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Intercultural Counselling and Psychotherapy with new immigrants and refugees

Abstract

This chapter will review what is meant by intercultural therapy and discuss the relevant terminology in relation to refugees and migrants. It will then briefly consider some of the major differences between an immigrant and a refugee and the implications that this may have for intercultural therapy. Shifts across narratives about migrants and refugees in the new country will be discussed and their possible implications for psychological well-being considered. The issue of power operating at multiple levels will be reviewed. Therapeutic services which concentrate only on an individuals' refugee or migratory status may inadvertently minimise the experience of a service user and reduce an individual to a part of their life (as a migrant or refugee) rather than considering the whole lived experience of that person. This reductionist approach may also risk underestimating the strengths that an individual possesses. The use of therapeutic skills in innovative ways and in diverse contexts will be discussed and their potential in working with refuges and migrants in culturally and non-stigmatising ways discussed.

Key words: Intercultural Therapy, refugees, help-seeking, well-being, health pluralism, cultural sensitivity

Introduction

The role of geo-politics and globalisation which forms the overarching context for people moving countries requires consideration, if their circumstances are to be understood (1).   These are important factors in relation to transition and how these may affect individual migrants' and refugees' sense of well-being and mental health (2, 3). International migration across the globe was approximately 258 million people in 2017, this was 48 million more people than migrated the previous year (4). Whilst, only approximately 18 % of refugees flee to high- and middle-income countries (5), the majority flee to other parts of their country of origin or to neighbouring low income countries. The period between a person applying for refugee status and them being informed that a decision has been being made varies by country, it can take between a number of weeks to many years (6). As recognized in this volume, this period can be a very anxiety provoking and uncertain time, when asylum-seekers are in a state of limbo, unable to plan for the future and often frightened of being returned to their country of origin. It can be a time when psychological well-being is challenged and therapeutic support might be requested.

Case vignette 1. Mahmoud a refugee from the Middle East -

"I was forced to leave my homeland, due to the war. I am a peace-loving person, but I knew that I would be picked up and imprisoned or even tortured on account of my family's ethnicity. They were looking for people like me. I fled to a refugee camp and then came to Europe. I feel very alone and I am existing from day to day, this is not living for me. My family are scattered and I don't know where many of them are living. I feel like a child and less than human. I am scared and don't know what the future will bring. I am a burden and people in this country are not interested in what happened to me. They do not want me in this or my home country. They get cross here when I can't speak good English. What can I do?"

Culture, context and therapy

In this chapter, the concepts and thinking around mental health in this context are reviewed. The chapter will analyse how these were developed and the fact that they are often been based on models developed within high income countries often without adequate consideration of the rich traditions found in low and middle-income countries (7, 8). Case vignettes will be used where appropriate (all personal details have been changed). A critical psychology perspective will be used throughout.

Culture has frequently been viewed in the literature and by some policy makers as an " othering device" where culture is seen as only relating to ethnicity, "race" and on occasions religion and a history of coming from or living in a low or middle income country (9). It was also frequently used in relation to service users without any or adequate consideration of the culture of the therapist. This distancing ploy was racist, sexist, discriminatory and reductionist. Culture has also been reified (when a notion or abstract concept is viewed as something definitive and measurable) and used to stereotype people. Much psychological theory minimises the role of power and privilege (3, 10, 11). The attribution of power on occasions to those from high income countries and setting up implicit hierarchies of difference takes place. This "othering" also minimises individual agency and choice and ignores a range of variables and contextual factors and can lead to stereotyping (11). Whilst

there may be commonalities due to ethnicity, religion, gender or other characteristics, the culture an individual possesses is fluid (3).

Within any intercultural mental health consultation there will be views of culture and of mental health/well-being held by the service user, the therapist, and the employing agency, or practice, as well as the presence of the professional culture in which the therapist trained (9). These all require attention when working with all service users including refugees or new immigrants, where these may have particular resonance. Clinicians often think they are being culturally sensitive practitioners by attending to the views of mental health held by the service user. They may fail to give the same attention and reflection to their own culturally constructed notions which are frequently embedded in a western psychology and which may ignore global psychologises and other models of mental health (8). Therefore, how these varied views and cultures are reflected upon and negotiated within intercultural therapy provides a multifaceted but rich range of possibilities.

The discourse around culture and intercultural working is beginning to change in some places to something more complex and inclusive (7, 8, 9). The sense of cultural identity an individual develops or selects is multi-factorial and may be influenced throughout life by a range of events and experiences. It may be entirely different to that attributed by others on the basis of visible difference or stereotyping. Therefore, all clinicians need to be open and curious about an individuals' view and personal culture and meaning-making processes. Clinicians also need to be cognisant of intersectionality (12) where different forms of structural inequality or discrimination coalesce or intersect leading to further marginalisation and exclusion. (13). These hierarchies of exclusion and inclusion may vary depending on the time frame and prevailing national and international discourses including those on migration.

Case Vignette 2:-Precious an asylum seeker from Uganda

Precious is a gay woman from Uganda of 49 years of age who is disabled, she has experienced multiple forms of discrimination and marginalisation. She recalls how she went to a specialist therapy service, but they only wanted to discuss the issues relating to her application for refugee status, and are not really concerned about her disability, which makes moving around and travelling on public transport very difficult which is leading to her becoming increasingly socially isolated. They refer her elsewhere to discuss these issues.

Therapeutic services are often set up to be either very generic or to specialise in one area of a person's life, for example in relation to someone's asylum status, or a services for LBTGI + people or for people with disabilities, rather than focusing on issues relating to the intersectionality of these factors and the subsequent marginalisation and discrimination that an individual may face. If therapists are working in a

specialist service it is important to ensure that a holistic perspective is taken which includes all aspects of a service user's life.

(14) writes of 'marginalising dynamics' for people with 'protected characteristics' under the UK Equality Act (2010), although this term has currency in any country. (Protected characteristics include age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation). Many migrants may be subject to discrimination on account of their race or/and religion as well as on other protected characteristics. This may be further compounded in an environment which is openly hostile to migrants.

Narratives about migrants

The narratives about migration will shift according to wider national and global politics. As nationalism and populism are increasing in significance in many countries around the globe, (15) being from a community or group who are labelled by politicians as 'problematic' may lead to real or perceived social exclusion or on occasions internalised racism (16, 17). Nationalism and post truth is seen as being acceptable and of value by some people. Post truth has been defined as "Relating to or denoting circumstances in which objective facts are less influential in shaping public opinion than appeals to emotion and personal belief" (18). History shows that the victor or the powerful can always influence how events and their effects are portrayed and recorded to the wider community. Geopolitical contexts at present include the rise of nostalgic nationalism in a number of countries including the USA, Japan, India, China, Britain, Turkey, India South Africa and Russia (19). The latter has been suggested as leading to increases in racist attitudes (20) and social exclusion.

Definitions of migrancy are both multi-faceted and contested, and therefore the term migrant is perhaps best considered as one of self-definition (21). People who have been born or spend periods of their life in a country and consider themselves nationals may find that others regard them as migrants. This may occur, even if they are in reality second or third generation nationals, but owing to racist or outdated notions of nationalism or populism, nationals who look or sound different to a majority, dominant or powerful group may be incorrectly labelled by some individuals or political groups as migrants. These categories are very wide and will contain a heterogeneity of people. Intercultural therapists need to keep this in mind. Most migrants have developed strong survival skills and coping strategies but may require the services of an intercultural therapist.

Psychologically this labelling as a migrant may lead to representations of someone who is viewed in some way as different to the dominant host community or powerful group as diverse or as 'not really being of the place/country or belonging' has the potential to be detrimental to an individual, family or community's sense of belonging, social inclusion and sense of wellbeing. Visible and invisible differences are likely be positioned differently (22) with racism (23) and religious intolerance playing

a role. Citing cross sectional studies in the USA (24) noted associations between perceived racial discrimination and a range of health measures, these included weight at birth, (25) sick leave taken, hypertension and perceptions of their own health (26).

Although it is also not essential to know in detail about everyone's country, views and beliefs in advance of working with them, if a therapist is open and curious, a service user/expert by experience will usually be very happy to inform them. This can also assist with developing the therapeutic alliance and may go some way to recognising the knowledge and background of the service user. The latter is essential if intercultural therapy is to be useful and effective for refugees and migrants, not discriminatory and attempts to recognise and reflect upon the inherent power differentials.

The Issue of power

This is often ignored in discussions of therapy (27, 28) and has additional importance in intercultural therapy). A particular power structure is often accepted, where the clinician/service provider is in charge (assumed or ascribed power) and is there to help the service user sort out their issues (less ascribed power). This has particular relevance in intercultural therapy where issues of racism and post-colonial legacies may be both overt and covert. Power and privilege in many guises will be present in the room, some of which may be in conscious awareness by one of the two or by both parties. An important counter narrative to this positioning of power in therapy, which foregrounds these issues and asks clinicians to question aspects of their practice and theorising in relation to this has been put forward (28). The issues she raises have particular relevance to intercultural therapy. A post-structuralist notion of power has been proposed, where power is viewed as 'something that is present in the relationship rather than being in the possession of one person, is bi-directional, may be influenced by outside factors, and can be potentially negative or positive' 27. (Proctor, 2017:136). Whilst this sounds positive, the reality may be more complex. Power comes in many forms including role power, ascribed, achieved and structural power. It also does not exist in a vacuum but is situated within a global power structure.

> *Case vignette 3:* *This provides one example of a therapist reflecting upon their experience of privilege and power when working with an asylum seeker and how this issue might be compounded further for an interpreter.*
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> *"... In terms of social power and class and privilege, I would often if not always be the person with more cultural and social capital. Sometimes that would make me feel guilty or ashamed. I mean a really awful situation was a woman whose visa had expired and she was sofa surfing and she had two kids. It was all just horrible. She was just trying to stay under the radar till her child was 10 and obviously then could apply for British citizenship in his own name and I would just feel terrible. But the interpreter...I could imagine if I had a...she spoke English well enough, the interpreter would also feel terrible. So often the share in balance of social power was awful but I don't know that that can be avoided..."*

Refugees, migrants and intercultural therapy

Many refugees and asylum seekers have survived a range of challenges which may include, but are not limited to multiple losses including country, culture, family, profession, language, friends and existential losses including   an imagined and plans for the future (see 29) in this volume). Voluntary migrants may also face these issues, but they have more options including the ability to return to their home country at any point, should things not work out as they had hoped.

The differences between a refugee and a migrant are many, the two discrete groups are usually differentiated into forced or voluntary migrants. Forced migrants includes refugees (people who have been given formal legal refugee status) and people seeking legal and formal refugee status (known as asylum-seekers). Forced migrants usually have to flee their country, often in fear of their lives at short notice and to unknown destinations. Voluntary migrants make a positive decision to move to another country, within some constraints they can select which country they wish to move to and are usually able to arrange when they will migrate, so can make a psychological adjustment over time. The definition is not always as clearly demarcated in real life, as needing to provide for your family or employment being dependent on migrating, reduce the notion of individual choice.

The reasons people are forced to flee their home countries and seek asylum include war, human rights abuses, persecution on the grounds of politics, religion, gender, ethnicity and sexuality. Issues that asylum seekers and refuges may face include multiple change, psychological and practical adjustment, uncertain future, traumatic life events, hardship, racism, stereotyping by host community and unknown cultural tradition. All of the above have a number of implications for therapy.

Case vignette 4:   A refugee named Janet explaining their reasons for fleeing to the UK

"I first arrived in Birmingham when I was 20. I was way too young to be coming to a new country, but if you have a problem and you can't stay alive at home, that's the way it must be."

As stated earlier, therapeutic services which focus only on a potential traumatic event or on a person's status as someone who has migrated for example, may inadvertently diminish the experience of a service user and reduce an individual to a part of their life (as an immigrant or refugee) rather than considering the whole lived experience of that person.   That is not to say that there will be times when concentrating on these issues is not important. This reductionist approach may also risk underestimating the survival strategies and strengths that an individual possesses. Requirements for mental health services are very varied, and pre-migratory health, reasons for migration, age, explanatory health beliefs, help-seeking behaviour, health status and language may all play a part.

Migrants might want to see a therapist for the same kind of reasons as any other person, they might also present with issues relating to migration.

In addition, contextual factors may all be relevant for people who have migrated, for example we know that poverty is detrimental to mental health (30), as is homelessness (31). Asylum seekers in the UK receive £36.95 (€ 31.89 euros) a person a week from the government which is £1,921.40 (€2,140.07 euros) year. Each country has slightly different ways of assisting asylum seekers, but the principals are largely similar. Hence, money is extremely tight and little is available for any kind of activities which cost money. This is unlikely to be conducive to a sense of wellbeing, security and good mental health. Therapy may not be prioritised over keeping fed and warm. Therefore, therapists may need to think around this and not assume someone not turning up is related to their lack of desire to engage, it may be a matter of survival.

> *Useful resources*
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> *Service users who have grown up in countries where English or the language of the country to which they have migrated, may not be fluent in the language of their new country. Therapists will need to work with interpreters. The resources listed below may be useful for those offering intercultural therapy with newly arrived migrants or refugees.*

> *32..British Psychological Society Guidelines (2017) On Working with Interpreters can be located at*
> *www.bps.org.uk/sites/bps.org.uk/files/Policy%20%20Files/Working%20with%20interpreters%20-%20guidelines%20for%20psychologists.pdf*

> *33.A DVD on Working with Interpreters in Mental Health*
> *https://www.youtube.com/watch?v=k0wzhakyjck*

Refugees have often been viewed as a homogenous group, who were 'victims' in need of help to cope with their lives, they were described by some mental health professionals as if they were the only ones who could help them (34). There was also an assumption in the early work that all refugees must be suffering from trauma, and the diagnosis of Post-Traumatic Stress Disorder (PTSD) for refugees and asylum seekers was used widely and sometimes unquestioningly (35). This failed to account for the many and varied survival and coping strategies used by many refugees. Very few refugees or asylum seekers seek out mental health services (36). The diagnosis of PTSD when applied to people from other cultures, may fail to account for cultural or contextual factors and specifically refugees and

asylum seekers is a contested diagnosis (35). A number of other concepts which it may be useful for the intercultural therapist to be aware of include the concepts of survivor guilt and moral injury. The latter is when someone sustains an injury to their conscience or moral code owing to something that they did or did not do in in a specific situation (37).

Additional resources

A refugee portal on refugee mental health and well-being is available at (38)

https://www.uel.ac.uk/Schools/Psychology/Research/Refugee-Mental-Health-and-Wellbeing-Portal

The Mental Health and Wellbeing Portal for Refugees & Asylum Seekers has been created to be utilised as a first stop resource to enable mental health and social care professionals, community organisations, statutory, international and national third sector organisations and refugees and asylum seekers themselves, to easily access the wealth of information and resources, and practical tools many of which are not accessible in one place. These resources have been produced and developed by health care practitioners, international and national organisations and academic and research bodies with experience and expert knowledge of working with refugees and asylum seekers, both in the UK and internationally. The resource has a number of downloadable resources. Some of the web site is available in different languages.
The resources include:

- Mental Health Resources in English
- Translated Mental Health Resources
- Guides & Downloads on Mental Health and Social Care of Refugees & Asylum Seekers
- Therapeutic Approaches with Refugees & Asylum Seekers
- Audio and Video Resources
- Relaxation Techniques and Exercise Audios
- Presentations & Teachings on Working with Refugees & Migrants
- Personal Experiences & Stories of Young Refugees & Asylum Seekers
- Directory of Services and Organisations for Refugees & Asylum Seekers
- References on Mental Health of Refugees, Asylum Seekers & Migrants British

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(39). The British Psychological Society Guidelines for Psychologists working with Refugees and Asylum-seekers in the UK are available;

Full version at

. https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Guidelines%20for%20Psychologists%20Working%20With%20Refugees%20and%20Asylum%20Seekers%20-%20Extended%20Version_0.pdf

(40). Summary version at

https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Guidelines%20for%20Psychologists%20Working%20With%20Refugees%20and%20Asylum%20Seekers%20-%20Summary_0.pdf

Health pluralism, global help-seeking globally and developing appropriate services

Health pluralism is where a service user or service provider may draw upon or merge traditions of explanation, treatment or cure.   Health pluralism might for example, include combining allopathic medicine with Ayuverdic medicine or combining therapy with undertaking religious practices or complementary medicine. Clinicians practicing intercultural therapy need to be open to a range of practices and meaning-making which may be outside their personal repertoire and knowledge. In addition clinicians will find that entering therapy is not something that is offered or recognised in some cultures, as its premise is very western oriented, with an emphasis on individual autonomy and self-actualisation , rather than a more collective focus or one of duty (3). Therapy may not feature among the help-seeking repertoires of many migrants or refugees suffering psychological distress, as most cultures contain rich traditions relating to keeping establishing and managing psychological well-being (7, 8). Therapists should ask about what they might have done in their country or region of origin and what they think will assist them, rather than assuming that traditional therapy is the most appropriate intervention.

> *Case examples:-The quotes below is a quote from a refugee living in the UK in relation to help-seeking*
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> *"I was trying to keep myself to myself, as its part of my culture you can't really go and talk to a stranger about my feelings or if I really need help or support, I just couldn't and it was really hard for me to be able to open up to a stranger as I really need them so to be honest I could not really ask for help from anyone else."*

Innovative ways of working / appropriate intercultural therapy services:

Clinicians may wish to consider the unit of focus for their work. Whilst intercultural individual, couples and family work has a place, consultation with the communities mental health practitioners serve (including migrants and refugees may be beneficial. It can offer service providers and therapists the opportunity to use their skills as well as widen their knowledge and understanding and help in developing services in an appropriate and helpful manner which is grounded in the requirements of the communities they serve.   This partnership working harmonises with a number of national and international directives around equality of access. For example in the UK the Equality Act (2010) (41). Evidence shows that people from groups which are labelled 'hard to reach' (and which frequently include those with migratory histories) or who are ascribed marginalised status, access mental health services less than other groups, (42, 7). Some theorists have argued that people working in the psy

professions should also consider whether their role should encompass that of advocating for social justice at a wider level over and above that of just working with individuals (43). This might involve taking a human rights based approach or campaigning for policy changes or just more public awareness of an issue (43). Whilst, the importance of community engagement is being increasingly recognised in the NICE Guidance (44). Guidelines on working with community organisations, were recently published by the British Psychological Society (45).

Example of a training based mental health intervention with a refugee community group:-The Tamil Community Centre based in London.

The author was asked to assist the staff develop their knowledge and skills around mental health and provide support to voluntary workers at the Tamil Community Centre (TCC), a refugee community group, and registered charity located in London. The TCC provides a drop in and advice centre, in addition to providing a hot meal for anyone who visits every day, English language and homework classes and a place for people to meet and promote social inclusion. Many Tamil people had been exposed to war, conflict and trauma in Sri Lanka, which took place for over 25 years and led to one million people fleeing the country. Information about the TCC and the mental health issues that many of their members experience can be located in a short DVD (46) http://www.rota.org.uk/category/our-work/healthy-mobilised-and-bame

The author invited colleagues from another charity the UK: Sri Lanka Trauma group (UKSLTG) (47) www.uksrilankatrauma.org.uk to join her in this work. This group comprises of mental health professionals from the Sri Lankan diaspora and several other interested mental health professionals, who had a cultural understanding and commitment to working in partnership with organisations to improve mental health knowledge and understanding. The TCC staff report that attending their community centre does not carry the connotations or fear which may be associated with attending a clinic or hospital.

In 2017, TCC assisted approximately 3000 people, in addition to seeing people of Tamil heritage, they have people using the centre from a range of other migrant communities. All their staff members are volunteers with Tamil heritage. A ten week training programme was co-produced by TCC and the UKSLTG. The Team offering the training included Psychiatrists, Psychologists, a Priest who was also trained as a psychologist and a GP. The training was mainly conducted in English, though the team also offered sessions in Tamil or with an interpreter. The team were all volunteers. The training included sessions on traumatic experiences and surviving as an asylum seeker, refugee or migrant (including self-care)*; mental health and well-being of children and families including gang awareness*; parenting; negotiating the National Health Service effectively; domestic violence; Somatisation; adapting to cultural change and a different country; Postnatal depression; addiction; nurturing; resilience and strengths and using available services and making appropriate referrals to other agencies and finally a review of the programme.

An audit of the work was undertaken by a trainee psychologist with Tamil heritage (Angeline S Dharmaindra, who was independent of the team and TCC and we are grateful for her input). The TCC volunteers who undertook the training completed a range of questionnaires at 3 time points; t1 (baseline), t2 (post training) and t3 (1 month follow up). The purpose of the audit was to explore if the mental health literacy of volunteers increased as a result of the training programme. Mental health literacy in this instance referred to confidence in working with mental health issues, stigmatising attitudes, knowledge and skills. The median scores for the subjective measure of knowledge and skills indicated an increase in knowledge from pre training to post training which was maintained at 1 month follow-up. The session where a number of local mental health professionals were invited to talk about their services, to establish links and open communication channels and referral pathways was found to be particularly useful. A number of these mental health professionals remain in contact with the TCC staff and this session proved to be mutually beneficial. The findings from this evaluation lend some support to the value of mental health training programmes for volunteers working with people with mental health issues, however further research involving larger samples and using culturally specific tools would be helpful. Many mental health professionals could offer similar work.

Example of the use of therapeutic knowledge and skills in an innovative way and in a diverse context - Bridging barriers - Equality and diversity: Making a difference through improving communication across language and culture in community settings

Academics and students at the University of East London (UEL) in partnership with a national organisation, the Refugee Council, developed a project around mental health which celebrated and used the dual cultural heritage of many UEL students. The students developed a range of psychological skills and knowledge which could be used to enhance social inclusion and wellbeing for members of their linguistic and cultural communities. The programme formed part of our commitment to civic engagement, inclusion and social justice. The programme has run for three years. Participants undertook training in working as interpreters/community brokers, acquiring knowledge, skills, developing competencies and networks and enhancing their contribution to their communities. The training also generated a range of cultural and interpreter related resources for the wider community in relation to mental health and wellbeing. Many of the students are now working as interpreters or cultural brokers or undertaking therapeutic work with their linguistic or cultural community within statutory and non-statutory organisations.

The use of sport in conjunction with therapeutic group support – Football for facilitating therapeutic intervention among a group of refugees and asylum seekers

This therapeutic intervention was based at a medical charity working for survivors of organised violence or torture located in Britain.   The vast majority of the service users were asylum seekers and refugees. (48) notes that 141 countries are reported to use torture regardless of the fact that it is outlawed by the Universal Declaration of Human Rights article 5, (49) and Article 7 of the International Covenant on Civil and Political rights (50) and international law. This psychological intervention was co-produced with a service user/expert by experience, who I had worked with for about a year (here given the pseudonym of Peter).

When reviewing our work together, I asked Peter if there might be anything that could aid his recovery as well as others visiting the clinic. Peter had been suffering from depression, had active suicidal ideation and met the diagnostic criteria for post-traumatic stress disorder, as well as a range of physical complaints. Peter felt that his body (and mind) had been violated and was damaged by his experience of organised violence.   He thought about my request and came up with the idea of a team sport that could be played regardless of language or nationality and alongside others who had shared experiences of surviving organised violence or torture. He felt that undertaking a team sport might assist him in recapturing his sense of his own physicality and control over his body. He believed that a position in a team and community might do the same for the other service users who might choose to join a team. The team would   consist of people who had experienced torture and organised violence where this experience was shared but was not the main focus. Peter felt this might be therapeutic.   There is a developing literature on the positive psychological benefits of exercise (in addition to physical heath gains) these include intrinsic pleasure, affiliation and a sense of belonging (51). In addition, exercise can help with anxiety, depression and a range of health issues (52, 53). This is recognised, as for example, in Britain an exercise prescription can be obtained from GPs which enables access to free or reduced rates to sports facilities.

Whilst, this piece of work was with a group of refugees and asylum seekers, the underlying principles could be used with most team sports and with a range of expert by experience groups or communities. The author and Peter developed the use of football as part of a psychological intervention which initially contained three linked components.   These were, weekly competitive football matches within a local league, training sessions for the football team and group meetings/talking therapy for the team members. It appeared that there was also an unexpected   fourth component, which was the psychological benefits the team's supporters drew from their involvement with the team and the clinicians. The supporters were almost exclusively asylum seekers and refugees, many of whom came every week to matches. It seemed that identifying and belonging to a welcoming and inclusive group increased feelings of belonging and social inclusion for players and supporters.   Whilst watching their team win appeared to offer a number of therapeutic benefits. The regular supporters often took time to talk to the clinicians at matches and at other events we organised.   As discussed earlier, refugees (and migrants) are often viewed as unwelcome by the host country and many report trying to remain 'invisible' or to merge in some way with the wider society. Meeting others (from their own team and other teams) as equals on the football pitch provided a normalising experience.

The exact relationship between body and mind is still being investigated and Cartesian dualism might not be as distinct or discrete as has been envisaged and there may be cultural variations (54, 55, 56). The people we worked with were survivors (despite the atrocities they had been subjected to).   They had exhibited immense resilience and strength in having managed to flee their country of birth, develop an escape plan, travel across the world to seek asylum and were now trying to establish a new life for themselves in Britain. Our work tried to help them process some of their personal experiences in the group setting and to help them share and strengthen their survival skills and resilience both individually and as a group.

All of the interlocking components were important parts of this psychological intervention. Two therapists facilitated the group meetings where the team and some supporters met weekly to consider issues relating to their past and present lives, as well as issues relating to the football team. This group which was named the football group seemed to enable many of the players to talk about issues which might not have felt comfortable if the group had been labelled a therapy group. Gender expectations and ascribed roles relating to discussing emotions may have been in operation. The therapeutic effects of sport have been noted in relation to mental health (57, 58. 59.).

Our team was particularly helped by having a keen team member who had been a national player in his country of origin and several others who had played football in their countries of origin at competitive levels.   The team appeared to help the players to begin to develop feelings of control and mastery of their own physicality and bodies and a growing sense of their own resilience as individuals and a team. The creation of a routine and reason to develop their fitness and interaction with other footballers all brought benefits.   Although, it was not all plain sailing, there were issues when the players' anger about their experiences of organised violence in their countries of origin surfaced on the football field and the team had an unfortunate disciplinary record. We were called to a disciplinary meeting with the league's management on several occasions, as the league were considering suspending the team.   This was discussed in our regular team meetings. Things began to improve after our team won their league in their first season, this contributed to a sense of pride and achievement for the individuals and team. Researchers have noted that participating in sport when also linked to "wins" may lead to positive feelings of self-identity and achievement (60), which was the case here.

We obtained some external funding for the team, a television programme was made for German TV and we obtained the free services of football coach. A couple of the players were trained by the league we joined to become referees, which again contributed to the provision of an additional opportunity, a sense of belonging and social inclusion.   All of this combined with regular wins in the league worked to assist the team develop a sense of achievement and support on the field which the players (and supporters) realised could be replicated in their lives more generally.   As well as their descriptions of this, outcome data revealed that 57 % of the team took advantage of educational opportunities and 19% obtained employment. All the participants described being part of this team as providing a range of benefits these included a sense of belonging, meaning and inclusion, psychological and practical support on and off the pitch from each other, a sense of camaraderie, making new friends. Improvements in their physical and psychological health, well-being were also noted.

Conclusion

In summary, this chapter has considered some of the issues which intercultural therapists may wish to consider when working with new immigrants and refugees. It looked at a range of contextual factors at the international and national geo-political level. It briefly reviewed the   way political narratives around migration have been used and considered how these may impact upon an individual's sense of place in the country of migration and psychological wellbeing. It has reviewed the way culture has been problematized and constructed within the literature and in therapeutic services. Finally, it has stressed the importance of considering power, health pluralism, language and meaning-making and of intercultural

therapists being curious, and open to other ways of viewing wellbeing   and of striving to work to develop appropriate and accessible services which consider the relevant issues and which may include one:one work but may also include using therapeutic skills in innovative ways and in different contexts.

Acknowledgements

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