehension.

Item 27 showed generally good comprehension, with four participants providing appropriate examples, but also some issues with clarity, as it became clearer for one participant after the interviewer gave an example. A participant commented that the length of the sentence made it harder to hold in mind and required repetition from the interpreter due to his short-term memory difficulties. Item 29 demonstrated mixed comprehension and it was the only item with this scoring in this domain. While most participants understood it and gave relevant examples, one participant struggled to understand the item until the interpreter explained the concept of daydreaming in simpler terms. He commented that “daydreaming” does not have a direct equivalent in Persian, that the wording did not sound natural, and that in Persian they would instead use a phrase meaning “we try to make things happen for us in our mind”. Taken together, the vivid internal world domain showed good comprehensibility across items overall, but with some issues of clarity and semantic equivalence for longer items and those relying on specific terms such as “daydreaming”.

In addition to the domain-level patterns derived from top-down coding, a thematic analysis of the interviews identified several bottom-up themes that provided more detailed data on how participants understood and responded to the Persian DEMO items.

1) Clarity and specificity issues

This theme captured recurring problems with clarity and specificity across items, where participants described questions as too general, “meaningless”, or having “millions of ways” to answer. Participants frequently found it difficult to understand items that lacked specificity and concreteness. This was often the case for items that described an absence of an experience. These difficulties were particularly evident for items within the Numb and Disconnected, Memory Blanks and Zoned Out domains. For example, in Item 8 (“I just feel numb and empty inside”), one participant asked:

“What do you mean by feeling empty from inside? Do you mean emotionally, physically and now what? ... Maybe if they could explain it a bit better like....what do you mean by feeling empty? Because, you know, you can, physically or energy-wise feel empty, or you can feel empty that you don't have any emotions or any feelings or anything.” (George)

Another participant understood the question but felt the wording lacked specificity of meaning in Persian:

“Puchi word it is better. I feel it's a better word than 'feelings' [the word used in this question], because with 'feeling' it means you have no feelings at all, left towards anything.” (Ahmad)

This also seemed relevant for Item 10 (“I do not seem to feel anything at all”), the idea of clarity of meaning when there is an absence of an experience. Most participants commented on this and it was exemplified:

“So, these questions are quite general and because they are not specifically talking about something, so that is why there are millions of answers for these types of questions. Because when you are asking me that I don't feel anything, it can be regarding my pain, physical health problems, or like, you know, physical activities, or like, you know, connection with your friends, and I can give you millions of examples.” (George)

Another participant did not understand the question at all:

“He doesn't understand the question... Is this in regards to a particular thing or anything? He says, what would you say, when you say I don't have any feelings., or I don't have any feelings, towards what?” (Darius)

Across the CI, participants actively worked to understand each item and to relate it to their everyday lives, often using their own metaphors to make sense of the wording and to explain to VS and the interpreter their process of understanding. For Item 23 (“Sometimes my mind is absolutely blank”), one participant described how confusing the question felt using a metaphor:

“For instance, if you say 'can you pass me that from the table', there are so many things on the table, it's confusing for you, because you say which one do you mean... do you mean laptop, or do you mean the recorder or do you mean the paper? ... To him the question means you pointing out and saying 'pass me that one', but he doesn't know which one... When they ask 'your mind is blank', blank of what?” (Arash)

In terms of clarity, some questions were also experienced as too long, which added complexity and made them more confusing. For Item 15, one participant commented:

"...In Farsi one, it makes it confusing because it's long. It's far too long." (Ahmad)

This suggests that longer items may place an additional load on short-term memory and make it harder for participants to hold the full meaning in mind.

More crucially, most of the items under the Unreality domain showed poor comprehension, which could likely be linked to the abstract nature and lack of concreteness of these items. In addition, several participants associated the wording with cultural and religious ideas (e.g. the afterlife, religion, philosophical questions about existence) and sense of fairness, which further contributed to ambiguity and moved their interpretations away from the intended unreality construct. For example, in relation to item 6 (I feel like the external world is not real, a joke, a lie), one participant reflected:

" Unless it's orthologic or, you know, the science of it, I wouldn't believe that kind of thing. (..) I think maybe it works for the people, religious people, but the people who don't believe on any religion, it [the question] might not apply to those. (Darius)

Other participants interpreted these items more in terms of broader existential or fairness ideas or constructs. These interpretations may have been shaped by their own experiences of unfairness in the world, both as survivors of torture and forced displacement and as people navigating the asylum process in the UK. In response to item 3, one participant spoke about the unfairness of bad people being successful while a young child dies "without any reason", asking "Does it sound fair?.. What's the point?", and another described item 6, in terms of the world being unfair rather than unreal.

"Yes, I feel sometimes the world around us could have been a much better. I just think it's not a fair world, that's my take of it. I know, you know that most of the questions is real or is it not real. I know the world is real, but it could have been more.. But when you say it's real we all know it's real, but it's not what you expect it to be." (Arash)

Generally, the construct of unreality was not clear to participants as evidenced below:

"He didn't understand when you say when it is around me is not real. (..) When the people around me.. you cannot say they are not real. Do you mean, when I am sleeping?" (Arash)

Another participant associated this item with political events and state violence in Iran and seemed confused about the question.

"That's why that kind of question is also complicated because it's trying to be judgemental if it's bad to treat people [influenced by his example of state violence], why would you then bring people from outside for a treatment?... When you say the world is not real. Or if you mention it is it real or am I playing computer game, you know?"

In several cases, participants initially stated that an item was "easy" or "clear", but their subsequent explanations and examples indicated misunderstanding or a focus on a different construct. This suggests that self-reported answer of understanding does not always map onto actual comprehension of the intended meaning.

Taken together, these examples illustrate that the Unreality items were often experienced as abstract and lacking concreteness, prompting participants to draw on religious, political and existential meanings. More broadly, when items do not specify what type of feeling or experience, they refer to and lack concreteness or somatisation, participants have to guess the meaning themselves, which amplifies ambiguity and leads to multiple plausible interpretations, inconsistent responses and reduced comprehension.

2) Translation Issues

Despite following gold-standard procedures for adapting questionnaires, the cognitive interviews still uncovered translation issues, including potentially incorrect terms, unidiomatic expressions and grammar mistakes (Miller et al., 2014). Some of the struggle to understand emerged in relation to issues of translation particularly in relevance to items 15 and 18. Item 15 was a clear example of a semantic equivalence problem, where the English phrase "articles of clothing" had been translated literally into Persian as "articles", as evidenced by participants:

"...What does it mean? Book or something like that? ...Or Newspaper?" (Ahmad)

The interviews also identified unidiomatic expressions such as "zone out", which participants pointed out does not exist in Persian:

"We wouldn't say 'zone out', we don't use it." (Arash)

Although all participants showed good comprehension of what "zone out" means, their interpretation was more closely aligned with losing focus or concentration, which does not

fully capture the intended meaning in English. Other translation issues took the form of grammatical mistakes identified by participants, such as misplaced words or awkward word order, likely reflecting word-for-word translation without adapting the phrasing to Persian grammar with this exemplified as seen below:

" They don't make sense. I think they haven't been maybe aligned or managed properly."
(George)

For Item 18, the general idiom of having “gaps” in one’s memory was partially conveyed, with some participants offering relevant examples, but its meaning was undermined in some cases by awkward word order and the Persian word chosen for “gap”, which was closer to “space”. These translation issues made the question feel like a “Google translation” for participants, creating ambiguity and lack of specificity about what exactly was being asked and reducing overall clarity.

" In terms of grammar, it's not easy to understand that question.... Yeah. I would say it's like me going into google translation. I don't understand something. I put it in. It might not give me the exact, but it gives me the idea, you know, what the answer would be in English."
(Ahmad)

Taken together, these examples suggest that literal translations, unidiomatic phrases and grammatical problems reduced the semantic equivalence and clarity of the Persian items and, in some cases, shifted participants’ interpretations away from the intended construct and reduced comprehension, despite best efforts to adapt the questionnaire into a different language. These translation issues added to participants' struggle to make sense of the items, particularly for the items highlighted above.

3) Broader reflections on the questionnaire and its relevance to lived experience

Participants also offered broader reflections based in their interaction with the questionnaire as the questionnaire struggles to adequately represent and convey the complexity of their lived experiences or to represent what dissociation meant to them. Several commented that a two-page measure could not capture the depth or complexity of what they were going through, or that their feelings were “not possible to explain with one question” and that the questionnaire on its own is not enough if clinicians do not take the time to understand the person beyond their replies on the questionnaire:

"I mean, it's not even possible to put into the words the struggles that, I, that people like me are going through into a questionnaire, into a 2-page questionnaire, if I were to write down my thoughts and everything, it would be like hundreds of books." (Cookie)

Two participants commented on the wider therapeutic context, sharing that "just talking" or clinicians "only listening" did not feel helpful for them, and that they valued more collaborative, problem-solving approaches which reflects wider research on refugee groups valuing problem-solving over talking therapies (Ziyachi et al., 2025). Although these reflections were not tied to specific items, they provide important contextual understanding into how participants perceived the questionnaire and the interview process within the broader landscape of their lived experience:

"For 8 to 10 years I've been receiving services... I just felt during all that time they just been asking me questions. There were only two practitioners... they really helped me and they didn't ask me how I felt; they tried to help me with my problems." (Ahmad)

Several participants felt that the questionnaire might be more helpful for clinicians than for them, and that some questions were too general or confusing:

"In normal circumstances, I don't like somebody asking me these questions, because I feel that 50% of the questions are quite confusing, not very clear. It could have been asked in a much easier way. ...Questions 1-6, I had to explain, it was very difficult to understand." (Arash)

Others suggested that there are aspects of dissociation and of accessing services more generally that people from Western societies "cannot even comprehend", potentially pointing to wider issues in how questionnaires are designed and how dissociation is conceptualised across cultures:

" This captures a lot of it but, at the same time, there are a lot of things that people from Western societies cannot even comprehend. There are somethings, for example, I am here, and I am being like this because of the things that I've gone through, and those things are things that might even never happen in Europe. That's why it is very difficult, if there was an Iranian therapist, then definitely they would know what the deal is, because the majority of Iranians have some extent of dissociation because the Iranian communities are not very close, you know, you Iranian families usually escape from each other." (Cookie)

Participants also questioned the response format and two-week timeframe, highlighting how their distress fluctuates in response to ongoing events and the wider instability of their lives.

This underscores the limitations of relying solely on symptom questionnaires at a single time point and the importance of clinicians situating scores within participants' shifting contexts. One participant explained:

"And I said what I'm answering is only for two weeks. You know, but lots of things are happening. If you ask me what three weeks ago would have been even worse because of the things are happening back home with the war and everything." (Ahmad)

Finally, some participants expressed concerns about the perceived applicability and tone of the unreality items, suggesting that they felt more appropriate for "somebody who's really got a problem" and would be clearer if written as questions rather than statements:

"Yeah, some of them needed explanation. And that question, the first one, needed lots of explanation (..) I want to say, this question, you know, from 1 to 6 applies to somebody who's really got a problem, you know, but not for everyone.... If it was asking a question 'Do you feel...?' it might be clearer... because when it comes as a question, it makes it clear for the person, do you have such a feeling? Sometimes the question has to be asked in the way that it applies only to me or it applies to everyone, to make it clear because some questions might not relate to his condition." (Darius)

These broader reflections suggest that participants emphasised the limits of a brief questionnaire in capturing the complexity of their experiences, the need for clearer and more specific questions, and the importance of using questionnaires within meaningful, collaborative conversations about their lives in clinical practice.

Discussion

The purpose of this study was to use cognitive interviews to explore how a clinical sample of Iranian refugee participants understood and interacted with the DEMO items. This study offers preliminary, descriptive evidence regarding the content and face validity of the Persian DEMO (Dissociative Experiences Measure Oxford Persian - DEMOp) in a small, specific clinical sample. Overall, the cognitive interviews suggested that the Unreality and Memory Blanks domains showed the most substantial comprehension and equivalence problems, Numb and Disconnected items functioned more variably, and the Zoned Out and Vivid Internal World domains generally performed better and were closer to their intended constructs.

Similar to Andersen et al. (2014), many of these problems would not have been detected through forward-backward translation processes alone. The inductive, organising analysis

highlighted three overarching themes: clarity and specificity issues, translation issues, and broader reflections on how the questionnaire relates to participants' lived experience and their general views of the measure.

The CI revealed multiple language-related issues in the Persian DEMO. Participants identified terms and phrases that were ambiguous, vague or unnatural, and some of the difficulties appeared to stem from the original measure's use of colloquial and idiomatic English wording, such as "zone out", "staring into space" or words with no clear Persian equivalence such as "daydreaming". Several items were also experienced the DEMO as overly long or containing multiple parts, which increased their complexity. This is consistent with survey-methodology research showing that answering questionnaire items places cognitive demands on respondents, and that longer, multi-component items are more difficult to process accurately (Brosnan et al., 2021).

Comprehension problems were closely linked to how familiar a word or construct was, the complexity of sentence structure and the degree of semantic equivalence between the source and target versions. In some cases, this reflected specific translation errors (such as literal translation of "articles"), the choice of terms (e.g. words for "gap", "space", "blank" or "empty" that carried different or overly vague connotations in Persian) and in others, the effect of length and grammatical awkwardness. In line question-answering models (Conrad, 2011), participants worked hard to make sense of the items by drawing on their own experiences, life circumstances and social situations, even when this meant moving away from the intended meaning. This was evident, for example, when items were interpreted through religious or scientific understandings, experiences of being Iranian and living with state violence, perceptions of an unfair world, or everyday experiences of distraction and forgetfulness and their impact on short-term memory.

In addition, there were items and constructs that were hard to understand due to their lack of specificity and concreteness. Theories about concrete and abstract words may help explain why certain items and domains of the DEMO, particularly the Unreality domain, performed so poorly. Some items aimed to measure highly abstract ideas with few links to clear, sensory experiences, placing them at the very abstract, "inner experience" end of the continuum described by Troche et al. (2017), where abstract concepts suffer from reduced contextual support (Troche et al., 2017; Schwanenflugel et al., 1988). In this context, understanding depends heavily on people's existing associative and emotional links, which are shaped by language, cultural and personal experiences (Conrad, 2011). For the participants in this study,

vague phrases such as “parallel world” or “unreal” appeared to activate meanings unrelated to the intended dissociative sense of unreality. The items were presented as decontextualised statements, translated into Persian with limited scaffolding. Under these conditions, participants had to construct their own contextual understanding, which frequently led to concrete, religious or existential interpretations that diverged from the intended unreality meaning. This pattern fits with theories that stress the role of context and association for abstract concepts (Troche et al., 2017), and underlines how vulnerable cross-cultural adaptations are when they rely on very abstract, weakly contextualised items to capture complex clinical experiences. These interpretive understandings are also unlikely to be random; rather, they may reflect culturally influenced “idioms of distress”, which shaped how participants understood and responded to the DEMO items (Nichter, 2010). A clear strength of the DEMO in UK context is the involvement of people with lived experience in the co-production of items. Whilst this strengthens its use with English-speaking participants and native speakers in UK settings, it may also privilege idioms that become harder to translate and may not meet semantic and conceptual equivalence.

Across interviews, participants’ interpretations drew on culturally situated idioms to make sense of dissociative experiences, particularly within the Unreality domain. Rather than viewing these items as subjective experiences of unreality as defined by Cernis et al. (2018), participants frequently filtered them through religious, political, moral, scientific and social frameworks). For example, “parallel world” was interpreted through the scientific concept of the multiverse, while descriptions of the world as “a joke” or “not real” were linked to the socio-political unfairness of the world or state violence in Iran. Furthermore, the “external world” was often framed through religious concepts, such as being referred to as “another world from this one” or as the afterlife. A participant noted that this question might only resonate with religious people. Others understood some of the unreality items as implying hallucinations or severe mental illness. These findings echo broader work on idioms of distress, which emphasises that people express and understand suffering using culturally patterned metaphors and narratives rather than purely diagnostic language (Nichter, 2010). In this study, translated items that lack specificity may be assimilated into more familiar explanatory frameworks by participants (e.g. “people are fake”, “this world is unfair”) that diverge from the intended construct of dissociative unreality. Following Nichter (2010), this paper understands idioms of distress not as diagnostic categories but as socially and culturally mediated ways of experiencing, communicating and articulating distress that take shape through metaphors, narratives and meanings in context.

A similar pattern was observed for items describing feeling nothing, the mind being “blank” or “empty”, or a more general absence of experience. Participants often treated these items as broad, vague and non-specific, noting that they could apply to different meanings, such as physical sensations, social relationships, mood or physical energy. In this context, items that lacked somatic or concrete relevance and instead relied on very general internal statements (e.g. “I do not seem to feel anything at all”) were experienced as “vague” or “meaningless”. In contrast, the Vivid Internal World domain performed much better across participants as statements seemed more concrete and described an experience. The need for more concrete references and examples suggested by participants is consistent with cross-cultural work showing that distress is often articulated in more embodied, situationally grounded ways in many migrant and global majority groups (Lanzara et al., 2019). Participants drew on their own language to pin down the meaning, contrasting the translated wording with alternative terms they deemed more specific and suitable, and using metaphors to explain both the constructs and their misunderstandings. Taken together, these comments suggest that, in the absence of concrete or somatised meaning, participants fill in the gaps using their own interpretations, leading to multiple plausible interpretations. In this study, these interpretations often did not match the intended construct, which raises serious questions about the validity of the translated measure for this population.

The findings of the present study contrast notably with those reported by Hosseini et al. (2025), who found good psychometric properties and validity of the Persian DEMO in a general Iranian population sample. These divergent results likely reflect substantial methodological and contextual differences between the two studies. Hosseini et al. (2025) adopted a quantitative approach using CFA with a large non-clinical sample. In contrast, the present study used an in-depth qualitative cognitive interviewing design with a small clinical sample. While Hosseini et al.'s (2025) adapting findings suggest satisfactory statistical performance of their version of a Persian DEMO at a population level, the current qualitative results reveal that several items are semantically, conceptually and culturally problematic for Persian-speaking refugees when used in clinical settings. Following completion of the present study, our Persian-speaking collaborator also compared the version of the DEMO used here with the Hosseini adaptation and noted significant discrepancies between the two, particularly in items describing unreality, which appeared to diverge markedly from the intended constructs in the original English measure. These differences highlight how contested and complex the adaptation of dissociation measures can be: translating and back-translating a questionnaire is not sufficient to ensure conceptual equivalence. Rather, there is

a need for further work conducted within the Iranian context that explores the phenomenological experience of dissociation from the perspective of Persian speakers themselves. Hearing people's own descriptions of dissociative experiences may provide a stronger empirical and cultural foundation for developing a culturally valid Iranian version of the DEMO or an alternative Persian measure that more accurately reflects local understandings and expressions of dissociation. This reflects a broader body of research suggesting that dissociative experiences cannot be universally defined without first exploring how a specific culture constructs selfhood (Şar, 2022; Seligman & Kirmayer, 2008). For example, while Western psychological frameworks often view the self through an independent and autonomous lens, many non-Western societies conceptualise the self as "relational, multiple, and context-dependent" (Hassen, 2026). Consequently, understanding how Persian populations navigate these constructs is crucial. Such a focus may clarify why 'unreality' items which rely on a specific Western boundary of the self and how it relates to the world and others proved difficult for participants to interpret. This highlights the need of aligning clinical measures with local ontological and phenomenological understandings of reality, depersonalisation/derealisation and identity.

From a measurement perspective, this raises questions about whether the Persian DEMO versions, particularly the Unreality, Numb and Disconnected and Memory Blanks domains, currently differentiates adequately between dissociative phenomena, religious concepts and other forms of distress, such as existential despair, social disconnection, and attentional or memory lapses. Our descriptive CI findings therefore suggest that future cross-cultural adaptation work may need to attend not only to semantic equivalence at the word or phrase level, but also to the ways in which items intersect with local idioms of distress and participants' experiences. This is further exemplified by the breadth of phenomena that are included in dissociative measures, including the DEMO, as these measures often operate to assess dissociative symptoms across a continuum of severity and not everyone will experience all these symptoms. The DEMO was designed to reflect "the broad range of experiences" associated with dissociation, with the involvement of SUs. This is particularly important in a field where there is no clear consensus on a single definition of dissociation and where its boundaries remain contested (Cernis et al., 2018). However, the DEMO domains differ in some respects from structured diagnostic interviews such as the SCID-D, which assesses depersonalisation and derealisation, dissociative amnesia, identity confusion, and identity alteration (Krause-Utz, 2025). In contrast, the DEMO does not include explicit categories for identity alteration or identity confusion. However, this may reflect differences in purpose.

Instruments such as the SCID-D are diagnostically oriented and are mapped onto DSM-5 criteria to identify specific dissociative disorders. Ultimately, these measures serve distinct clinical and psychometric functions as one aim to capture the breadth of dissociative experience, whereas the other is designed to identify specific psychopathology. This comparison demonstrates the broader diversity in how dissociation is conceptualised and operationalised within the field.

Current literature conceptualises dissociation as a transdiagnostic phenomenon prevalent across a multitude of disorders, yet its precise definition remains a subject of ongoing debate (Cernis et al., 2021). This lack of consensus is reflected in the absence of NICE guidance for dissociative disorders, suggesting these phenomena remain clinically under-recognised (Loewenstein, 2018), an issue that also extends to cross-cultural understandings of dissociation. Although the core clinical symptoms of dissociation (amnesia, depersonalisation, derealisation, identity confusion and identity alteration) remain consistent across diverse cultures, they are interpreted through various definitions; with how they are expressed and conceptualised are often shaped by an individual's specific cultural, social and religious contexts (Sar, 2022). For example, in many global majority cultures, "identity shifts" may be understood as trance states, ancestral communication, or spirit possession, whereas in western societies, these are often pathologised as "alters" (Hassen, 2026). Other cross-cultural dissociative presentations may include somatic symptoms (Hassen, 2026), as evidenced by the current research where more concrete items of the DEMOp representing somatic experiences or the presence of an experience were easier to understand.

The phenomenology of dissociation is highly heterogeneous, not only across cultures but also between individuals within the same cultural group, which makes their dissociative needs and ways they experience dissociative experiences to differ (Hassen, 2026). While participants in this study shared an Iranian linguistic background, there were items that were interpreted differently both in comparison to how the measure intended and both within their own understandings. This suggests that cultural background is not the only predictor of how people understand these phenomena. Instead, an intersectional lens is required to understand how individual life histories, degrees of acculturation, how a person is positioned in society, and exposure to systems of power may shape personal phenomenologies of dissociation and different types of "internal fragmentation" or coping strategies (Hassen, 2026). For example, UK-based racialised populations may experience their heritage and dissociative distress in ways that differ markedly from populations in their country of origin (Hassen, 2026). Further,

although cultural understandings shape these concepts, what is viewed as pathological in the western world may be understood as meaningful in non-western cultures (Seligman & Kirmayer, 2008), yet even within cultures one person might experience dissociation through physical symptoms, while another in the same community might experience it as "spirit possession" (Sar, 2022).

This study also has implications for translation procedures. Although the study followed gold-standard guidelines for adapting the DEMO from English into Persian, it did not include an expert review panel, and a number of translation issues were still identified. The evidence from this study suggests that cross-cultural adaptations of abstract constructs such as dissociation requires involving bilingual translators and experts who are familiar with both the clinical concepts and the lived experiences of the target population. In line with cross-cultural survey methodology, the cognitive interviews revealed differences in naturalness of language, where items that were semantically accurate to the English source did not sound idiomatic in Persian (Miller et al., 2014). In some cases, the structure or expressions of the source items appeared to have been followed too closely, making the questions sound like translations rather than natural Persian sentences and shaping how participants interpreted them.

Consistent with previous cognitive interviewing research, this study also identified problems that would not have been visible from the questionnaire alone (Andersen et al., 2014; Miller et al., 2014). Participants sometimes reported that an item was "easy" or "clear" and selected a response, but when asked to explain the item in their own words, their interpretations diverged markedly from the intended dissociation constructs. This pattern underlines the importance of respondent-based pre-testing for translated instruments, as self-reported understanding and psychometric performance can mask substantial problems in how items are actually comprehended (Knekta et al., 2019; Willis, 2015a).

It is important to note that the data generated in this study were shaped by a three-way, co-constructed process involving participant-researcher, participant-interpreter and interpreter-researcher interactions. From a constructionist view (Charmaz, 2016), these findings are understood as co-produced interacting layers rather than being simply captured by the questionnaire as a neutral tool. First, participants interacted with the questionnaire, interpreting item wording as they tried to understand and interact with items based on their lived experiences. Second, participants' meanings were negotiated with interpreters, who queried terms that "did not exist" in Persian, suggested alternatives and occasionally commented that the text read like a literal, "Google-style" translation, highlighting translation

as an active process of meaning-making rather than a neutral technical step. Third, participants interacted with the researcher, whose prompts, clarifications and clinical lens on dissociation shaped which interpretations were elaborated, which were taken up as relevant and how they were ultimately written into the analysis. In this sense, the questionnaire, participants, interpreters and researcher all participated in co-producing meanings of how the items were understood and how these items were culturally and contextually situated, rather than revealing a single, underlying construct. These findings underline the importance of co-production with Persian-speaking clinicians, interpreters and people with lived experience to ensure that measures are ecologically valid and that their underlying conceptualisations are acceptable to insiders from different viewpoints. They also lay the groundwork for reparative phase of item revision, which may contribute to the development of culturally valid Persian dissociation measure for clinical samples.

Strengths and Limitations

A key strength of this study is that CI was conducted with the people most likely to encounter the DEMO in routine trauma services: Iranian participants with a refugee background referred to UK psychological services. Their perspectives shaped judgements about item functioning, in contrast to adaptations tested in student or general population samples (Hosseini et al., 2025; Ng & Chan, 2023). CI with monolingual Persian-speaking participants, supported by bilingual interpreters and a bilingual Iranian colleague, provided detailed information into how items sounded and worked in practice. However, although gold-standard guidance was followed, a formal expert review panel was not used, and several translation problems were only identified during CI. Evidence suggests that combining expert review with respondent-based methods is most effective for item development and adaptation (Susanto et al., 2023). Future adaptation work on the Persian DEMO should therefore include a structured expert panel alongside further rounds of CI to refine problematic items.

The sample was small and drawn from a specific group of participants. In line with informational power (Malterud et al., 2015), the intensive, item-by-item focus and consistent patterns across interviews support the dataset's value for the study aims, particularly given the specificity of the sample and the insights into this group's perceptions of dissociative experiences. However, important perspectives are likely missing, including other genders and people with different migration journeys or service contexts and the findings cannot be assumed generalise to all Persian-speaking groups or Iranian communities elsewhere.

Information on trauma exposures, education and socio-economic circumstances was not collected, limiting interpretation of item performance across subgroups.

A significant limitation is that the lead interviewer (VS) was a non-Persian speaker, and all interviews were conducted via interpreters. Interpreters were both necessary and enabling, allowing participation from individuals who would otherwise be excluded from English-only research and ensuring clinically relevant perspectives from the target population. Interpreter-mediated interviews introduce an additional layer of co-construction, particularly when interpreters share cultural membership with participants. Despite briefing interpreters about the study aims and CI, and discussing unclear phrases before and after interviews, it was not always possible to determine precisely why an item lacked clarity or comprehension in Persian, and some nuances were likely lost or transformed. The study also benefited from collaboration and rapport. VS worked closely with a bilingual Iranian colleague and held an ambivalent insider/outsider position as an ethnic minority immigrant to the UK who shared some cultural similarities and bilingualism, particularly accent. Participants and interpreters sometimes perceived her as being from a similar region, which appeared to support trust and openness. However, this did not remove the power imbalance or fully offset the limitations of CI through interpreter.

Finally, the study did not include a reparative phase of item revision or quantitative psychometric evaluation. The findings offer item-level insights into content and face validity in a small clinical sample rather than definitive evidence about the DEMO's psychometric properties. Further research is needed to revise problematic items and examine reliability and validity in larger and more diverse Persian-speaking populations. A strength of the present study is that it captured how participants actually interacted with DEMO items, providing in-depth qualitative data on understandings and misunderstandings and contextualising dissociative items through participants' own meaning-making.

Practical and research Implications

Although item-level "repair" decisions were beyond this study's scope, the pattern of problems identified has clear implications for clinicians and interpreters using the DEMO in routine care. Given difficulties with comprehension, clarity and semantic equivalence, DEMO scores should not be treated as straightforward indicators of dissociation for Iranian participants with a refugee background. Instead, the DEMO may be better used as a

structured prompt for collaborative discussion rather than a stand-alone screening or severity tool.

In practice, this involves asking for concrete examples of endorsed items, exploring how individuals understand phrases such as “mind is blank” or “the world feels unreal”, and explicitly distinguishing dissociative experiences from other forms of distress. Attending to how unreality may be linked to state violence, unfairness or afterlife beliefs may help clinicians avoid over-pathologising culturally shaped experiences (Lanzara et al., 2018) or misdiagnosing dissociation.

A practical step would be to develop, alongside interpreters and Persian-speaking clinicians, a brief guidance sheet to accompany the DEMO for Persian-speaking clients. This could clarify the intended construct behind key problematic items (e.g. “unreal”, “parallel world”, “mind blank/empty”) and suggest alternative Persian phrasings that preserve that construct. Such a shared resource could support more consistent interpreting and clinical use across services and be adapted for other language groups as similar work develops.

Participants’ broader reflections also suggest that questionnaires alone can feel insufficient or frustrating when not embedded in meaningful, problem-oriented conversations. This underlines the importance of explaining why the DEMO is being used, how responses will inform care, and what follow-up will involve. Rather than simply handing over a questionnaire, clinicians may need to frame the DEMO as one tool within a broader, collaborative assessment process that makes space for the person’s priorities and links responses to concrete, context-sensitive support.

Finally, future work should co-produce revisions with Persian-speaking clinicians, interpreters and people with lived experience to ensure ecological validity and cultural relevance. Research conducted within an Iranian context could explore the phenomenological experience of dissociation from the perspectives of Persian speakers and SU, developing a culturally relevant measure from the bottom up rather than adapting a questionnaire developed within a Western framework.

Conclusions

This study used cognitive interviewing to examine the face and content validity of the DEMOp with Iranian refugees in the UK and identified substantial problems, particularly in the Unreality and Memory Blanks domains, with more mixed but still concerning performance in some Numb and Disconnected items. These findings show that gold-standard forward-backward translation alone is not enough for adapting dissociation measures for this population; cognitive interviewing is needed to identify item-level problems and to support ongoing revision of items in collaboration with bilingual clinicians, researchers and communities so that measures are both linguistically and conceptually appropriate in multicultural settings. In addition, this exploration shows that the validity of a translated dissociation measure cannot be reduced to linguistic accuracy or statistical fit as it highly depends on how people from non-English-speaking backgrounds actively make sense of and interact with its items. These findings underline the need for co-produced, bottom-up adaptation and potentially the development of new, culturally grounded measures that emerge from Persian-speaking communities themselves, rather than relying solely on the secondary translation of tools developed in Western and/or English-speaking contexts.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.
- Andersen, R. D., Jylli, L., & Ambuel, B. (2014). Cultural adaptation of patient and observational outcome measures: a methodological example using the COMFORT behavioral rating scale. *Int J Nurs Stud*, 51(6), 934-942. <https://doi.org/10.1016/j.ijnurstu.2013.10.006>
- Arafat, S. M., Chowdhury, H., Qusar, M. M. A., & Hafez, M. A. (2016). Cross cultural adaptation and psychometric validation of research instruments: A methodological review. *Journal of Behavioral Health*, 5(3). <https://doi.org/10.5455/jbh.20160615121755>
- Bae, H., Kim, D., & Park, Y. C. (2016). Dissociation predicts treatment response in eye-movement desensitization and reprocessing for posttraumatic stress disorder. *Journal of Trauma & Dissociation*, 17(1), 112–130. <https://doi.org/10.1080/15299732.2015.1037039>

- Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociative scale. *The Journal of Nervous and Mental Disease*, 174(12), 727–735. <https://doi.org/10.1097/00005053-198612000-00004>
- Bjork Bramberg, E., & Dahlberg, K. (2013). Interpreters in cross-cultural interviews: A three-way construction of data. *Qualitative Health Research*, 23(2), 241–247. <https://doi.org/10.1177/1049732312467705>
- Boyer, S. M., Caplan, J. E., & Edwards, L. K. (2022). Trauma-related dissociation and the dissociative disorders: Neglected symptoms with severe public health consequences. *Delaware Journal of Public Health*, 8(2), 78–84. <https://doi.org/10.32481/djph.2022.05.010>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, 13(2), 201–216. <https://doi.org/10.1080/2159676X.2019.1704846>
- Briere, J., Weathers, F. W., & Runtz, M. (2005). Is dissociation a multidimensional construct? Data from the Multiscale Dissociation Inventory. *Journal of Traumatic Stress*, 18(3), 221–231. <https://doi.org/10.1002/jts.20024>
- British Psychological Society. (2017). *Working with interpreters: Guidelines for psychologists*. <https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Working%20with%20interpreters%20-%20guidelines%20for%20psychologists.pdf>
- Brosnan, K., Grün, B., & Dolnicar, S. (2021). Cognitive load reduction strategies in questionnaire design. *International Journal of Market Research*, 63(2), 125–133. <https://doi.org/10.1177/1470785320986797>
- Bukamal, H. (2022), Deconstructing insider–outsider researcher positionality. *British Journal of Special Education*, 49: 327–349. <https://doi.org/10.1111/1467-8578.12426>
- Carlson, E. B., & Putnam, F. W. (1993). An update on the Dissociative Experiences Scale. *Dissociation*, 6(1), 16–27.
- Carlson, E. B., Waelde, L. C., Palmieri, P. A., Macia, K. S., Smith, S. R., & McDade-Montez, E. (2018). Development and validation of the Dissociative Symptoms Scale. *Assessment*, 25(1), 84–98. <https://doi.org/10.1177/1073191116645904>

- Černis, E., Evans, R., Ehlers, A., & Freeman, D. (2021). Dissociation in relation to other mental health conditions: An exploration using network analysis. *Journal of Psychiatric Research*, *136*, 460–467. <https://doi.org/10.1016/j.jpsychires.2020.08.023>
- Černis, E., Cooper, M., & Chan, C. (2018). Developing a new measure of dissociation: The Dissociative Experiences Measure, Oxford (DEMO). *Psychiatry Research*, *269*, 229–236. <https://doi.org/10.1016/j.psychres.2018.08.060>
- Charmaz, K. (2016). The Power of Constructivist Grounded Theory for Critical Inquiry. *Qualitative Inquiry*, *23*(1), 34-45. <https://doi.org/10.1177/1077800416657105> (Original work published 2017)
- Collins, D. (2015). *Cognitive interviewing practice*. <https://doi.org/10.4135/9781473910102>
- Connell, J., Carlton, J., Grundy, A., Taylor Buck, E., Keetharuth, A. D., Ricketts, T., Barkham, M., Robotham, D., Rose, D., & Brazier, J. (2018). The importance of content and face validity in instrument development: Lessons learnt from service users when developing the Recovering Quality of Life measure (ReQoL). *Quality of Life Research*, *27*(7), 1893–1902. <https://doi.org/10.1007/s11136-018-1847-y>
- Conrad, F. G. (2011). Response 2 to Miller's Chapter: Cognitive Interviewing. In *Question Evaluation Methods* (pp. 93-102). <https://doi.org/https://doi.org/10.1002/9781118037003.ch7>
- Cruchinho, P., López-Franco, M. D., Capelas, M. L., Almeida, S., Bennett, P. M., Miranda da Silva, M., Teixeira, G., Nunes, E., Lucas, P., & Gaspar, F. (2024). Translation, Cross-Cultural Adaptation, and Validation of Measurement Instruments: A Practical Guideline for Novice Researchers. *J Multidiscip Healthc*, *17*, 2701-2728. <https://doi.org/10.2147/jmdh.S419714>
- Egger-Rainer A. (2019). Enhancing validity through cognitive interviewing. A methodological example using the Epilepsy Monitoring Unit Comfort Questionnaire. *Journal of advanced nursing*, *75*(1), 224–233. <https://doi.org/10.1111/jan.13867>
- Egger-Rainer, A. (2019). Enhancing validity through cognitive interviewing. A methodological example using the Epilepsy Monitoring Unit Comfort Questionnaire. *J Adv Nurs*, *75*(1), 224-233. <https://doi.org/10.1111/jan.13867>

- Ellickson-Larew, S., Stasik-O'Brien, S. M., Stanton, K., & Watson, D. (2020). Dissociation as a multidimensional transdiagnostic symptom. *Psychology of Consciousness: Theory, Research, and Practice*, 7(2), 126–150. <https://doi.org/10.1037/cns0000218>
- Ghannam, R. T., & Thabet, A. (2014). Effect of trauma due to war on dissociative symptoms and resilience among Palestinian adolescents in the Gaza Strip [doi:10.12816/0006760]. Arab Federation of Psychiatrists.
- Gušić, S., Cardeña, E., Bengtsson, H., & Søndergaard, H. P. (2017). Dissociative experiences and trauma exposure among newly arrived and settled young war refugees. *Journal of Aggression, Maltreatment & Trauma*, 26(10), 1132–1149. <https://doi.org/10.1080/10926771.2017.1365792>
- Gušić, S., Malešević, A., Cardeña, E., Bengtsson, H., & Søndergaard, H. P. (2018). “I feel like I do not exist”: A study of dissociative experiences among war-traumatized refugee youth. *Psychological Trauma: Theory, Research, Practice, and Policy*, 10(5), 542–550. <https://doi.org/10.1037/tra0000348>
- Harder, T. (2014). Some notes on critical appraisal of prevalence studies: Comment on “The development of a critical appraisal tool for use in systematic reviews addressing questions of prevalence.” *International Journal of Health Policy and Management*, 3(5), 289–290. <https://doi.org/10.15171/ijhpm.2014.99>
- Harper Shehadeh, M., Heim, E., Chowdhary, N., Maercker, A., & Albanese, E. (2016). Cultural adaptation of minimally guided interventions for common mental disorders: A systematic review and meta-analysis. *JMIR Mental Health*, 3(3), e44. <https://doi.org/10.2196/mental.5776>
- Hassen, K. (2026). Cross-cultural considerations and culturally informed practice with trauma-related dissociation. In H. Crockford, M. Goodwin, & P. Langthorne (Eds.), *Working with dissociation in clinical practice: Guidance for mental health professionals and multi-disciplinary teams* (pp. 306–322). Routledge. <https://doi.org/10.4324/9781003625650-19>
- Heim, E., & Kohrt, B. A. (2019). Cultural adaptation of scalable psychological interventions: A new conceptual framework. *Clinical Psychology in Europe*, 1(4), 1–22. <https://doi.org/10.32872/cpe.v1i4.37679>
- Hlavac, J. (2017). *Mental health interpreting guidelines for interpreters*. Monash University.

- Hosseini, S. R., Maghsoudi, S., Firoozabadi, A., Ghanbari, N., & Shamsaei, M. (2025). Psychometric properties of the Iranian version of the dissociative experiences measure, Oxford (DEMO). *BMC Psychiatry*, 25(1), 8. <https://doi.org/10.1186/s12888-024-06399-3>
- Jia, M., Lu, H., Olutoye, F., Li, J., Huang, S., & Zhou, H. (2022). Translation and cross-cultural adaptation of Post-Stroke Checklist into Mandarin: A cognitive interview study. *Neuropsychiatric Disease and Treatment*, 18, 87–95. <https://doi.org/10.2147/NDT.S342464>
- Jowett, S., Argyriou, A., Scherrer, O., Karatzias, T., & Katona, C. (2021). Complex post-traumatic stress disorder in asylum seekers and victims of trafficking: Treatment considerations. *BJPsych Open*, 7(6), e181. <https://doi.org/10.1192/bjo.2021.1007>
- Kaushik, V., & Walsh, C. A. (2019). Pragmatism as a Research Paradigm and Its Implications for Social Work Research. *Social Sciences*, 8(9), 255. <https://doi.org/10.3390/socsci8090255>
- Kennedy, F., Clarke, S., Stopa, L., Bell, L., Rouse, H., Ainsworth, C., Fearon, P., & Waller, G. (2004). Towards a cognitive model and measure of dissociation. *Journal of Behavior Therapy and Experimental Psychiatry*, 35(1), 25–48. <https://doi.org/10.1016/j.jbtep.2004.01.002>
- Knafl, K., Deatrick, J., Gallo, A., Holcombe, G., Bakitas, M., Dixon, J., & Grey, M. (2007). The analysis and interpretation of cognitive interviews for instrument development. *Res Nurs Health*, 30(2), 224-234. <https://doi.org/10.1002/nur.20195>
- Knekta, E., Runyon, C., & Eddy, S. (2019). One size doesn't fit all: Using factor analysis to gather validity evidence when using surveys in your research. *CBE—Life Sciences Education*, 18(1), rm1. <https://doi.org/10.1187/cbe.18-04-0064>
- Krause-Utz, A. (2025). Assessment of Dissociation and Diagnostic Process. In: *Dissociation in Borderline Personality Disorder*. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-032-06339-7_3
- Lanzara, R., Scipioni, M., & Conti, C. (2018). A clinical-psychological perspective on somatization among immigrants: A systematic review. *Frontiers in Psychology*, 9, 2792. <https://doi.org/10.3389/fpsyg.2018.02792>
- Longden, E., Branitsky, A., Moskowitz, A., Berry, K., Bucci, S., & Varese, F. (2020). The relationship between dissociation and symptoms of psychosis: A meta-analysis. *Schizophrenia Bulletin*, 46(5), 1104–1113. <https://doi.org/10.1093/schbul/sbaa037>

- Lynn, S. J., Maxwell, R., Merckelbach, H., Lilienfeld, S. O., van der Kloet, D., & Miskovic, V. (2019). Dissociation and its disorders: Competing models, future directions, and a way forward. *Clinical Psychology Review, 73*, 101755. <https://doi.org/10.1016/j.cpr.2019.101755>
- Lyssenko, L., Schmahl, C., Bockhacker, L., Vonderlin, R., Bohus, M., & Kleindienst, N. (2018). Dissociation in psychiatric disorders: A meta-analysis of studies using the Dissociative Experiences Scale. *American Journal of Psychiatry, 175*(1), 37–46. <https://doi.org/10.1176/appi.ajp.2017.17010025>
- Malterud, K., Siersma, V. D., & Guassora, A. D. (2015). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753–1760. <https://doi.org/10.1177/1049732315617444>
- Miller, K. (E.), Willson, S., Chepp, V., & Padilla García, J. L. (2014). *Cognitive interviewing methodology* (pp. 1–185). <https://doi.org/10.1002/9781118838860>
- Miller, K. E. (2004). Beyond the frontstage: Trust, access, and the relational context in research with refugee communities. *American Journal of Community Psychology, 33*(3–4), 217–227. <https://doi.org/10.1023/B:AJCP.0000027007.14063.ad>
- Mohd Mahudin, N. D., Cox, T., & Griffiths, A. (2012). Measuring rail passenger crowding: Scale development and psychometric properties. *Transportation Research Part F: Traffic Psychology and Behaviour, 15*(1), 38–51. <https://doi.org/10.1016/j.trf.2011.11.006>
- Morgado, F. F. R., Meireles, J. F. F., Neves, C. M., Amaral, A. C. S., & Ferreira, M. E. C. (2018). Scale development: Ten main limitations and recommendations to improve future research practices. *Psicologia: Reflexão e Crítica, 30*, 3. <https://doi.org/10.1186/s41155-016-0057-1>
- Ng, A. S. Y., & Chan, W. S. (2023). Psychometric evaluation of the Hong Kong Chinese version of the Dissociative Experiences Measure, Oxford (HKC-DEMO). *Journal of Trauma & Dissociation, 24*(3), 321–332. <https://doi.org/10.1080/15299732.2023.2171173>
- Nichter, M. (2010). Idioms of Distress Revisited. *Culture, Medicine, and Psychiatry, 34*(2), 401–416. <https://doi.org/10.1007/s11013-010-9179-6>
- Nijenhuis, E. R. S. (2017). Ten reasons for conceiving and classifying posttraumatic stress disorder as a dissociative disorder. *European Journal of Trauma & Dissociation, 1*(1), 47–61. <https://doi.org/10.1016/j.ejtd.2017.01.001>

- Pan, J.-Y., Wong, D. F. K., & Ye, S. (2013). Post-migration Growth Scale for Chinese international students: Development and validation. *Journal of Happiness Studies*, 14(6), 1639–1655. <https://doi.org/10.1007/s10902-012-9401-z>
- Qouta, S. R., Palosaari, E., Diab, M., & Punamäki, R. L. (2012). Intervention effectiveness among war-affected children: a cluster randomized controlled trial on improving mental health. *J Trauma Stress*, 25(3), 288-298. <https://doi.org/10.1002/jts.21707>
- Refugee Council. (2019). *The truth about asylum*. Refugee Council. <https://www.refugeecouncil.org.uk/information/refugee-asylum-facts/the-truth-about-asylum/>
- Richter, K., Peter, L., Lehfeld, H., Zanke, H., Brar-Reissinger, S., & Niklewski, G. (2018). Prevalence of psychiatric diagnoses in asylum seekers with follow-up. *BMC Psychiatry*, 18, 206. <https://doi.org/10.1186/s12888-018-1783-y>
- Saggino, A., Molinengo, G., Rogier, G., Garofalo, C., Loera, B., Tommasi, M., & Velotti, P. (2020). Improving the psychometric properties of the Dissociative Experiences Scale (DES-II): A Rasch validation study. *BMC Psychiatry*, 20, 8. <https://doi.org/10.1186/s12888-019-2417-8>
- Şar V. (2022). Dissociation Across Cultures: A Transdiagnostic Guide for Clinical Assessment and Management. *Alpha psychiatry*, 23(3), 95–103. <https://doi.org/10.5152/alphapsychiatry.2022.21556>
- Schauer, M., & Elbert, T. (2010). Dissociation following traumatic stress. *Zeitschrift für Psychologie / Journal of Psychology*, 218(2), 109–127. <https://doi.org/10.1027/0044-3409/a000018>
- Schwanenflugel, P. J., Harnishfeger, K. K., & Stowe, R. W. (1988). Context availability and lexical decisions for abstract and concrete words. *Journal of Memory and Language*, 27(5), 499-520. [https://doi.org/https://doi.org/10.1016/0749-596X\(88\)90022-8](https://doi.org/https://doi.org/10.1016/0749-596X(88)90022-8)
- Seligman, R., Kirmayer, L.J. Dissociative Experience and Cultural Neuroscience: Narrative, Metaphor and Mechanism. *Cult Med Psychiatry* 32, 31–64 (2008). <https://doi.org/10.1007/s11013-007-9077-8>
- Sha, M. M., & Pan, Y. (2013). Adapting and Improving Methods to Manage Cognitive Pretesting of Multilingual Survey Instruments. *Survey Practice*, 6(4), 1-8. <https://doi.org/10.29115/sp-2013-0024>

Singh, A., Nemiro, A., Malik, A., Guimond, M. F., Nduwimana, E., Likindikoki, S., ... Tol, W. A. (2021). Cultural adaptation of a scalable psychological intervention for Burundian refugee adolescents in Tanzania: A qualitative study. *Conflict and Health*, 15, 73.

<https://doi.org/10.1186/s13031-021-00391-4>

Spitzer, C., Barnow, S., Freyberger, H. J., & Grabe, H. J. (2007). Dissociation predicts symptom-related treatment outcome in short-term inpatient psychotherapy. *Australian and New Zealand Journal of Psychiatry*, 41(8), 682–687. <https://doi.org/10.1080/00048670701449146>

Susanto, H., Wedyaswari, M., & Dalimunthe, K. L. (2023). A content validity and cognitive interview to develop the HARMONI items: Instrument measuring student well-being in West Java, Indonesia [Original Research]. *FRONTIERS IN EDUCATION*, Volume 8 - 2023.

<https://doi.org/10.3389/feduc.2023.1132031>

Terwee, C. B., Bot, S. D., de Boer, M. R., van der Windt, D. A., Knol, D. L., Dekker, J., Bouter, L. M., & de Vet, H. C. (2007). Quality criteria were proposed for measurement properties of health status questionnaires. *Journal of clinical epidemiology*, 60(1), 34–42.

<https://doi.org/10.1016/j.jclinepi.2006.03.012>

Troche, J., Crutch, S. J., & Reilly, J. (2017). Defining a conceptual topography of word concreteness: Clustering properties of emotion, sensation, and magnitude among 750 English words. *Frontiers in Psychology*, 8, 1787. <https://doi.org/10.3389/fpsyg.2017.01787>

Wand, A. P. F., Pourmand, D., & Draper, B. (2020). Working with interpreters in the psychiatric assessment of older adults from culturally and linguistically diverse backgrounds. *International Psychogeriatrics*, 32(1), 11–16. <https://doi.org/10.1017/S1041610219000280>

Wild, D., Grove, A., Martin, M., Eremenco, S., McElroy, S., Verjee-Lorenz, A., & Erikson, P. (2005). Principles of Good Practice for the Translation and Cultural Adaptation Process for Patient-Reported Outcomes (PRO) Measures: Report of the ISPOR Task Force for Translation and Cultural Adaptation. *Value in Health*, 8(2), 94-104.

<https://doi.org/https://doi.org/10.1111/j.1524-4733.2005.04054.x>

Willis, G. B. (2015a). *Analysis of the cognitive interview in questionnaire design*. Oxford University Press.

Willis, G. B. (2015b). The Practice of Cross-Cultural Cognitive Interviewing. *Public Opinion Quarterly*, 79(S1), 359-395. <https://doi.org/10.1093/poq/nfu092>

Willis, G., & Lessler, J. (1999). *Question Appraisal System QAS-99* By.

Wolf, E. J., Miller, M. W., Reardon, A. F., Ryabchenko, K. A., Castillo, D., & Freund, R. (2012). A latent class analysis of dissociation and posttraumatic stress disorder: Evidence for a dissociative subtype. *Archives of General Psychiatry*, *69*(7), 698–705.

<https://doi.org/10.1001/archgenpsychiatry.2011.1574>

Ziyachi, M., & Castellani, B. (2024). A 'Cultural Models' Approach to Psychotherapy for Refugees and Asylum Seekers: A Case Study from the UK. *International journal of environmental research and public health*, *21*(5), 650. <https://doi.org/10.3390/ijerph21050650>

Appendices

Appendix 1.1: Prisma Checklist



PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	pp.10
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	pp.11
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	pp.13-14
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	pp. 14
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	pp.15-16
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	pp.14 appendices, 152-178
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Appendices, 152-178
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	pp.17, 21- 23
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	pp. 17, 21- 23
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	pp.17, 21- 23
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	pp.17-18
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	pp.18
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	n/a
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	pp.17
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	n/a
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	pp.17-18 figure1, pp23 table 2 pp.27 appendix 1.6, 187



PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	pp. 18-19
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	n/a
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
n/a Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	n/a
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	n/a
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	pp.21—23 Figure 1
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Figure 1 pp. 23
Study characteristics	17	Cite each included study and present its characteristics.	pp.24-27 Table 3
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	pp. 70-72 Table 4
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	Table 3
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	pp.74-88
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	n/a
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	n/a
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	n/a
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.88-90
	23b	Discuss any limitations of the evidence included in the review.	pp.91-93
	23c	Discuss any limitations of the review processes used.	pp.91-93
	23d	Discuss implications of the results for practice, policy, and future research.	pp.94-95
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	pp. 14
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	pp.14



PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	pp.14
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	n/a
Competing interests	26	Declare any competing interests of review authors.	n/a
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	n/a

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ* 2021;[372:n71](https://doi.org/10.1136/bmj.n71). doi: [10.1136/bmj.n71](https://doi.org/10.1136/bmj.n71). This work is licensed under CC BY 4.0. To view a copy of this license, visit <https://creativecommons.org/licenses/by/4.0/>

Appendix 1.2: ENTREQ Checklist

Item No.	Guide and Description	Report Location
1. Aim	State the research question the synthesis addresses	pp. 14
2. Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis)	pp.18-21
3. Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved)	14-15
4. Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type)	pp. 15-17
5. Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, <u>psycINFO</u>), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources	pp. 14-15
6. Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits)	pp. 14-15 appendix 1.3 pp 157
7. Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies)	pp.15, 21-22 fig.1 pp. 23
8. Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions)	pp. 24- 27 Table 1
9. Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development)	Fig 1. pp. 23
10. Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness),	pp. 18

	assessment of reporting (transparency), assessment of content and utility of the findings)	
11. Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting)	pp. 18
12. Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required	pp.18, pp 70-71
13. Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale	Table 4 pp.72 pp. 70-72
14. Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software)	pp. 17-18
15. Software	State the computer software used, if any	pp.17
16. Number of reviewers	Identify who was involved in coding and analysis	pp. 18-19
17. Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts)	pp.19
18. Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary)	pp. 18-19 Appendix 1.6
19. Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive	pp.18-19
20. Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation	pp. 74-88
21. Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct)	pp. 74-91

Appendix 1.3: Search Terms and Search History (Conducted 26th June 2025)

Systematic Review search strategies

Database	Limiters	Search Strategy	Date search ran	Initial results
<p>OID Embase (1947-present, updated daily + 1996 to 2025 week 25)</p>	<p>Small number of results therefore no additional limiters were chosen</p>	<ol style="list-style-type: none"> 1. exp United Kingdom/ 2. (national health service* or nhs*).ti,ab,in. 3. (english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab. 4. (gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in. 5. (bath or "bath's" or (birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not ("new south wales*" or nsw)) or ("liverpool's" not ("new south wales*" or nsw)) or (london not ("ontario*" or ont or toronto*)) or ("london's" not ("ontario*" or ont or toronto*)) or manchester or "manchester's" or (newcastle not ("new south wales*" or nsw)) or ("newcastle's" not ("new south wales*" or nsw)) or norwich or "norwich's" or nottingham or 	<p>26/06/2025</p>	<p>433</p>

Final V 1.

{ PAGE * MERGEFORMAT }

Systematic Review search strategies

		<p>"nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or "st albans" or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))).ti,ab,in.</p> <p>6. (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in.</p> <p>7. (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in.</p> <p>8. (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in.</p> <p>9. or/1-8</p> <p>10. (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp oceania/) not (exp great britain/ or europe/)</p> <p>11. 9 not 10 (UK FILTER)</p> <p>12. exp refugee/ or exp asylum seeker/</p> <p>13. (asylum seeker* or refugee* or forced migrant* or displaced persons).ti. or (asylum seeker* or refugee* or</p>	
--	--	---	--

Systematic Review search strategies

		<p>forced migrant* or displaced persons).ab. or (asylum seeker* or refugee* or forced migrant* or displaced persons).kw. 14. (force? adj2 (migrat* or immigrat* or emigrat*)).ti,ab,kw. 15. (displac* adj1 (forced or mass or person* or people* or population*)).ti,ab,kw. 16. 12 or 13 or 14 or 15 (ASR FILTER) 17. exp mental health service/ 18. exp community mental health service/ 19. exp psychosocial rehabilitation/ 20. exp therapy/ 21. exp school mental health service/ 22. exp mental health care/ 23. (Community Mental Health Service* or Therapeutic* or Mental Health Service* or School Mental Health Service* or Psychiatric Rehabilitation or Psychological Therap* or Counsel?ing).ti. or (Community Mental Health Service* or Therapeutic* or Mental Health Service* or School Mental Health Service* or Psychiatric Rehabilitation or Psychological Therap* or Counsel?ing).ab. or (Community Mental Health Service* or Therapeutic* or Mental Health Service* or School Mental Health Service* or Psychiatric Rehabilitation or Psychological Therap* or Counsel?ing).kw. 24. ("Improving Access to Psychological Therapies" or IAPT or Therap* or psychiatry or clinical psychology or "psychological therap*" or "psychological treatment*" or counselling or psychotherapy or "behaviour* therap*" or "behaviour* modification" or "social skills training" or "behaviour contracting" or "activity scheduling" or "exposure therap*" or psychoeducation or CBT or "rational emotive therap*" or "acceptance and commitment therap*" or mindfulness or "meta-cognitive therap*" or compassion-focused or "narrative therap*" or "narrative exposure</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>therap*" or "psychodynamic therap*" or "insight-orientated therap*" or "psychoanalytic therap*" or "humanistic therap*" or "existential therap*" or "expressive therap*" or "supportive therap*" or "non-directive therap*" or "integrative therap*" or "motivational interviewing" or "interpersonal therap*" or "eclectic therap*" or transtheoretical or "systemic therap*" or "psychologically orientated intervention*" or "art therap*" or bibliotherap* or "colour therap*" or "music therap*" or psychodrama).ti. or ("Improving Access to Psychological Therapies" or IAPT or Therap* or psychiatry or clinical psychology or "psychological therap*" or "psychological treatment*" or counselling or psychotherapy or "behaviour* therap*" or "behaviour* modification" or "social skills training" or "behaviour contracting" or "activity scheduling" or "exposure therap*" or psychoeducation or CBT or "rational emotive therap*" or "acceptance and commitment therap*" or mindfulness or "meta-cognitive therap*" or compassion-focused or "narrative therap*" or "narrative exposure therap*" or "psychodynamic therap*" or "insight-orientated therap*" or "psychoanalytic therap*" or "humanistic therap*" or "existential therap*" or "expressive therap*" or "supportive therap*" or "non-directive therap*" or "integrative therap*" or "motivational interviewing" or "interpersonal therap*" or "eclectic therap*" or transtheoretical or "systemic therap*" or "psychologically orientated intervention*" or "art therap*" or bibliotherap* or "colour therap*" or "music therap*" or psychodrama).ab. or ("Improving Access to Psychological Therapies" or IAPT or Therap* or psychiatry or clinical psychology or "psychological therap*" or "psychological treatment*" or counselling or psychotherapy or "behaviour* therap*" or "behaviour* modification" or "social skills training" or "behaviour contracting" or "activity scheduling"</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>or "exposure therap*" or psychoeducation or CBT or "rational emotive therap*" or "acceptance and commitment therap*" or mindfulness or "meta-cognitive therap*" or compassion-focused or "narrative therap*" or "narrative exposure therap*" or "psychodynamic therap*" or "insight-orientated therap*" or "psychoanalytic therap*" or "humanistic therap*" or "existential therap*" or "expressive therap*" or "supportive therap*" or "non-directive therap*" or "integrative therap*" or "motivational interviewing" or "interpersonal therap*" or "eclectic therap*" or transtheoretical or "systemic therap*" or "psychologically orientated intervention*" or "art therap*" or bibliotherap* or "colour therap*" or "music therap*" or psychodrama).kw.</p> <p>25. 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 (MH SERVICE FILTER)</p> <p>26. qualitative stud\$.mp.</p> <p>27. nursing methodology research.mp.</p> <p>28. questionnaire/</p> <p>29. attitude/</p> <p>30. focus group\$.mp.</p> <p>31. discourse analysis.mp.</p> <p>32. content analysis.mp.</p> <p>33. ethnographic research.mp.</p> <p>34. ethnological research.mp.</p> <p>35. ethnonursing research.mp.</p> <p>36. constant comparative method.mp.</p> <p>37. qualitative validity.mp.</p> <p>38. purposive sample.mp.</p> <p>39. observational method\$.mp.</p> <p>40. field stud\$.mp.</p> <p>41. theoretical sampl\$.mp.</p> <p>42. phenomenology/</p> <p>43. phenomenological research.mp.</p>		
--	--	---	--	--

Systematic Review search strategies

		<p>44. life experience\$.mp. 45. cluster sampl\$.mp. 46. or/26-45 47. ethnnonursing.af. 48. ethnograph\$.mp. 49. phenomenol\$.af. 50. grounded theory.mp. 51. (grounded adj (theor\$ or study or studies or research or analys?s)).af. 52. (emic or etic or hermeneutic\$ or heuristic\$ or semiotic\$).af. or (data adj1 saturat\$).tw. or participant observ\$.tw. 53. (social construct\$ or postmodern\$ or post-modern\$ or post structural\$ or post-structural\$ or poststructural\$ or post-structural\$ or interpret\$).mp. 54. (action research or cooperative inquir\$ or co operative inquir\$ or co-operative inquir\$).mp. 55. (humanistic or existential or experiential or paradigm\$).mp. 56. (field adj3 (study or studies or research)).tw. 57. human science.tw. 58. qualitative validity.af. 59. (purposive sampl\$ or theoretical sampl\$).af. 60. ((purpos\$ adj4 sampl\$) or (focus adj group\$)).af. 61. (account or accounts or unstructured or open-ended or open ended or text\$ or narrative\$).mp. 62. (life world or life-world or conversation analys?s or personal experience\$ or theoretical saturation).mp. 63. lived experience\$.tw. or life experience\$.mp. or cluster sampl\$.mp. or (theme\$ or thematic).mp. or field stud\$.mp. or focus group\$.af. or questionnaire\$.mp.</p>	
--	--	--	--

Systematic Review search strategies

		<p>64. (content analysis or thematic analysis or constant comparative or discourse analys?s).af. or ((discourse\$ or discours\$) adj3 analys?s).tw. or narrative analys?s.af.</p> <p>65. 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60 or 61 or 62 or 63 or 64</p> <p>66. 46 or 65 (QUAL FILTER)</p> <p>67. 11 and 16 and 25 and 66 (FINAL SET = UK_FILTER AND ASR_FILTER AND MH_SERVICE_FILTER_AND_QUAL_FILTER)</p>		
<p>OVID Medline(r) ALL (1946 to June 25, 2025)</p>	<p>Small number of results therefore no additional limiters were chosen</p>	<p>1. exp United Kingdom/</p> <p>2. (national health service* or nhs*).ti,ab,in.</p> <p>3. (english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab.</p> <p>4. (gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in.</p> <p>5. (bath or "bath's" or (birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not</p>	26/06/2025	888

Systematic Review search strategies

		<p>(carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not ("new south wales*" or nsw)) or ("liverpool's" not ("new south wales*" or nsw)) or (london not ("ontario*" or ont or toronto*)) or ("london's" not ("ontario*" or ont or toronto*)) or manchester or "manchester's" or (newcastle not ("new south wales*" or nsw)) or ("newcastle's" not ("new south wales*" or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or "st albans" or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))).ti,ab,in.</p> <p>6. (bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in.</p> <p>7. (aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in.</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>8. (armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in.</p> <p>9. or/1-8</p> <p>10. (exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp oceania/) not (exp great britain/ or europe/)</p> <p>11. 9 not 10 (UK FILTER LINE)</p> <p>12. exp Refugees/</p> <p>13. (asylum seeker* or refugee* or forced migrant* or displaced persons).ti. or (asylum seeker* or refugee* or forced migrant* or displaced persons).ab. or (asylum seeker* or refugee* or forced migrant* or displaced persons).kw.</p> <p>14. (force? adj2 (migrat* or immigrat* or emigrat*)).ti,ab,kw.</p> <p>15. (displac* adj1 (forced or mass or person* or people* or population*)).ti,ab,kw.</p> <p>16. 12 or 13 or 14 or 15 (ASR FILTER)</p> <p>17. exp Mental Health Services/</p> <p>18. exp Community Mental Health Services/</p> <p>19. exp Psychiatric Rehabilitation/</p> <p>20. exp Therapeutics/</p>		
--	--	---	--	--

Systematic Review search strategies

		<p>21. exp School Mental Health Services/</p> <p>22. (Community Mental Health Service* or Therapeutic* or Mental Health Service* or School Mental Health Service* or Psychiatric Rehabilitation or Psychological Therap* or Counsel?ing).ti. or (Community Mental Health Service* or Therapeutic* or Mental Health Service* or School Mental Health Service* or Psychiatric Rehabilitation or Psychological Therap* or Counsel?ing).ab. or (Community Mental Health Service* or Therapeutic* or Mental Health Service* or School Mental Health Service* or Psychiatric Rehabilitation or Psychological Therap* or Counsel?ing).kw.</p> <p>23. ("Improving Access to Psychological Therapies" or IAPT or Therap* or "mental health" or psychiatry or clinical psychology or "psychological therap*" or "psychological treatment*" or counselling or psychotherapy or "behaviour* therap*" or "behaviour* modification" or "social skills training" or "behaviour contracting" or "activity scheduling" or "exposure therap*" or psychoeducation or CBT or "rational emotive therap*" or "acceptance and commitment therap*" or mindfulness or "meta-cognitive therap*" or compassion-focused or "narrative therap*" or "narrative exposure therap*" or "psychodynamic therap*" or "insight-orientated therap*" or "psychoanalytic therap*" or "humanistic therap*" or "existential therap*" or "expressive therap*" or "supportive therap*" or "non-directive therap*" or "integrative therap*" or "motivational interviewing" or "interpersonal therap*" or "eclectic therap*" or transtheoretical or "systemic therap*" or "psychologically orientated intervention*" or "art therap*" or bibliotherap* or "colour therap*" or "music therap*" or psychodrama).ti. or ("Improving Access to Psychological Therapies" or IAPT or Therap* or "mental health" or psychiatry or clinical psychology or "psychological therap*" or "psychological</p>		
--	--	---	--	--

Systematic Review search strategies

		<p>treatment*" or counselling or psychotherapy or "behaviour* therap*" or "behaviour* modification" or "social skills training" or "behaviour contracting" or "activity scheduling" or "exposure therap*" or psychoeducation or CBT or "rational emotive therap*" or "acceptance and commitment therap*" or mindfulness or "meta-cognitive therap*" or compassion-focused or "narrative therap*" or "narrative exposure therap*" or "psychodynamic therap*" or "insight-orientated therap*" or "psychoanalytic therap*" or "humanistic therap*" or "existential therap*" or "expressive therap*" or "supportive therap*" or "non-directive therap*" or "integrative therap*" or "motivational interviewing" or "interpersonal therap*" or "eclectic therap*" or transtheoretical or "systemic therap*" or "psychologically orientated intervention*" or "art therap*" or bibliotherap* or "colour therap*" or "music therap*" or psychodrama).ab. or ("Improving Access to Psychological Therapies" or IAPT or Therap* or "mental health" or psychiatry or clinical psychology or "psychological therap*" or "psychological treatment*" or counselling or psychotherapy or "behaviour* therap*" or "behaviour* modification" or "social skills training" or "behaviour contracting" or "activity scheduling" or "exposure therap*" or psychoeducation or CBT or "rational emotive therap*" or "acceptance and commitment therap*" or mindfulness or "meta-cognitive therap*" or compassion-focused or "narrative therap*" or "narrative exposure therap*" or "psychodynamic therap*" or "insight-orientated therap*" or "psychoanalytic therap*" or "humanistic therap*" or "existential therap*" or "expressive therap*" or "supportive therap*" or "non-directive therap*" or "integrative therap*" or "motivational interviewing" or "interpersonal therap*" or "eclectic therap*" or transtheoretical or "systemic therap*" or "psychologically orientated intervention*" or "art therap*" or bibliotherap* or "colour therap*" or "music therap*" or psychodrama).kw.</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>24. 17 or 18 or 19 or 20 or 21 or 22 or 23 (MH FILTER)</p> <p>25. 11 and 16 and 24 (FINAL SET = UK_FILTER AND ASR_FILTER AND MH_SERVICE_FILTER)</p>		
<p>EBSCOhost: PsychINFO</p>	<p>Academic Journals</p> <p>English Only</p>	<p>S1 TI (united kingdom or uk or england or great britain or britain or scotland or wales or northern ireland) OR AB (united kingdom or uk or england or great britain or britain or scotland or wales or northern ireland) OR KW (united kingdom or uk or england or great britain or britain or scotland or wales or northern ireland)</p> <p>S2 TI ((national health service* or nhs*)) OR AB ((national health service* or nhs*)) OR AF ((national health service* or nhs*))</p> <p>S3 TI (english NOT ((published OR publication* OR translat* OR written OR language* OR speak* OR literature OR citation*) N5 english)) OR AB (english NOT ((published OR publication* OR translat* OR written OR language* OR speak* OR literature OR citation*) N5 english))</p> <p>S4 TI (gb OR "g.b." OR britain* OR (british* NOT "british columbia") OR uk OR "u.k." OR "united kingdom*" OR (england* NOT "new england") OR "northern ireland*" OR "northern irish*" OR scotland* OR scottish* OR ((wales OR "south wales") NOT "new south wales") OR welsh*) OR AB (gb OR "g.b." OR britain* OR (british* NOT "british columbia") OR uk OR "u.k." OR "united kingdom*" OR (england* NOT "new england") OR "northern ireland*" OR "northern irish*" OR scotland* OR scottish* OR ((wales OR "south wales") NOT "new south wales") OR welsh*) OR KW (gb OR "g.b." OR britain* OR (british* NOT "british columbia") OR uk OR "u.k." OR "united kingdom*" OR (england* NOT "new england") OR "northern ireland*" OR "northern irish*" OR scotland* OR scottish* OR ((wales OR "south wales") NOT "new south wales") OR welsh*)</p>	26/06/2025	975

Systematic Review search strategies

		<p>S5 TI (bath OR "bath's" OR (birmingham NOT alabama*) OR ("birmingham's" NOT alabama*) OR bradford OR brighton OR bristol OR carlisle OR (cambridge NOT (massachusetts* OR boston* OR harvard*)) OR canterbury OR chelmsford OR chester OR chichester OR coventry OR derby OR (durham NOT (carolina* OR nc)) OR ely OR exeter OR gloucester OR hereford OR hull OR lancaster OR leeds* OR leicester OR (lincoln NOT nebraska*) OR (liverpool NOT ("new south wales*" OR nsw)) OR (london NOT ("ontario*" OR toronto*)) OR manchester OR newcastle OR norwich OR nottingham OR oxford OR peterborough OR plymouth OR portsmouth OR preston OR ripon OR salford OR salisbury OR sheffield OR southampton OR "st albans" OR stoke OR sunderland OR truro OR wakefield OR wells OR westminster OR winchester OR wolverhampton OR (worchester NOT (massachusetts* OR boston*)) OR (york NOT ("new york*" OR ny OR ontario* OR toronto*))) OR AB (same terms) OR KW (same terms)</p> <p>S6 TI (bangor OR cardiff OR newport OR "st asaph" OR "st davids" OR swansea) OR AB (bangor OR cardiff OR newport OR "st asaph" OR "st davids" OR swansea) OR KW (bangor OR cardiff OR newport OR "st asaph" OR "st davids" OR swansea)</p> <p>S7 TI (aberdeen OR dundee OR edinburgh OR glasgow OR inverness OR (perth NOT australia*) OR stirling) OR AB (aberdeen OR dundee OR edinburgh OR glasgow OR inverness OR (perth NOT australia*) OR stirling) OR KW (aberdeen OR dundee OR edinburgh OR glasgow OR inverness OR (perth NOT australia*) OR stirling)</p> <p>S8 TI (armagh OR belfast OR lisburn OR londonderry OR derry OR newry) OR AB (armagh OR belfast OR lisburn OR londonderry OR derry OR newry) OR KW (armagh OR belfast OR lisburn OR londonderry OR derry OR newry)</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>S9 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8</p> <p>S10 DE "Refugees" OR DE "Asylum Seeking"</p> <p>S11 TI (asylum seeker* OR refugee* OR forced migrant* OR displaced persons) OR AB (asylum seeker* OR refugee* OR forced migrant* OR displaced persons) OR KW (asylum seeker* OR refugee* OR forced migrant* OR displaced persons)</p> <p>S12 TI (force* N2 (migrat* OR immigrat* OR emigrat*)) OR AB (force* N2 (migrat* OR immigrat* OR emigrat*)) OR KW (force* N2 (migrat* OR immigrat* OR emigrat*))</p> <p>S13 TI (displac* N1 (forced OR mass OR person* OR people* OR population*)) OR AB (displac* N1 (forced OR mass OR person* OR people* OR population*)) OR KW (displac* N1 (forced OR mass OR person* OR people* OR population*))</p> <p>S14 S10 OR S11 OR S12 OR S13 (ASR FILTER)</p> <p>S15 DE "Mental Health Services" OR DE "Mental Health Programs" OR DE "Preventive Mental Health Services" OR DE "Community Mental Health Centers" OR DE "School Based Mental Health Services" OR DE "Community Mental Health Services" OR DE "Mental Health Care Utilization" OR DE "Mental Health Care Access" OR DE "Community Mental Health" OR DE "Public Mental Health" OR DE "Community Psychiatry" OR DE "Community Psychology" OR DE "Treatment Barriers" OR DE "Psychological Assessment"</p> <p>S16 TI ("Community Mental Health Service*" OR "Mental Health Service*" OR "School Mental Health Service*" OR "Psychiatric Rehabilitation" OR "Psychological Therap*" OR "Clinical Psychology" OR IAPT OR Counsel#ing OR Psychotherapy OR "help-seeking" OR</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>"Behaviour* Therap*" OR "Behaviour* Modification" OR "Social Skills Training" OR "Behaviour Contracting" OR "Activity Scheduling" OR "Exposure Therap*" OR Psychoeducation OR CBT OR "Rational Emotive Therap*" OR "Acceptance and Commitment Therap*" OR Mindfulness OR "Meta-Cognitive Therap*" OR "Compassion-Focused" OR "Narrative Therap*" OR "Narrative Exposure Therap*" OR "Psychodynamic Therap*" OR "Insight-Orientated Therap*" OR "Psychoanalytic Therap*" OR "Humanistic Therap*" OR "Existential Therap*" OR "Expressive Therap*" OR "Supportive Therap*" OR "Non-Directive Therap*" OR "Integrative Therap*" OR "Motivational Interviewing" OR "Interpersonal Therap*" OR "Eclectic Therap*" OR Transtheoretical OR "Systemic Therap*" OR "Psychologically Orientated Intervention*" OR "Art Therap*" OR Bibliotherap* OR "Colour Therap*" OR "Music Therap*" OR Psychodrama) OR AB (same terms) OR KW (same terms)</p> <p>S17 S15 OR S16 (MH SERVICE FILTER)</p> <p>S18 TI ("qualitative" OR "ethnograph*" OR "grounded theory" OR "naturalistic*" OR "IPA" OR "phenomenolog*" OR "experience*" OR "perception*" OR "narrative" OR "interview*" OR "content analysis" OR "focus group*" OR "questionnaire*" OR "survey*" OR "thematic analysis") OR AB (same terms) OR KW (same terms)</p> <p>S19 TI (africa OR asia OR india OR pakistan OR china OR japan OR korea OR "latin america" OR brazil OR argentina OR mexico OR chile OR peru OR colombia OR "north america" OR "united states" OR usa OR canada OR california OR texas OR australia OR "new zealand" OR oceania OR antarctica OR "south africa" OR "United States N2" OR "America*") OR AB (same terms) OR KW (same terms)</p> <p>S20 S9 NOT S19 (UK FILTER)</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>S21 DE "Qualitative Methods" OR DE "Interviews"</p> <p>S22 DE "Questionnaires"</p> <p>S23 DE "Attitudes" OR DE "Attitude Change" OR DE "Attitude Formation" OR DE "Attitude Similarity" OR DE "Client Attitudes" OR DE "Community Attitudes" OR DE "Cultural Attitudes" OR "Health Attitudes" OR DE "Values"</p> <p>S24 DE "Focus Group"</p> <p>S25 TX "discourse analysis" OR TX "content analysis" OR TX "ethnographic research" OR TX "ethnological research" OR TX "ethnonursing research" OR TX "constant comparative method" OR TX "qualitative validity" OR TX "purposive sample" OR TX "observational method*" OR TX "field stud*" OR TX "theoretical sampl*" OR DE "Phenomenology" OR TX "phenomenological research" OR TX "life experience*" OR TX "cluster sampl*" OR perception* OR experience*</p> <p>S26 S21 OR S22 OR S23 OR S24 OR S25</p> <p>S27 TX ethnonursing OR TX ethnograph* OR TX phenomenol* OR TX "grounded theory" OR TX ((grounded W1 (theor* OR study OR studies OR research OR analys#s))) OR TX ("life stor*") OR TX (emic OR etic OR hermeneutic* OR heuristic* OR semiotic*) OR TI (data N1 saturat*) OR AB (data N1 saturat*) OR TI ("participant observ*") OR AB ("participant observ*") OR TX ("social construct*" OR postmodern* OR "post-structural*" OR interpret*) OR TX ("action research" OR "cooperative inquir*" OR "co operative inquir*" OR "co-operative inquir*") OR TX (humanistic OR existential OR experiential OR paradigm*) OR TI (field W1 (study OR studies OR</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>research)) OR AB (field W1 (study OR studies OR research)) OR TI ("human science") OR AB ("human science") OR TI ("biographical method") OR AB ("biographical method") OR TX ("qualitative validity") OR TX ("purposive sampl*") OR TX ("theoretical sampl*") OR TX ((purpos* N3 sampl* OR focus W group*)) OR TX ((account OR accounts OR unstructured OR "open-ended" OR "open ended" OR text* OR narrative*)) OR TX ("life world" OR "life-world" OR "conversation analys#s" OR "personal experience*" OR "theoretical saturation") OR TI ("lived experience*") OR AB ("lived experience*") OR TX ("life experience*") OR TX ("cluster sampl*") OR TX (theme* OR thematic) OR TX categor* OR TX "observational method*" OR TX "field stud*" OR TX "focus group*" OR TX questionnaire* OR TX ("content analysis") OR TX ("thematic analysis") OR TX ("constant comparative") OR TX ("discourse analys#s") OR TI ((discourse* OR discours*) N2 analys#s) OR AB ((discourse* OR discours*) N2 analys#s) OR TX (constant W1 (comparative OR comparison)) OR TX ("narrative analys#s")</p> <p>S28 TX findings OR TX interview* OR TX qualitative</p> <p>S29 S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 (QUAL FILTER)</p> <p>S30 S14 AND S17 AND S20 AND S29 (FINAL SET = UK_FILTER AND ASR_FILTER AND MH_SERVICE_FILTER_AND_QUAL_FILTER)</p>		
<p>EBSCOhost: CINAHL</p>		<p>S1 (MH "United Kingdom+") OR (MH "Great Britain+")</p> <p>S2 TI (national health service* OR nhs*) OR AB (national health service* OR nhs*) OR AF (national health service* OR nhs*)</p> <p>S3 TI (english NOT ((published OR publication* OR translat* OR written OR language* OR speak* OR literature OR citation*) N5 english)) OR AB (english NOT ((published OR publication* OR</p>	<p>26/06/2025</p>	<p>259</p>

Systematic Review search strategies

		<p>translat* OR written OR language* OR speak* OR literature OR citation*) N5 english)) OR AF (english NOT ((published OR publication* OR translat* OR written OR language* OR speak* OR literature OR citation*) N5 english))</p> <p>S4 TI (gb OR "g.b." OR britain* OR (british* NOT "british columbia") OR uk OR "u.k." OR united kingdom* OR (england* NOT "new england") OR northern ireland* OR northern irish* OR scotland* OR scottish* OR ((wales OR "south wales") NOT "new south wales") OR welsh*) OR AB (same terms) OR AF (same terms)</p> <p>S5 TI (bath OR "bath's" OR (birmingham NOT alabama*) OR ("birmingham's" NOT alabama*) OR bradford OR "bradford's" OR brighton OR "brighton's" OR bristol OR "bristol's" OR carlisle OR "carlisle's" OR (cambridge NOT (massachusetts* OR boston* OR harvard*)) OR ("cambridge's" NOT (massachusetts* OR boston* OR harvard*)) OR (canterbury NOT zealand*) OR ("canterbury's" NOT zealand*) OR chelmsford OR "chelmsford's" OR chester OR "chester's" OR chichester OR "chichester's" OR coventry OR "coventry's" OR derby OR "derby's" OR (durham NOT (carolina* OR nc)) OR ("durham's" NOT (carolina* OR nc)) OR ely OR "ely's" OR exeter OR "exeter's" OR gloucester OR "gloucester's" OR hereford OR "hereford's" OR hull OR "hull's" OR lancaster OR "lancaster's" OR leeds* OR leicester OR "leicester's" OR (lincoln NOT nebraska*) OR ("lincoln's" NOT nebraska*) OR (liverpool NOT ("new south wales*" OR nsw)) OR ("liverpool's" NOT ("new south wales*" OR nsw)) OR (london NOT ("ontario*" OR ont OR toronto*)) OR ("london's" NOT ("ontario*" OR ont OR toronto*)) OR manchester OR "manchester's" OR (newcastle NOT ("new south wales*" OR nsw)) OR ("newcastle's" NOT ("new south wales*" OR nsw)) OR norwich OR "norwich's" OR nottingham OR "nottingham's" OR oxford OR "oxford's" OR peterborough OR "peterborough's" OR plymouth OR "plymouth's" OR portsmouth OR "portsmouth's" OR preston OR "preston's" OR</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>ripon OR "ripon's" OR salford OR "salford's" OR salisbury OR "salisbury's" OR sheffield OR "sheffield's" OR southampton OR "southampton's" OR "st albans" OR stoke OR "stoke's" OR sunderland OR "sunderland's" OR truro OR "truro's" OR wakefield OR "wakefield's" OR wells OR westminster OR "westminster's" OR winchester OR "winchester's" OR wolverhampton OR "wolverhampton's" OR (worcester NOT (massachusetts* OR boston* OR harvard*)) OR ("worcester's" NOT (massachusetts* OR boston* OR harvard*)) OR (york NOT ("new york*" OR ny OR ontario* OR ont OR toronto*)) OR ("york's" NOT ("new york*" OR ny OR ontario* OR ont OR toronto*)) OR AB (same terms) OR AF (same terms)</p> <p>S6 TI (bangor OR "bangor's" OR cardiff OR "cardiff's" OR newport OR "newport's" OR st asaph OR "st asaph's" OR st davids OR swansea OR "swansea's") OR AB (same terms) OR AF (same terms)</p> <p>S7 TI (aberdeen OR "aberdeen's" OR dundee OR "dundee's" OR edinburgh OR "edinburgh's" OR glasgow OR "glasgow's" OR inverness OR (perth NOT australia*) OR ("perth's" NOT australia*) OR stirling OR "stirling's") OR AB (same terms) OR AF (same terms)</p> <p>S8 TI (armagh OR "armagh's" OR belfast OR "belfast's" OR lisburn OR "lisburn's" OR londonderry OR "londonderry's" OR derry OR "derry's" OR newry OR "newry's") OR AB (same terms) OR AF (same terms)</p> <p>S9 S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8</p> <p>S10 (MH "Africa+")</p> <p>S11 (MH "Americas+")</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>S12 (MH "Antarctic Regions")</p> <p>S13 (MH "Asia+")</p> <p>S14 (MH "Australia+") OR (MH "Pacific Islanders+") OR (MH "Pacific Islands+")</p> <p>S15 S10 OR S11 OR S12 OR S13 OR S14</p> <p>S16 S9 NOT S15 (UK FILTER)</p> <p>S17 (MH "Refugees+")</p> <p>S18 TI (asylum seeker* OR refugee* OR forced migrant* OR displaced persons) OR AB (asylum seeker* OR refugee* OR forced migrant* OR displaced persons)</p> <p>S19 TI (force* N2 (migrat* OR immigrat* OR emigrat*)) OR AB (force* N2 (migrat* OR immigrat* OR emigrat*))</p> <p>S20 TI (displac* N1 (forced OR mass OR person* OR people* OR population*)) OR AB (displac* N1 (forced OR mass OR person* OR people* OR population*))</p> <p>S21 S17 OR S18 OR S19 OR S20 (ASR FILTER)</p> <p>S22 (MH "School Mental Health Services") OR (MH "Community Mental Health Services+") OR (MH "Mental Health Services+") OR (MH "Mental Health Counseling") OR (MH "Psychiatric Service")</p> <p>S23 TI ("Community Mental Health Service*" OR Therapeutic* OR "Mental Health Service*" OR "School Mental Health Service*" OR "Psychiatric Rehabilitation" OR "Psychological Therap*" OR</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>Counseling OR Counselling) OR AB (same terms) OR TI ("mental health" N2 (service* OR care OR support* OR intervention* OR provision)) OR AB (same terms) OR TI ("mental health")</p> <p>S24 TI ("Improving Access to Psychological Therapies" OR IAPT OR Therap* OR Psychiatry OR "Clinical Psychology" OR "Psychological Therap*" OR "Psychological Treatment*" OR Counselling OR Counseling OR Psychotherapy OR "Behaviour* Therap*" OR "Behaviour* Modification" OR "Social Skills Training" OR "Behaviour Contracting" OR "Activity Scheduling" OR "Exposure Therap*" OR Psychoeducation OR CBT OR "Rational Emotive Therap*" OR "Acceptance and Commitment Therap*" OR Mindfulness OR "Meta-Cognitive Therap*" OR "Compassion-Focused" OR "Narrative Therap*" OR "Narrative Exposure Therap*" OR "Psychodynamic Therap*" OR "Insight-Orientated Therap*" OR "Psychoanalytic Therap*" OR "Humanistic Therap*" OR "Existential Therap*" OR "Expressive Therap*" OR "Supportive Therap*" OR "Non-Directive Therap*" OR "Integrative Therap*" OR "Motivational Interviewing" OR "Interpersonal Therap*" OR "Eclectic Therap*" OR Transtheoretical OR "Systemic Therap*" OR "Psychologically Orientated Intervention*" OR "Art Therap*" OR Bibliotherap* OR "Colour Therap*" OR "Music Therap*" OR Psychodrama) OR AB (same terms)</p> <p>S25 S22 OR S23 OR S24 (MH SERVICE FILTER)</p> <p>S26 (MH "Qualitative Studies+") OR (MH "Qualitative Validity+") OR (MH "Research Nursing")</p> <p>S27 (MH "Questionnaires")</p> <p>S28 (MH "Attitude+")</p>		
--	--	--	--	--

Systematic Review search strategies

		S29	(MH "Focus Groups")		
		S30	(MH "Discourse Analysis")		
		S31	(MH "Content Analysis")		
		S32	(MH "Ethnographic Research")		
		S33	(MH "Ethnological Research")		
		S34	(MH "Ethnonursing Research")		
		S35	(MH "Purposive Sample")		
		S36	(MH "Observational Methods+")		
		S37	(MH "Field Studies")		
		S38	(MH "Theoretical Sample")		
		S39	(MH "Phenomenology") OR (MH "Phenomenological Research")		
		S40	(MH "Life Experiences+")		
		S41	(MH "Cluster Sample+")		
		S42	S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41		
		S43	TX (ethnonursing)		
		S44	TX (ethnograph*)		

Systematic Review search strategies

		<p>S45 TX (phenomenol*)</p> <p>S46 TX ("grounded theory")</p> <p>S47 TX (grounded N3 (theor* OR study OR studies OR research OR analys?s))</p> <p>S48 TX (emic OR etic OR hermeneutic* OR heuristic* OR semiotic* OR (data N1 saturat*) OR "participant observation")</p> <p>S49 TX (social construct* OR postmodern* OR post-modern* OR post structural* OR post-structural* OR poststructural* OR interpret*)</p> <p>S50 TX ("action research" OR "cooperative inquir*" OR "co operative inquir*" OR "co-operative inquir*")</p> <p>S51 TX (humanistic OR existential OR experiential OR paradigm*)</p> <p>S52 TX (field N3 (study OR studies OR research))</p> <p>S53 TX ("human science")</p> <p>S54 TX ("qualitative validity")</p> <p>S55 TX (purposive sampl* OR theoretical sampl*)</p> <p>S56 TX ((purpos* N4 sampl*) OR (focus N1 group*))</p> <p>S57 TX (account OR accounts OR unstructured OR "open-ended" OR "open ended" OR text* OR narrative*)</p>		
--	--	---	--	--

Systematic Review search strategies

		<p>S58 TX ("life world" OR "life-world" OR "conversation analys?s" OR "personal experience*" OR "theoretical saturation")</p> <p>S59 TX ("lived experience*" OR "life experience*" OR "cluster sampl*" OR theme* OR thematic OR "field stud*" OR "focus group*" OR questionnaire*)</p> <p>S60 TX ("content analysis" OR "thematic analysis" OR "constant comparative" OR "discourse analys?s" OR ((discourse* OR discours*) N3 analys?s) OR "narrative analys?s")</p> <p>S61 S43 OR S44 OR S45 OR S46 OR S47 OR S48 OR S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60</p> <p>S62 S42 OR S61 (QUAL FILTER)</p> <p>S63 S16 AND S21 AND S25 AND S62 (FINAL SET = UK_FILTER AND ASR_FILTER AND MH_SERVICE_FILTER_AND_QUAL_FILTER)</p>		
Web of Science Core Collections	<p>(Science Citation Index Expanded (SCI-EXPANDED), Social Sciences Citation Index (SSCI), Emerging Sources Citation Index (ESCI)</p> <p>Only articles (didn't include reviews)</p> <p>English Language</p>	<p>#1. TS=("united kingdom" OR uk OR britain* OR british* OR scotland* OR england* OR wales OR "northern ireland" OR nhs OR "national health service" OR gb OR "g.b." OR bath OR birmingham OR bradford OR brighton OR bristol OR carlisle OR cambridge OR canterbury OR chelmsford OR chester OR chichester OR coventry OR derby OR durham OR ely OR exeter OR gloucester OR hereford OR hull OR lancaster OR leeds OR leicester OR lincoln OR liverpool OR london OR manchester OR newcastle OR norwich OR nottingham OR oxford OR peterborough OR plymouth OR portsmouth OR preston OR ripon OR salford OR salisbury OR sheffield OR</p>	26/06/2025	1,541

Systematic Review search strategies

		<p>southampton OR "st albans" OR stoke OR sunderland OR truro OR wakefield OR wells OR westminster OR winchester OR wolverhampton OR worcester OR york OR bangor OR cardiff OR newport OR "st asaph" OR "st davids" OR swansea OR aberdeen OR dundee OR edinburgh OR glasgow OR inverness OR perth OR stirling OR armagh OR belfast OR lisburne OR londonderry OR derry OR newly</p> <p>)</p> <p>NOT</p> <p>TS=(</p> <p>africa OR asia OR "latin america" OR "north america" OR "united states" OR usa OR canada OR australia OR "new zealand" OR oceania OR antarctica OR "south africa"</p> <p>)</p> <p>#2.</p> <p>TS=("asylum seeker*" OR refugee* OR "forced migrant*" OR "displaced person*" OR (force* NEAR/2 (migrat* OR immigrat* OR emigrat*)) OR (displac* NEAR/1 (forced OR mass OR person* OR people* OR population*)))</p> <p>)</p> <p>#3.</p> <p>TS=(</p> <p>"mental health service*" OR "community mental health" OR "school mental health" OR "psychosocial rehabilitation" OR "mental health care" OR "mental health program*" OR "mental health support" OR "mental health" OR "psychological therap*" OR psychotherapy OR psychiatry OR "clinical psychology" OR counselling OR counseling OR IAPT OR CBT OR</p>		
--	--	---	--	--

Systematic Review search strategies

		<p>"acceptance and commitment therap*" OR "rational emotive therap*" OR "psychodynamic therap*" OR "interpersonal therap*" OR "systemic therap*" OR "motivational interviewing" OR "humanistic therap*" OR "existential therap*" OR "art therap*" OR "narrative therap*" OR "narrative exposure therap*" OR "supportive therap*" OR "integrative therap*" OR "insight-orientated therap*" OR "meta-cognitive therap*" OR compassion-focused OR psychoeducation OR "behaviour* therap*" OR "behaviour* modification" OR "social skills training" OR "activity scheduling" OR "exposure therap*" OR psychodrama OR bibliotherap* OR "colour therap*" OR "music therap*")</p> <p>#4. TS=("discourse analysis") OR TS=("content analysis") OR TS=("ethnographic research") OR TS=("ethnological research") OR TS=("ethnonursing research") OR TS=("constant comparative method") OR TS=("qualitative validity") OR TS=("purposive sample") OR TS=("observational method*") OR TS=("field stud*") OR TS=("theoretical sampl*") OR TS=("phenomenological research") OR TS=("life experience*") OR TS=("cluster sampl*") OR TS=("perception*") OR TS=("experience*")</p> <p>#5. TS=(ethnonursing OR ethnograph* OR phenomenol* OR "grounded theory" OR (grounded NEAR/1 (theor* OR study OR studies OR research OR analys*)) OR "life stor*" OR "women's stor*" OR emic OR etic OR hermeneutic* OR heuristic* OR semiotic* OR "social construct*" OR postmodern* OR "post-structural*" OR "post structural*" OR poststructural* OR "post modern*" OR "post-</p>		
--	--	--	--	--

Systematic Review search strategies

		<p>modern* OR feminis* OR interpret* OR "action research" OR "cooperative inquir*" OR "co operative inquir*" OR "co-operative inquir*" OR humanistic OR existential OR experiential OR paradigm* OR "qualitative validity" OR "purposive sampl*" OR "theoretical sampl*" OR (purpos* NEAR/3 sampl*) OR (focus NEAR/1 group*) OR account OR accounts OR unstructured OR "open-ended" OR "open ended" OR text* OR narrative* OR "life world" OR "life-world" OR "conversation analysis" OR "personal experience*" OR "theoretical saturation" OR "life experience*" OR "cluster sampl*" OR theme* OR thematic OR categor* OR "observational method*" OR "field stud*" OR "focus group*" OR questionnaire* OR "content analysis" OR "thematic analysis" OR "constant comparative" OR "discourse analysis" OR (constant NEAR/1 (comparative OR comparison)) OR "narrative analysis" OR findings OR interview* OR qualitative) OR</p> <p>TI=(data NEAR/1 saturat* OR "participant observ*" OR field NEAR/1 (study OR studies OR research) OR "human science" OR "biographical method" OR "lived experience*" OR (discourse* NEAR/2 analysis))</p> <p>OR</p> <p>AB=(data NEAR/1 saturat* OR "participant observ*" OR field NEAR/1 (study OR studies OR research) OR "human science" OR "biographical method" OR "lived experience*" OR (discourse* NEAR/2 analysis))</p> <p>#6. #4 OR #5</p> <p>#7. #1 AND #2 AND #3 AND #6 (FINAL SET = UK_FILTER AND ASR_FILTER AND MH_SERVICE_FILTER AND_QUAL_FILTER)</p>		
--	--	--	--	--

Appendix 1.4: CASP Checklist

<https://casp-uk.net/casp-checklists/CASP-checklist-qualitative-2024.pdf>

Appendix 1.5: Extract of reflexive journal entry / Bracketing (SR)

Reflective journal entry – 28/11/2025

So far, several papers have highlighted the need for holistic mental health support that takes into account the social, cultural and political. This feels so crucial. Papers have been calling for this for years, and yet the current climate in the UK is pushing refugees and asylum seekers even further into marginalisation, humiliation and scapegoating.

I feel angry and sad reading these quotes about what people need and how they experience services, knowing that in 2025 our systems for supporting them are even more hostile than ever. I find myself wondering what they are thinking now when they watch the news, their fear, heartbreak, and how that sense of “otherness” is being further intensified. It is a scary and VERY dark time!!

On one hand, doing research like this feels very important. Language matters, and naming things as they are feels crucial, particularly in academia and especially in psychology, where our institutions often sanitise things. I do not want to sanitise things. I want to say them as they are, to talk about the unfairness, injustice and dehumanisation that takes place. It reminds me of a quote I read asking, “Who decides what is critical and what is not critical enough [in the context of academia and language] or if my language is too political?” I am also asking: what are our ethical responsibilities if not to take a stance in moments like this? It makes me think about ideas of “neutrality” in psychology, and I realise this is something I disagree with. We cannot be neutral when we are trained in institutions and live in countries that often perpetuate the very violence we see in our communities, particularly towards marginalised groups such as refugees and asylum seekers.

On the other hand, although I know research and sharing people’s voices is important, I also feel disillusioned with research at times. There are so many papers, so many policies, and it feels as though we are descending into darker times. What good does it do if we, as academics and psychologists, are not listened to by those in power?

And yet, I also have hope. It feels like the least I can do. Patients that I had, people I know, have hope, so I must too. Hope is, in many ways, the only thing we have, to keep hoping, and to keep fighting for a more just world. Back to reading my papers, back to coding, and back to being sad, angry with occasional glimpses of hope.

Appendix 1.6. Recurrence of Themes

Authors (Year)	Structures and systems that produce both distress and inaccessibility		Negotiating distress and help-seeking within cultural, religious and social worlds				Conditions under which care feels safe, trustworthy and genuinely helpful				
	<i>Institutional gatekeeping and fragmented pathways into care</i>	<i>Language, culture and institutional blind spots as systemic barriers</i>	<i>Cultural and religious concepts of distress and mental health</i>	<i>Stigma, shame and feared consequences of a mental health label</i>	<i>Patterns and processes of help-seeking</i>	<i>Coping strategies and non-clinical supports</i>	<i>Trust and safety with non-clinician professionals</i>	<i>Trust and safety with clinicians</i>	<i>Experiences of talking therapies</i>	<i>Views on medication and preferred forms of support</i>	<i>Communication and language support as conditions for feeling understood</i>
Zivachi & Castellani (2024)		X	X	X			X	X	X	X	X
Trueba et al (2023)	X	X	X	X	X					X	X
Paudyal et al (2021)	X	X	X	X	X	X	X	X			X
Majumder et al (2019)		X		X	X			X	X	X	X
Fish & Fakoussa (2018)	X	X	X	X	X	X	X	X			X
Fazel et al (2016)	X		X	X	X		X	X	X	X	X
Majumder et al (2014)	X	X	X	X	X			X	X	X	X

Authors (Year)	Structures and systems that produce both distress and inaccessibility		Negotiating distress and help-seeking within cultural, religious and social worlds				Conditions under which care feels safe, trustworthy and genuinely helpful				
	<i>Institutional gatekeeping and fragmented pathways into care</i>	<i>Language, culture and institutional blind spots as systemic barriers</i>	<i>Cultural and religious concepts of distress and mental health</i>	<i>Stigma, shame and feared consequences of a mental health label</i>	<i>Patterns and processes of help-seeking</i>	<i>Coping strategies and non-clinical supports</i>	<i>Trust and safety with non-clinician professionals</i>	<i>Trust and safety with clinicians</i>	<i>Experiences of talking therapies</i>	<i>Views on medication and preferred forms of support</i>	<i>Communication and language support as conditions for feeling understood</i>
Palmer & Ward (2007)	X	X	X	X	X	X	X	X	X	X	X
Leavey et al (2007)		X	X	X	X	X	X	X		X	
Misra et al (2006)	X	X	X	X	X		X	X	X		X
Palmer (2006)	X	X	X	X	X		X			X	X

Appendix 1.7. Supplementary Detailed Version of Critical Appraisal

<https://osf.io/yzf5b>

Appendix 2.1: Ethical Approval Letter

North of Scotland Research Ethics Committee

Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Email: gram.nosres@nhs.scot



07 November 2024

Ms Viktoria Stelikou

Dear Ms Stelikou

Study title: Content and Face Validity of the Farsi Adaptation of the Dissociative Experiences Measure Oxford (DEMO) for Iranian Refugees Experiences of Dissociation: A cognitive interview study

REC reference: 24/NS/0112

Protocol number: 339031

IRAS project ID: 339031

Thank you for your letter of 05 November 2024. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 15 October 2024

Documents received

The documents received were as follows:

Document	Version	Date
IRAS Checklist XML [Checklist_07112024]		07 November 2024
Favourable Opinion Letter with comments	V.1	02 November 2024
Participant consent form - Farsi	4	30 September 2024
Participant information sheet - English	V.8	24 October 2024
Participant information sheet - Farsi	V.7	01 November 2024

Approved documents

The final list of approved documentation for the study is therefore as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) Insurance		28 June 2024
GP/consultant information sheets or letters - GP/Clinician Letter	0.4	08 August 2024
GP/consultant information sheets or letters - Clinician Recruitment Letter	.2	27 August 2024
Interview schedules or topic guides for participants - Topic Guide	0.3	15 April 2024
IRAS Application Form [IRAS Form 19092024]	339031/1690881/37/765	04 September 2024
IRAS Checklist XML [Checklist_07112024]		07 November 2024
Letters of invitation to participant - Farsi	0.6	30 August 2024
Letters of invitation to participant - English	0.7	11 September 2024
Non-validated questionnaire - Farsi	.2	19 August 2024
Consent to Contact English	1	16 September 2024
PIS Quality Standard Staff Checklist		10 September 2024
Consent to Contact Farsi	1	30 September 2024
Response to REC valid under consideration		23 September 2024
Favourable Opinion Letter with comments	V.1	02 November 2024
Participant consent form - English	0.4	21 September 2024
Participant Consent form - Farsi	4	30 September 2024
Participant information sheet - English	V.8	24 October 2024
Participant information sheet - Farsi	V.7	01 November 2024
Research protocol or project proposal	0.8	12 August 2024
Summary CV for Chief Investigator and Supervisor: Andrew Gumley		20 February 2022
Summary CV for student - Viktoria Stelikou		08 January 2024
Validated questionnaire - The Dissociative Experiences Measure OXFORD (DEMO)	.1	30 May 2024

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

IRAS Project ID: 339031	Please quote this number on all correspondence
--------------------------------	---

Yours sincerely

Karen Stephen
Ethics Administrator

Appendix 2.2: Managerial Approval



Research & Innovation
Gartnavel Royal Hospital
Admin Building, Level 2
1055 Great Western Road
Glasgow, G12 0XH
Scotland, UK

Coordinator/administrator: Rozanne Suarez
Telephone Number: NA
E-Mail: Rozanne.Suarez2@nhs.scot
Website: <https://www.nhsggc.org.uk/about-us/professional-support-sites/research-innovation>

14/11/2024

Viktoria Stelikou
NHS Highland
Trainee Clinical Psychologist
Inverness

NHS GG&C Board Approval

Dear Viktoria

Study Title:	A Qualitative Exploration of Iranian Refugees Experiences of the Dissociative Experiences Measure Oxford (DEMO)
Principal Investigator:	Viktoria Stelikou
GG&C HB site	NHS Greater Glasgow and Clyde – CMHTs, Mental Health Partnership and the Anchor Service
Sponsor	University of Glasgow
R&I reference:	UGN24MH201
REC reference:	24/NS/0112
Protocol no: (including version and date)	v8 – 12.08.2024

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
 - a. During the life span of the study GGHB requires the following information relating to this site
 - i. Notification of any potential serious breaches.
 - ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file. Researchers must follow NHS GG&C local policies, including incident reporting.

2. **For all studies** the following information is required during their lifespan.
 - a. First study participant should be recruited within 30 days of approval date.
 - b. Recruitment Numbers on a monthly basis
 - c. Any change to local research team staff should be notified to R&I team
 - d. Any amendments – Substantial or Non Substantial

- e. Notification of Trial/study end including final recruitment figures
- f. Final Report & Copies of Publications/Abstracts
- g. You must work in accordance with the current NHS GG&C COVID19 guidelines and principles.

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,

Rozanne Suarez
Research Administrator

CC: **Professor Andrew Gumley**
University of Glasgow

Appendix 2.3: Final approved MRP proposal

<https://osf.io/muvq9/files/3u64d>

Appendix 2.4: Study Documentation

Consent forms:

- <https://osf.io/muvq9/files/ejpr9> - English
- <https://osf.io/muvq9/files/agdvc> - Persian

Participant Information Sheet with Privacy Notice:

- <https://osf.io/muvq9/files/q3akc> - English
- <https://osf.io/muvq9/files/wbhj> - Persian

Participant Information Leaflet:

- <https://osf.io/muvq9/files/9u3es> - English
- <https://osf.io/muvq9/files/w4gnr> - Persian

Consent to Contact:

- <https://osf.io/muvq9/files/ykmjt> - English
- <https://osf.io/muvq9/files/6fdum> - Persian

Clinician Information Letter:

- <https://osf.io/nsy5q>

Appendix 2.5: CORE-Q

COREQ (Consolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	116
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	118
Occupation	3	What was their occupation at the time of the study?	118
Gender	4	Was the researcher male or female?	118
Experience and training	5	What experience or training did the researcher have?	118
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	115-117
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	115-117, 192
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	118-119, 139
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	117-118, 138
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	114
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	115-118
Sample size	12	How many participants were in the study?	114-115
Non-participation	13	How many people refused to participate or dropped out? Reasons?	n/a
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	115-118
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	115-118
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	115
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	116, 199
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	116
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	116
Field notes	20	Were field notes made during and/or after the interview or focus group?	116
Duration	21	What was the duration of the interviews or focus group?	116
Data saturation	22	Was data saturation discussed?	115
Transcripts returned	23	Were transcripts returned to participants for comment and/or	116

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	117-118
Description of the coding tree	25	Did authors provide a description of the coding tree?	117-118, 201
Derivation of themes	26	Were themes identified in advance or derived from the data?	117-118
Software	27	What software, if applicable, was used to manage the data?	117
Participant checking	28	Did participants provide feedback on the findings?	n/a
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	127-133
Data and findings consistent	30	Was there consistency between the data presented and the findings?	127-140
Clarity of major themes	31	Were major themes clearly presented in the findings?	127-140
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	127-140

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

Appendix 2.6: DEMO

Dissociative Experiences Measure, Oxford (DEMO)

Please answer the questions below based on how things have been for you in the past two weeks. If you are not sure, go with your best guess.

Please only answer about experiences you have had while not under the influence of alcohol, drugs or 'legal highs'.

		Not at All	Rarely	Some-times	Often	Most of the time
1	I have the feeling that other people, other things and the world surrounding me are not real	1	2	3	4	5
2	I have the feeling that everything is unreal	1	2	3	4	5
3	I feel as if I don't exist, am not real	1	2	3	4	5
4	I feel like I am in a parallel world	1	2	3	4	5
5	The world around me feels detached or unreal, as if there were an invisible barrier between me and the outside world	1	2	3	4	5
6	I feel like the external world is not real, a joke, a lie	1	2	3	4	5
7	I feel emotionally numb	1	2	3	4	5
8	I just feel numb and empty inside	1	2	3	4	5
9	I feel I can't make a proper connection with anyone around me	1	2	3	4	5
10	I do not seem to feel anything at all	1	2	3	4	5
11	I feel like I'm 'just existing'	1	2	3	4	5
12	I turn inwards, trying to work out why I feel so disconnected	1	2	3	4	5

13	I find myself in situations or places with no memory of how I got there	1	2	3	4	5
14	I suddenly notice that I find myself in a place that is unknown to me without knowing how I got there	1	2	3	4	5
15	I find evidence of something I've done recently (e.g. through finding notes or drawings) but I don't remember doing it	1	2	3	4	5
16	I find new articles among my things without being able to remember ever having purchased them	1	2	3	4	5
17	I find myself somewhere and do not remember how I got there	1	2	3	4	5
18	I have big gaps in my memory for recent things in my life	1	2	3	4	5
19	I stare aimlessly without thinking about anything	1	2	3	4	5
20	I 'zone out' and don't see or hear what's going on around me	1	2	3	4	5
21	I sometimes sit staring off into space, thinking of nothing, and am not aware of the passage of time (or other people tell me that I do this)	1	2	3	4	5
22	I often think about nothing	1	2	3	4	5
23	Sometimes my mind is absolutely blank	1	2	3	4	5
24	My mind just goes empty	1	2	3	4	5
25	I can remember something that happened before so vividly that it's like a video playing in my head	1	2	3	4	5

26	Unwanted images from my past come into my head	1	2	3	4	5
27	I am surprised by or don't expect some of the thoughts or images that happen in my head	1	2	3	4	5
28	I experience past memories as if they are happening here and now	1	2	3	4	5
29	I can get so involved in fantasies or daydreaming that it seems to be really happening and I lose touch with what is happening in the real world at that moment	1	2	3	4	5
30	I hear someone talking when no-one nearby has actually said anything	1	2	3	4	5

Items:

Factor 1	Items 1-6	Unreality
Factor 2	Items 7-12	Numb and Disconnected
Factor 3	Items 13-18	Memory Blanks
Factor 4	Items 19-24	'Zoned Out'
Factor 5	Items 25-30	Vivid Internal World

Appendix 2.7: Extract reflective notes

Interview 1 – 14/05/2025

Interview 1 – 14/05/2025

Items 1-6 were hard to understand for the participant but I found myself finding it difficult to explain however, I was able to give examples of what helped.

He had good rapport with the interpreter. Important to have an interpreter who felt comfortable with and understanding the limitations of not being able to obtain one. The participant needed lots of examples in order to understand the questions. It seemed he ~~had~~ ^{has} a tendency to overthink his answers which was later confirmed by the interpreter (they worked together in the past). It seemed that ~~the~~ metaphors with metaphors landed well with the participant and it ~~also~~ reminded me of theories on how mental distress in collectivist cultures tend to be described in somatic, social, relational terms as in the Global north which is more individualistic.

Metaphors in the context of cultural epistemology - frameworks for making meaning

Conceptual Metaphor Theory (1980)

Thinking about suitable idioms of distress. Understand concepts as

Interview 4 - 12/06/2025

Participant ~~was~~ understood English. I was leading the items in English and the interpreter was reading the focus to him. I think he was able to understand some of the items better ~~because~~ because he could understand the English version. I realised that I shall have contacted me and ask for more graphs. I think my interview skills have been largely impacted from my placements with CERP as I used DPP principle such as talking for/about which usually it's not necessary to the context. My difficulty was leading at times. Also we had to rush because the interpreter had to leave unexpectedly. It was difficult to arrange an interpreter for this interview due to the participant requirements. Highlights I struggled with cross-cultural cognitive interviewing. Certain items I didn't probe much or if it was clear the participant understood it.

Appendix 2.8: Topic Guide

<https://osf.io/n2vhx>

Appendix 2.9: Data Availability Statement

The study data cannot be shared for important ethical and privacy concerns. The data is of a highly personal nature and participants have not given consent for the study data to be shared with third parties. Interested authors should contact the named author for any information pertaining to study data.

The study data cannot be shared for important ethical and privacy concerns. The data is of a highly personal nature and participants have not given consent for the study data to be shared with third parties. Interested authors should contact the named author for any information pertaining to study data.

Appendix 2.10: Codebook

<https://osf.io/muvq9/files/9gy4d>

Appendix 2.11: Item-by-Item review

<https://osf.io/muvq9/files/2hpxu>