The Psychological Impact of Music Workshops on Immigration Detainees

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Overview

The difficult process of acculturation with which refugees are faced after displacement following war and gross human rights abuses is a significant problem at both the individual and societal level. As a result of the high incidence of prolonged and repeated pre-migration traumas and post-migration stressors, refugees are at an increased risk of developing a wide range of mental health problems. This thesis examines interventions for refugees, asylum seekers and internally displaced persons that use innovative approaches to promote psychosocial wellbeing and aid acculturation.

Part One is a literature review of the effectiveness of treatments for refugees, other than trauma-focused therapies, that target the broad range of mental health problems and difficulties with everyday functioning with which they present.

Part Two is an empirical study of group music-making workshops run for immigration detainees in Immigration Removal Centres. The workshops aim to foster self-expression and autonomy in detainees and culminate in the production of original music that is either shared with other detainees through performances or recorded and shared with community groups. Applied ethnography was used to investigate whether the workshops had any short and/or long-term effect on participants' psychological wellbeing, and the mechanism through which this effect was enabled.

Finally, Part Three is a reflection on the research process and discusses the considerations and compromises made to conduct exploratory research in complex settings.

Table of Contents

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Part 1: Literature Review

Integrated Approaches to Treating Refugees' Broad Mental Health Presentations and Psychosocial Difficulties

Abstract

Objective: A greater incidence of mental health problems is reported amongst refugees than in the general population. Refugees' difficulties are often multiple and wide-ranging due to a combination of repeated and prolonged pre-migration traumas and post-migration stressors. Recent reviews of treatments for refugees have tended to focus on studies that use trauma-focused approaches to address symptoms of PTSD. Given the range of mental health problems and wider, social difficulties with which refugees are faced, the overall aim of the review is to assess the extent to which treatments that seek to respond to refugees' broader psychosocial needs are effective.

Method: Systematic review of quantitative and qualitative studies evaluating integrated or holistic treatments for adult refugees, asylum seekers and internally displaced persons.

Results: Twelve relevant papers were located. These included multimodal, community and ecological, and CBT-based stress reduction approaches. The majority of studies reported improvements in mental health or functioning as a result of the treatment delivered. However, the research designs had methodological limitations that included the absence of control groups and lack of long-term follow-up.

Conclusions: The limited evidence base and methodological shortcomings restrict the extent to which any firm conclusions could be drawn. Future research employing randomised control designs is needed.

Introduction

Around 300,000 people who have sought refuge from war and human rights abuses live in the United Kingdom (UNHCR, 2009). In 2009 alone, 24,485 asylum applications were made. These applicants represented a cross section of over 50 different nationalities (Home Office, 2010). The range of cultures and understanding of health, and mental health, amongst refugees is, therefore, wide and presents as a significant challenge for health services. A systematic review has shown that resettled refugees are more likely than the general population to present with mental health problems, most significantly post traumatic stress disorder (PTSD) (Fazel, Wheeler & Danesh, 2005). There is, though, a distinction between the impact of discrete traumas such as road traffic accidents and the more severe, multiple and prolonged traumas commonly experienced by refugees, such as torture and loss (Marshall, Schell, Elliot, Berthold & Chun, 2005). Complex traumas are associated with broad, chronic presentations (Courtois, 2004; Herman, 1992a): amongst refugees there are high rates of comorbidity between PTSD, anxiety, depression and somatisation (Porter & Haslam, 2005; Steel, Silove, Phan & Bauman, 2002). These difficulties often persist long-term (Birck, 2001; Kinzie, 2006). The impact of contextual and social stressors associated with the process of acculturation also plays a part in the development and course of these difficulties (Porter et al, 2005). Delayed asylum application processes, detention, unemployment, social isolation and poor socioeconomic living conditions are also associated with poor mental health (Carswell, Blackburn & Barker, 2011; Gorst-Unsworth & Goldenberg, 1998; Ichikawa, Nakahara & Wakai, 2006; Schweitzer, Melville, Steel & Lacherez, 2006).

Recent reviews of treatments for refugees have tended to focus on studies that use trauma-focused approaches to address the narrow symptoms of PTSD (Crumlish & O'Rourke, 2010; Nickerson, Bryant, Silove & Steel, 2011; Palic & Elklit, 2011). Given the range of mental health problems and wider, social difficulties with which refugees are faced, this review will consider treatments other than trauma focused therapies; treatments that seek to respond to refugees' broader psychosocial needs.

The 1951 United Nations Convention on the Status of Refugees define a refugee as, 'A person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country...' Asylum seekers are individuals who have fled their country of origin and are seeking refugee status and, thus, permanent residency in a host country. A displaced person is someone who is forced to leave their home, but stays within their country's borders (UNHCR, 2010). For simplicity, I will refer to displaced persons, refugees and asylum seekers as refugees except where a distinction is required.

PTSD can develop as a reaction to one, or a number of traumatic events, in which a threat to physical safety or integrity is experienced or witnessed. The subjective assessment of this incident is causal in the development of the disorder: feelings of fear, terror or helplessness in response to the trauma are key to diagnosis. Three key persisting symptoms characterise the disorder: re-experiencing of the traumatic incident, avoidance of reminders of the trauma, and chronic physiological arousal (American Psychiatric Association *[DSM-IV-TR],* 2000).

The exact mechanism responsible for this phenomenon is still under some debate. Broadly, it is theorised that the overwhelming nature of the trauma disrupts

the process by which the event is laid down in memory (see Brewin & Holmes, 2003). Fear conditioning may also be responsible. The stimuli present during the traumatic event can acquire strong associations with feelings of fear or terror, which may be triggered should similar stimuli be encountered in the future (see Keane, Zimering & Caddell, 1985).

Trauma-focused therapies, such as Cognitive Behaviour Therapy (CBT) for PTSD, are recommended for the treatment of PTSD (National Institute for Clinical Excellence (NICE), 2005). CBT is a now a well-established and empirically supported psychological therapy that works to identify and alter the maladaptive patterns of negative thinking and unhelpful behaviours that maintain emotional distress and reduce functioning (Beck, Rush, Shaw & Emery, 1979). The most efficacious CBT treatments specifically designed to alleviate PTSD (e.g. Ehlers & Clark, 2000; Foa et al 2005; Resick, Nishith, Weaver, Astin & Feuer, 2002) combine repeated exposure - either using techniques whereby a temporal, detailed ordering of events is recounted using imagery or as a written narrative, or the sufferer is encouraged to confront the feared, but now safe, event/situation 'in vivo' - with cognitive restructuring. This process allows the meaning of the traumatic event and its consequences to be reconsidered (See Ehlers and Clark, 2000; NICE, 2005). Adaptations to trauma-focused therapies that show promise in helping to alleviate PTSD symptoms in refugees have now been developed (Crumlish et al., 2010; Nickerson et al., 2011; Palic et al., 2011).

However, given refugees' complex traumatic experiences, difficult life circumstances post migration and broad mental health presentations, it has been argued that PTSD alone may be an insufficient focus for treatment (Beltran, Llewellyn & Silove, 2008; Bhui, Warfa & Mohamud, 2010; Miller & Rasco, 2004;

Rosen, Spitzer & McHugh, 2008). Disorders of Extreme Stress Not Otherwise Specified (DESNOS), although not a diagnostic category in its own right, attempts to identify these broader reactions. DESNOS describes alterations in six areas of functioning: regulation of affect and impulses; attention or consciousness; self-perception; interpersonal relationships; somatisation; and systems of meaning (APA *[DSM-IV-TR],* 2000). It is not clear how such attempts at categorisation of the reactions to repeated and prolonged trauma can be applied to refugees (Herman, 1992a), but they do provide consensus that such responses may be difficult to place within discrete diagnostic categories. Although there is currently very little evidence on how best to treat reactions such as DESNOS (Cloitre, 2009), it does offer insight into potential areas of functioning at which treatment may be usefully directed, for example interpersonal relationships, which extend beyond those encouraged in trauma-focused therapies for PTSD.

Cultural relativists further expand the argument against a narrow focus on PTSD, criticising the apparent need to index refugees by western standards (Summerfield, 1999). It is argued that the category of PTSD is a socially constructed concept derived from particular socio-political events, and that its relevance has been generalised to victims of war and persecution from other countries with scant evidence to support these wider applications (Summerfield, 2001). Such attempts to apply a system of knowledge based on western values and studies with white, largely middle class, participants lack validity (Watters, 2001). Similarly, the notion of therapy, a regular person-to-person meeting where talking takes the form of healing is a culturally specific to the West (Summerfield, 1999).

People from other cultures may approach the notion of mental health very differently. Their particular socio-cultural experiences will bestow them with

alternative language or conceptual models for understanding what may, at root, be the same phenomena (Kleinman, 1987). Essentially, the imposition of a western model of mental health may reduce the cultural relevance of a treatment approach. Poor cultural fit between treatment approaches and refugees has been associated with the low take-up of mental health services (Bhui, Audini, Singh, Duffett & Bhugra, 2006) even amongst those experiencing severe difficulties (McCrone et al., 2005) and increased levels of mental health related stigma (Miller, 1999). As opposed to a model of care that focuses on trauma and psychological therapy, refugees have been found to favour advocacy and practical support to aid their acculturation (Summerfield, 1999).

In the UK, specialist provision designed to meet the complex and multiple needs of refugees has been described as sporadic, short term and often provided on an ad hoc basis (Watters & Ingleby, 2004). The mental health charity Mind (2009) reviewed services for refugees and found that they were hard to access and lacking in cultural sensitivity or relevance. The Race Relations (Amendment) Act (2000) asks that those in the public sector actively work to reduce inequality in service provision; and The Delivering Race Equality in Mental Health Care (Department of Health (DoH), 2005) white paper advocates the use of community engagement to involve refugees in service planning, an approach that is also supported by the World Health Organisation (WHO, 2001).

It is argued that the range of difficulties with which refugees present cross service boundaries and so require a combination of health and social care (WHO, 1996; 2001). Others are more forceful in stating this case: the extreme life disruption that refugees face must be met by an intensive and wide-ranging service response (Silove, 1999). Integrated or holistic approaches to the treatment of refugees are

perceived as a means of providing this level of care (Mind, 2009; Watters, 2001). A review of service provision for refugees in Western Europe defined such an approach as including: specialist attention given to access and promotion; continuity of care; multi-agency co-ordination; cultural sensitivity; advocacy; and monitoring and evaluation (Watters & Ingleby, 2004).

A phased approach to the management of traumatised refugees often acts as an overarching framework in integrated treatments (Herman, 1992b). This is a broad framework that is intended to guide the course of treatment. In the early stages there is a focus on stabilisation. The therapeutic relationship and development of trust is emphasised and the refugee's practical needs addressed. Later in the therapeutic process traumatic memories can be discussed before life consolidation and restructuring is considered.

There is some debate about the practicality and efficacy of such an approach. PTSD is not the only mental health problem with which refugees present, but it is a common one, and can have a profound effect on functioning. Addressing symptoms of PTSD may help an individual to operate more effectively in the World and to become better able to address other additional, social problems (Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004; Weine, Kulenovic, Pavlovic & Gibbons, 1998). As an extension of this argument, others have queried whether a phased approach is too passive, the demands for safety as a prerequisite for effective treatment excluding individuals who are in a position of uncertainty (Drozdek, 1997), but have nonetheless been found to make good use of therapy, for example asylum seekers (Neuner et al., 2010).

Counter arguments cite the potential for re-traumatisation if the traumatic history is examined too early in therapy and claim that client engagement is made

difficult and therapy protracted when exposure and cognitive restructuring is attempted too soon (Herman, 1992b). On first entering treatment refugees can often find themselves in a situation of extreme uncertainty: the status of their asylum claim unclear; perhaps the situation from which they fled ongoing; and basic security and safety issues such as housing and money yet to be established (Silove, Sinnerbrink, Field, Manicavasagar & Steel, 1997). Despite the lack of empirical evidence, the NICE (2005) guidelines have advocated a phased approach, recommending that safety from future persecution and practical issues be addressed before specific therapies are delivered.

This review will, therefore, examine the evidence that exists for interventions that apply what could be considered integrated or holistic approaches to the treatment of refugees, according to the definition previously described by Watters and Ingelby (2004). Given the recent, extensive reviews of trauma focused therapies these will not be considered. Instead the focus will be on treatments that address a broader range of difficulties than PTSD alone.

Method

Inclusion and Exclusion Criteria

Four types of criteria were employed, covering study participants, setting, interventions and design.

Participants

Studies that recruited adult refugee, asylum seeker, or internally displaced person (IDP) participants were included in the study for review. Studies were excluded if participants, at the time of recruitment into the study, were no longer considered refugees, asylum seekers or IDPs. This included returned refugees, returned IDPs and stateless persons. Trafficked persons were not considered for inclusion. The review intended to look at the impact of the intervention on the broad range of difficulties with which refugees present. Therefore an established mental health diagnosis, such as PTSD, was not necessary, but a measure of psychosocial functioning was required as a minimum.

Setting

Studies conducted in both western countries and refugee camps where internally displaced people had been forced to reside were considered for review.

Interventions

Using the definitions established in the NICE (2005) guideline for PTSD, studies concerning individual, trauma focused therapies - those that incorporated exposure and/or cognitive restructuring - were omitted from the review. This included Narrative Exposure Therapy (Neuner et al, 2004). Individual and group CBT-based stress/relaxation interventions were included in the study. In accordance with NICE (2005), those studies that included an element of cognitive restructuring in the intervention, but were predominantly concerned with stress management or relaxation were classified as the latter and included. Medication only trials were excluded.

Holisitic or integrated interventions were included. These were selected on the basis that they matched the Watters and Ingelby (2004) definition. These

included multidisciplinary or multimodal approaches, community based treatment approaches, approaches that encouraged engagement and access, and those that emphasised advocacy. Where a treatment contained a number of different elements and one of these was a trauma-focused therapy the study was included.

Design

Studies were included if they reported an evaluation of the intervention and presented the data, either quantitative or qualitative. Comparative and randomised designs were included but were not a necessary requirement for inclusion. Retrospective studies were included. Case studies and studies that did not measure outcome and were excluded.

Search Strategy

Studies were identified using the EMBASE, Google Scholar, MEDLINE, PsycCRITIQUES, PsycEXTRA, PsychINFO and PubMed databases. The keywords used in the search related to refugees (refuge*, Asylum*, immigra*, migra*), mental health problems ("post traumatic stress disorder", PTSD, trauma*, somatis*, depress*, anxi*, "mental health", "mood disorder") and interventions (therap*, treat*, psychother*, counsel*, psychoeducation, "ecological approach", "community intervention", prevent*). The reference lists of previously conducted reviews for refugee treatment were examined (Crumlish et al., 2010; Nicholl & Thompson, 2004; Nickerson, et al., 2011**;** Palic et al., 2011). The Journal of Refugee Studies, Traumatic Stress and Torture were manually searched for relevant literature.

The search turned up many thousands of results. They were checked for suitability by reading the abstract and using the 'cited by' function. The majority of

results were excluded on the basis that they solely measured the extent of mental health problems in refugees. Another large collection of studies focused on the take-up of health services amongst refugees. A number of studies included rich description of the treatment offered, but failed to provide data to support the evaluation (Curling, 2005; Berliner, Nikkelsen, Bovbjerg & Wiking, 2004; Reeler, Chitsike, Maizva & Reeler, 2009; Stepakoff et al., 2006; Tribe & De Silva, 1999; Wenk-Anshon, 2007).

Table 1.

Summary of studies reporting an integrated approach to the treatment of refugees.

Author	Study aims	Sample size	Participants	Setting	Intervention	Measures	Design	Main outcome	Effect size
Multimodal approaches									
Boehnlein et al. (2004)	Assess effectiveness of 10 years of continuous multidisciplinary treatment	23	Cambodian refugees. All met diagnostic criteria for comorbid PTSD and Major Depression.	Specialist US refugee treatment centre.	Supportive psychotherapy, weekly 'socialisation group treatment', medication management and practical help organising benefits and citizenship issues.	Hamilton Depression Scale (HADS), Sheehan Disability Scale, Global Assessment of Functioning Scale (GAF). Quality of life rated on visual analogue scale.	One group post-test only. Case notes reviewed and rated every 3 months for symptom severity.	Significant reductions in PTSD and depression. Majority still experiencing at least mild PTSD symptoms after 10 years treatment.	Not reported.
Brune et al. (2002)	Examine association between refugee belief systems and psychotherapy outcome.	141	Traumatised refugees from different countries resettled in Sweden.	Six specialist refugee treatment centres in Sweden.	Psychotherapy combined with other therapeutic, medical and social support. No information on specific approaches within therapies.	HADS; Clinical Global Impressions Scale.	One group pretest-posttest.	Reduction in depression and increase in global functioning. No statistical analysis to determine whether change significant.	Baseline to post treatment. HADS: d = 1.60.

Carlsson et al. (2005)	Assess effectiveness of multidisciplinary treatment.	55	Torture victims from different countries granted asylum in Denmark.	Specialist service in Denmark for torture victims.	Psychotherapy, physiotherapy, social counselling, medical help, plus specialist treatment dependent on refugees' needs.	Harvard Trauma Questionnaire (HTQ) Part IV, Hopkins Symptom Checklist-25 (HSCL-25), HADS, World Health Organisation Quality of Life-Bref (WHOQOL-BREF).	One group pretest posttest and 9-month follow-up.	No significant reductions in PTSD, depression, anxiety or increase in quality of life.	Not reported.
Carlsson et al. (2010)	Assess effectiveness of multidisciplinary treatment.	45	Cohort of sample from 2005 paper.	As above	As above	As above	One group pre test posttest plus 9-month and 23-month follow-up.	Significant reductions in PTSD, depression, and anxiety from pre treatment to 23 months follow-up. Clinically sig. change in one third.	Baseline to 23-month follow-up. HTQ: d = 0.34. HSCL-25: d = 0.30. HADS: d = .45.
Palic et al. (2009)	Assess effectiveness of multidisciplinary treatment.	26	Refugees from different countries granted asylum in Denmark. All met criteria for PTSD, Adjustment Disorder or Enduring Personality Change after Catastrophic Experience.	Specialist refugee service in Denmark.	Weekly psychotherapy: mainly CBT, but some variation. Weekly physiotherapy.	Schedules for Clinical Assessment in Neuropsychiatry (SCAN); GAF; HTQ; Trauma Symptom Checklist-33 (TSC-33); Crisis Support Scale (CSS).	One group pretest-post test and 6-month follow-up.	Significant reductions in PTSD, anxiety and depression; significant increase in global functioning. Gains maintained at follow-up. All participants assessed as suffering from at least mild PTSD at follow-up.	Baseline to follow-up. HTQ: d = 1.01. TSC-33: d = 0.51 GAF: d = 1.41.

Community/ecological approaches

Dybdahl (2001)	Assess effectiveness of parenting programme for traumatised refugees.	87	Displaced Bosnian mothers with children aged 5-6.	Town in Bosnia acting as a refuge for families displaced by war.	Psychosocial intervention for mothers addressing mental health needs. Both control and treatment groups received free healthcare.	Impact of Event Scale - Revised (IES-R); adjusted War Trauma Questionnaire; and idiosyncratic social support questionnaire and visual analogue scale to assess wellbeing.	Randomised control trial. No post-test follow-up.	Significant reduction in levels of PTSD amongst intervention group.	Baseline to post treatment. IES-R: d = 0.63.
Goodkind (2005; 2006)	Assess effectiveness of community-based advocacy and learning programme for refugees.	28 refugees ; 27 Undergr aduates	Hmong refugees living in the United States.	Community centres in the United States.	Community-based advocacy and learning programme.	Basic English Skills Test (BEST), Citizenship Knowledge Test; Satisfaction with Resources Scale, Difficulty Obtaining Resources Scale, Satisfaction with Life Areas Scale; Psychological well-being Scale to assess happiness and distress. Semi structured interview exploring experience of intervention.	One group pretest postest: data collection at 3-month intervals - pre treatment, midpoint, post treatment and 3-month follow-up. Semi-structured interview at 3-month follow-up.	Significant reduction in levels of distress and increase in quality of life, satisfaction with resources, English proficiency and US citizenship knowledge. No significant increase in happiness or accessing resources. Gains not maintained at follow-up.	Not reported.

Weine et al. (2008)	Assess the effectiveness of family intervention to engage refugees in mental health services.	197 (87 controls; 110 intervention group)	Bosnian refugees living in the US diagnosed with PTSD but not receiving mental health services, and members of their family of adult age.	Community centres in the United States	Coffee And Families Education and Support (CAFES)	Mental health visits; The PTSD Symptom Scale (PSS); The Centre for Epidemiological Studies Depression Scale; idiosyncratic scales to assess knowledge regarding trauma related mental health and family comfort discussing trauma.	Randomised control trial. Post intervention assessment of mental health visits at 6, 12 and 18 months following treatment.	Increased access to mental health services amongst intervention group. Greater access with higher depression scores.	Not reported.
Yeomans et al. (2010)	Assess the impact of PTSD psychoeducation on a community trauma intervention.	113	Displaced Hutus and Tutsis.	Rural Burundian refugee camps	Reconciliation workshop with and without PTSD psychoeducation.	HSCL-25; HTQ parts I and IV;	Randomised control trial. 3 groups: workshop with psychoeducation; workshop without psychoeducation; waitlist control. Assessed pre and post intervention. No follow-up.	Significantly reductions in PTSD in treatment conditions. Significantly greater reduction in non-psychoeducation group compared to psychoeduction group. No reduction in depression or anxiety and no between group differences.	Baseline to post treatment. HTQ part IV: d = 0.66. HSCL-25: d = 0.69.

CBT-based stress reduction/relaxation approaches

Kruse et al. (2009)	Assess effectiveness of trauma focused CBT therapy without using techniques of exposure – use in stabilisation phase of treatment.	70	Bosnian refugees diagnosed with comorbid PTSD and somatoform disorder. All experienced severe trauma.	Specialist service for psychosomatic medicine based in a German University.	CBT-based stress reduction and relaxation treatment.	HTQ part IV; Used the Global Severity Index (GSI) of the Symptom Checklist (SCL-90) to measure mental health functioning; physical and mental subscales of SF-36 Health Survey Questionnaire.	Quasi-experimental. Non-random assignment to intervention or TAU condition. Pre treatment and 12 month follow-up assessment.	Significant reduction in PTSD, anxiety and depression from pre to post in intervention group. At follow-up 83% of participants were in remission from PTSD symptoms.	Baseline to follow-up. HTQ: d = 2.8. GSI: d = 1.24. SF-36 health subscale: d = 1.83. SF-36 Physical subscale: d = 1.44.

Muller et al. (2009)	Assess feasibility and efficacy of short-term CBT biofeedback intervention for refugees with chronic pain.	11	Severely traumatised refugees from different countries diagnosed with comorbid PTSD and chronic pain.	Two specialist centres for the treatment of torture victims, one based in Switzerland, the other Germany.	CBT-based biofeedback intervention.	Mini International Psychiatric Interview (MINI); Posttraumatic Diagnostic Scale (PDS); HSCL-25; German Pain Coping Questionnaire.	One group pretest-posttest and 3 month follow-up.	Significant improvements in pain-related cognitive and behavioural coping. No significant reduction in PTSD, anxiety or depression.	Baseline to follow-up. Cognitive coping: d = 0.38. Behavioural coping: d = 0.71. PDS: d=0.86. HSCL (depress.): d=0.56. HSCL (anxiety): d= 0.66.
Snodgrass et al. (1993)	Assess effectiveness of CBT-based stress reduction intervention.	8	Vietnamese refugees, who were also undergraduate students, living in the United States.	University based in the United States.	CBT-based stress reduction and relaxation treatment.	Avoidance Questionnaire; Ability to Function Scale; Reaction Index.	Quasi-experimental Treatment group completed all measures pre and post treatment. Participants family/friends acted as yoked control – completed Reaction Index at same times.	Significant reductions in PTSD amongst treatment group. Also improved in ability to relate to others.	Not reported.

Results

In total 12 studies were deemed suitable for review. These were grouped according to the following approaches to treatment: multi-modal; community and ecological; and CBT-based stress reduction or relaxation. Multimodal approaches provide integrated or multidisciplinary treatment for refugees. Given the consistency of these approaches with this review's aims these will be considered first. Next community or ecological approaches to treatment, which can be loosely equated with Watter and Ingelby's (2004) definition of 'holistic' or integrated treatment, will be examined. Finally, CBT-based stress reduction/relaxation therapies will be reviewed.

Multimodal Approaches

The term multimodal has been used in previous reviews of treatments for refugees to describe approaches where psychological interventions are provided alongside other treatments, often from other domains, such as medical or resettlement assistance (Nickerson et al., 2011). A number of specialist treatment centres have been established in the Western world that follow this approach. Six studies were identified that evaluated the approach of such centres. Various methodological limitations were common to all of the studies within this category. Foremost amongst these was the failure amongst all studies to include a control group for comparison. Such a failure reduces the certainty with which findings can be ascribed to the treatment delivered. Treatment tended to be non-manualised, poorly described and studies neglected to compare participants who received different combinations of the various therapies on offer. The problem of bias was

introduced in a number of the studies where the main clinician or members of the treatment team were the principal researchers. One study (Palic & Elklit, 2009) included elements of trauma-focused CBT. As this was offered within a wider, integrated system of therapies, the study was included for review.

Brune et al. (2002) retrospectively analysed the chart notes of traumatised refugees receiving specialist psychological and medical treatment in Sweden. Whilst the study was primarily interested in the outcome of treatment as a function of a refugee's belief system, overall pre to post treatment outcomes and depression levels were also analysed. Treatment was only briefly described as '…in general, patient-centred psychotherapies often accompanied by other therapeutic, medical and social supportive measures' (Brune et al., 2002, p. 253). Attendance at ten sessions was a minimum inclusion requirement. Mean length of treatment was 21.5 months and ranged from three months to six years.

The lead researcher was the primary clinician and selected participants for inclusion in the study from his own case notes. It was difficult to assess whether this selection was biased: an independent researcher randomly inspected only 10% of cases for suitability. There was no formal assessment of PTSD diagnosis or symptoms. Instead participants completed a self-report depression measure and a measure of global functioning more commonly used in drug trials for schizophrenia. Average rates of depression decreased and global levels of functioning increased over the course of treatment. Unfortunately, other than presenting mean scores, no further statistical analysis to determine the extent of pre to post change was provided, nor was the data considered with regard to levels of clinically significant change. It is unclear whether this change persisted over time; no follow-up assessment was conducted.

To understand better the longitudinal impact of psychological treatment on refugees, Boehnlein et al. (2004) retrospectively analysed outcome data from a small cohort of Cambodians who received specialist multidisciplinary treatment over ten consecutive years in the United States. Their traumas were multiple and extreme. All participants were diagnosed with co-morbid PTSD and depression at entry to the service.

Treatment was described minimally as a combination of medication, psychotherapy, weekly 'socialisation group treatment' and assistance with issues regarding citizenship and benefits. Participants received varying combinations of these treatments for different lengths of time. The same two psychiatrists and Cambodian counsellor treated all participants.

An independent researcher - recruited to reduce assessment bias - interviewed participants and reviewed chart notes with the treating psychiatrist. They found that PTSD symptoms, as measured by the Clinician Administered PTSD Scale (CAPS) (Blake et al., 1995) – the ' gold standard' in PTSD assessment (NICE, 2005) – reduced significantly in over half of the participants. There was, however, no baseline PTSD measure. When participants entered treatment, between 1979 and 1989, no validated measures existed. Instead chart notes were retrospectively analysed using the CAPS. Depressive symptomatology reduced significantly in 83% of participants and quality of life improved. This was reflected by the high numbers who passed their citizenship test over the 10-year period. Asymptomatic participants continued to visit the centre; proof, according to the authors, that the centre provided an important continuing social function beyond treatment. Yet the majority of participants still exhibited at least mild PTSD symptoms at follow-up. Levels of everyday functioning were varied and only one participant had entered employment.

All participants had experienced at least one prolonged recurrence of their PTSD symptoms over the course of ten years. This was often linked to a clear environmental stressor.

In a similar study Carlsson, Mortensen and Kastrup (2005) attempted to chart changes in symptoms of PTSD, depression, anxiety and health related quality of life amongst refugees receiving treatment in a specialist Danish centre for torture victims. Referral to the service was only provided to those refugees who had been granted asylum and were deemed to require treatment in more than one modality.

Treatment at the centre was described as multidisciplinary. Participants were offered psychotherapy, physiotherapy, 'social counselling' and medical assistance, but no further description of the components of these treatments was provided. Seventy-one percent of participants received treatment in more than one modality. The centre aimed to be flexible in meeting the needs of participants: 12.7% received specialist group therapy; and a further 9% underwent family therapy.

Participants were administered validated self-report and observer-rated measures at intake into the service and at nine-month follow-up. Small but non-significant improvements were found on all measures indicating that the changes witnessed were random or, as the researchers suggest, a result of extreme baseline measures regressing towards the mean. The number of participants who scored above cut-off on both the PTSD and general psychological distress measures decreased from pre treatment to nine-month follow-up, but minimally – this change was not deemed significant. At nine-month follow-up the majority of participants were still in treatment, a possible reason, the authors argued, for the minimal changes found. A longer follow-up was required.

Carlsson, Olsen, Kastrup and Mortensen (2010) later provided further 23-month follow-up data on a sub sample of this same treatment cohort. They found statistically significant improvements on all mental health measures from baseline to 23-month follow-up; this was not reflected in quality of life measures. Effect sizes, though, were small. Although roughly a third of the participants reliably improved, around 10% reliably deteriorated and very few participants were found to have made complete or clinically significant recovery. On a self-report measure of perceptions of treatment, participants stated that they found treatment helpful; around a third believed their mental health state had improved.

Palic and Elklit (2009) conducted the one study to date that has provided sufficient detail on the types of therapy offered in multidisciplinary setting. Participants were refugees from a range of countries, diagnosed with PTSD, adjustment disorder or enduring personality disorder after catastrophic experience. A phased model of treatment was adopted and psychotherapy and physiotherapy sessions provided. The psychotherapy component was based on CBT treatment for panic and used techniques such as, '…psychoeducation, trauma hierarchies, in vitro exposure, reliving through remembering, breathing exercises and training in coping with anxiety and fear' (Palic & Elklit, 2009, p. 252). One therapist arbitrarily incorporated Eye Movement Desensitisation and Reprocessing Therapy (EMDR) when treating three of the participants. The physiotherapy focused on 'education in body awareness in coping with pain and stress' (Palic & Elklit, 2009, p. 252). The centre took a 'shared care' approach to its work acting as the coordinating body for regular network meetings between professionals involved in the case. All participants received one psychotherapy and one physiotherapy session each week. Treatment lasted for between 16 and 18 weeks.

Participants were assessed for levels of PTSD, anxiety, depression, somatisation, social support and global functioning, using a mix of observation and self-report measures before treatment commenced, at the end of treatment, and 6 months after its completion.

Significant improvement on all measures of psychological functioning were evident over the course of treatment. Global functioning and levels of social support significantly increased. Effect sizes of reduction in PTSD symptoms were large; the magnitude of change in depressive and anxiety symptoms was more modest. Treatment gains were maintained at follow-up although a significant reduction was observed in levels of current social support.

Evidence of clinical effectiveness was less encouraging. In general, levels of PTSD, depression, anxiety and somatisation remained high at follow-up despite improvements. Prior to treatment all participants had received a diagnosis of PTSD. At the end of treatment, observer ratings indicated that 92% continued to exhibit symptoms sufficient for a diagnosis of PTSD; the remaining 8%, however, were not symptom free, their diagnosis had been altered to enduring personality change after catastrophic experience.

Summary

The studies adopted a multimodal approach to the care of refugees. They reviewed work being conducted in major treatment centres in Europe and the US. A combination of psychosocial, psychotherapeutic and medical treatments were deployed. The package of care was individualised dependent upon refugees' multifarious needs.

Overall, a mixed view of the effectiveness of this approach was presented. Generally, improvements in PTSD, depression, global functioning and perceived

social support were evidenced but they were minimal to modest. Where more sizeable changes were documented, the study tended to be retrospective and involved treating clinicians reviewing case notes, raising questions of bias. Furthermore, remission rates from PTSD and other disorders of psychological distress, namely depression and anxiety, were low despite lengthy follow-up periods. The fact that participants were often still in treatment during follow-up assessment could explain these findings, but we cannot be clear without a post treatment assessment. It remains possible that such chronicity is endemic within this population, exposed as they are to such complex trauma: researchers have commented that treatment goals may be better aimed at symptom alleviation than cure. It is possible that the centres reviewed provide treatment for refugees who present with particularly severe difficulties who, without attention, would only deteriorate further.

The absence of a control group in all instances makes disentangling the positive effects of treatment from other environmental factors difficult. Future studies with a control group and fuller description of therapy are needed. The centres adopted very different approaches to treatment, but they provided insufficient information for replication. It was unclear as to why one client would receive a particular combination of treatments, or whether different combinations of treatments had different impacts on outcome. None of these studies used manualised treatment approaches, nor were any adherence checks put in place. In presenting treatment as a homogenous entity, we are offered little information as to what the active elements of therapy were and how the inclusion of, say, physiotherapy or medication impacted on the process of therapy or outcome.

Community and Ecological Approaches

From an ecological perspective problems are not only present in the individual, but embedded in communities. This approach, closely related to community psychology, is a reaction to standard psychiatric care and its conceptualisation of mental health. It is argued that Western models of mental health do not hold cultural relevance for refugees and services fail to address post-displacement needs, hence the poor take-up of services. Instead interventions should happen in the community, incorporating that community's beliefs and knowledge of psychological problems. Cultural relevance is paramount, as is a focus on strengths, building capacity through empowerment and encouraging members of the community to become equal partners in an intervention (Miller & Rascoe, 2004). This idea has parallels with the definition of integrated/holistic approaches. Four studies were identified that approached the treatment of refugees from this perspective.

Dybdahl (2001) understood the importance of context in devising a group intervention for refugee children that focused on their mother's mental health and wellbeing. Eighty-seven mothers with children aged fived to six were recruited from a town in Bosnia, a refuge for people displaced during the war. Roughly half the participants were living in private accommodation, the other half residing in a refugee camp.

The psychosocial intervention sought to foster quality interactions between caregivers and their children. The programme, based on a pre-existing parenting programme and prior experience of running trauma focused, mental health workshops, was developed by the author and manualised so preschool teachers could be trained to be group leaders. Direct attention was given to the mothers' mental

health needs and reactions to traumatic events. The programme reinforced existing skills and indigenous practices, particularly those concerning child rearing. Groups met weekly for five months and contained a maximum of five participants. Facilitators received weekly group supervision. It was unclear whether this supervision was only a source of support or also provided checks of adherence to the treatment manual.

Participants were randomly assigned either to a control or treatment group. Assessors, separate from the treatment team, were blind to this assignment. The treatment group received the group psychosocial intervention and basic health care once a month; the control group received basic health care only. The free health care was an incentive to participate in the study. A further control group that also received some alternative form of psychosocial assistance would have helped to clarify whether it was the specific or non-specific elements of therapy that were effective.

PTSD symptoms and wellbeing amongst participants in the treatment group improved significantly over the course of treatment. Overall levels of social support did not alter significantly but there was a trend of improvement. By contrast, participants in the control group displayed a non-significant trend of deteriorating levels of perceived social support. Most notably the children of mothers who had attended the psychosocial intervention showed improved weight gain and psychological wellbeing. However, post treatment a large proportion of the mothers still exhibited symptoms of PTSD and the gains identified were small. Not all participants completed all measures at all time points. It is therefore possible that the results presented did not reflect the experience of all participants. Post hoc analyses indicated that families in private accommodation were less likely to have suffered the loss of their partner, suggesting that other variables may have mediated treatment

effects. Furthermore, the authors commented that the town used for the study was small and contamination of treatment effects likely.

Yeomans, Forman, Herbert and Yuen (2010) examined the impact of a PTSD psychoeducation module that had been incorporated into a community intervention. This was designed to help Hutu and Tutsi's subject to violence during the Rwandan conflict who were in refugee camps in rural Burundi. They raised concerns that the inclusion of psychoeducation could impose a western view of trauma, medicalising the problem and potentially undermining the impact of 'protective culturally specific strategies' (Yeomans, et al., 2010, p. 308).

The basic intervention deployed was a manualised group approach that considered recovery from trauma as necessarily involving the 'restoration of relations between community members' (Yeomans et al., 2010, p.308). Experienced Burundian facilitators were used to lead the groups. There was a lack of detailed information about how facilitators maintained adherence to the manual. They wrote notes on the content of group sessions, but it was unclear how this information was used to ensure consistency.

Using stratified randomisation procedures to ensure a mix of ethnicities in groups, participants were assigned to either standard treatment, standard treatment plus psychoeducation or waitlist control. The psychoeduction component consisted of a 90-minute presentation and discussion of the specific symptoms of PTSD. To ensure that both treatment conditions were of equal length, the non-psychoeducation treatment devoted extra time to an exercise that focused on discussion around 'trust, safety and interethnic relations in the community'. Whilst this helps to control for any dosage effect, it means that the different impacts of the therapies cannot be ascribed purely to the inclusion of psychoeducation. It was unclear whether or not

the treatment team were separate from the assessors nor whether they were blind to the treatment.

No formal PTSD diagnoses were made. Instead a well-validated self-report measure of PTSD was administered and the extent of difficulties assessed using established cut-off points. Reduction of PTSD symptom severity was significantly greater in the treatment groups from baseline to two-week post intervention follow-up in comparison to the waitlist control; and greater in the non-psychoeducation group. However, no such reduction was evidenced in any of the groups on a self-report measure of depression and anxiety. No long-term follow-up was included, nor was there any mention of the clinical effectiveness of the intervention.

Weine et al. (2008) evaluated the impact of a group intervention that adopted a strength and resilience approach to the treatment of refugee families. They conceptualised the family as central to any traumatic recovery and an influential force on help-seeking behaviour and access to mental health care. The nine-session, 16-week, manualised intervention entitled Coffee and Family Education Support (CAFES), was facilitated by Bosnian laypersons. Developed collaboratively between Bosnians and Americans, it contained elements of mental health awareness training and family psychoeducation, with space for informal discussion. Facilitators were extensively trained prior to the study and assessed for adherence to the treatment model in weekly supervision and through analysis of videotaped sessions. Participants were recruited via the local community and group sessions were held in community centres close to participants' homes. Seventy-three percent of those invited attended. Fifty-six percent of these were present at eight or more sessions. Primary participants suffered from PTSD. They were asked to invite family members over the age of 17 to the group. Participants were randomised to the intervention or

control groups after initial assessment. The control group received no care. Those participants who attended all sessions were found to be those who initially had higher levels of PTSD and depression.

Visits to mental health services, mental health knowledge, comfort within the family to talk about mental health and mental health services were measured at six, 12 and 18 months follow-up. The assessors were independent of the facilitators. Results indicated that access to mental health services amongst participants in the intervention group significantly increased over the course of the intervention. Level of depression mediated this effect: the higher the depression the more the intervention had an impact. Severity of PTSD did not have the same mediating effect. The authors regarded this finding as evidence that the family is an important mediator in access to mental health services amongst refugees. Depression amongst the group was regarded as a greater cause for concern than PTSD symptoms and more available to treatment, hence its impact on access.

Goodkind (2005; 2006) evaluated a manualised community-based advocacy intervention for Hmong refugees aimed at improving community responsiveness and reinforcing strengths. This programme was developed collaboratively between undergraduate students and Hmong refugees**.** It was run in communities where Hmong refugees had been placed in the United States.

The intervention spanned a sixth month period and consisted of two main components: 'Learning Circles' and advocacy. 'Learning Circles' were held twice weekly for two-hours and facilitated by one Hmong refugee and one undergraduate student. Participants shared cultural information and experiences and spent time in pairs working on practical skills, such as learning English, studying for the citizenship test or completing job applications. The advocacy component comprised

four to six hours spent outside the learning circles with an undergraduate helping a Hmong refugee - the pairing based on natural relationships formed during the learning circles - on a topic of their choosing. Advocacy followed an iterative process of assessment, implementation and monitoring, an emphasis on the transfer of skills. Whilst the length of treatment was universal for all participants, different participants received different numbers of contacts and treatment hours. Undergraduate participants received weekly supervision to ensure that they were adhering to the treatment manual.

Participants were recruited into the study by the author who had been working within the Hmong communities for four years prior to commencement of the study. A predominance of females agreed to participate.

Participants were assessed by trained, bi-cultural professionals separate from the treatment team. Quantitative measures were completed prior to treatment commencing and then at three, three monthly intervals: mid intervention, post intervention and three month follow-up.

Growth trajectory analysis indicated improvements in quality of life, English language proficiency, US citizenship knowledge and reduction in distress over the course of the intervention. Improvement in participants' quality of life was mediated by an increased sense of satisfaction with resources. There were no improvements in levels of happiness nor was there a reduction in difficulty accessing resources. English language proficiency continued to significantly improve at follow-up, but on all other measures there was a tendency for the gains made to recede. Given the lack of a control group it is difficult to ascribe any gains made to the treatment. Also, not all participants completed the measures at all the different time points, again suggesting that the results may not be indicative of everyone who received treatment.

No analysis of clinical significance was included. Instead, post intervention, refugees were joined by their undergraduate advocate and encouraged to explore their experiences of the intervention in a semi-structured interview with the lead author. Qualitative analysis of transcripts and field notes suggested that a genuine process of mutual learning was taking place. Both the refugees and undergraduates felt that they had something to contribute: Hmong refugees felt that their culture, knowledge and experience had been valued during the intervention and had increased their sense of environmental mastery and self-confidence; undergraduates came to recognise the strength and resilience of the refugees, and society's responsibility for them, a learning point they communicated to peers and family. Themes regarding power imbalance did, however, emerge. For instance, the Hmong refugees commented that, at times, they had little real input and simply played the role of being pupils.

Summary

The studies reviewed provide evidence of potentially effective, culturally relevant approaches to addressing the holistic needs of refugees. Although the studies employed reasonably rigorous designs - all but one compared treatment with a control; one randomised the blinding process and another used an active comparator – methodological problems existed.

Two studies were based in refugee camps and aimed at internally displaced persons; two focused on refugees resettled in western countries. With regard to the former, although a reduction in PTSD symptomatology was recorded in both studies, effect sizes were modest and there was little evidence of clinically significant change. Where examined, the impact of the interventions on depression and anxiety was minimal and no measures of functioning were included. Both studies failed to

provide any follow-up data and there were problems with the control groups. The latter studies detailed acceptable interventions capable of providing refugees and their families with the skills necessary to aid their integration and improve access to services. It was found that increased access to services improved quality of life. The impact of the interventions on psychiatric symptomatology, however, was not recorded. Gains made in the Goodkind (2005) study tended to reduce at follow-up.

CBT-Based Stress Relief Interventions

Three studies were identified that adapted a CBT approach, principally through the omission of exposure practices, to better suit the early stages of treatment. The focus in these treatments was the teaching of behavioural and cognitive techniques that encouraged emotional regulation and relief from somatic symptoms. Although some cognitive restructuring is involved in two of the studies (Kruse, Joksimovic, Cavka, Woller & Schmitz, 2009; Muller et al., 2009), this was not the focus of the treatment and so, in accordance with the NICE categories previously discussed, they were included as stress relief/relaxation interventions.

Snodgrass et al. (1993) evaluated the effectiveness of a CBT-based intervention adapted from a stress reduction module designed for use with rape victims. Entitled, 'coping with stressful experiences', it involved psychoeducation, training in relaxation and thought catching and techniques for challenging. Six members of the research team who had culturally diverse backgrounds served as facilitators for the group. Each session lasted three hours.

The intervention was promoted to Vietnamese students at a university in America who had fled Vietnam as children because of the war. There were difficulties in recruiting and retaining participants: from the 50 students who were

approached 11 took part, eight of whom completed all six sessions. This is too small a sample to make generalisations from the findings to a wider population. A control was included: participants were asked to recruit a family member or friend from the same cultural background. Only six control participants were recruited into the study. It was difficult to ascertain the suitability of the control group as no further demographic information was included.

Both the treatment and control group completed the reaction index, a measure of PTSD symptomatology. Scores were closely matched pre-treatment and indicated moderate to severe symptoms. The treatment group's scores significantly reduced over the course of treatment; no such reduction was evidenced in the control group. In the treatment group levels of social functioning were also found to improve. Social functioning was not assessed in the control group. No information on the clinical significance of these findings was provided and participants were not assessed at a later stage, post treatment.

Responding to concerns that the premature confrontation of traumatic memories in treatment can be destabilising, Kruse et al. (2009) focused, in their treatment, on 'skill training, affect regulation and interpersonal relationships with goals of symptom stabilisation and improved all-day functioning' (Kruse, et al., 2009, p. 587) . The development of an effective therapeutic relationship and the practical needs of participants were given prominence and behavioural and cognitive techniques utilised to increase emotional regulation skills. In place of exposure, cognitive restructuring was taught to address the catastrophic misinterpretations of traumatic memories, somatic symptoms and 'culture related convictions and worries' (Kruse, et al., 2009, p. 587). In total, treatment consisted of 25 sessions occurring

over a nine-month period. Two experienced Bosnian female therapists conducted the treatment. No procedures to check treatment fidelity were reported.

Participants, Bosnian refugees who met DSM-IV criteria for PTSD and somatoform disorder, completed a range of self-report measures at intake and 12 month follow-up to assess for PTSD symptom severity, levels of psychological distress and health status. The study failed to include an assessment immediately post treatment. This makes it difficult to disentangle the impact of the intervention and the events following its completion on psychological function. Whilst the study did include a control, the non-randomised assignment of participants to either the intervention or treatment as usual group, meant that systematic differences in participants could potentially obscure findings. No information was provided on types or levels of medication prescribed for either condition.

The intervention group improved significantly on all measures from baseline to 12-month follow-up. Effect sizes demonstrated a large magnitude of change. Eighty-two percent of participants were in remission from PTSD symptoms at follow-up. There was a small increase in psychological distress and reduction in physical health in the comparison group. The authors hypothesised that an increased sense of control and feeling of safety had been the active elements of therapy.

Muller et al. (2009) trialled the use of a biofeedback intervention to treat Bosnian and Kurdish refugees diagnosed with comorbid PTSD, depression and somatoform pain disorder. Participants were recruited from three specialist centres in Berlin and Zurich for the treatment of torture victims. Sample size was small: only thirteen participants were recruited into the study. Other than the use of electromyography (EMG) electrodes on participants' foreheads and shoulders to help participants regulate pain using muscle contraction feedback, the ten-session

treatment resembled a CBT-based approach, including psychoeducation, relaxation techniques such as deep progressive muscle relaxation and one cognitive restructuring session.

As this was a preliminary study, no control group was recruited. All participants completed a number of observer and self-report measures regarding PTSD symptoms, anxiety, depression, pain intensity, pain disability, coping with pain and satisfaction with treatment, at pre and post treatment and three month follow-up.

Results indicated that coping with pain had significantly increased over the course of the intervention, indicating that participants' pain management skills had improved, although this was not maintained at follow-up. No significant changes in any of the other measures were found. Only seven of the thirteen participants completed the follow-up measures, indicating that the study may not have reflected the experiences of all participants. Participants rated the intervention as acceptable.

Summary

Skill based forms of CBT without the potentially destabilising modules of exposure were generally effective in reducing participants' PTSD symptom severity, levels of psychological distress and somatisation. Effect sizes from the Kruse et al. (2009) study were large. These results, however, need to be considered with respect to the many methodological limitations present in the studies. Small and select sample sizes were recruited, non-randomised designs utilised, no comparative treatment controls included and self-report measures relied upon. Furthermore there was limited information on the longer-term impact of the interventions. Limitations such as these reduce the extent to which the findings can be generalised to a wider

population. It is also unclear whether it was the specific or non-specific elements of the therapies that had an impact.

Discussion

Twelve papers evaluating treatments that attempted to address a broader range of symptoms with which refugees present, rather than PTSD alone, were reviewed. The approaches were further subdivided into: multimodal, ecological/community based and CBT-based stress/relaxation treatments. Within these categories a diverse range of treatments was identified. They were trialled on a wide variety of participants, with respect to ethnicity and diagnoses, and in a number of different settings, from clinics in the western world to refugee camps. The majority of studies reported improvements in mental health symptomatology or functioning as a result of the treatment delivered. The evidence base, though, was very limited. All studies were beset with serious methodological limitations constraining the extent to which any firm conclusions can be drawn.

Common to the majority of multimodal treatment studies were severe levels of PTSD symptomatology, anxiety and depression and low levels of functioning amongst participants. Post treatment very few individuals across studies entered remission from PTSD symptoms, although a general trend existed: the longer the course of treatment the greater the number of participants who evidenced clinically significant levels of change. The lack of a control group in all studies reduces the certainty with which this trend can be attributed to multimodal treatment. However, the findings do provide further support for the existing evidence that refugees are

likely to present with complex and severe mental health difficulties that follow a chronic course (Porter & Haslam, 2005; Steel, Silove, Phan & Bauman, 2002). Palic and Elklit (2009) were alone in detailing a large magnitude of change in PTSD symptoms as a result of a multimodal treatment approach. Theirs was the only study to explicitly mention the use of trauma-focused CBT, but the lack of information across studies regarding the exact treatments offered make comparison difficult.

The impact of multimodal approaches on symptoms of depression, anxiety and somatisation was mixed. Boehnlein et al. (2004) found marked clinically significant improvement in levels of depression and anxiety - above that evidenced in rates of remission from PTSD - over the course of ten years of treatment, but this was a select participant group committed to treatment. Elsewhere, gains made in these areas tended to attenuate at follow-up (Palic et al., 2009). It remains under debate as to what extent PTSD is at the core of refugees' difficulties, depression and anxiety mere consequences, or one of a number of presentations, of which depression and anxiety fulfil an equal role, linked to both pre and post displacement stressors. That depression and anxiety follow a different trajectory to PTSD symptoms over the course of and beyond treatment provides potential support for the latter argument. This, though, is a large leap for data that is so limited by methodological drawbacks and inconsistencies.

Quality of life and levels of global functioning showed little improvement after multimodal treatment. Where significant gains were made, levels of post treatment functioning remained poor. Again, this may reflect the chronicity and extent of difficulties that refugees face. The rationale for multimodal approaches is to meet the various needs of this heterogeneous population flexibly (Nickerson et al, 2011). Treatments, therefore, can include practical advice and support for finding

housing and work or managing legal issues and administration. Treatment description was poor amongst studies. As it was not possible to identify the level of practical support provided, an assessment of the utility of multimodal treatment approaches for functioning cannot reliably be made. Palic and Elklit (2009) found that perceived levels of social support significantly decreased once treatment had ended to six month follow-up. This suggests, as Boehnlein et al. (2004) commented, that treatment itself provides a form of social support for refugees. Although low levels of social support have been found to increase the risk of mental health difficulties (Gorst-Unsworth & Goldenberg, 1998; Porter & Haslam, 2005), the question remains as to how treatment should meet refugees' needs in this area.

Two studies indicated that community-based group interventions for internally displaced persons living in refugee camps could be effective in the treatment of PTSD symptoms (Dybdhal, 2001; Yeomans et. al, 2010). Yeomans et al. (2010) found greater efficacy of group treatment with the omission of PTSD psychoeducation, opening further debate as to the impact of western models of mental illness on divergent cultures. Ultimately conclusions are difficult to reach given the incomparable test conditions, but the findings do begin to dismantle the effects of psychosocial treatments and provide possible alternative mechanisms of change, such as the importance of interpersonal dialogue, in attempts to address community level traumatisation.

The inability of the interventions to address wider areas of psychological and overall functioning was notable across the two studies. Although this was partly due to measurement issues, it does provide further weight to the argument that a broad treatment base is required to address the broad needs of refugees. These studies were the most methodologically robust in the review employing control groups, methods

of random allocation and blind assessment but, nonetheless, presented with a number of drawbacks, namely lack of long-term follow-up and measures of global functioning. Furthermore the interventions were based in refugee camps where participants could make use of an existing community with a shared culture and stories. It is unclear how they would generalise to the western world, where refugees are often isolated and forced to exist without such social support.

Community-based, ecologically informed interventions trialled on refugees resettled in the West, focused more on access to services and global functioning than psychiatric symptomatology (Goodkind, 2005; Weine, et al., 2008). They indicated that involving refugees, and preferably their families, in developing and discussing treatment can help in improving levels of engagement and the relevance of an intervention. Furthermore increasing access to resources was associated with increased quality of life (Weine et al., 2008). This suggests that interventions need to think beyond treatment of mental disorder, and to broaden their focus to methods of engagement. The intervention trialled by Goodkind (2005) offers a model for such an approach, providing advocacy that focuses on refugees' strengths and treatment priorities. Noteworthy was the tendency for gains made in the study to tail off at follow-up. This may, again, reflect the chronicity of difficulties faced by refugees and provides an indication that the transfer of skills to improve access to resources is a lengthy process. However, methodological issues such as the absence of a control group limit the extent to which the findings can be attributed to the treatment and generalised beyond the very specific population with which the study was concerned. It is also important to recognise that acceptable treatments do not necessarily equate to effective treatments. PTSD is defined by high levels of avoidance of difficult memories (APA *[DSM-IV-TR],* 2000). The confrontation of these memories may,

initially, be distressing but, as evidenced, can lead to considerable reduction in symptoms (NICE, 2005). Although some improvements in levels of distress were recorded in these studies, changes in psychiatric symptomatology in response to the interventions were not closely measured and as such cannot be assessed. Weine et al. (2008) did, though, find a key role for depression in mediating access to resources. This may suggest that depression can have a debilitating affect on functioning and should be considered a treatment priority, at minimum as important as symptoms of PTSD.

Stress reduction/relaxation studies provided evidence that CBT approaches without exposure to traumatic memories could assist emotional regulation in the early stages of treatment, thereby reducing symptom severity and increasing perceived levels of control. The Muller et al. (2009) study indicates that adaptations to CBT can be made to address refugees' wider difficulties, such as pain or somatisation, and could act as an adjunct to other forms of therapy. The fact that the biofeedback intervention had little impact on PTSD symptomatology, anxiety or depression is open to interpretation. It could suggest that pain is secondary to these disorders or could support the case that different treatments are needed to address the heterogeneity of refugees' presentations. The absence of a control condition means the effect of treatment is difficult to judge. Across all studies, moderate to large effect sizes were reported. However serious limitations existed such as non-random assignment to intervention and control conditions, small sample sizes and no long-term follow-up.

Overall, firm conclusions are difficult to draw given the serious limitations within the studies reviewed. A few themes, though, do emerge. Refugees' difficulties appear to be severe, complex and follow a chronic course. Presentations are far wider

than PTSD alone. There is evidence that depression, anxiety and somatisation alters over the course or treatment independent of PTSD symptomatology, but this is not in itself enough to repudiate the claim that PTSD is at the core of refugees' difficulties. A tentative call for long-term treatment could be made, particularly with regards to difficulties around depression and quality of life or global functioning, when considering the tendency for gains in these areas to attenuate post treatment. Although the multimodal treatment studies were seriously flawed, evidence does exist that different treatment approaches may be suitable for the different difficulties with which refugees present. It seems that engagement may be a legitimate focus of treatment for those who find services hard to access, and that a client led, ecologically informed and community based approach is well suited to deliver this.

Evidence from trauma focused therapies

Previous reviews have tended to centre on the largest body of evidence of treatment for refugees: trauma-focused therapies for symptoms of PTSD. Narrative Exposure Therapy (NET) is the best supported of these treatments (Crumlish et al., 2010; Nickerson et al. 2011; Palic et al., 2011). A brief, manualised therapy designed specifically for victims of organised political violence, NET adopts techniques from witness testimony therapy and CBT. Clients are encouraged to construct a written narrative of their life that they can then keep and use or distribute as they see fit. Traumatic events or periods of time are given particular attention, the client instructed to pay attention to sensory and emotional information. NET is very brief (often only four sessions), can be delivered by lay therapists, and is of particular use in the treatment of refugees due to the lack of focus on individual events, following instead a refugee's life course (Neuner et al, 2004). It has been found to reduce

symptoms of PTSD to a greater extent than other psychosocial treatments (Neuner et al., 2004) in a variety of settings (Neuner et al., 2010; Neuner et al., 2004) using both trained and lay therapists (Neuner et al., 2004; Neuner et al., 2008). Large effect sizes have been reported (Robjant & Fazel, 2010).

However, a reduction of PTSD symptoms does not necessarily equate to increased functioning. Findings have shown that NET does not have a superior impact to other forms of treatment on refugees' wider presentation of symptoms such as depression (Neuner et al., 2004), and levels of global functioning have gone unexamined (Neuner et al. 2008; Neuner et al., 2010). While effect sizes are large, the average level of PTSD symptoms is still high post treatment (Neuner, et al. 2004). This was highlighted when NET was used to treat asylum seekers in Germany. NET was superior to treatment as usual in reducing PTSD symptoms, but average levels of PTSD symptoms were still moderate to severe at follow-up and only one participant in the NET group had entered remission from PTSD (Neuner et al., 2010). These findings were well below what had been observed previously, when the population had been IDPs and the setting refugee camps. The authors voiced the possibility that the very particular and unsettling post-displacement stressors faced by refugees attempting to resettle in the west interfere with trauma-focused treatment.

Clinical Implications

Taken together, these findings suggest that no one treatment will be sufficient to meet the needs of refugees. NET may be efficacious in the treatment of PTSD symptoms, but a more complete treatment package is required if the broader range of mental health difficulties and post displacement stressors is to be addressed.

Similarly a long-term approach may be required to match these often chronic and severe presentations. Unfortunately the studies reviewed failed to provide a coherent picture of what such a package may look like.

Parallels can, however, be drawn from the literature on treatment approaches for other populations who present with similar difficulties. For children and adolescents subject to family violence and survivors of childhood sexual abuse who, after prolonged and repeated trauma, can present with features of complex PTSD, a phased, multimodal and transtheoretical approach has been advocated (Courtois, 2004) and is supported in the literature (Vickerman & Margolin, 2007). Traumatic experiences and responses are addressed, but not given emphasis over all else (Courtois, 2004). Treatment is tailored to an individual's needs dependent upon their presentation. Particular care is given to stabilise clients and provide them with the skills for emotional regulation before efficacious trauma focused CBT-based treatments are delivered (see Vickerman & Margolin, 2007).

Also relevant may be literature from treatments for psychosis. Similar to refugees, people who develop psychosis have been found to be more likely to have experiences of social adversity, stressful life events (Bebbington et al., 2004), trauma (Shevlin, Houston, Dorahy & Adamson, 2008) and migration (Hutchinson & Haasen, 2004). Presentations are highly variable: comorbidities such as physical health problems, anxiety, personality disorder, substance abuse and, notably, PTSD, are relatively common (Strakowski, Shelton & Kolbrener, 1993; McFarlane, Bookless & Air, 2001). Early intervention services are now widely accepted as a suitable and effective treatment at early stages of psychosis (NICE, 2010). In registering the importance of social context in the development and maintenance of difficulties, work with clients happens in the community and support is provided to those in the

wider network. The multidisciplinary team is able to provide a comprehensive service that addresses treatment needs beyond the primary diagnosis of psychosis, including the skills required to improve levels of functioning. Restrictions to service access are addressed and the importance of engagement and prevention given prominence (see McGorry & Jackson, 1999). Unique to early intervention services is the notion of clinical staging. Research has identified the course of psychosis, how this may present and what different combinations of treatment are most efficacious at the different stages of the disorder's development (Andresen, Oades & Caputi, 2003).

It is difficult to apply these models to the care of refugees, given the limitations of the existing evidence. It may be that, similar to the approaches described above, a comprehensive and integrated response utilising a phased model of delivery that allows the tailoring of treatment to individuals' precise needs, is required. But unlike the early intervention model a clear empirical basis to apply methods of clinical staging does not exist. A very preliminary model based on the evidence described may first involve community based, client led and culturally relevant advocacy services, such as that described by Goodkind (2005), followed by CBT-based stress relief interventions that focus on stabilisation. Later stages, for those identified as requiring further services, could focus on symptoms of PTSD or other psychiatric diagnoses, using the most efficacious treatment as guided by the literature. Interventions should operate at individual, family and community levels, in response to the levels at which disruption to a refugee's life occur. This may include NET, but could also include family therapy or psychotherapy and again should be delivered in a culturally sensitive manner. A longer-term aim for a service

may be in empowering and promoting refugees' resources, thereby aiding integration.

Future research recommendations

Randomised control trials of multimodal treatments for refugees remain a priority. Currently multimodal approaches constitute the most prevalent form of treatment for refugees in western countries and closely match the recommendations outlined above. A more detailed description of the treatments delivered in these centres is also required. This could help to clarify how phased treatments are delivered and begin more focused investigation as to the course of refugees difficulties, thus opening up the possibility of empirically informed clinical staging. Also of help in this endeavour would be further research as to how pre and post displacement factors interact and change over time to contribute towards mental health difficulties in refugees. Although the community interventions described showed promise, more research is needed using randomised controls and different populations to clarify the findings.

The wider mental health difficulties of refugees', such as depression, have generally been underplayed and considered subsidiary to PTSD. Given the high levels of disruption which refugees face, it seems likely that adapted forms of treatment will be required to treat these difficulties. Research examining the efficacy of treatments for refugees who present with depression and not PTSD would provide further insight. The increasing evidence for trauma-focused treatments is promising, but PTSD, albeit central to this, is just one of the difficulties faced by refugees as a result of the profound level of disruption imposed on their lives. Refugees' needs are multiple and require an adequately varied and adaptable response.

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Part 2: Empirical Paper

The Psychological Impact of Music Workshops on Immigration Detainees

Abstract

Objective: Research suggests that immigration detention negatively impacts asylum seekers' mental health. Currently there is no research on interventions that attempt to improve wellbeing amongst immigration detainees. This study investigated three-day, group music-making workshops for detainees regularly run by a charity in Immigration Removal Centres. Applied ethnographic methods were used to examine what impact workshops had on participants' psychological wellbeing, and the mechanisms through which this effect operated.

Methods: Focus groups and individual interviews were conducted immediately after the workshops and repeated after an interim period of no less than two-weeks. Additionally field notes were assembled through participant-observation of the last day of five music workshops and field documents gathered. Materials were subjected to thematic analysis.

Results: There was evidence that participation in the music workshops facilitated the development of supportive relationships, encouraged the use of strategies for improved emotion regulation and reconnected participants with a more positive view of themselves. The extent and longevity of this effect seemed, in part, to be determined by the levels of engagement in the workshop, the variation between detainees' musical skills within a workshop and access to music-making facilities between workshops.

Conclusion: Group music-making activities can improve the psychological wellbeing of immigration detainees. Regular access to music facilities is key if this effect is to be established in the longer-term. However, further research to clarify which detainees derive most benefit from the workshops is required.

Introduction

A growing body of literature suggests that detention in Immigration Removal Centres can have an adverse effect on an asylum seekers' mental health (e.g. Ichikawa, Nakahara & Wakai, 2006; Robjant, Robins & Senior, 2009; Silove, Austin & Steel, 2007; Steel et. al., 2006). Robjant, Hassan and Katona (2009) conducted a systematic review of studies investigating the impact of immigration detention on the mental health of detainees in Australia, the UK and the USA. They found that the studies consistently supported an association between immigration detention and increased rates of anxiety, depression and Post Traumatic Stress Disorder (PTSD). A high rate of self-harm and suicidal ideation amongst immigration detainees was also indicated.

The UK has eleven Immigration Removal Centres, secure environments where asylum seekers and other foreign nationals are detained indefinitely, with an average length of stay of three months. From January to March 2011, 2,665 individuals were detained and over 58 nationalities represented in removal centres in the UK (Home Office, 2011). Detention is used on a number of grounds: to establish the identity and basis of an asylum claim; to fast-track asylum procedures where possible; to reduce the risk of absconding; and, in the case of failed asylum applications and people who have no legal right to be in the UK, to support removal (Home Office, 2011).

Immigration detainees are a heterogeneous population that includes asylum seekers awaiting the processing of their claims; illegal immigrants; people who have failed to leave the country on expiry of their visas; ex-prisoners awaiting deportation; or failed asylum seekers awaiting removal (Silverman, 2011). Current figures show

that 58% of immigration detainees have, at some stage, made an application for asylum (Home Office, 2011). This figure includes repeat claimants.

The use of detention has been viewed as a response to the 42 million refugees, asylum seekers or internally displaced people worldwide (UNHCR, 2008) and the consequent worries of uncontrolled migration that this has aroused in host nations, particularly those in the Western world (Silove, Steel & Watters, 2000).

An asylum seeker is an individual who has fled their country of origin and is seeking refugee status and thus permanent residency in a host country under the 1951 United Nations Convention on the Status of Refugees (UNHCR, 2010). There is a greater prevalence of mental health problems amongst asylum seekers when compared to the general population, most commonly PTSD, depression and anxiety (Porter & Haslam, 2004). These problems are often associated with a high incidence of pre-migration trauma (Silove, Sinnerbrink, Field, Manicavasagar & Steel, 1997). However, the association is not necessarily a simple causal one. Post-migration living difficulties such as unemployment and social isolation also contribute to mental health functioning (Carswell, Blackburn & Barker, 2011; Gorst-Unsworth & Goldenberg, 1998; Schweitzer, Melville, Steel & Lacherez, 2006). This situation is heightened in detained asylum seekers. They face high levels of uncertainty, can be socially isolated or separated from family, may be re-traumatised by the confines of a closed institution and, in general, have little worthwhile day-to-day activity to keep them occupied (Pourgourides, 1997; Silove et. al., 2007; Silove et. al, 2000).

Robjant, Robbins and Senior (2009) compared rates and severity of depression, anxiety and PTSD between two groups of immigration detainees - detained asylum seekers, and foreign nationals who had formerly been imprisoned in the UK - and a group of asylum seekers living in the community. All three groups

reported high levels of depression, anxiety and PTSD. Detained asylum seekers had higher rates of depression, anxiety and PTSD when compared to asylum seekers in the community. It was also found that detained asylum seekers had experienced a higher number of traumas than the other two groups.

Similarly, Steel et al. (2006) found that prolonged detention had an adverse, long-term impact on the mental wellbeing of refugees, independent of other risk factors such as past trauma. In addition, a higher proportion of those who had been detained for over six months compared with those who had been detained for less than six months met diagnostic criteria for PTSD and depression.

These studies suggest that immigration detention exacerbates asylum seekers' mental health problems and that its effects persist after release. They also suggest that those with pre-existing mental health difficulties are more likely to be detained.

Currently there is no research on attempts to alleviate suffering and improve wellbeing amongst immigration detainees. Research has focused exclusively on asylum seekers and refugees in the community. NICE (2005) has highlighted the difficulty in providing treatment for refugees and asylum seekers. They are a heterogeneous population who present with complex difficulties. A phased model of treatment where safety from future persecution and practical issues are addressed before specific therapies can be delivered has been suggested (Courtois, 2004; Herman, 1992; NICE, 2005). Reviews have indicated that Narrative Exposure Therapy (NET), a short-term therapy combining CBT and testimony, is the most efficacious treatment in reducing PTSD symptoms amongst refugees (Crumlish & O'Rourke, 2010; Robjant and Fazel, 2010). It has been trialled in non-clinical settings (Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004) and with asylum seekers facing uncertain outcomes (Neuner et al. 2008).

However, there still remain few clinical trials or consensus on what may constitute an effective approach (Nickerson, Bryant, Silove & Steel, 2011; Palic & Elklit, 2011). Different cultures have different understandings of mental health and help-seeking in a crisis (Kleinman, 1987). The concept of psychotherapy and talking through past events, while useful for some, may lack cultural relevance and validity for others (Summerfield, 1999; Watters, 2001). Western approaches to relieving psychological distress tend to focus on the individual, whereas the difficulties experienced by asylum seekers may be held at a community or family level (Weine et al., 2008). Moreover, many asylum seekers and refugees exhibit considerable resilience in spite of significant pre- and post-migration adversities (Miller & Rasco, 2004). As a response, an approach focused on strengths and wellbeing that is based in the community, and led by or developed in consultation with asylum seekers and refugees, has been proposed (Miller & Rasco, 2004; Watters, 2001; Watters & Ingleby, 2004). It is suggested that community organisations who help to reduce isolation amongst refugees and asylum seekers, and facilitate engagement in creative activities, can do much to improve their levels of functioning and reduce the impact of mental health problems, such as depression and anxiety (Burnett & Peel, 2001).

One approach for improving the wellbeing of immigration detainees has been to provide musical activities. Music in Detention (http://www.musicindetention.org.uk), an independent, well-established charity, runs open music workshops for detainees in six of the UK's eleven immigration removal centres. They aim to '…ensure the delivery of regular participatory music activities for detainees to improve their wellbeing; use music to build wider understanding of detainees, and lasting connections between them and people living near detention centres, to improve community relations; and develop the quality of participatory and

inter-cultural music-making with and around detainees, to enable marginalised people to express themselves, listen to each other and share the experience of music'. (Music in Detention, 2010).

There are a number of potential benefits to providing music-making activities in Immigration Removal Centres. Detainees come from a variety of backgrounds and, as a consequence, Immigration Removal Centres are multilingual. Music's ability to transcend language (Pavlicevic, 1997) negates the difficulties social interaction poses in such a setting. Similarly, the situation of detainees is one of uncertainty with high levels of commensurate tension and anxiety. Music's ability to regulate or release emotions (Krout, 2007; Dissanayake, 2009) may act directly on such feelings. Finally, music is thought to improve levels of social contact and co-operation between individuals and groups (Clayton, 2009; Dissanayake, 2009; Sawyer, 2005). Research has shown that the perceived and actual levels of social support amongst refugees are significant determinants of mental health functioning (Carswell et. al., 2011; Schweitzer et. al., 2006).

While no studies investigating the impact of music therapy on immigration detainees have been conducted, it has been used widely in the treatment of trauma (Sutton, 2002). Findings suggest that it can reduce symptoms of PTSD and comorbid depression, even amongst the treatment resistant (Carr et al., In Press). It has been found to foster a safe therapeutic environment (Carr et al. In Press), increase engagement in treatment (Gold, Solli, Kruger & Lee, 2009) and improve social interactions (Bensimon, Amir & Wolf, 2008) and emotion regulation (Carr et al. In Press). Similarly, music workshops run in prisons have been found to increase prisoners' sense of wellbeing, autonomy, self-efficacy, competency, and relationships and relatedness,

both between inmates and with family members outside the prison setting (Cox & Gelsthorpe, 2008). In using group music therapy with traumatised refugees it has been suggested that a focus on enjoyable activities and providing distraction should be emphasised, given the difficulties in communication and achieving feelings of safety (Orth, 2005).

The workshops run by Music in Detention are different from traditional forms of music therapy. They are neither delivered by trained music therapists; nor structured using an established therapeutic framework; and are fewer in number than would be the case in a formal course of music therapy. They more closely resemble a version of everyday individual and group musical activity. This is perhaps best described using Small's (1998) term 'musicking', a broad notion that encompasses the whole range of music-related activities, such as listening, performing, practising, rehearsing or dancing. Small (1998) has suggested that musicking is an essential cultural activity used by individuals and groups to create a sense of agency, regulate emotions and bring people together and has implicated it in contributing to quality of life and well-being.

This study sought to investigate the psychological impact on detainees of music workshops currently being run in Immigration Removal Centres by Music in Detention. Applied ethnographic methods (Savage, 2006) were employed, which included participant observation, focus groups, individual interviews, and the use of field documents, such as song lyrics and workshop facilitator comments. Several characteristics of this approach made it relevant to research being carried out with immigration detainees and participatory music-making activities. The approach is suited to exploring new or under-researched areas of enquiry (Brewer, 2000), has been proven useful in identifying the impact of an intervention on individuals and

their social contexts (Natasi & Berg, 1999), and is able to make use of multiple methods to inform the inquiry (Savage, 2006).

The main research questions were:

1. What are the short-term and long-term advantages and disadvantages of music workshops on immigration detainees' psychological state?
2. What are the mechanisms by which the music workshops have a psychological impact?

Method

Setting

Interviews were conducted and observations made in five of the UK's eleven Immigration Removal Centres (IRCs). One was formerly part of the prison estate and operated by HM Prison Service; private firms, on behalf of the Government, operated the other four. One of the centres housed families and women; the remaining four held male detainees only. As of March 2011 these centres housed a total of 1,610 detainees, 62% of whom were recorded as having made an asylum claim at some stage (Home Office, 2011).

Although all IRCs are closed institutions, staffed by officers recruited in the first instance to maintain security, they vary in the types of detainees they house and the levels of security and freedom allowed. Two centres held detainees whose cases were managed under the 'fast track' system and so were expected to have relatively brief stays; another was designed to have capacity to manage more challenging detainees, including those who were ex-prisoners or had been disruptive in other

IRCs and presented with significant health and mental health problems. One centre was modelled on a category B prison, locked detainees in their rooms at night and restricted the amount of time they could spend in communal areas; others allowed free movement within the estate and provided detainees with a key to their own rooms.

Similarly, all centres provided facilities for recreational activity, education and religious practice, but the extent of these provisions was variable. Two centres provided no musical equipment or facilities. The location for workshop was, in both instances, a multi-purpose room that, in one of the IRCs, was also used as a thoroughfare. By contrast, another centre offered a large, dedicated music room, qualified music teacher, full recording facilities and a number of quality instruments that were able to meet the needs of culturally diverse approaches to music making. The remaining two centres provided dedicated music rooms but few instruments and limited recording equipment. Detainees in these two centres reported poor access and only occasional staff support.

Intervention

The music workshops were organised and conducted by Music in Detention (www.musicindetention.org.uk), an independent UK charity that, '…works through music to give voice to immigration detainees and create channels of communication between them, immigration and detention staff, local communities and the wider public' (Speyer, 2008, p. 1). Music in Detention emphasises music participation among as many detainees as possible.

Each workshop comprised six sessions held over three consecutive days or in close succession. In total, workshops comprised in total 12 hours of input; sessions

typically lasted for two hours. I attended the last day of five different workshops, each in held in a different Immigration Removal Centre.

Two trained and experienced musicians facilitated each music workshop. A total of eight musicians were involved in the study: two of the musicians were involved in two separate workshops although they partnered with a different musician on each occasion.

A detention centre officer also supported each workshop. This was primarily for security reasons: both the workshop facilitators and I required constant supervision in accordance with the regimes' protocols. The extent of the officers' involvement varied. In three of the centres the officers were accomplished musicians and took an active role in instructing and supporting the sessions. On the other two occasions the officers were only present in the room and did not outwardly engage in the activities.

Music workshops were participatory and interactive, and aimed to provide space for many levels of learning, self-development and creative expression. The planned outcome of the workshops was to provide detainees with the opportunity to write their own songs, which were then shared with community groups via recordings or other members of the centre through performances.

The content of each workshop was tailored to the particular needs and preferences of the respective Immigration Removal Centre at any given time. If, for example, a particular cultural or national festival was approaching, or there were a high proportion of detainees of a particular nationality or cultural group at a centre, or there were particular interests expressed by detainees, then workshops would be tailored accordingly. Typically the facilitators, who provided instruction if necessary, would encourage participants to use the available instruments – percussion, guitars,

keyboards etc – and explore different rhythms and melodies. Often the facilitator would introduce a particular song or rhythm and participants would then be encouraged to improvise or build on other participants' contributions. On other occasions participants would bring ideas for songs that facilitators would encourage them to develop and other participants to contribute towards. These works were then prepared for performance or recording.

Participation by immigration detainees in the workshops was voluntary and open - detainees could join or leave the workshop at any point. Workshops were advertised in the week prior to their commencement using posters displayed throughout the Immigration Removal Centres.

Participants

Participant numbers varied both within and between workshops. Generally a small core group, ranging in number across the workshops from five to 11, would engage fully for the duration. The arrival of more peripheral figures, sometimes for a very short, sometimes more prolonged period, meant this number would fluctuate. At its fullest, 18 detainees were together and engaging in the workshop held at IRC3, albeit for a brief period. This fluctuation was less pronounced in other workshops (see Table 1).

In total 71 detainees (15 women, 56 men) participated in the five music workshops, 39 (55%) of whom attended all three days. Immediately after the workshops 38 detainees (54%) contributed to an initial focus group discussion, of whom 12 (17%) engaged in a follow-up focus group discussion two weeks after the workshop. A further five participants (7%) were available for individual interview. For a breakdown of participant numbers across the five workshops see Table 1.

Age and ethnicity of participants was estimated and cross-referenced with workshop facilitators' own estimates. Ages ranged from 18 to 54. Ethnicity was diverse within workshops on all but one occasion, where all members of the workshop were of Bangladeshi origin (see Table 2).

Not all participants were able to speak English, but due to lack of translation facilities those who did not were only invited to participate if they were acquainted with others who were capable and willing to translate for them.

Table 1.

Focus Grous and Individual Interview Participant Numbers by Immigration Removal Centre (IRC).

		IRC (No. of participants who attended all 3 days of workshop)					Total (No. of participants who attended all 3 days of workshop)
		1	2	3	4	5	
Time 1 (Post-workshop)	Focus Group	11 (11)	7 (6)	4 (3)	9 (6)	7 (5)	38 (31)
	Individual Interview	-	-	-	1 (1)	-	1 (1)
Time 2 (Minimum 2 week follow-up)	Focus Group	2 (2)	-	2 (1)	-	3 (3)	7 (6)
	Individual Interview	-	1 (1)	-	4 (4)	-	5 (5)

Table 2.

Participant Demographics.

		Immigration Removal Centre (IRC)					Total (%)
		1	2	3	4	5	
Age	18-24	5	3	5	10	5	28 (39)
	25-29	3	2	7	3	6	21 (30)
	30-34	1	1	4	3	3	12 (17)
	35-39	1	1	1	1		4 (6)
	40-44	1	1		1	1	4 (6)
	45-49		1				1 (1)
	50-54			1			1 (1)
Ethnicity	White			2	1		3 (4)
	Indian					1	1 (1)
	Pakistani		1	5			6 (8)
	Bangladeshi	11		3	4	3	21 (30)
	Sri Lankan					3	3 (4)
	South East Asian					2	2 (4)
	Caribbean		1	1	3		5 (7)
	African		4	5	4	5	18 (25)
	Middle Eastern		2	1	3	1	7 (10)
	North African		1	1	3		5 (7)
	Chinese						0 (0)
	Total (%)	11 (15)	9 (13)	18 (25)	18 (25)	15 (22)	

Ethical Approval

Ethical approval for the study was granted by University College London Research Ethics Committee in September 2010 (see Appendix A). Access to IRCs was also approved with the UK Border Agency (see Appendix B). Written, informed consent was required for the focus group and interview participants (see Appendices C and D). Where participants were unable to understand or read English and a

detainee was willing to translate for them, that detainee was enlisted to help with the translation of forms. Verbal, informed consent was required for participant observations and informal conversations and this was ensured through both the facilitators and me.

Data Collection Procedure

The research was conducted within an applied ethnographic approach (Savage, 2006). Ethnography is understood here as a set of methods for collecting and producing data that are concerned with insider perspectives and context. The researcher's immersion in naturalistic settings and personal involvement in the intervention are key features of the approach (Hammersley & Atkinson, 2006). Applied ethnography differs from traditional ethnography in its focus on specific enquiries (Kleinman, 1992) and shorter lengths of time spent in the field (Savage, 2006).

Qualitative data was gathered from a number of sources: participant observation, focus groups, individual interviews, lyrics and facilitators' written reflections.

At the beginning of the music workshop session, the facilitators introduced the research, mentioned my proposed attendance as an observer on the last day and the possibility of my conducting a focus group discussion or individual interviews. A brief information sheet (see Appendix C) was given to each participant explaining the rationale of the research and what it would entail, stressing its voluntary and confidential nature.

Prior to the last day of the three-day music workshops, participants were asked to give permission for my attendance as a participant-observer and reminded

of the research. I introduced the research to the detainees and asked participants if they would like to be involved in further interviews. Again, it was emphasised that participation was not compulsory.

Participant-observation

Participant-observation was conducted on the last day of each of the five workshops attended. I discussed my role with facilitators before the workshops and joined with the music-making activities, including performances as far as was possible. When recording of songs that I had not been involved in was taking place I would take on more of an observer role. I was open with all participants about my reason for attending sessions.

My observations were guided by the research questions. I was focused on workshop attendance, levels of participant engagement and the relationships that developed between participants and between participants, workshop facilitators and officers. Where possible I talked to participants, workshop facilitators and officers about their engagement in the workshops, focusing on the language used to describe their experiences.

I overtly made regular, systematic notes of my observations. As soon as was practicable, these were elaborated upon and typed-up into field notes in accordance with standard ethnographic practice (Fetterman, 1989). Personal reflections and possible psychological processes were also noted. In total I spent 20 hours observing the workshops (see Appendix E for example field note).

Focus groups

Focus groups, a form of group interview, are a well-established method for gaining insight into participants' experiences of services. They benefit from the dynamics within a group, encouraging participants to interact with each other and

explore issues from a position that is meaningful to them. This person-centred focus helps the researcher to observe everyday communication, highlighting often hidden aspects of participants' knowledge and experiences (see Kitzinger, 1995).

Two focus groups were conducted: one immediately after the last day of the workshop and the other at least two weeks later. On average 24 days (range: 15 to 35 days) had elapsed between the first and second focus groups. In two IRCs no follow-up focus groups were conducted: only one participant was available for interview at IRC2; and it was requested that individual interviews were undertaken at IRC4 because of staff shortages (see Table 1 and 'individual interviews section' for more details).

The aims of the first focus group were twofold: to give me, the researcher, an opportunity to develop a relationship with the participants, so aiding data collection in the follow-up focus group; and to assess the immediate impact of the workshop, providing useful comparison for the follow-up.

At the end of this focus group I asked participants if they would be willing to participate in a similar discussion again in roughly two weeks time. The names of interested participants were noted. At a later date I visited the Immigration Removal Centre and met with the interested participants from the first focus group (as long as they were still at the centre and available). Again it was made clear that participation was entirely voluntary. The second focus group lasted a maximum of 30 minutes and aimed to assess the longer-term impact of the workshop.

The focus group discussions were based on two semi structured interview schedules (see Appendices F and G). The questions were concerned with participants' experiences of the workshop, particularly with regard to its benefits and drawbacks and any psychological or behavioural changes that it was perceived to

have brought about in both the short and long-term. All questions were asked by me. The discussion was recorded using a digital recorder and notes on any other interactions were made with the participants' prior agreement.

I endeavoured to create an accepting atmosphere, giving everyone the opportunity to offer their own opinions and encouraging group interaction. The workshop facilitators and attending officers were present during all focus groups, the latter for security reasons, and were encouraged to participate in the discussions.

Individual interviews

Individual interviews were conducted on an ad hoc basis in response to demands made by participants or the IRCs, or because of low participant numbers at the point of follow-up. An officer was present at all times during individual interviews.

In addition to the first focus group, one individual interview was conducted at IRC4 on the last day of the workshop at the participant's request: he wanted the opportunity to talk privately about his experiences of participating in the music workshop. He did later participate in the focus group discussion, but remained relatively silent.

At the point of follow-up no focus group discussion was conducted at IRC4. All participants were interviewed individually, in the music room, with other detainees and an officer present. The centre requested this procedure due to staff shortages.

At follow-up in IRC2 only one participant from the first focus group was available to participate.

The same semi-structured schedules as used in the focus groups were used in the individual interviews and written consent was obtained before the interviews commenced.

Facilitator data

At the end of each day's workshop both facilitators independently completed a Music in Detention 'Artist and Staff Log' (see Appendix H), a form that encouraged the recording of participant numbers, subjective views of the levels of participant engagement, types of musical activity and the levels of possibility for creative expression through the music. This data was provided with prior agreement from Music in Detention and the workshop facilitators.

Lyrics and songs

Where possible music was recorded using a digital recorder and lyrics transcribed.

Analytic Procedure

Following the procedures outlined by Braun and Clarke (2006), field and facilitator notes, song lyrics and transcripts from focus groups and individual interviews were all subjected to thematic analysis. The analysis adopted a realist/essentialist epistemology: semantic themes were derived after considering meanings and patterns across the whole data set. This process was essentially theoretically driven, the research questions providing the focus for analysis.

Analysis began during data collection. While writing field notes I regularly included information on my own reflections and the psychological processes observed. After data collection I familiarised myself with the data by listening to recordings, re-reading and refining field notes and transcribing recordings.

Initial analysis involved coding basic units of meaning in the data (see Appendix I) and then comparing these codes across the data. Through this process of constant comparison (Strauss & Corbin, 1990) potential themes that identified semantic meaning were recorded. These were later checked against initial codes and the overall data set. Where necessary, refinements were made and themes were organised according to broader domains.

The credibility of the analysis was checked by triangulating focus group, interview, field note and workshop facilitator data. Two researchers examined the initial coding from randomly selected data, comparing the codes to preliminary themes and domains (Barker & Pistrang, 2005; Elliott, Fischer & Rennie, 1999). Further refinements to the analysis were made after a consensus had been reached.

Researcher Perspective

Making clear the researcher values and beliefs is necessary to establish a basis for validity in qualitative research (Barker et al. 2005; Elliott et al., 1999). I am a white, middle-class, British male in my thirties. I conducted the research whilst in my second and third years of a doctoral course in clinical psychology. I perceive the detention of refugees (under its broad heading) as unlawful and unnecessary. I believe it is used as a policy of deterrence and has deleterious effect on mental health. I play several musical instruments, am an avid consumer of various types of music, believe music is an essential art form for life and has beneficial effects on health. In line with qualitative research guidelines, I attempted to 'bracket' these beliefs while conducting the research (Strauss & Corbin, 1990).

Results

Before providing a detailed thematic analysis of qualitative data, general comments from participants concerning life in detention and their attitudes towards being detained will be presented, in order to establish the context and situate the findings.

Data from focus groups, individual interviews, field notes and song lyrics are used to illustrate comments. Participant quotes are coded as follows: the setting is first indicated, IRC1 etc; followed by the source of each quotation, P for detainee/participant, O for officer and Fa for facilitator, each with an attached identification number; next an indication of whether the quote came from an individual interview, 'I', or focus group 'F'; and at which time point, 1 for immediately post workshop, and 2 for follow-up. Field notes or song lyrics are indicated as such and are followed by the immigration removal centre code. IV denotes interviewer.

Context

During the time I spent as a participant-observer, in focus group discussions and in individual interviews, participants were keen to talk about their experiences of detention. They described a stressful environment that was extremely difficult to tolerate. What was prominent in these discussions was dissatisfaction about the route by which they had found themselves in their current situation. There was a sense of injustice at not having committed a crime or having already served their sentence, but nonetheless finding themselves detained.

> *This place lots of stress, lots of people have much problem. People think about your country, your family, lots of things. Because the people don't think about the good situation, just bad bad bad situation. Because people meant to be in this place just for immigration. They didn't anything. They said this come for too much stress for your heart when you didn't anything wrong, and I'm in prison because I didn't do anything wrong, just for illegal [immigration]*. (IRC2 P2 F2)

Participants equated detention with prison, despite acknowledging that it was intended to be something different. They reasoned that the restrictions imposed upon them, which they perceived as excessive, justified this analogy.

> *You know we are not in jail? This is supposed to be something else. But the officers they behave in the same way, like we are in jail: we have to get locked up at a certain time… and that's not right.* (IRC3 P8 F2)

A common feeling amongst participants was one of powerlessness. They said that in providing for their basic needs, it felt as though the IRCs were minimising the level of control they had over their own lives and thereby reducing their sense of independence.

> *The whole thing: eat, sleep and shower everyday - just that. We're not children, you know… There's so many things which you could be doing for yourself and then you can't because there's no information coming to you.* (IRC5 P9 F1)

Participants often remarked on the uncertainty of their situation. They were mistrustful of the Home Office and unclear as to its decision-making process. They said that this created a sense of threat of deportation that was a constant. Many had stories about fellow detainees whose cases had dramatically and unexpectedly changed for the better or worse: they departed the IRC abruptly, their futures unclear. As a consequence, participants felt that they were being dehumanised: they were regarded not as human, but as numbers for whom the immigration authorities had little regard.

> *… and they leave you. It's like you buy a Christmas toy and you leave it on the shelf - you got no connections to that toy - that's exactly how it feels. It's like you're being left on the shelf and you're waiting for the immigration,*

> *which is the little kid, to come and play with you, to come and take you and connect you back to the world and put you in use. And then when they don't want you again they just put you back on the shelf.* (IRC4 P15 I2)

Participants noticed the negative impact of this uncertainty on their own and other detainees' mental and physical health.

> *We're being tortured… We're not physically bullied, but we're mentally beaten. I had a mate that cut himself up - bleeded himself - and luckily he got someone to take him and then they put him in the healthcare where he's not even allowed to go out and they keep an eye on you. I mean just kill me, what's the point, you know?* (IRC4 P9 I1)

Thematic analysis of experiences of the music workshops

Thematic analysis yielded eight key themes. These reflect common experiences across individuals and different settings of engaging in music workshops, the impact of doing so on life in detention and the processes through which music had this impact. Themes were organised into three domains, influenced by the research questions, participant responses, and my observations. The first domain regards the relationships among detainees and between detainees and officers and how these had been altered through engaging in music making. Emotion regulation, the second domain, displays ways in which participants were using music to manage the uncertainty and other difficulties of their situation. Thirdly, identity concerns the process by which participants used music to re-establish a sense of self outside their normal experience of living as an immigration detainee. Each domain and related themes are discussed in turn and illustrated using participant quotes from focus groups and individual interviews. Field notes and song lyrics are used to complement the quotes.

Table 3.

Overview of Themes

Domain		Theme	
1.	Relationships	1.1	Connecting detainees through reciprocal learning
		1.2	Meeting officers in a different space
2.	Emotion Regulation	2.1	Relief from the situation
		2.2	Self-expression
		2.3	Instillation of hope
3.	Identity	3.1	Feeling valued
		3.2	Realising strengths
		3.3	Finding a voice and being heard

1. Relationships

The themes in this domain reflect the ways in which music acted as an aid to improving relationships in the IRCs and the processes by which it altered or strengthened these relationships.

Theme 1.1 Connecting detainees through reciprocal learning

There was a common belief amongst participants that music held particular qualities that helped to bring people closer together, whatever their background. They found that these qualities, coupled with the act of engaging in a shared task encouraged them to form new relationships with other detainees.

> *It does bring people together. Because before we came to the music, I've been here for almost a week now, and it was yesterday that I came and I got to know people more and I was able to say hello to them.* (IRC2 P4 F1)

> *We see each other outside but in here [music room] is where we communicate, we have contact.* (IRC4 P9 I1)

This was reflected in the field notes. During every workshop multiple instances of participants enjoying a shared musical experience and helping one another were witnessed.

> *P2 enters the room, grabs the microphone and begins to MC. P13 takes a seat at the drums and begins playing a beat that matches P2's rhythm. They look at one another, smiling, nodding their heads and rocking to the beat.* (Field Note, IRC3)

> *... participants are given the opportunity to create their own rhythm,... Some find this easy and enjoyable, receiving appreciative nods; others come up with a rhythm and then stop playing to laughs and smiles. 'I can't do it' says P6. 'I'll teach you' says P3 before tapping out a beat that P6 follows.* (Field Note, IRC5)

Where engagement in music was more involved and access to facilities regular, participants reported that music-making activities provided an opportunity to develop closer relationships with other detainees. They often talked about the importance of engaging in a shared musical experience, learning from one another. This learning was predominantly focused on musical skills, but also included an increased understanding of one another's experiences regarding both their current circumstances and their cultures. As a consequence, they said that they had established closer relationships and were more respectful and supportive of one another.

> *... a guy would be sitting around the computer making a rhythm and he would say, 'Rasta man come on over, listen to this'. I listened to it and I say, 'Yeh, it sounds good', and he say 'Well do you have anything to put on it? Can we do something together?' And I say, 'Yes'. So we just quickly put our song together, both of us, listen it back and at the end of the day we both feel good about it.* (IRC4 P6 I2)

> *'Listen' says P1. P2 puts on a pair of headphones, nods his head, his body rocking with the music. 'See, you like it now. That's the same thing you said you didn't like yesterday. I'm teaching you to listen' says P1 smiling. P2 nods, shakes his head, then says 'Yeh, you need to teach me. It's excellent'. 'Excellente, yeh' agrees P1.* (Field note, IRC4)

And then when you hear them talk you learn something about them that they never said before… everyone has different situations innit… sometimes in a workshop or music we're doing about something then I'll just come up with my real feelings or how is my life... Since I've been in this place I've realised there's plenty people who've got worse case scenario than mine. It's not good, innit. I don't know. It's really weird position… we're all going through the same process. (IRC4 P9 I2)

…the people come and try play something about your traditional country, your musical country, your people, talk after, everybody do something for him, help. (IRC2, P2 I2)

Occasionally, detainees said that the relationships formed during the workshops did not develop further, post workshop.

IV…have you developed any relationships with people that were in that group?
P9: Not really, no.
IV: Do you talk to people in that group more or less?
P9: The same as before. (IRC5 P9 F2)

On one occasion, those participants who were more musically capable became frustrated at detainees who were less so. They felt that they were restricting their opportunities to play.

Do you know what's happening here? Some of the people don't know how to do this, ok. They come in here and start... I don't know they just make too much noise… just banging on things. If you don't know how to play just get out. (IRC2 P8 F1)

Theme 1.2 Meeting officers in a different space

Participants regarded officers as enforcers: there to restrict their movement, tell them what to do and maintain security. However, positive interactions were witnessed when officers were involved in the workshops.

O1 has begun to play the djembes. He plays with a large smile on his face, dancing and enthusiastically holding and adding to the beat. P6 walks into the room… O1 encourages him into the semicircle and gives him a shaker, instructing him on how to make a noise along with the music. As the music continues, O1 and P6 regularly make eye contact, smiling at one another. (Field note, IRC2)

In two of the IRCs, where music activities were more accessible, participants said that their relationship with the officer involved in music activities involved less of a power imbalance. They felt that the officers were there to support and tutor them.

> *He's not an officer. [laughs]. He's more like a friend to be honest with you. I'm actually being serious. He actually is. He wants me to improve so he will help me with it. So that's not like what an officer is doing, you know?* (IRC3 F2 P8)

Where officers did not join in with music workshops, their normal role was confirmed and they were regarded with suspicion.

> *Just sitting there it looks like you're [officer] policing us. That was the opinion I got. It's like they watch every moment in case you do this, in case you do that. Because I'm not sure exactly what they're sitting there for. So that's the opinion I got. I'm not sure what the aim of that was… When they sat there was like we're being monitored…* (IRC5 F2, P9)

A smaller number of participants had more entrenched views of officer roles.

> *He's still an officer, he's still an officer. Because he's in the music room doesn't change the fact he was placed here to do his job, he's following strict orders from his boss. So it change nothing.* (IRC3 F2, P13)

2. Emotion Regulation

Themes in this domain concern the ways in which the music workshops provided a means of coping for participants, helping to reduce stress and frustration.

Theme 2.1 Relief from the situation

The majority of participants said that engaging in the music workshops helped to improve their mood. There was a distinction, though, between those that thought the music provided only temporary relief from the concerns of being in detention and those that saw it as having longer term benefits.

Most often participants described how the music workshops helped to occupy their thoughts and so distract them from their normal concerns. This was also witnessed during the workshops. Participants became absorbed in the process of music making.

> *Like, whenever I come here I've got… I've got loads on my mind and I can set them aside for the two hours I'm here. So if I could come to this workshop 24 hours then I would be sorted. I wouldn't want to go home. Leave me here. I would survive.* (IRC3 P8 F2)

> *P7 begins hopping up and down as he is singing, looking into the distance, smiling. He pumps his arms up and down, and then points to people in the semi-circle.* (Field note, IRC2)

Being able to escape from worries had an impact not only on thought processes, but was also felt physically.

> *If… sing a song… is any tension… and is tension time is a song is gone the tension… leave there from the heart… is mind is keep the fresh.* (IRC1 P2 F1)

Participants were clear that this did not change their situation. They were just able feel better momentarily. At the end of the workshop they would return to their original state.

> *It doesn't change it. What it does, it makes you feel relaxed. You don't worry too much about your case. I feel more relaxed. I'm not thinking too much.* (IRC2 F1, P4)

Other detainees felt that this momentary experience of relief had longer-term benefits. It provided them with a memory of being able to cope that made the situation more tolerable.

> *What I'm saying is, you know, we have loads on our mind here, yeh? I personally get really worked up.... Down there people get into fights and all of that, start abusing you verbally. You come into this workshop for two hours and get all of that out of your head. And you sort of get really cool. And you go back and you do your thing.* (IRC3 P8 F1)

It seemed that this memory was protective for participants, helping to shield against future difficulties and reminding them of their capacity to cope.

Music is a thing that keep you going strong… music help you on the inside and as well on the outside. I have these type of mental problem. Most of the time I get frustrated and then if I'm in a mood swing I put on a bit of Sizzler, a bit of Bob Marley and then it bring out the true me. So it make me overstand, cause me no really deal with understand, so make me overstand and wise up to the occasion and look at me self and say me strong. So in a sense music it bring out the true you… because in a sense music hit you, you feel no pain. [Sings] One thing about music, you feel no pain. Hit me with music. (IRC4 P17 F2)

Theme 2.2 Self-expression

It was important to participants that they were able to express their feelings in the workshops. They regarded this as a means of giving rise to and a release from their emotions, helping them to better tolerate their situations. Within workshops participants would express a wide range of emotional reactions even when engaged in the same activity.

…to be honest in this kind of environment it's just something to get people's minds off the situation and it is helping because it helps them to express themselves... put themselves out there, the way they're feeling and just vent basically... (IRC4 P15 F1)

Without tiring P5 strolls around the room, dancing with his shoulders thrust back, a serious expression on his face. P2 appears to be on the verge of tears, his eyes red, often looking skywards as he sings, a clenched fist raised. P6 is smiling, looking at all of the other musicians and laughing. (Field Note, IRC1)

Those participants who had access to music facilities over the longer-term noticed that their feelings, as reflected in their music, changed over time.

That's why, like [P8] was saying, when people first come in here their lyrics are more usually violent and angry and they're all frustrated. And then as time goes on they start progressing to like normal bars and normal lyrics and normal kind of music. They get rid of all that frustration… (IRC4 P15 I2)

As a means of accessing and communicating emotions, music was perceived as far more useful and acceptable than talking.

As far as I'm concerned music is a way to express your feeling, yourself. You can probably express yourself more in music than you can express yourself with your friends and that. (IRC4 P12 F1)

Participants noted that this act of self-expression, whilst not necessarily changing the way they felt, provided a sense that they were doing something productive with the feelings

> *I don't know. I'm always trying to show my feelings all the time when I'm writing. That's the only thing that inspires me to write, the pain I'm going through or whatever innit… It makes me feel good, innit. At least I'm putting it in some sort of… like rhyme it innit and just hope that other people like it. (IRC4 I2 P9)*

At times, though, participants felt curtailed in their need for self-expression by the institution's rules, particularly with regards to criticising the institution itself.

> *You're not allowed to glamorise violence or sexual something da da da da. But anybody that want to talk about immigration or the people that does it, the Home Office, they're not going to come out with clean language to say how they feel about them. So you can't really say it.* (IRC4 P9 I1)

> *The Chaplain says he doesn't want detainees to sing songs that are negative. I sense a nervousness amongst the officers that the performance could be used by the detainees as an opportunity to air their grievances.* (Field note, IRC3)

Theme 2.3 Instillation of hope

The majority of participants found the music workshops enjoyable. They said that they were able to hold them in mind and project themselves forward to a time when they would have the opportunity to participate again.

> *So each time you come inside here and do something, and when the day finish you look forward to come back and do something again.* (IRC4 P6 I2)

Participants used music and the music workshops as an opportunity to positively reframe their situation. Most often this was communicated through song lyrics.

> *P13 takes the mic, gathers himself and sings:*
> *'Everybody has his time*
> *Everybody has his season*
> *This man don't waste your life*
> *Every morning you be counting the ceiling*
> *Do something with your life*

There is no end without a beginning.' (Field note, IRC3)

Do you really know yourself?
Success is what you make it
If you really know yourself
The world is yours so take it. (Song lyrics, IRC4)

Where participants had better access to music facilities and the opportunity to develop their musical skills they would begin to imagine a more positive future, utilising their newfound talent.

> *It just makes me think that maybe when I get out I can do something better with my life, get involved in the music business or something.* (IRC4 P9 I1)

3. Identity

Themes in this domain reflect comments from participants that the music workshops provided them with the opportunity to view themselves and be viewed by others as people who were not solely detainees.

Theme 3.1 Feeling valued

Workshop facilitators encouraged detainees to lead the workshop or provide input that would shape a song or performance. Often this would involve the whole group playing a song that one of the participants had created/written. Participants said that this experience increased their belief that their ideas and opinions were valid.

> *Fa1 lets P4 know that he wants him to take a solo – P4 looks at him smiling, shrugging his shoulders as though he wouldn't know what to play. Fa2 sits with P4 to help him figure something out.* (Field note, IRC2)

> *…they ask P3 if he would like to play with them. Fa1 says the song is in C so P3 need only play the white notes. They play together, Fa1 singing, but the piano sounds off key. P3 says that he only likes to play the black notes. Fa1 adjusts his song putting it in the key of F# so that P3 can play along with the*

> *black notes. Fa1 refers to this as 'improving the song'. It works. P3 improvises over the top of the song in key.* (Field note IRC4)

> *Yeh because it was open, you know how can we make the thing interesting. Just like bring the ideas and see if they work. If you have good ideas you know you can contribute something that makes sense.* (IRC5 P9 F1)

Many participants commented upon the importance of having workshop facilitators from outside the immigration system coming in to meet them. They said that they ordinarily felt forgotten. The fact that musicians were taking the time to help them create music provided them with the sense that they were being cared for and thought about outside the Immigration Removal Centre.

> *...the thing about the whole immigration situation, the whole system, is people outside they don't know about it. It's like it doesn't exist... it's nice to see that people outside who live their own life, who have stuff to do, are taking an interest in people in my situation where my life has been obstructed and taken away from me.* (IRC4 P15 I2)

On occasion detainees could be excluded from the music workshop sessions. This tended to occur when the facilitators were pressed for time, for example when preparing songs for a performance, or because of the restrictions imposed on detainee movements by the regime.

> *Fa1 says to Fa2 that she is worried that a group of detainees from Pakistan who had attended the past two days of workshops didn't get a chance to sing their song. Fa2 says that they needed to be more patient and wait for their turn. Fa1 says that although the participants did not wait around they came back to the music room frequently. They both express disappointment that now they won't feature in the performance.* (Field note, IRC3)

Theme 3.2 Realising strengths

In engaging in the workshops, participants said that they were able to learn or develop their musical skills. This was reflected in their accounts as an experience outside the everyday regime; a realisation that they could exert control over their environment and make some form of progress.

> *Yes, it made my three days just be occupied, very useful and innovative. I feel so good about myself that I've learnt something… I don't think I'm going to forget, I'm going to carry the little talents that I have learned in this three days.* (IRC5, P8 F1)

For participants the music provided an opportunity to focus on and notice their strengths. They felt that they were ordinarily portrayed negatively. To them the music was proof that they held qualities beyond the label of 'detainee'.

> *You know what, there's a lot of true potential inside here, behind bars… In the eyes of most people we are bad people, but behind that there is something good. They say positive can come out of the negative. I think that show up the positive side of us and the better side of us as well.* (IRC4 P6 I2)

The interview data and my own reflections on the workshops suggested that, in coming to realise their musical skills, participants grew in self-esteem.

> *Yeh. It's given me the opportunity… like with the keyboard… I didn't know how to… and we were playing something earlier and it was really fun. I was the one that started it and I was like… Yeh. I didn't know I could do it before.*
> *Fa: So it's given you…*
> *P4: More confidence.* (IRC2 P4 F1)

> *I witnessed what I interpreted to be a significant change in P4. At the beginning of the day she was very shy: her drumming was barely audible and she refused to dance. Later on, during the performance, she asked to use the large drum and began leading the rhythm. Even after the performance had ended she continued to play with P8 and P9, rocking to the beat, smiling*. (Field Notes, IRC5)

However, these comments and observations were made immediately after or during the workshop. There was little evidence to establish if or how self-esteem altered over time. In one focus group, participants remarked that they found the workshop too easy. They wanted to be challenged to develop their skills further.

> *I thought we was going to progress to something. Have I known we were just going to do a basic thing the first day would've been enough.* (IRC5 F2 P9)

Theme 3.3 Finding a voice and being heard

Participants were keen to share their music and story with a wider audience. In two of the workshops they were given the opportunity to perform their songs to

staff and detainees at the centres. They received recognition from detainees and officers for their performances and said that this made them feel good about themselves.

> *…when P13 starts singing everyone in the audience looks in his direction… Members of the audience then start joining in on the chorus… P13 gets a loud round of applause. He moves towards a group of detainees who punch his fist, slap him on the shoulder or shake his hand. He is smiling.* (Field note, IRC3)

> *Yeh. Seeing me doing all that [drumming and dancing during performance], they found that quite interesting and they wished they were coming a bit earlier. They kind of underestimated what it was all about.* (IRC5 F2 P9)

However, on both of these occasions, participants remarked that they felt unsupported by the Immigration Removal Centres during their performances. They said that the centres either failed to promote the event properly or gave them insufficient amounts of time to complete the full performance.

> *Yeh. Because we actually came in here and we worked for it. We actually got things sorted in a very short amount of time. We had just a day to sort things out. And we did it and then we had only two minutes to do our things. Not good.* (IRC3 F2 P8)

On the remaining three occasions, workshops concluded with the recording of participants' songs, which were then transferred onto CD. Participants often proudly retained these CDs and distributed them to other detainees.

> *'Does it drop in ok' asks P5 again. P1 nods his head, smiling. 'I want a copy of this, I like it' says P5 walking away from the microphone.* (Field note, IRC4)

Participants said that they hoped these recordings would reach people outside detention via the music facilitators. The accounts suggested that the CD would act as a permanent reminder of this hope.

> *And the fact that it was complete and we could listen to it back again, everyone feel like we are doing something and making progress in a sense.* (IRC4 P6 I2)

Often these recordings were shared with community groups, who then provided feedback. Participants were enthusiastic about this process. They said that it gave them a tangible sense that their message was impacting upon and being heard by the outside world.

> *…there was this one particular workshop where there was these guys that they came in and they were working with a primary school and they were showing the primary school about people in detention. I wrote a couple of poems for the people in the primary school… I got some feedback from the kids as well and that was really nice. I was like, ah these kids, they're really liking my poems... So you do get stuff back from it like that and that's really encouraging and uplifting at the same time.* (IRC4 P15 I2)

> *But then it also give you strength to know that this is not the end of the world, you have something that the world wants, and people like. That also give you strength. And at the same time when people listen to your music and you watch them react to it, that positive mind make you feel good, it make you feel happy because you are making people happy as well.* (IRC4 P6 I2)

However, it was difficult to gauge to what extent all the workshops' participants were able to find their voices through the music in this way. This notion tended to be expressed more in those participants who actively engaged in the workshop. There were a significant number of participants in each workshop whose level of engagement was far more passive, as my reflections suggest.

> *There seems to be a real change in some of the detainees, for example P7's emotional state seemed to shift from angry and frustrated to happy over the course of his performance. By the end he was pointing into the distance smiling. Others are in the distance barely playing their instruments. They don't seem that connected to what is going on in the room.* (Field note, IRC2)

Discussion

The study found evidence that participation in the music workshops facilitated the development of supportive relationships, encouraged the use of strategies for improved emotion regulation and reconnected participants with a more positive view of themselves. The extent and longevity of this effect seemed, in part, to be determined by the level of engagement of both detainees and officers in the workshop, the variation between detainees' musical skills within a workshop and access to music making facilities between workshops.

The majority of workshop participants reported better relationships with fellow participants immediately post-workshop. This effect was not found in the one setting where musical abilities within the session were variable. On occasion, long-term, mutually supportive relationships were reported. These had begun and were maintained through joint involvement in music. Where prolonged access was not provided, participants reported that their new relationships were fleeting.

In three settings where officers were heavily involved in the workshops and music-making activities, participants said they perceived those officers as more helpful and supportive than others. For some, though, their negative views of officers were entrenched and could not be bridged through music.

Distraction was a common process through which participants derived benefit from the workshops. Although for many this was only temporarily helpful, some found this memory of momentary coping useful in the longer-term. The latter effect was found more commonly during follow-up focus groups or interviews where participants were asked to reflect back on their experiences of the workshop.

Participants valued music and the music workshops as a useful means of identifying and expressing or communicating their emotions. They believed that this was helpful in different ways. For some it allowed a 'release' of negative feelings while others profited from the sense of agency that arose from the act of channelling their feelings into a creative form. There was evidence that, where access to music facilities and expression through music was prolonged, negative emotions dissipated over time. On occasion the settings' regimes could limit the extent of self-expression permitted.

The hope instilled in participants through participation in the workshops was most often short term: an enjoyable activity to look forward to in the future. However, a number of participants used music as a means of positively reframing their situation. Some evidence suggested that this feeling of hope could, with greater time spent developing musical skills, project to life outside detention and persist in the long-term.

Some of the participants said that through engaging in the workshops they were able to view themselves more positively. Findings suggested that these same participants increased in confidence over the course of the workshop. Aspects of the workshops that seemed key to this process were the valuing of participants and their experiences as detainees; noticing strengths; offering opportunities to lead and impact upon the workshop; teaching new skills or developing current skills; and providing a medium through which participants could share their message and musical talents.

There was, however, little evidence to suggest that any such increase in self-esteem or self-efficacy was sustained beyond the workshop. Furthermore, levels of engagement in the workshops were variable and some detainees were unable to

provide input because of the regimes' restrictions or time limitations. It remains unclear why certain detainees were better able to engage with the workshops; what level or type of benefit, if any, participants who were mere bystanders derived from the workshop; and whether exclusion from the workshop resulted in any negative impact.

The positive effect of the workshops on relationships between participants has been replicated in studies using group music therapy with comparable populations, for example war veterans suffering from PTSD (Bensimon, Amir & Wolf, 1998), schizophrenic inpatients (Talwar et al, 2006; Gold, Heldal, Dahle & Wigram, 2008) or prisoners (Cox & Gelsthorpe, 2008). That this impact was dependent upon prolonged, joint musical activity is also reflected in the music therapy literature (Gold et al., 2008). Where relations had improved, it seemed that the reciprocal process of learning from and supporting one another through music, in terms of skills, emotional content expressed and cultural belief, helped to establish these closer alliances. This suggests that the workshops aided the development of mutually supportive relationships, which are linked to improved mental and physical health outcomes (Cohen, 2004).

Yet it is unclear to what extent music's involvement in the workshops facilitated these relationships. Could any joint task have resulted in the same outcomes, or was there something unique about this intervention? Music is thought to have played an adaptive function in human development, impacting particularly on our ability to work together in groups. Theories supported by neurobiological data (Kosfield, Heinrichs, Zak, Fischbacher & Fehr, 2005) propose that music helps to synchronise and conjoin individuals (Levitin, 2009), thereby increasing co-operation and collaboration (Clayton, 2009; Dissanayake, 2009; Sawyer, 2005). Yalom (1985)

has written about the necessity of group cohesion as a condition from which group therapy can bring about change. Given the evolutionary arguments that music helps in conjoining individuals, it could be hypothesised that music workshops provided detainees with an activity that facilitated cohesion and the conditions under which positive change, or benefits from working in groups could be derived.

The music therapy literature suggests that in providing the opportunity to express and share feelings music-making can improve communication and the identification and control of emotions, thereby increasing self-efficacy (Cox & Gelsthorpe, 2008; Carr et al., In Press). Such a concept would be closely related to mentalisation, the act of knowing one's own and other's minds, which has been found to have therapeutic effects (Bateman & Fonay, 2004). According to Yalom (1985), group cohesion creates an environment in which 'interpersonal sharing' can take place, thereby increasing the likelihood of positive change. But to what extent were the participants 'communicating' to or with one another through the music? The meaning inherent in any musical form is necessarily ambiguous. Cross (2006) has suggested that this ambiguity could be beneficial, particularly in socially uncertain situations where it allows individual meanings to be held, meanings that may even oppose one another while contributing towards a shared goal. It is, therefore, possible that the music workshops not only provided the means for creating a cohesive group environment but also, given the context, a route for the development of levels of effective communication that enhanced feelings of self-efficacy and social support.

The impact of social support is usually researched at an individual level (Orford, 2008), yet the relationships formed via the music workshops may also have had a broader, contextual impact. Where mutually supportive relationships between

participants existed, the social support garnered through the workshops appeared to be fostering a sense of belonging and establishing a group identity. This was an experience that was reported as countering the uncertain, culturally disparate and ultimately disempowering nature of the Immigration Removal Centres researched. The trusting, reciprocal, supportive relationships established through the workshops could be considered indicators of social capital, the idea that strong social networks can have benefit in building community capacity (Putnam, 2000). The accounts given suggest that 'bonding' or intra-group networks were developed, as were 'bridging' or inter-group networks (McKenzie, 2008). Evidence for the latter can be found in the reporting of improved relationships between officers and detainees and increased links with organisations and individuals outside the immigration removal centres. The impact of these networks was witnessed both at a structural level, as in the opportunity for detainees to voice their opinions through song, and at a cognitive level, in the belief that participants could trust and rely on one another (De Silva, McKenzie, Harpham & Huttly, 2005). Although the impact of social capital has not been researched in Immigration Removal Centres, neighbourhood social capital is broadly related to increased mental health and wellbeing (Almedom, 2005; De Silva, McKenzie, Harpham & Huttly, 2005; Kawachi & Berkman, 2001; Putnam, 2000; Shinn & Toohey, 2003).

The facilitation of improved relationships between detainees and officers with increased participation in the workshops was unexpected. In particular it seemed that detainees could adjust their attitudes towards officers and accept that they may be able to adopt a helping role, particularly in the transfer of skills. The maintenance of boundaries is obviously of some concern in these settings; perhaps music-making provides a concrete task through which officers can maintain these

boundaries while adopting a more supportive role. More equal power status amongst the marginalised has been found to promote improved mental health in a range of settings (Orford, 2008).

The use of the workshops as a form of distraction can be understood within the coping styles literature. Coping as a response to stress has been situated within a wider transactional framework, where a person's reciprocal interactions with their context determine the level of distress experienced (Lazarus & Folkman, 1984). Core to this process is the perceived level of control over the situation. Where there is little available control, as in detention, emotion focused coping - a broad category of coping styles within which distraction sits - has been found to be a potentially adaptive strategy in reducing levels of distress (Folkman, Lazarus, Gruen & DeLongis, 1986). In prison settings distraction or avoidance strategies are predictive of higher levels of wellbeing amongst prisoners (Gullone, Jones & Cummins, 2000).

For those participants who perceived longer-term benefits to the workshops with regard to emotion regulation, the accounts gave the sense that the memory of being able to cope, even in the short term, was protective against future stressors. Research on resilience supports this notion. Experiences of effective coping can increase resilience and so protect against the development of mental health problems (Edward & Warelow, 2005).

Given the high level of uncertainty amongst detainees and lack of control over their futures, the tendency among many to use music as a means of expressing a hopeful message seems surprising. The data suggested that this was a deliberate coping strategy, a cognitive style that better helped them to manage their uncertainty. Hope or optimism and striving towards a goal are thought to underpin psychological

wellbeing (Snyder, 1994) and are related to adaptive coping styles (Chang & DeSimone, 2001).

That participants were given the opportunity to lead workshops, voice their difficulties and share these with other detainees accords with suggested, ecological, strengths-based approaches for refugee interventions (Miller & Rasco, 2004). A core principle of these approaches is to increase empowerment, which is associated with physical and mental health benefits (Wallerstein, 2006)

However, participants remarked that the music did not fundamentally change their situation: it did not remove the threat of deportation nor encourage their release. Furthermore, the centre regimes were prone to curtailing participants' attempts at self-expression and performance. This fundamental inability to take control over their external situation may, to some extent, explain the failure to identify long-term improvements in self-esteem or self-efficacy.

Limitations

This study is, in part, limited by the drawbacks inherent in retrospective recall. Although two-week follow-up interviews were conducted to capture the longer-term effects of the workshops, it is not clear that this is a sufficiently extended follow-up to make such claims. Furthermore, participants, often with limited English, were asked to reflect on a process that was complex and required a high degree of insight. Lack of translation facilities meant that some of the music workshop participants were omitted from the focus groups or interviews. The analysis, therefore, failed to capture the full range of perspectives. Furthermore, the presence of an officer at all workshops, interviews and focus groups may have affected the opinions expressed,

possibly encouraging reticence or socially desirable responding. My position as a white, middle class male may also have had a detrimental impact.

The use of ethnographic methods was an attempt to overcome some of these drawbacks. However, attendance on the last day of only five workshops represents a somewhat short-term and limited approach to this methodology. Again my cultural background may have limited my observations and own reflections on the processes that were present during workshops.

The relatively small number of workshops investigated also calls into question the generalisability of the findings. The workshops are a heterogeneous intervention. Typically they adapted to the demands and needs of the culturally heterogeneous immigration detainee population. The extent to which the findings presented may apply to a different mix of ethnicities is unclear.

Although such data is difficult to collect given the nature of the population, the study may have been better served by using quantitative measures to triangulate with interview and observational data. The individual interviews were conducted on an ad hoc basis, dependent largely on the preferences expressed by different Immigration Removal Centres. However, they tended to yield far richer data than the focus group interviews. This suggests that they are possibly the best means of establishing immigration detainees' opinions and should have been utilised to a greater extent.

Implications and Future Research

Music workshops are a culturally sensitive means of encouraging group cohesion, emotion regulation and communication. They may, therefore, help to foster a healthier and more supportive detention environment. The evidence suggests that,

for the workshops to be effective, participants require freedom of movement and expression, and the long-term involvement of officers. Currently there is a great degree of variability of music-making facilities between Immigration Removal Centres. The finding that music workshops are more beneficial and, therefore, more protective against mental health problems where these facilities are extensive, indicates that, where it is currently lacking, more investment could be made.

Beyond the scope of immigration detainees, this study adds weight to the notion that everyday music activities can, like physical activities, promote wellbeing, participation, social cohesion and empowerment and should be considered as valid prevention or health promotion strategies.

As an exploratory, qualitative study many of the tentative conclusions drawn from the data require further research. A longer follow-up, using a control and established measures of social support and mental health, would enable a clearer assessment of the impact of the music workshops and address the issue of generalisation. Although it has been proposed that the workshops help to empower detainees, the exact mechanism of this empowerment is unclear. Measures of collective efficacy and social capital could help to further elucidate this process. Similarly, the mechanism by which potentially nurturing relationships between officers and detainees were established remains unclear and requires detailed analysis, perhaps using more involved ethnographic methods.

It has been proposed that the involvement in music was key to the effectiveness of the intervention, particularly with regard to developing mutually supportive relationships. However, it is not clear whether this impact would be different using an alternative, non-musical activity nor whether there are any additional effects that may arise from being involved either in music-making or other

creative activities. A comparison study would provide clearer data. Lastly, more research is required to better understand the mechanisms by which detention impacts upon asylum seekers' psychological wellbeing to influence the day-to-day operation of Immigration Removal Centre regimes.

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Part 3: Critical Appraisal

Introduction

In the early stages of this research, while generating ideas and questioning the feasibility of the study, I visited Immigration Removal Centres (IRCs) and observed the music workshops. I had worked in prisons and inpatient units, both closed institutions, but IRCs held a quality that seemed entirely different. The difference, as I experienced it, was a difficulty in settling on any general impression. Each IRC varied: a different set of procedures; a different quality of relationship between detainees and officers; a different attitude and way of being between detainees. The workshops varied: different musicians facilitated the sessions; each one of them had different ideas on how a successful workshop would ideally proceed; detainees approached, used and reacted to the workshop in many different ways. Added to this was the variety and diversity of cultures and nationalities represented within centres. It quickly became clear that, to be of any merit, the study would have to embrace the complexity of handling these different perspectives and processes.

Approach

The obvious choice was to use qualitative methods and approach the workshops from the viewpoint of phenomenological epistemology. But, as a trainee clinical psychologist, schooled in the need for quantitative measurement and experimental control, and based within the NHS culture of working from an evidence base, I felt a pressure to temper my phenomenological leanings. I did not want to depart too far from the paradigm of positivism: I wanted quantification to dismantle

and isolate some of these complex processes I had witnessed. I settled, initially at least, on something of a hybrid.

The rationale for using focus groups was both pragmatic and theory driven: a means of making the most of my limited time and reducing disruption to the centre's regime; the group empowering participants to talk more openly, minimising the power imbalance that my presence and the presence of an officer inevitably brought. I had experienced and witnessed, during these early stages, a post workshop buzz. I left feeling elated and I guessed the participants did too. But what happened in the longer term? Did this feeling of elation remain? The follow-up focus group sought to answer these questions. Ideally the follow-ups would have been repeated and traced participants over long periods of time. Instead only a two-week follow-up was agreed. This was a balance between making the follow-up meaningful and ensuring that the detainees, by their nature a transient group, would still be available for interview. This arrangement resembled a pre-post test, but really the initial focus group was meant only as an engagement tool, an opportunity to get to know faces and ideas before we met later and talked at length.

To satisfy my clinical psychology urges for uncovering the 'right' kind of evidence, I aimed to support data from these focus groups by additionally administering a battery of three lengthy questionnaires, covering two sides of A4, front and back. These questionnaires, the Hospital Anxiety and Depression Scale (HADS: Zigmond & Snaith, 1983), the Impact of Event Scale-Revised (IES-R: Weiss, 1996) and a purpose built demographic questionnaire, were a replication of those used by Robjant, Robins and Senior (2009), to date the most robust of studies investigating the impact of UK Immigration Removal Centres on the mental health of detainees. My intention was not to employ an experimental design – the

questionnaires were only to be administered after the first focus group - but to provide contextual information and help determine the nature of the sample. Recording this information, I theorised, would help to keep the study in touch with the existing evidence base. It would also provide much needed data on the mental health of detainees in the UK.

After piloting a disappointingly short focus group, where insights were few and language a huge barrier, I administered the questionnaires to four of the participants, those who had the language capacity to complete them. The reaction was overwhelmingly negative. Detainees either refused to engage or left them half done. They began to treat me with suspicion. Why did I want this information? Their lives were an endless stream of forms, why fill in another that they did not fully understand?

This reaction was in complete contrast to the nature of what had happened in the workshop. There participants had danced around the room, some elated, others on the verge of tears; they sang freely about a life in detention; were supportive of one another's need for expression. Clearly my methods were missing something. Or worse, were they serving to repeat the detainees' experiences of life in detention? Prior research has used quantitative measures and semi-structured interviews in these settings to good effect (Robjant et al. 2009); before embarking on the research I had talked with other researchers in the field who experienced no such difficulties. I was concerned, though, that these measures in categorising and restricting the opportunities for people's individual voices to be heard were, in the context of the music workshops, interrupting the sense of autonomy provided; they held the potential to disrupt the beneficial elements of the very thing I was attempting to study.

It was disappointing that discussion failed to ignite in the focus group. There were elements of my questioning that certain participants connected with, but still what they said did not seem to provide a true insight into the impact of the workshop nor reflect what I had observed. Over the course of the study, focus groups, both initial and follow-up, did not last longer than 30 minutes. Some involved true debate, but the majority offered only moments of free conversation. Everywhere I went the message was the same: we communicate through music, not talking. Given the nature of the population and their difficulties with language this was, perhaps, not surprising. Yet despite this, the focus groups provided some interesting opinions. They were a valid source of research data but perhaps, I realised, could and should not be relied upon as its sole source.

Observer-Participant

My response was to adopt the approach of applied ethnography (Savage, 2006). A number of data sources arose out of the workshop: lyrics, music, and workshop facilitator comments and reports. Clearly too, my observations were informing what I deemed to be suitable methods. I was developing theories on how the workshops were operating, but these were unchecked and had little form. Ethnography provided the framework to amass what I was collecting from these many sources, a formal structure from which my observations could provide valid data. What became evident too was that, with the emphasis on insider perspectives, naturalistic settings and subjectivity (Hammersley & Atkinson, 2006), it seemed a good fit.

I am not an anthropologist. This was a new approach to me and despite meeting with past trainees who had undertaken similar projects, consulting with my

supervisor, and spending useful time referring to the standard texts on the subject, it was a considerable shift from where I had begun my study. This was particularly so in my use of the participant-observer method. Grey areas appeared where, in my previous experiences of research, I had been sure of my course. For instance I had to rely on workshop facilitators and staff to ensure that my purpose was made clear and that informed consent was obtained. How enlisting their help may have interrupted the later interviews or the workshops is unclear. Ideally I would have spent time at all sessions and been on hand to provide more information and develop closer relationships with the participants.

And where to position myself on the observer-participant continuum (Atkinson & Hammersley, 1994)? This required managing. Like most, I love listening to and playing music (amateurishly). The opportunity to learn from and contribute towards what was going on in the workshops was a huge temptation. I would consult with the facilitators before each workshop to keep myself in check. It was clear to participants that I was not a detainee, but my role shifted. It fluctuated from the observer as participant – standing at the back of the room whilst participants worked on their tracks – to participant as observer - fluffing a drum solo and receiving laughs and encouragement in equal measure. At other times I stood at neither pole. I was often allied with the facilitators, aiding them, and I am sure this was often how I was viewed. More confusing still was when I became an interviewer, introducing the participants to the unusually formal procedure of research and written consent. And then, on one occasion, a clinical psychologist managing risk after a disclosure of suicidal ideation.

This balancing of roles had an undoubted effect on my task as observer. In part I felt more comfortable with this task. As a psychologist working in child or

learning disability departments I had been trained in and practised quantitative measures of observation. I could, I thought, separate my inferences from the observed. But methods such as functional analysis are structured. They offer a clear course that helps one to navigate the complexity of human behaviour. Here the research questions guided my observations, a wide scope that meant the focus of my attention altered with each workshop. And never before had I been presented with such vast quantities of information. Multiple interactions developed around me, participants moved in and out of the session, both in terms of engagement and presence, facilitators and officers led or let detainees lead the sessions. Add to this my involvement as participant and my on-going concern over how best to position myself and move between my many roles, then the reliability of my observations have to be brought into question. I believe my skills in memorising events and transforming these into field notes improved over the course of the study but I was constantly plagued by what had been missed. I thought I could retain an objective stance but my role as participant introduced interference, a somewhat distorted lense through which my observations were determined. Ethnographers would respond that these subjective experiences were a useful source of data (Hammersley & Atkinson, 2006). But for me it took time to accept the inherent level of subjectivity in the method and to separate my own reactions from what I observed.

Possibly my task would have been made easier, and the study certainly more robust, had I spent more time in the Immigration Removal Centres observing detainees both inside and outside the workshops. Standard ethnographic practice promotes prolonged immersion in the field (Goffman, 1989). Even within current, applied ethnographic thought where, with focused research questions, this need not necessarily be the case, my involvement would be deemed brief (Savage, 2006). The

aim is to develop a 'thick description' of a setting and the people in it, one detailed enough that a reader could comfortably locate themselves in that setting and adhere to its many written and unwritten rules (Geertz, 1973). My gathering of a number of different sources of data was an attempt to reach this point. I am not sure that doing this overcame the difficulty of getting to a sufficient understanding of such a diverse setting, population and complex intervention. Unfortunately I did not have much choice. As a trainee I had limited time available; the process of gaining access to the immigration removal centres was incredibly time consuming; I was refused entry on arrival on more than one occasion; and, within the limited timeframe in which I had to collect data, the number of workshops that were being run was relatively few.

Bracketing Beliefs

I wonder, too, whether my brief visits complicated the task of 'bracketing' my beliefs (Strauss & Corbin, 1990). I approached the project concerned for the welfare of immigration detainees and unconvinced of the legality of immigration detention, given what I perceived to be the unnecessary restrictions to their human rights. Having spent no time in Immigration Removal Centres (IRCs) prior to embarking on this study, I was suspicious of how detainees were being treated. In owning these prejudices I hoped to lay them to one side, or at least be made more aware of times when they were colouring my thought. Yet my dealings with the centres tended to reinforce them.

Initially, the project was dominated by difficulties in gaining access to the IRCs. Although I was helped through this process via my involvement with Music in Detention who had good, pre-established relationships with the centres and the UK Border Agency (UKBA), acquiring official permission to conduct the research was a

long and anxiety-provoking process and one I often felt was out of my control. Once permission was granted, despite spending time to establish relationships with key staff, I was turned away at the gates from prearranged visits on a number of occasions and often left waiting with security for hours. At every centre photographic ID was required, my picture and fingerprints recorded. I had to leave all personal belongings in a locker and my digital voice recorder needed official clearance from management – this clearance was rarely communicated to staff on the gate. Once inside I was always given a warm welcome and my prejudices were often challenged by the positive interactions I witnessed between officers and detainees, something I was able to reflect on between workshops during supervision. Nonetheless, I would often arrive at a workshop feeling frustrated and dismissive of the centre and its regime. I felt myself allied with the detainees and as such, less able to take an objective stance.

Bracketing is closely linked to the practice of phenomenology and a core element of qualitative research (Gearing, 2004). In essence it is the act of setting out one's biases, assumptions and preconceptions to aid the study of the essence of something. There is an array of approaches to bracketing, each based on different epistemological and ontological stances (Gearing, 2004). At one extreme is descriptive bracketing, the holding in abeyance of all suppositions personal to the researcher and those concerned with the phenomena being studied (Ashworth, 1999). This is generally applied to studies with a strong quantitative element that maintain a strong positivist epistemology. More relevant to my study is the practice of reflexive or cultural bracketing, a postmodernist approach that is sceptical of a person's ability to hold their beliefs in abeyance. Instead the approach encourages that these are claimed and brought into conscious awareness, thereby reducing their influence

(Ahern, 1999). Although this was my intention, I am not confident that I was particularly self-aware, given my emotional reaction to the situation and the high level of accord between my experiences and prior assumptions. Yet from the perspective of ethnography my subjective experience could be regarded as useful data, an insight into the world of detainees. This approach could be allied with the process of analytic bracketing, where an attempt is made to put personal presuppositions to one side, although it is accepted that this is unlikely to happen. Instead the researcher is encouraged to step in and out of the bracketing process to engage in the experience of the phenomena being studied (Gubrium & Holstein, 1998). Reflecting on the workshops through supervision helped me to re-establish my objective stance and use what subjective information I experienced to further inform the research. My emotional reactions became part of the iterative process of research.

Power

It is possible, though, that my experiences in gaining access to conduct research in the Immigration Removal Centres (IRCs) led to me sacrificing on methodological consistency. Prior to starting the study I was acutely aware of the difficulties of persuading the Home Office to allow independent research in IRCs: to date only two such other studies have been undertaken. The lengthy process of persuasion was frustrating and I felt relief when I was eventually granted access. I visited each IRC and met with the activities' managers to reiterate my research proposal and ensure that the focus groups would follow their planned course. In reality running the focus groups proved to be far more difficult than this. The music rooms varied – one was a thoroughfare – as did meal times and staffing levels. I was

frequently given very little time to conduct the focus groups and it was rarely the case that these were not interrupted. On one occasion I was asked to do individual interviews in a room with other detainees present. In trying to ensure that the research went ahead, I tended to be too acquiescent, too ready to agree to the centres' demands to be sure that I could collect my data. True, this was an unusual, and hard to access, setting. Maybe some level of flexibility was required on my part. But I often left thinking I should have been more assertive. Once inside the IRCs I generally felt out of control of the process of the research. To an extent this may have been useful and aided my role as participant-observer, again reflecting the power imbalance experienced by detainees. However, it must be said that it did impact on the focus group data.

This issue of power imbalance was also present between the participants and me. As I have already mentioned they tended towards reticence in the focus groups. There seemed to be a wariness of me, white, middle class and allied with the regime staff as I was. On two occasions, however, a microphone was used to help record the conversations. This seemed, to some extent, to redress the balance. On these occasions participants wanted to hold the mic, wanted to have their say. Being interviewed made them feel important and provided them with the chance to sing and get their music projected out to a wider audience. In future such strategies, in settings where participants are very rarely given a voice, may need more consideration.

Conclusion

Despite the many hurdles and limitations I have listed, the flexibility afforded me by taking an applied ethnographic approach supported the collection of a complex body of data that offers insight into an under-researched population

working with a new intervention. Inevitably the exploratory nature of my research required me to make compromises. The pragmatic and methodological considerations of the study required balancing, and for the large part I achieved this.

My concern at the outset of the research process had been around capturing the complexities of the settings, the population and the intervention. Coming to the end of the process, I can reflect back on the certainty that ethnography, with its structured approach to the incorporation of multiple data sources, together with my own subjective responses helped me to take and retain a position, relative to the study, that avoided unnecessary reductionism; provided me with a means by which I could respect and take into consideration the many and differing viewpoints of workshop participants; and, through taking this broadly balanced approach, support them in giving voice to opinions that had hitherto been marginalised by the restrictions and difficulties that epitomised their current situations.

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Appendix A

UCL Ethical Approval

-------- Original Message --------
Subject: Re: Ethics application: 2660/001: The psychological impact of music workshops on immigration detainees
Date: Thu, 30 Sep 2010 12:01:43 +0100
From: Ethics <ethics@ucl.ac.uk>
To: Chris Barker <c.barker@ucl.ac.uk>
CC: j.underhill@ucl.ac.uk

Dear Dr Barker,

I am pleased to confirm that, further to your satisfactory responses to Committee members comments, I am pleased to confirm that your project has been granted for the duration of the study (i.e. to December 2011), subject to receipt of your CRB disclosure numbers. A formal hard copy letter of approval will follow in the post today.

I would be grateful if you could send through confirmation of the reference numbers for your CRB checks completed through UCL.

With best wishes
Angela

Appendix B

UKBA Approval to Conduct Research in UK Immigration Removal Centres

Home Office
UK Border Agency

Philip Schoenenberger
Assistant Director, Detention Services
Criminality and Detention Group
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Web

James Underhill

UCL Research Department of Clinical, Educational & Health Psychology

University College London

Gower Street

. .

16th September 2010

Ref: Music in Detention James Underhill Research University College London

Dear Sir

I have been approached by Music In Detention (MID) in relation to research work based on the workshops MID run in a number of immigration removal centres. This research is to be carried out by James Underhill as part of his Clinical Psychology Doctorate thesis. The proposal from MID being that James conducts research during workshops in the removal centres.

I have given my support to this proposal with the proviso that we (the UK Border Agency) have sight of the research in its formative stages and that the research relates solely to the work of MID and its effects on the lives of the detainees who may participate in the research.

I understand that MID have provided some excellent workshops in removal centres and that the centres they work in value the music sessions and the effect they have on detainees.

Yours sincerely,

Philip Schoenenberger
Assistant Director
Detention Services
Cc Bob Evans

Appendix C

Participant Research Information Sheet

DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

Participant Information Sheet

Title of Research Project
The psychological impact of music workshops on immigration detainees

Invitation
I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.
Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?
I am interested in what people who have taken part in a three-day music workshop (run by Music in Detention) thought of the experience. I hope this information will be helpful in improving the experiences of immigration detainees.

Why have I been invited?
You have taken part in today's music workshop. I want to recruit up to 20 people into the study.

Who is organising and funding the research?
I am completing this research as part of a thesis for a Doctorate in Clinical Psychology. University College London is sponsoring the research. I do not work for the Borders Agency or for the detention centre. I am doing independent research with Music in Detention, which puts on the music workshops here.

Do I have to take part?
It is up to you to decide. I will describe the study and go through this information sheet, which I will then give to you. You are free to withdraw at any time, without giving a reason. This would not make any difference to your case or situation here.

What will happen to me if I take part?
I will interview you along with other people who have taken part in today's workshop for up to 30 minutes. I will then return in 2 weeks time to ask you and the other people who took part in today's workshop some more questions about your experiences. The second group interview will last no more than 50 minutes. I will record both interviews and take notes. These recordings are confidential to the research team.
Before the first interview, I will ask you to sign a consent form. You will get to keep a copy of this form.
The interviews will be informal and should be enjoyable. The questions are designed to let you talk freely about your experiences of the music workshop.

Will my taking part in the study be kept confidential?
All information which is collected about you during the course of this research will be kept confidential, and any information about you will have your name and address removed so that you cannot be recognised. Myself and my research supervisor are the only people that will have access to the data. All recordings will be erased immediately after they have been transcribed. All data will be collected in accordance with the Data Protection Act 1998.

What are the possible disadvantages and risks of taking part?
You will need to give up a maximum of 2 hours of your time. I will make every effort to arrange the second group interview at a time convenient to you.

What are the possible benefits of taking part?
This interview will give you a chance to let your opinions on the music workshop be known. There is very little research on how making music affects people's experiences of detention. Your opinion is important in improving our understanding of how music can affect people's experiences.

What will happen if I don't want to carry on with the study?
You can cancel your participation in the research at any time without giving a reason. Any information that we have taken from you will be destroyed and no record will be kept. Withdrawing from the study will not make any difference to your case or your situation here.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak to me (James Underhill; 020 7679 1897; j.underhill@ucl.ac.uk) and I will do my best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting my research supervisor, Dr Chris Barker, *UCL Research Department of Clinical, Educational and Health Psychology, University College London, Gower Street, London WC1E 6BT; c.barker@ucl.ac.uk*.

What will happen to the results of the research study?
The research will be prepared for internal reports, conference presentations and for publication in scientific journals. The research may contain quotes from your interview, but all identifying information will be removed.

Who has reviewed the study?
All psychological research is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been approved by the University College London Ethics Committee [*Project ID Number:* 2660/001].

You will get to keep a copy of this information sheet and your signed consent form before you take part in the study.

If you have any further queries please contact:

James Underhill, BSc
UCL Research Department of Clinical, Educational and Health Psychology,
University College London,
Gower Street,
London WC1E 6BT
Tel: 020 7679 1897
Email: j.underhill@ucl.ac.uk

Appendix D

Participant Consent Form

CONSENT FORM

Title of Project:
The psychological impact of music workshops on immigration detainees

This study has been approved by the UCL Research Ethics Committee [Project ID Number: 2660/001]

Name of Researcher:
James Underhill

(The participant should complete the whole of this sheet himself/herself)
Please circle "YES" or "NO"

Have you read the participant information sheet? **YES NO**

Have you had the opportunity to ask questions and discuss the study? **YES NO**

Have you received satisfactory answers to all your questions? **YES NO**

Who have you spoken to?.....

……

Have you understood that your interview will be recorded? **YES NO**

Do you understand that your participation is voluntary and that you are free to withdraw from the study:
- At any time?
- Without having to give a reason?
- Without affecting your future medical care, or legal rights? **YES NO**

Do you consent to the processing of your personal information for the purposes of this study? **YES NO**

Do you understand that all information will be treated as strictly confidential and handled in accordance with the Data Protection Act 1998? **YES NO**

Do you agree to take part in this study? **YES NO**

Name of participant	Date	Signature

Researcher	Date	Signature

Appendix E

Example Field Note

Date

Location

People
F1 and F2 – two music workshop facilitators
O1 – IRC officer
Highest number of detainees = 11; lowest 3; core group of 6.

First music session*:* 3pm-5pm.

When I arrive five detainees are gathered in a large semi circle, playing a steady 3 chord groove: P1 on the drum kit, P2 on electric guitar, P3 on doumbec, P4 on keyboard and P5 on keyboard. The drumbeat stays steady whilst the other players move in and out of key. Some are able to follow the beat and the melody being played; others are playing a melody or rhythm very different to that of the group.
It's a large rectangular room. Two windows on the far wall look out onto a courtyard. Strung CD's hand from the windows – decorative blinds. There are silhouettes of musicians painted onto the right hand wall. The most striking is that of Freddie mercury on one knee, head bowed with his arm holding a microphone aloft in the air. There is a rack full of music books on the wall opposite the door where I enter and to my left a blackboard that reads 'make music, not noise'.

F2 is playing bass, facing the semi circle with his back to the windows. F1 is sat with P4, directing him on how to play the keyboard. O1 is fixing a djembe immediately in front of me on the floor.

F1 gets everyone's attention – some carry on playing, but with F2 and O1 signalling that they need quiet through arm gestures, people eventually quieten and focus their attention on F1. He tells them that he is going to act as a director, a conductor who guides them through the music telling them when and when not to play and what they should be playing. He lets everyone know that P4 has a tune that he would like to play and wants everyone else to help him play it. He counts the drums and bass in and then turns to the other players, swinging hands and mouthing the timing: 'one, two, three four…' He gradually brings the other players in, moving to the people playing the various instruments to make sure that they know their part. They play the four bar (?) piece on a loop.

The music continues, everyone smiling, nodding heads and swaying with the beat. F1 tells everyone that he wants, when he instruct them, to play quietly. He lets P4 know that he wants him to take a solo – P4 looks at him smiling, shrugging his shoulders as though he wouldn't know what to play. F1 sits with P4 to help him figure something out. The other players continue whilst this is happening. F2 on his bass instructs the guitarist, indicating which notes he should be fretting.

F1 turns his attention back to the band. He quietens everyone down using arm gestures and P4 takes his solo on the piano. F1 strolls around the semi circle, counting out the rhythm that has the function of letting the group know where they are within the music. In the meantime O1 has begun to play the djembes. He plays with a large smile on his face, dancing and enthusiastically holding and adding to the beat. P6 walks into the room… O1 encourages him into the semicircle and gives him a shaker, instructing him on how to make a noise along with the music. As the music continues, O1 and P6 regularly make eye contact, smiling at one another.

Then P1 takes a solo, followed by O1 on the Djembe. F1 checks in with all the other players seeing if they want to take a solo. They shrug, smiling, as if to say that they are not sure how, but agree. P5 in particular found the solo difficult, playing out of key. The other players nod and make eye contact with him once he returns back to the groove. Everyone smiles looking whilst looking at one another.

F2 lets everyone know that we are about to take a break. The guitarist says, 'No, no break. Play.' Another detainee (P7) enters the room. He doesn't look at the others in the room, but walks directly into the middle of the semicircle, pointing at one of the small amps. F2 says, 'sorry, we haven't got the microphone'. F2 then talks to O1 about getting hold of the microphone and lets P7 know that it is coming.

We take a short break. F2, F1 and I go to a quiet room to chat. They talk about how each IRC has a distinctive atmosphere. F2 says that he has done a few workshops at IRCB before, but that regardless of the change in detainees, they all seem a little diffuse, somehow dissociated and distant. He said that this is in contrast to Colnbrook, where there is more of an angry feel to the detainees who want to vent some of their frustration. I discuss my research and ask them how they want me to approach the day. It is agreed that I will properly introduce the research and myself and make attempts to join the music.

We can hear music walking through the corridor back to the music room. F2 turns to me and says, 'see they don't even need us, they don't need us'. As we enter the room various detainees have swapped instruments. P7 now has a microphone and is singing over P4's rhythm (he's now playing the drum kit). The original drummer (P1) has left the room.

F2 and F1 nod in P4's direction smiling at one another. They listen briefly to what P7 is singing. They ask him if he would like to create a song that everyone can contribute to. He struggles to understand, often turning to P4 for guidance. P4 guides him to start singing his song without any backing. F2 asks him just to sing the first verse. P7 sings, 'What you want to be in this life, God is now'. There is some confusion about what it is that he is singing as he often begins to sing the song in his mother tongue. F2 and F1 on two occasions ask him just to repeat the first line. Again he becomes confused, turning to P4. P4 is able to translate saying that the lyrics are a form of broken English used in Nigeria. P7 asks if they want him to translate everything. F2 and F1 let him know that he

can sing in his own language. They have an idea that they will use the first line as the melody line and chorus that everyone will play.

To get the melody F2 asks P7 to repeat the first line again. Whilst P7 is doing this he tries to pick out the melody on his bass. He then shares the key and melody notes with F1 who helps those on the keyboard to play it. They are struggling to select the correct key, because P7 often sings off keys or changes the register. O1 walks up to the microphone and sings with P7. P7 is now better able to hold the same key.

F2 then talks to P4 about the rhythm he wants to play. F2 gives some tips on playing the drums and P4 comes up with a rhythm. F2 then shows P2 the notes on the guitar.

Everyone begins playing, looping this new three chord progression. P7 sings over the top. This continues for some time. P7 begins hopping up and down as he is singing, looking into the distance, smiling. He pumps his arms up and down, and then points to people in the semi-circle. P5 sways in time with the music whilst sat at the keyboard. He looks in my direction, smiling. P2 stands up with the guitar strapped over his shoulder. O1 takes over on the drum kit. P4 moves to the djembes, occasionally helping out with the singing. P2 plays the guitar next to P7 and P4 whilst they are singing.

F1 begins to play one of the keyboards. He lets P7 know that he wants them to take turns by pointing at himself and then at P7. P7 sings the chorus. F1 then points at himself and begins to improvise on the keyboard, he points back to P7 and he sings the chorus again.

The original drummer (P1) is back in the room. He stands between P4 on the djembes and O1 on the drum kit, staring into the distance. He doesn't move, just stands still for some minutes. Roughly fifteen minutes later he is back playing the drums.

P5 leaves the piano, requiring a crutch to walk to the door. He says to me that he will be back soon. Not long after a new detainee enters the room. He sits on the chair closest to the door, slightly out of the semi-circle. F1 offers him a selection of tambourines to play. He grabs a large rattle, shaking it to the beat. He is encouraged to sit in the circle, taking a seat next to P2. P2 isn't playing the guitar anymore, but still has it on his lap, his body moving in time with the music.

Another two detainees enter, dancing. They look around the room smiling. I hand them both percussion instruments and encourage them to sit in the room. They stay for around 15 minutes, before waving at everyone in the room and dancing as they leave through the door.

F1 leaves the piano, moving around the room again, whispering in players' ears. He finally talks to P1 on the drums. P1 does a large drum solo that ends the piece. Everyone claps.

Emotions/reflections

Field note, IRC2: There seems to be a real change in some of the detainees, for example P7's emotional state seemed to shift from angry and frustrated to happy over the course of his performance. By the end he was pointing into the distance smiling. Others are in the distance barely playing their instruments. They don't seem that connected to what is going on in the room.

F2 talks about the clear split between workshops which are much more just distraction, others where something more creative happens. Was this one more about distraction?

The workshop had a good balance between being led by musicians and giving detainees the opportunities to take control and lead. It seemed to me that the facilitators provided a framework from which the detainees could easily create music without too much anxiety/worry about their musical capacity.

Is there enough space/time to help those less proficient on their instruments?

I got a real sense of being lost in the music – what they are playing is fairly repetitive and I easily forgot where I was or what I was meant to be playing.

Psychological processes

Voice/story heard – relate to testimony therapy??

Self-efficacy

Autonomy – in/out of room.

Appendix F

Time 1 Semi-Structured Interview Schedule

Time 1 Semi-Structured Focus Group and Individual Interview Schedule

Introduction

Thank you for agreeing to take part in today's group discussion. My name is James Underhill and I am a researcher from University College London working with Music in Detention. The reason I want us to have this discussion is for me to get a sense of how music workshops like today's might affect your experiences. I want your honest opinions, but I also want us to respect one another even if we have differing opinions so that everyone has a chance to speak. Please feel free to discuss any questions or opinions you may have between yourselves – don't feel you have to be answering me all the time. I want this to be an open and informal discussion. I will be recording this discussion and later I will transcribe the recording. Once I have transcribed the recording it will be destroyed. This information will be held securely and will not carry any of your names.

Questions

1. Overall, what was today's workshop like?

   Prompts: Enjoy vs. dislike it – reasons why?

2. What did you get out of today's workshop?

3. What was good about the workshop?

   Prompts for immediate effects:

   a. Was it just something to do – better than sitting around doing nothing? Did it help to keep you occupied?

   b. Did it help you feel better? If so how?

   c. Were you able to forget your worries through the music?

   d. Were you able to express how you were feeling through the music?

   e. What did you think about the way that the group was open – you could come and go as you please?

   Prompts for long term effects:

   f. Did it change the way you think about your self

g. Did it remind you that you were good at music/that you could be good at music?

h. How do you think the workshop will affect the way you feel on a daily basis?

i. Did it change the way you think about yourself in relation to the situation you are in?

j. Did it make you feel more free/in control/able to cope?

k. Did it help you to meet people you hadn't met before?

l. Did it change the way you felt about someone else in the removal centre?

m. Did it in any way affect how you relate to other detainees, staff, people outside the centre?

n. Did it in any way change the way that you felt emotionally? In what way?

4. What was bad about the workshop?

Prompts:

a. Did it make you feel bad in any way?

b. Was there anything in the way that it was set up that frustrated you?

i. No instruments to play/couldn't get hold of my preferred instrument.

ii. No continuity – people walking in and out as they pleased

c. Was there any point at which you felt you weren't able to get involved as you might have liked?

i. Were you able to play the music that you wanted?

ii. Did you feel alienated, like you didn't belong?

iii. Did you feel you weren't good enough and that you were being judged?

d. At any point did you feel like you were criticised or that you didn't belong in the group?

i. Did you feel comfortable enough to improvise?

ii. Did you feel that other members of the group and facilitators respected your voice/suggestions/contributions?

5. Do you think you'll remember this workshop in the future?

   Prompts:

   a. Will that memory be good or bad to you? In what way?

      i. Tolerating uncertainty of my situation

      ii. Reminding me that I'm good at something

      iii. Reminding me of a time when I felt happy

6. Do you have any suggestions for how the workshop could be improved?

Debrief

As I've said, today's discussion was intending to get a sense of your experiences of the music workshop. I would like to meet with you again in two weeks time to talk about some of the things we discussed today in more detail. If you are interested in meeting again, please let me know. Thank you all for your contributions. Please feel free to ask me any questions you may have about what we've been talking about or the purpose of my research. Thanks again and I hope to see you again soon.

Appendix G

Time 2 Semi-Structured Interview Schedule

Time 2 Semi-Structured Focus Group and Individual Interview Schedule

Introduction

Thank you for agreeing to take part in today's group discussion. My name is James Underhill and I am a researcher from University College London working with Music in Detention. Some of you will have been in a previous group that I held two weeks ago. Some of the questions I have today are repeats of what I asked you then. The idea of today is, again, to get a sense of how the music workshop that you took part in 2 weeks ago impacted on your experiences of being in detention and to see if you have taken anything you gained from the workshop forward.

I want your honest opinions, but I also want us to respect one another even if we have differing opinions so that everyone has a chance to speak. Please feel free to discuss any questions or opinions you may have between yourselves – don't feel you have to be answering me all the time. I want this to be an open and informal discussion. I will be recording this discussion and later I will transcribe the recording. Once I have transcribed the recording it will be destroyed. This information will be held securely and will not carry any of your names.

Questions

1. What memories do you have of the music workshop?

   Prompts:

   a. Do you have any good memories of the workshop, things that you remember enjoying?

   b. Do you have any bad memories of the workshop, things that you didn't like?

2. What impact did the workshop have on you?/ Was there a particular part of the workshop that had the most impact on you?

3. What was good about the workshop?

   Prompts for immediate effects:

i. Was it just something to do – better than sitting around doing nothing? Did it help to keep you occupied?

ii. Did it help you feel better? If so how?

iii. Were you able to forget your worries through the music?

iv. Were you able to express how you were feeling through the music?

v. What did you think about the way that the group was open – you could come and go as you please?

Prompts for long term effects:

vi. Did it change the way you think about your self

vii. Did it remind you that you were good at music/that you could be good at music?

viii. How do you think the workshop will affect the way you feel on a daily basis?

ix. Did it change the way you think about yourself in relation to the situation you are in?

x. Did it make you feel more free/in control/able to cope?

xi. Did it help you to meet people you hadn't met before?

xii. Did it change the way you felt about someone else in the removal centre?

xiii. Did it in any way affect how you relate to other detainees, staff, people outside the centre?

xiv. Did it in any way change the way that you felt emotionally? In what way?

4. What was bad about the workshop?

Prompts:

a. Did it make you feel bad in any way?

b. Was there anything in the way that it was set up that frustrated you?

i. No instruments to play/couldn't get hold of my preferred instrument.

ii. No continuity – people walking in and out as they pleased

c. Was there any point at which you felt you weren't able to get involved as you might have liked?

    i. Were you able to play the music that you wanted?

    ii. Did you feel alienated, like you didn't belong?

    iii. Did you feel you weren't good enough and that you were being judged?

d. At any point did you feel like you were criticised or that you didn't belong in the group?

    i. Did you feel comfortable enough to improvise?

    ii. Did you feel that other members of the group and facilitators respected your voice/suggestions/contributions?

5. Has the workshop changed the way you've approached life in the IRC?

    Prompts

    a. Has it changed the way you approach stressful situations?

    b. Has it changed any of your relationships with other detainees/staff/family?

    c. Has it changed the way you think about yourself?

6. How do your feelings about the workshop now compare to how you felt when you first completed it/whilst you were doing it?

7. Is there anything that you learnt/people you met during the workshop that you have taken forward over the past two weeks.

8. Do you have any suggestions for how the workshop could be improved?

Debrief

As I've said, today's discussion was intending to get a sense of your experiences of the music workshop. Thank you all for your contributions. Please feel free to ask me any questions you may have about what we've been talking about or the purpose of my research. Thanks again.

Appendix H

Music in Detention Artist and Staff Log

ARTISTS' LOG • to be completed after <u>EACH</u> session

as soon as possible after session completion so your memory is fresh!

- ***This form is designed to help you create a record of your work for MID, which will help us assess the impact of music making for detainees in IRCs.***
- ***Please answer truthfully. We aren't going to judge you or your work, and there are no right or wrong answers.***
- ***It's the information we need, not the form, so if you prefer to report in a different way, please do so.***

Artist name: …… Date of session:
Location:

Please answer the following questions about today's session:

1) Total number of restore/detainees attending:

2) How many of these detainees stayed for more than half of the session?

3) Of all detainees attending, how many actively participated?

4) What happened? Please tell us how the session went, what the musical content was, how people reacted and interacted, any particularly memorable moments, and so on:

In these questions, please circle a number from 1 ("Yes, very much") to 5 ("No, not at all").

5) The majority of participants: Were taking active part in the session
1 2 3 4 5

Were able to express themselves through music 1 2 3 4 5

Visibly enjoyed the activity
1 2 3 4 5

6) Did group dynamics today allow everyone to have some creative input?
1 2 3 4 5

If so, please briefly note down how?

7) Was anyone able to express particular feelings or concerns about their situation in the session?
1 2 3 4 5

If so, please briefly note down what was expressed and how?

8) Was it possible to involve detainees in the creative direction of the session? 1 2 3 4 5

If so, please briefly note down how?

9) Was it possible for participants to explore their own and each other's cultural
backgrounds through the activity?
1 2 3 4 5
If so, please briefly note down how?

10) Were IRC staff actively involved?
1 2 3 4 5

If so, please briefly note down how?

11) Did they engage positively with the detainees?
1 2 3 4 5

If so, please briefly note down how?

12) Do you have any further observations about individuals, the group or the session today? In particular: any comments you can make about how the activity may have contributed to detainees' wellbeing, for example lifting their mood or helping them to relax; detainees making new friends and improved relationships between detainees and between detainees and IRC staff; any challenges or successes relevant to today's session

……..……..……..……
……..……..

[Continue on a separate page if you need to]

PLEASE RETURN THIS FORM TO Liza Figueroa-Clark, Programme Manager, Music In Detention, Kir
Place Music Base, 90 York Way, London, N1 9AG or email it to liza@musicindetention.org.uk

Appendix I

Thematic Analysis Example

	Initial coding	Theme
P13: Yeh, yeh. When you're here you turn off for a bit for a moment when you're just in the music.	Being able to temporarily forget about situation.	Temporary distraction
P2: I think so long as you can organise a group of people to fit into the music room… everyone have a plan when they come in here to perform the music. They don't have to wait until they have set it up…	Needing structure and planning to get into the music.	Regime interrupting attempts at distraction
IV: So having more freedom…		
P2: Yeh, having more freedom to do the music. Then you'll find people dedicate themselves to it and be more better. So long as you focus on the music you taking off the inspiration matter off your mind altogether. Because the music then make them remember anything about it. You don't even think about it.	Music takes mind off stress but need freedom to achieve this.	
P8: There must be something good about it…		
IV: you've been sat here for…		
P8: If you did not have fun you wouldn't be sat here now. So you obviously had fun here. What I'm saying is, you know, we have loads on our mind here, yeh? I personally get really worked up, get really like, you know, I have loads going on. Down there people get into fights and all of that, start abusing you verbally. You come into this workshop for 2 hours and get all of that out of your head. And you sort of get really cool. And you go back and you do your thing. So it does help. That's what's really good about it.	Music workshops an enjoyable activity. Music helping to relieve stress by taking away participant away from situation. Able to relax more after workshop	Temporary distraction Long term coping through distraction