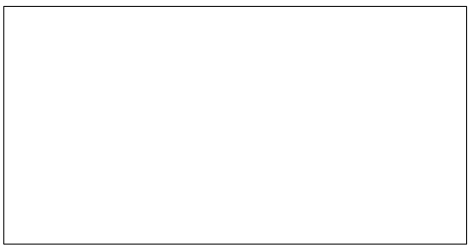

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ORIGINAL ARTICLE

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Advancing transculturally informed, humanistic therapeutic practice for refugees and asylum seekers presenting with embodied trauma

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Abstract

Introduction: A record of 122.6 million people have sought refuge and asylum across the globe in 2024, exacerbated by emergencies in Ukraine, Sudan, Afghanistan and by the Israel–Hamas war. This number is set to rise to over 130 million people in refugee situations in 59 countries this year alone. With refugees suffering from higher rates of mental health difficulties than the general population, there is an urgent need to provide an expedient, socially just, transculturally informed pathway into humanistic psychological care services for these individuals. The objectives of this study were to explore how therapeutic practitioners are working effectively with displaced individuals presenting with embodied trauma, their experiences of transcultural approaches to therapeutic work and the impact of working alongside psychopharmacological medications in this commonly overprescribed client group.

Method: A qualitative semi-structured interview was operationalised with 12 therapeutic practitioners who have worked with displaced individuals, utilising reflexive thematic analysis of the data.

Results: Findings highlight a critical need for an updated transculturally informed, humanistic, person-centred pathway of care for each displaced individual.

Discussion: This study offers facilitators and challenges to using a humanistic, transculturally updated assessment, formulation, treatment plan, and routine outcome measures for embodied trauma. It also considers the importance of working with a client's cultural context of origin, language, universally understood emotions, cultural strengths, preferences for therapy and use of a psychopharmacological review within a holistic constellation of care.

KEYWORDS
asylum seekers, humanistic, refugees, transculturally informed care, trauma

1 | INTRODUCTION

The plight of displaced individuals seeking refuge and asylum across the globe is an acute humanitarian crisis of our time (Blanchet et al., 2017), with a record of 122.6 million individuals becoming forcibly displaced or stateless in May 2024 (United Nations High Commissioner for Refugees [UNHCR], 2024). Forty per cent of displaced individuals will attempt to resettle in Europe and the Americas (UNHCR, 2023), accessing the local healthcare systems for physical and psychological support due to the traumatic experiences inherent in migration (Simsir et al., 2021). Of these displaced individuals, 61% will experience serious mental distress and are five times more likely to have mental health difficulties than the general population (Aspinall & Watters, 2010; Blackmore et al., 2020). There is an urgent need, therefore, to identify suitable humanistic, transculturally informed, psychological interventions for displaced individuals accessing Westernised services (Schaeffer & Cornelius-White, 2021).

Embodied trauma is regularly seen in traumatised populations, for example with displaced individuals (O'Brien & Charura, 2023; van der Kolk, 2014). It is now widely acknowledged that trauma and mental distress interweave with our human physiology (Murphy et al., 2021), affecting the individual at a whole systems level, and manifesting uniquely across cultures (Im & Swan, 2021; Levine & Land, 2016; van der Kolk, 2014). Embodied trauma can be seen to affect the individual not only mentally and physically but holistically across the bio-psycho-social-sexual-spiritual-existential realms of the individual (O'Brien & Charura, 2023).

There is a tendency in the global West to over medicalise experiences of embodied trauma, codifying and fragmenting them as symptoms of disease (Murphy et al., 2021; Pilgrim, 2016), rather than taking a non-pathologising, bottom-up, body-based approach that incorporates the idiosyncratic and transcultural expressions of trauma, which better facilitate resilience (Grabbe & Miller-Karas, 2018).

Both positive psychology and humanistic ontology, including the person-centred approach (Rogers, 1951, 1957a, 1957b), have long taught us to promote the innate human ability to flourish and self-actualise when provided with the necessary and sufficient core conditions in which to do so (Joseph, 2021; Rogers, 1957a, 1957b). Maslow et al.'s (1970) hierarchy of needs offers a practical, comprehensive humanistic framework, which from a post-modern, humanistic perspective allows for the fluidity of human experience (Lonn & Dantzler, 2017). Thus, at various times, a displaced individual's concerns may comprise multiple hierarchical needs, and at other times, there may be a specific focus on one.

Arguably, however, before any meaningful, structured psychological intervention can take place, as humanistic psychologists, we must first facilitate the foundational stages of Maslow's hierarchy (Maslow et al., 1970), by supporting fulfilment of their basic physiological and safety needs. Furthermore, we must also consider that for psychological change to manifest for displaced individuals, a change in their *social environment* must also occur (Joseph, 2021).

Recent work by Kaufman (2020) has built upon this idea, noting that Maslow did not prescribe his hierarchical structure to be the only way to self-actualisation, but instead believed that if *society* can create the conditions to satisfy one's basic needs, including the freedom to speak honestly and openly, the ability to grow and develop one's *unique* capacities and passions, and live in a society with *justice and fairness*, then what emerges tends to be the characteristics that resemble the best in humanity and psychological health.

Taking this one step further, Kaufman (2020) notes the need to enable people to become healthy in their *own style*, acknowledging the need to support the sacredness and uniqueness of *each kind of person*, which for us also includes all the intersectional and cultural aspects of self (Crenshaw, 1991). It is, therefore, within the humanistic psychology framework that one can be seen to move constantly towards freedom, responsibility, self-awareness, meaning, personal growth, integration and change, which is intrinsic and arguably fundamental to the needs of displaced individuals. Yet, in order to transcend beyond Maslow's concept of *basic needs* and to fulfil one's unique potential, Kaufman (2020) notes that we also need a commitment to meta-motivations outside the self, which incorporate the values of Being, such as truth, goodness, beauty, elegance, playfulness, simplicity, excellence, or perhaps most importantly for displaced individuals, aliveness, meaningfulness, wholeness and justice.

Humanistic approaches are therefore entirely befitting to therapeutic work with displaced individuals as they consider the full range of human experiences, valuing human rights, uniqueness and dignity. Care should also be taken not to pathologise a client's struggles by overtly focussing on diagnosis (Goede & Boshuizen-van Burken, 2019; Kim & Kim, 2014). Instead, we align with the humanistic perspective, which considers *what has happened to you* rather than *what is wrong with you*, looking beyond the generalised assumption that all displaced individuals have symptoms of post-traumatic stress disorder (PTSD) (Kim & Kim, 2014; Lonn & Dantzler, 2017).

From our own professional psychotherapeutic experiences, we have noted that embodied trauma for displaced individuals is ongoing. Highlighting the critical need to take a compassionate, humanistic and holistic approach to the psychological support of displaced individuals, who have often endured and continue to endure

Implications for Practice and Policy

- This study has three main implications for practice which are implementing a new humanising approach, anti-oppressive relational stance, and transculturally informed modality to psychotherapeutic care for each displaced individual.
- Secondly, the implication for policy is for all psychotherapeutic professional bodies and training organisations to provide a human rights focussed, transculturally informed framework and corresponding set of guidelines for working therapeutically with displaced individuals who present with embodied trauma.

profound violations of their body, mind and spirit, and atrocities against their fundamental human rights (Abdelaaty, 2021).

A recent comprehensive scoping review of the literature has found, however, that there are a plethora of therapeutic treatments and modalities used by practitioners working with displaced individuals experiencing embodied trauma (O'Brien & Charura, 2023). The most common therapeutic interventions include psychopharmacology, treatment for depression, psychological therapy and inpatient care (O'Brien & Charura, 2023). Whilst these interventions are evidence-based, the contemporary literature also notes the critical need for a humanistic, transculturally informed, socially just, equitable approach to psychological care, which is tailored to the unique needs of each displaced individual (O'Brien & Charura, 2023). This study therefore seeks to inform us which therapeutic interventions are working effectively in the field of embodied trauma with displaced individuals and why.

1.1 | Aims and objectives

This study aimed to qualitatively explore therapeutic practitioners' perspectives of therapy with displaced individuals to answer the research question:

How is embodied trauma being successfully treated by practitioners?

The objectives were to understand practitioners' experiences of the following:

- working therapeutically with embodied trauma;
- transcultural approaches to working with embodied trauma; and
- practitioners' awareness of the impact of working therapeutically with clients who are also prescribed psychopharmacological medications.

2 | MATERIALS AND METHODS

We adopted an experiential orientation to our qualitative research, which focussed on the meaning and experience of our participants, and explored what they thought and did in practice, and how they made sense of their experiences (Braun & Clarke, 2022). We also utilised a hermeneutics of empathy, which took an interpretative orientation in order to stay close to the participants' meaning, and to understand that meaning in the data captured (Braun & Clarke, 2022). This research is grounded ontologically and epistemologically in critical realism and phenomenology (Braun & Clarke, 2022). It utilised person-centred, humanistic theory (Kaufman, 2020; Maslow et al., 1970; Rogers, 1951, 1957a, 1957b), within a relational framework (Main & Ko, 2020; Paul et al., 1996) to conduct qualitative semi-structured interviews (Jacob & Furgerson, 2012), and utilised reflexive thematic analysis (RTA) of the data (Braun & Clarke, 2006, 2022).

2.1 | Procedures

The procedure for data collection in this study consisted of six main stages:

1. participant recruitment;
2. preliminary contact (to explain the study and aid informed consent);
3. informed consent process;
4. collection of demographic data (to describe the participant group);
5. semi-structured interview (consisting of structured and open exploratory questions); and
6. study debrief.

Reflective logs were completed after each interview to record reactions, experiences and biases, which were reflexively incorporated back into the study (Gibbs, 1988; Morrow, 2005).

2.2 | Participants

We used a convenience sample of therapeutic practitioners (Stratton, 2021) who work, or had worked, with displaced individuals from any therapeutic background, organisational affiliation, or area of holistic care. Sample size was estimated to be between 2 and 400 (Braun & Clarke, 2006) but was anticipated to be small due to the limited number of practitioners working with displaced individuals. The resulting 12 participants are demographically self-described in Table 1.

2.3 | Interview protocol

The first author wrote and conducted the semi-structured interviews based on the interview protocol for qualitative research proposed by Jacob and Furgerson (2012). Jacob and Furgerson (2012) suggest that successful interview protocols should use research to guide the questions; therefore, this study's questions were informed by a recent comprehensive scoping review of the research literature (O'Brien & Charura, 2023).

A pilot test of the semi-structured interview was performed as part of a commitment to reflexivity in this research and allowed the opportunity to change the open questions according to their level of effectiveness (DeJonckheere & Vaughn, 2019). Based on two pilot tests, no adjustments were deemed necessary for this participant group.

Interviews were conducted at the practitioners' location of choice either in person, in a quiet, confidential space, or online via Microsoft Teams. The in-person interviews were recorded using a professional digital voice recorder resulting in an MP4 file, establishing safety and trust in the capturing of sensitive data sets, and the online interviews were recorded via Teams.

TABLE 1 Results of 12 participants' self-described demographic data.

Gender	Age range	Country of birth	Ethnicity	Practitioner title	Professional body	Modality	No. of years of experience
Female	55–64	UK	White (English/Scottish/Welsh/Irish/Gypsy/Traveller/British/Other)	Psychotherapist	BACP	Relational dynamic	5
Female	35–44	UK	White (English/Scottish/Welsh/Irish/Gypsy/Traveller/British/Other)	Therapist	UKCP	Relationship-centred therapist	13
Female	45–54	UK	White (English/Scottish/Welsh/Irish/Gypsy/Traveller/British/Other)	Psychotherapist	UKCP	Integrative/somatic	11
Female	65–74	Canada	Other (Dutch Canadian)	Family and systemic psychotherapist and clinical director	UKCP	Multimodal therapist	40
Female	75–84	UK	White (English/Scottish/Welsh/Irish/Gypsy/Traveller/British/Other)	Psychotherapist	UKCP/BACP	Holistic	38
Male	55–64	England	Other (Jewish)	Pain, trauma and EMDR therapist	CPCAB	Hands-on work with massage, cranio-sacral therapy and EMDR	38
Male	25–34	UK	White (English/Scottish/Welsh/Irish/Gypsy/Traveller/British/Other)	CBT therapist	BABCP/BACP	CBT, integrative therapy with refugees using a humanistic and existential approach	3
Male	35–44	Portugal	White (English/Scottish/Welsh/Irish/Gypsy/Traveller/British/Other)	CBT therapist and counselling psychologist	HCPC/BACP/BPS	Integrative	7
Male	45–54	UK	White (English/Scottish/Welsh/Irish/Gypsy/Traveller/British/Other)	General practitioner	RCGP	General practice	30
Male	75–84	UK	White (English/Scottish/Welsh/Irish/Gypsy/Traveller/British/Other)	Director of Sheffield University Counselling Services & Independent Practitioner	Fellow of BACP	Client-centred	45
Female	35–44	Sri Lanka	Asian (Asian British/Indian/Pakistani/Bangladeshi/Chinese/Japanese/Philippine Islander/Thai/Vietnamese/Cambodian/Southeast Asian/Korean/Other)	Psychological therapist	BPS/BACP	Integrative	5
Female	55–64	UK	Mixed (Any mixed or multiple ethnic group)	Integrative art psychotherapist	UKCP	Integrative arts	16

Note: Key of professional bodies: BABCP—British Association for Behavioural and Cognitive Psychotherapies; BACP—British Association for Counselling and Psychotherapy; BPS—British Psychological Society; CPCAB—Counselling and Psychotherapy Central Awarding Body; HCPC—Health and Care Professions Council; RCGP—Royal College of General Practitioners; UKCP—United Kingdom Council for Psychotherapy.

The semi-structured interview was designed to be approximately an hour and a half based on the pilot studies but was flexible according to the needs of each participant and how much was shared. Each interview and debrief was, on average, 92 min. The interview began with structured questions, followed by open exploratory questions and a debrief. The full interview protocol can be accessed here (https://doi.org/10.25421/yorksj.26527981).

2.4 | Researchers

The first author of this research was a female trainee counselling psychologist, with a White-British cultural background, co-authored by a male professor of counselling psychology, with a Black-British cultural background and of African heritage. Both researchers were based at the University of York St John in the UK at the time this research was conducted.

2.5 | Ethics statement

This study was granted ethics approval by the Research Ethics Committee for the School of Science, Technology and Health at York St John University (approval code: RECCOUN00025). The research abided by the British Psychological Society's (BPS) ethical framework, codes and guidelines (2018, 2021a), and the Health and Care Professions Council (HCPC) (2015, 2024) Standards of Proficiency for Practitioner Psychologists.

2.6 | Analysis

Interviews were analysed using RTA (Braun & Clarke, 2022), following their six-phased process, which included the following: familiarisation with the data set, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. The first author transcribed the interviews, initially coded them and condensed them into overarching themes by immersing themselves iteratively in the data sets until saturation. The co-author who did not conduct the interviews then facilitated a reflexive space to discuss and critically audit the themes with the first author. The final themes were then agreed. All RTA took place manually using an Excel spreadsheet.

3 | RESULTS

3.1 | Structured question results

The average number of displaced individual therapeutic sessions a practitioner could provide each year was 1088. This was approximately four displaced individual sessions per day, taking into account holidays and working days, and also limits for self-care in trauma-focussed work (BPS, 2017, 2018, 2020b, 2021b; HCPC, 2015, 2024).

Practitioners noted that their therapeutic practice used either one-to-one, group, or, most commonly, a combination of therapeutic approaches. All practitioners highlighted the impact of COVID-19 (WHO, 2023) in terms of the need to move and provide therapeutic work online.

The nature of the therapeutic support offered (Table S1) included offering a relationship, a safe environment, individualised or person-centred care, trauma-informed work, body work, energy work or counselling psychology. The factors that practitioners noted were important for displaced individuals accessing therapeutic services (Table S2) were holistic care, competent interpreters, a non-judgemental welcome, being heard and understood, separate men's and women's groups, respect, safety, relaxation and flexibility.

The most commonly used measure to screen for trauma (Table S3) was the CORE-10 (Barkham et al., 2012), followed by the PCL-5 (Weathers et al., 2013). Notably, three practitioners did not use trauma screening measures at all. Half of the practitioners used feedback from clients to measure success or routine therapeutic outcomes (Table S4), with the CORE-10 (Barkham et al., 2012) remaining the preferred psychometric measure.

The most commonly reported area of the body linked to mental distress in displaced individuals as identified by practitioners (Figure S1) was the head, where individuals experience headaches or migraines. This is followed by the stomach, noting sickness and nausea, and the whole body, where pain is felt alongside undifferentiated diagnoses. Practitioners also noted endocrine issues with individuals experiencing diabetes or hormone related problems due to high cortisol or adrenaline levels.

This study made the stark revelation that half of practitioners had received little or no transcultural training apart from occasional workshops. Practitioners described their own transcultural training as experiences throughout the lifespan, which included growing up in diverse communities or as someone with individual differences. Practitioners also highlighted the importance of personal reading, learning from interpreters, and studying videos of other cultures, but noted that transcultural training was generally not part of their professional qualification.

The most commonly reported therapies used by practitioners working with embodied trauma in their qualitative interviews were person-centred, humanistic therapy, eye movement desensitisation and reprocessing (EMDR), systemic therapy and group therapy (Figure S2).

3.2 | Reflexive thematic data analysis results

We will now present four main themes and their related sub-themes (Table 2) utilising RTA (Braun & Clarke, 2022), which aims to answer the research question:

How is embodied trauma being successfully treated by practitioners?

TABLE 2 Themes and sub-themes generated by reflexive thematic analysis.

Themes			
No single therapy works	**Embodied trauma—What's in a name?**	**Transcultural training isn't part of the curriculum**	**A holistic constellation of care**
Sub-themes			
Therapy can be what *they* want, really	Not another diagnostic criteria	Transcultural training is more than another e-learning module	Joining the dots of coordinated, culturally informed care
A meaningful pathway back into the body, back into the world	What does a definition do?	I've missed the guidelines, if they're there?	They have to want you for you to feel you belong
Too many medications	A plain English summary please	Trauma-informed from the inside out	Impact of status and social justice

We present our results as a 'storyline' within each theme and sub-theme (Braun & Clarke, 2022, p. 140) using the practitioners' voices throughout the data to illustrate the story.

3.3 | Theme 1: No single therapy works

The first theme, *No Single Therapy Works*, is taken from practitioners' assertion that:

> Researchers want to identify the technique that works, *and there is no one single technique that works*. You're forever put on all kinds of trainings, because if trauma was easy you would just say, this is what you do. It's incredibly complex work.

Regarding the *complexity* of working with embodied trauma with displaced individuals, a practitioner noted that:

> If we are thinking about asylum seekers, you think about the threat of being deported, you're working relationally, psychotherapeutically on past kinds of issues, and what's really in the present.

Practitioners also reported the need to hold skills in *multiple modalities and therapeutic approaches* when working with the complexity of embodied trauma presentations in displaced individuals:

> 'Whatever works, you know, you have to have a repertoire'

Another participant stated:

> 'There wasn't a one size fits all approach.'

3.4 | Therapy can be what they want, really

This first sub-theme acknowledged that due to the complexity and idiosyncratic nature of each displaced individual's lived experiences: therapy can be what *they* want, really.

Practitioners noted the importance of an approach *which is person-centred*:

> (therapy is)…*collaborative in a person-centred way*, identifying what their particular issues of concern were, and exploring how we might go about working together. Which issues to focus on, giving people some choice about how we might go forward.

Practitioners also highlighted that being treated as an *individual person* is so important:

> …from the client side, it's that they felt heard, that they were listened to, and that they were seen as *a unique individual*.

When working therapeutically with embodied trauma, practitioners suggested a number of things that displaced individuals initially looked for, including a *holding relationship*:

> You start with the idea of a *holding relationship*, offering something stable, holding a relationship, a secure base and what that is for displaced people.

Practitioners also highlighted the importance of *safety* and *gender specific groups*:

> '…you have to have safe spaces for women only, that's really important', also noting that '…sometimes I wonder with men, that there's a bit of a gender barrier towards therapy.'

Single-sex groups are also crucial for religious purposes:

> …you've then got to look at religion, you have to have women only groups, and men's groups, *there's also a need to support cultural community and ways of being*.

Practitioners pinpointed the importance in therapy of *being, heard and understood*:

> Ground rule is make them feel heard irrespective of cultural differences and the stigma which is attached to being displaced and with this client group. So there's a lot coming from the society.

Practitioners also noted that clients want *flexibility*:

> ...it wouldn't work if we were a therapeutic service (who say) that's right, your appointment's at this time. I'll send you a letter...It just wouldn't work because that model wasn't meant for displaced people or vulnerable people who don't have money, who don't know the language, who are traumatised, who don't know what therapy is. So it's flexibility... it's going out and meeting them at the bus stop, it's giving them 3-4 attempts to arrive, it's flexibility and understanding their situation. Otherwise, it's not a service for *them*.

Practitioners also noted the *cultural barriers* of Westernised talking therapies:

> Well, I've been guided by the clients. Because, you know, I knew that some of the Congolese, they were never going to sit in a room and talk to me.

Instead, practitioners noted the importance of *practical and creative approaches*:

> I got people to come and do things like beadmaking, flower arrangements. I think people say more... than if you're sitting down talking to them face-to-face.

Practitioners also spoke of *integrating cultural and traditional treatments* in their work:

> I think many of the cultures that I've worked with have their own traditional remedies or folk medicine. Somebody who was Kurdish tied a red cloth if there was a pain in the arm, and I thought ah this is colour healing, because the associations they have with that colour and the blood flow.

In a final reflection that therapy can be what *they* want, a practitioner noted that:

> Some people wanted to talk about their experiences of their relationship with the church and God, and they would play music, even though we didn't understand what's going on, I could see that it was processing something, and I didn't maybe have to have the language.

3.5 | A meaningful pathway back into the body, back into the world

The next sub-theme that helped to answer the research question in this study concerning how embodied trauma is being successfully treated by practitioners considered that working therapeutically with embodied trauma involved finding a *meaningful pathway back into the body, back into the world*:

> I think it's about re-embodiment, coming back into the body. How can we, despite these conditions, find a way to orientate yourself meaningfully in the world.

Practitioners asserted that *embodied presentations* were an inherent part of the work:

> I was not prepared for the intense level of embodiment in practice with displaced individuals.

Practitioners observed that displaced individuals have *lost everything*:

> (they)...lament and they feel great loss, they've lost everything, they feel they've lost themselves.

Therapy therefore becomes about *starting with the body*:

> So it's about just gently drawing attention to people's bodily illness, because many people are cut off from their bodies, one of my favourite techniques is a body scan, it's very popular with lots of my clients.

Others noted the usefulness of *body mapping*:

> I would also use a body map to look at where there's tension or stress or pain in the body, to see how they're feeling and functioning. There's very high levels of physicality with refugees and asylum seekers.

Practitioners noted techniques that helped displaced individuals get *back into the body*:

> ...stablisation and grounding for further trauma work, (others noted that) some sessions with the body therapists, that's also been invaluable.

Finally, practitioner noted the importance of using an existential lens and re-thinking the *meaning of life* collaboratively with displaced individuals:

> I value an existential lens with respect to thinking about well, there's been something about what's meaningful to you, it's been arrested. You know, you were living a life and you were constructing a life that had some purpose for you before this, whether it be a relationship to your family, or whatever it might be. You're in this culture now, and you're in a climate now that doesn't favour your particular demographic of persons.

Practitioners also highlighted the struggle of *making meaning* in life after displacement:

> I'm struggling with meaning in life, I'm struggling to come to terms with once being a capable person, but now I feel that I'm no longer that capable self, so that would then perhaps give you the nature of the therapy…what's meaningful to you now?

3.6 | Too many medications

The final sub-theme concerns practitioners' awareness of the impact of psychopharmacological medications and the place of the medical model in the therapy.

Practitioners highlighted that clients come to therapy on *too many medications*:

> (they have a)…big rucksack full of empty medical packets, there was a mountain of packets and he said, it says I shouldn't be using it for more than six months, and I've been on it for three years.

Regarding why clients *need medications*:

> It's not uncommon to have medical medication for pain, medication for sleep, medication for mood, and medication for psychosis, really, you know for dissociative experiences.

Practitioners noted their *lack of training* to work alongside medications:

> It would be brilliant if we had a very competent and excellent prescriber, then we can talk to them and work alongside us. That would be brilliant, because then you'd have someone who really understood the refugee experience and could monitor things more closely, or ask you to monitor the effects of certain medications.

All practitioners in this study stated they *do not want prescribing rights*:

> …prescribe medication myself? Not interested.

3.7 | Theme 2: Embodied trauma—what's in a name?

The second theme explores the usefulness of the term *embodied trauma*. It explores whether there is value in using this term as opposed to other diagnostic criteria, such as PTSD, as practitioners stated:

> …there's always a question mark about needing to have a label.

3.8 | Not another diagnostic criteria

The first thing that practitioners noticed was a conflict between the *psychological and medical models* of treatment:

> …this is a generalisation, but a lot of medical people are very cut off, they want to intellectualise. I'll give you a bag of tablets for this, or we'll put you on some treatment for that, they don't have time to sit and listen.

Practitioners noted that whilst psychology is an evidence-based and research-led field, it does not necessarily need to be medicalised, instead preferring a *non-pathologising approach*:

> What is important? I think first of all, is humanism, is a humanising therapy. I think the NHS has a very top-down approach, I think that sometimes we diagnose very quickly, we pathologise. And the care that we provide is completely fragmented, because we have psychology and then we have social work, and then we have housing, and (displaced individuals) don't understand the system. So it needs to be a holistic support, multidisciplinary support and that doesn't exist in the NHS.

This idea of holistic care sets the scene for the theme entitled *Joining the dots of coordinated, culturally-informed care*.

Practitioners also noted the importance of existing *outside of a purely westernised diagnostic approach*:

> I think that apart from being humanistic, I want to be a scientist practitioner and a reflective practitioner. I don't want to be intrusive or pathologising or suggesting that their thoughts are faulty.

Therefore, instead of adding embodied trauma as another diagnostic criteria, there is value in using it as a non-pathologising definition or term in the field of psychology to understand lived experience in a culturally informed way, which is explored in the next sub-section.

3.9 | What does a definition do?

This sub-section explores the purpose, function and usefulness of using the term embodied trauma, as defined in a comprehensive scoping review (O'Brien & Charura, 2023).

Practitioners reflected that the term *'embodied trauma'* is useful as:

> ... part of psychoeducation around what is trauma, what does trauma mean.

Practitioners noted that the term 'embodied trauma' was useful as an *alternative to medical diagnoses*:

> ...it feels like you've really tried to embrace the extraordinary extent to which a human being's life, things manifest in so many ways. And the additional dimension of being culturally sensitive, that things manifest in different ways, differently culturally too. And so there's something about that all embracing nature of the definition you've used. You know I really respect that honestly, that's really quite something.

Practitioners also saw this non-medicalised definition as *holistic* and beneficial to their therapeutic approach and noted:

> ...I love this kind of differentiation, I'm non-pathologising, I mean we understand diagnosis and we work with the DSM and the ICD-11, but we see it more as a formulation of the person as a whole.

Importantly, practitioners added that this definition takes a more *expansive approach*:

> ...beyond just what the brain and the mind does. And that it can be felt in the body, and that can be a rupture in your relationship with God. It can shatter your assumptions about what the world is.

Practitioners have also noted how this could impact their *understanding of trauma*:

> Well, I think this is something that I didn't consider before because I think that (trauma) was just medical, and what you're saying it's psychological and cultural, and I think that if PTSD is thought about in such an encompassing way, I think it will be much richer.

3.10 | A plain English summary please

A final sub-theme in this section came from practitioners' reflections that the *definition of embodied trauma* is:

> Quite medical, or quite professional.

Practitioners noted the importance of understanding *what the term is used for*:

> ...what audience, and I guess for what purpose it's for? What's the plain English summary of that?

This helps us to ensure that it does not become *another diagnosis*:

> ...a category as opposed to an operational shared understanding...maybe it needs both.

Therefore, whilst the current definition of embodied trauma may be an effective, holistic, professionally understood term for humanistic practitioners, there is perhaps additional utilisation in creating a plain English summary, which is universally accessible to clients and practitioners alike, enabling a shared understanding, which is easily translatable, and includes culturally universal language.

On this basis, the following *plain English summary* of embodied trauma is proposed:

> 'Embodied trauma is physical pain or emotional distress felt in the body, mind or spirit, after a terrible life event, such as being separated from home or family, being tortured, or sexually abused. It can be hard to talk about, make you feel alone, or not present in your body, and you may avoid, or experience difficulties joining in everyday relationships or activities.'

3.11 | Theme 3: Transcultural training isn't part of the curriculum

The third theme in this study focussed on transcultural approaches to working with trauma, and the lack of transcultural training available to practitioners as a whole. The theme came from a reflection by a practitioner in this study that noted:

> ...where I trained, and at that time, it wasn't necessarily part of the curriculum.

Practitioners highlighted the fact that *transcultural training is essential* when working with displaced individuals:

> ... (it) is essential. And at the same time, you only ever learn it really in practice.

3.12 | Transcultural training is more than another E-learning module

This sub-theme came from a practitioner's assertion that:

> …what you don't want is everything to become a e-learning for health module, you might have that as a very brief framework for knowledge development, but then also, the key thing is then actually applying knowledge in practice and (in) communication with people.

Practitioners did, however, note that there are *common things* they do to become more transculturally informed:

> …reading a lot. I feel like that's influenced my practice.

Practitioners also noted that they are drawn to the work from their *own resonance with trauma*, being different, or being raised in diverse communities:

> …my Mother and her parents are also refugees from the Holocaust, they were in a concentration camp. I always thought of giving back to the community.

Additionally, practitioners noted the importance of *current affairs*:

> …just being really up to date with the world, and current affairs in the news.

Interpreters also played a key part in transcultural training:

> …in my trust we call interpreters cultural advocates, because they are able to give us insights about what is happening. They are cultural consultants.

There were, however, some *innovative training programmes* that were noted:

> I had four mornings of training, prior to even starting to work with clients face to face, training with one of the managers and also one of the therapists who did have a lot of experience being there for a long, long time. And also, they just piloted some online training.

Yet, there was also a wider conversation about *creating a transcultural model of therapy*:

> …it's got to be not an add-on part of training. There has to be a desire there though hasn't there? There's this whole thing in there about the profession and about the classic model of the profession which doesn't actually fit vulnerable, displaced people. I think there needs to be kind of a wider conversation about vulnerability and the therapeutic model and who it's for?

All practitioners echoed that *transcultural training was generally not available*:

> Not formal training. I don't think.

This leads us onto our next sub-theme around the difficulty of finding professional guidelines.

3.13 | I've missed the guidelines if they're there?

There was notably an absence of professional guidelines or frameworks for practitioners wanting to work transculturally with trauma, which led to this sub-theme:

> I might have missed some if there are.

Practitioners noted that *formal guidelines didn't appear to exist* or were not easily accessible or advertised:

> …I mean maybe I haven't looked, but nothing springs to mind. Maybe (the professional body) do have the guidelines and I'll check after this session, but I can't think of anything formal that I've drawn on.

This highlighted an urgent need for governing bodies to either clearly state and communicate their guidelines on working in a transculturally informed way with displaced clients, or the need to create such guidance.

3.14 | Trauma-informed from the inside out

The final sub-theme in this section reflected the overuse of the term *trauma-informed*. Practitioners noted that the phrase 'trauma-informed' had become a poorly understood term:

> It's become a sort of word of the moment. And so you do an afternoon on trauma-informed work, but you're not really understanding trauma. And I do think that one of my strengths is I've understood it from the inside.

When considering the *use of the definition of embodied trauma* instead, as a holistic living conceptualisation of trauma, practitioners noted:

> Trauma is subjective, simultaneously objective, there are medical components to it, but there are embodied existential, spiritual, somatic parts as well, that have to be merged together to understand the totality of what trauma is.

Therefore, the definition of embodied trauma appeared to encapsulate these complex, multifaceted realms of lived experiences of trauma experienced by displaced individuals, perhaps more fully than working with the term of being *trauma-informed*.

3.15 | Theme 4: A holistic constellation of care

The final theme in this reflective thematic analysis of the results considered how we treat the *bio-psycho-social-sexual-spiritual-existential realms* included in embodied trauma. Practitioners noted that this care was called:

> ...a holistic response.

This term helped us to explore with practitioners what a holistic constellation of care for displaced individuals would look like, which we will now consider in our sub-themes.

3.16 | Joining the dots of coordinated, culturally informed care

Practitioners acknowledged that working with displaced individuals is complex work with many facets and systems, requiring a *multitude of roles*:

> Sometimes you have to take your hat off and be right, well, maybe I feel like a bit of a social worker today. Or I feel like I am the mediator between the lawyer and the language to try and book an interview, that can be therapeutic as well. Or, you know, maybe having a conversation with the GP, we need to access the right services so maybe even the word therapeutic needs to be a bit broadened, you know, because doing paperwork with the patient could be therapeutic on that day, or putting down the psychotherapy tools and actually bearing witness to something could be therapeutic. So I think the first thing is, yeah, a shared understanding of what therapy is.

Thinking holistically about clients also needed *cultural and religious understanding*, sometime requiring:

> ...a minister who had a good understanding about his religion, his culture, his history of religion in his country, and the problems that were there.

Practitioners also noted the most important aspects of holistic care using a *humanistic, multidisciplinary approach*:

> What is important? I think first of all humanism...a humanising therapy. I think that sometimes we diagnose very quickly, we pathologise, and the care we provide is completely fragmented. So it needs to be a holistic support, multidisciplinary support, and that doesn't exist in the NHS.

There was also a need for transculturally informed care with displaced individuals:

> ...we have a menu of things that we can use, we don't have one that is culturally sensitive, we don't even have questionnaires that are culturally sensitive, let alone models.

Of *a holistic constellation of care* that practitioners had seen to work in practice, they stated:

> Now they didn't come straight to therapy, but all the other people could then do all the practical stuff with them and to get to know them, and then from that they were referred into therapy. But what was great about that is we were all in the same building. Client would come into my session...sometimes with a letter because they have an hour with you, and they know you, and they trust you, and they go, oh, this is happening and then you can go, one minute, and you can go out and you can introduce them to someone invite them into session, or you can say go an meet this person. And we're trying to do that now with having a social prescribing officer, all the services being under one roof, we could kind of pass that over and get on with the therapeutic work.

A final reflection in this section for practitioners was about the importance of the role and usefulness of *patient ambassadors*:

> ... joining those dots up and linking people to someone that really knows how to link and I think that's where the patient ambassadors have got (the) skill set.

3.17 | They have to want you for you to belong

The second sub-theme in this section focussed on how *practitioners and services* could engage and maintain a therapeutic relationship with displaced individuals so that the therapeutic work could take place:

> And the brief conclusion is that they have to want you in order for you to feel you belong.

Practitioners reflected on the importance of providing a *welcoming, engaging service*:

> So I think the first instance is for the service and for all the people involved is to be very welcoming, and to be understanding, to demonstrate that this is a place where you are welcome. It's you know, come in, have a cup of tea, can we explain what we do. So I think this sense of engagement is really important. My colleagues they keep talking about the NHS, but it's not about accessing, it's about engaging. And so many client will say, things began to get better when I first came to the (charity) there was this sense of being joined to something which could be holding, and provide the safety and there was a confidence that you would get the support you needed.

Practitioners also reflected on what *belonging means* in different cultures, and how that needs to be integrated into the therapeutic provision offered:

> …a Zulu proverb is 'I Am because We Are' and I just love that. And it seems to me that, therefore, very naturally for many displaced persons or particular cultures, the whole opportunity of being with others, rather than being individually in pairs, going to see a professional as it were for whatever the group did, it could be group therapy, or just group discussion. But it could go off into arts, it could go off into all sorts of other things. But there's something about bringing together, offering people that opportunity of being together in a group, for connectedness, for relatedness.

Practitioners also explored the need for *community-based interventions*:

> …there is a need to be thinking about communities, and now we've got communities of people, we've got Syrians coming as communities, of Afghans coming, as Ukrainians coming as communities. So I think there's a real need to be looking at community interventions as well, that can help communities.

We close with perhaps the most important sub-theme in this section regarding social justice.

3.18 | Impact of status and social justice

The final sub-theme in this study was the importance of social justice in accessing equitable therapeutic, culturally informed treatment or care, combined with acknowledging the *perpetuating impact of seeking refugee status on mental health*:

> I mean, status is everything…you can't do any therapeutic work until you know the person's status progress with asylum seekers it's completely dependent on the external environment, what's happening with the home office. And the answer is often not a lot.

Practitioners noted the powerful *embodied impact of status* on displaced individuals:

> …the damage that's been done to this Zimbabwean's body is immeasurable I think, mostly by the home office, because of what they did in the final decision to refuse her.

Noting the impact that the *status application* process can have on the individual's mental health:

> I think just that interface with the home office is central to the re-occurrence of trauma.

Of the *disposable nature* of displaced individuals in the health and care system, practitioners honestly reflected:

> It's easy in the system as an individual GP to avoid the difficulties that are encountered, particularly for people who are presenting with complexity, experiencing trauma, huge levels of poverty, it's easy to avoid engaging with that. And, you know, one way is to dispose, you know, push away, don't come back, don't let someone make a plan to come back and see me, that phrase of collusion of anonymity can readily get played out. And the hospital system suits actually to have a few DNAs (did not attends). You're discharged back to the GP, you go round the system.

Practitioners also noticed the impact of *racism* on displaced individuals:

> …racism is such a strong element. And if you're not aware of it, that's one of the problems, it's all very well to provide all this stuff for Ukrainians. What about the Afghans, what about the Syrians? What about everybody else?

The final aspect of *social justice* for therapeutic work with displaced individuals concerned difficulty in accessing funding:

> It's huge, it's huge. And there are a number of trusts that only fund in London.

Practitioners also note the *poverty and destitution*, which restricts access to therapy:

> …people can't afford therapy that I work with, remember that a lot of people want to make a lot of money out of this. I understand this, but the reason I choose to do this is that it's funded, and I go and get funding, and I actually do some of it voluntarily as well.

In summary, the results have shown that there is an urgent need to rethink a transculturally informed, person-centred, holistic approach to care when working therapeutically with displaced individuals. This includes the following: holding a repertoire of therapeutic approaches to fit the individual's cultural background and preferred approach to therapy; taking a non-pathologising approach to understand the meaning of embodied trauma for each individual; advocating for socially just services, within a holistic constellation of care; offering a safe, flexible space to be heard and understood; addressing barriers to therapy, such as poverty, racism and equitable funding of services; providing transculturally informed training and professional guidelines to practitioners; and utilising useful therapies, for example person-centred, humanistic therapy, EMDR, systemic therapy and group therapy for this sample.

4 | DISCUSSION

4.1 | Summary of themes

This study explored practitioners' perspectives of successful therapy with displaced individuals. The discussion that follows presents the overall themes and their findings within the headings of 'facilitators' and 'challenges' (Harris et al., 2020), to help us understand how we as practitioners can begin to advance therapeutic practice with displaced individuals experiencing embodied trauma.

4.2 | Challenges

The main challenges to successfully treating displaced individuals with embodied trauma were covered by four themes, which we will discuss below:

4.3 | No single therapy works

This study has clearly shown the broad range of therapies harnessed by practitioners to treat manifestations of embodied trauma for displaced individuals. Alongside psychopharmacology, commonly used therapies that were seen to be useful for treating embodied trauma in practice were person-centred, humanistic therapy, EMDR, systemic therapy and group therapy. Yet, there was also a wealth of body focussed and creative therapies, which were notably useful in practice, such as cranial-sacro therapy, trauma-informed yoga, engagement in art, music and drama therapy, including initiatives with local theatres, and narrative therapies in which clients' true experiences were heard and understood.

Practitioners highlighted EMDR (Shapiro, 2001) as a commonly recognised gold standard for working with trauma within the National Health Service (NHS). Psychopharmacological medications were commonly cited by all practitioners, and all of these findings were in line with the NHS's (2023) three main types of therapies recommended for treating individuals with PTSD, that is CBT, EMDR and medications (Bisson et al., 2019, 2020).

Recent systematic literature reviews have also reported the effectiveness of EMDR, trauma-focussed CBT, narrative exposure therapy (NET) and art therapy for refugees (Genc, 2022; Thompson et al., 2018). Yet, the limitations highlighted by these reviews noted the need for culturally sensitive therapies (Genc, 2022) and the lack of group therapies (Thompson et al., 2018), which was also acknowledged in this study. Group approaches were advocated for alongside individual approaches to therapy; however, the impacts of COVID-19 (WHO, 2023) had restricted practitioners' recent abilities to offer group approaches, and participants noted displaced individuals' reservations to attend due to possible contraction of the disease.

The need for a person-centred, humanistic therapeutic approach (Goldstein, 2000; Maslow, 2013; Rogers, 1951, 1957a, 1957b) according to the needs of each displaced individual was commonly advocated for by practitioners in this study. The person-centred qualities voiced as important and helpful in working with displaced individuals included a non-judgemental welcome, being listened to and heard, and offering trust and respect, alongside other environmental factors, such as safety, the need for relaxation, and flexibility within services, due to the often chaotic and transient nature of displacement. The research literature also supported this and noted that the provision of person-centred and culturally appropriate health and medicines counselling was a step in the right direction (Procter, 2016). However, there was also a lack of up-to-date research in this area, which is why this study is an important voice in humanistic psychological treatments for displaced individuals.

Practitioners instead could be seen to hold skills in multiple modalities and therapeutic approaches, asserting the need to have a therapeutic repertoire according to the needs of each displaced individual, as no one size fits all. This highlighted the need for a person-centred approach (Rogers, 1951, 1957a, 1957b), with practitioners seeing therapy with displaced individuals as two people trying to figure it out together, perhaps reflective of the belief in the humanistic actualising tendency (Goldstein, 2000; Maslow, 2013; Rogers, 1980).

Practitioners also noted the difficulty of having a fully integrated approach (Cooper & McLeod, 2011; Messer, 1992; Stricker, 2001), often seeing it as more eclectic (Hollanders, 1999). Therefore, this may also call for novel thinking around a new integrational approach to humanistic therapeutic work with displaced individuals outside the traditional models, which do not currently appear to be a transculturally comfortable fit.

Practitioners noted, however, that not all displaced individuals wanted to talk, with some preferring non-verbal, expressive forms of therapy, such as art, drama, music, movement, or spiritual approaches, such as mediation, requiring cultural adaptations to Westernised models of formulation and psychological therapy (Johnstone, 2014). These non-verbal, expressive forms of therapy may also have been preferred by displaced individuals due to language barriers and cultural expressions of distress, which are not transculturally understood, or due to preferences towards group activities, which felt more congruent to the client based on their traditional ways of living in their cultural context, and which could be successfully treated by using, for example, culturally adapted CBT group therapy (Kananian et al., 2022).

4.4 | A meaningful pathway back into the body, back into the world

This sub-theme arose from a pattern in the data but was also reflected by the findings of Shalka (2020) who proposed that in order to process embodied trauma, we must reacquaint ourselves with the body, decipher our emotions and make meaning of who we are in the world again, noting that further research was needed into how we do this in practice, which this study helps to inform.

Practitioners noted that they were not prepared for the intense level of embodiment involved in working with displaced individuals and that re-embodiment, or finding ways to reacquaint with a traumatised body that experienced the embodied trauma symptoms, was often the first challenge (Shalka, 2020), followed by finding a way to re-orient that changed body into a new environment in a meaningful way. Luci and Kahn (2021) eloquently explored these Dantean circles of the displaced individual's body, which were often marked by torture, shame and violence and were then uprooted and displaced from home, yet which remained the main vehicle for communicating the trauma. Luci and Kahn (2021) noted the need for re-narration and meaning-making through the body, juxtapositioned against the traumatic inhumane experiences and embodied narratives in the past and present.

Practitioners, therefore, advocated for body techniques when working with embodied trauma, bringing awareness back to the body and to its manifestations of distress. These body techniques included body scans, body mapping and visual representations, which practitioners noted were distinctly underestimated, and could also enhance a shared understanding of embodied trauma (Cesko, 2020). There were also a number of evidence-based therapeutic interventions which supported the usefulness of working with the body, such as mindfulness-based interventions (MBI) for trauma, which noted improvements in emotional regulation, self-awareness, attention, control and in skills for managing mood and stress (Powers et al., 2022).

Aizik-Reebs et al. (2022) also noted the value of MBI and compassion-based interventions in trauma treatment for refugees and asylum seekers, which were especially helpful for self-criticism, depression, PTSD and stress. After physically grounding back into the body, practitioners noted the importance of meaningful engagement back into a world that had distinctly changed for displaced individuals. Here, practitioners noted the usefulness of therapeutic groups, which could help restore relational connection (Paul et al., 1996), help to explore the existential meaning in life (Butler, 2021; Yalom, 1980), teach stress management skills, such as the emotional freedom technique (EFT) (Zehetmair et al., 2020), or utilise skills from other groups approaches, such as dialectical behavioural therapy (DBT) (Linehan, 2007). However, practical activities of everyday life were also seen to be therapeutic, such as cooking and walking in nature groups, reflecting the heart of this theme, which centred upon a collaborative humanistic formulation with the client, exploring what was therapeutic for them.

4.5 | Too many medications

In line with the findings of Strømme et al. (2020), who noted that psychopharmacological medications are often prevalent in this client group, the practitioners in this study agreed with these findings and highlighted that most displaced individuals are on high levels of medication for pain, sleep, mood regulation and psychosis, with most practitioners noting the regularity of prescriptions for antidepressants, including sertraline, citalopram, fluoxetine, paroxetine and mirtazapine.

Most practitioners had an awareness of selective serotonin reuptake inhibitors (SSRIs) and their side effects, such as numbing, tremors and flat affect. However, they also noted that whilst psychopharmacology was generally prescribed as part of the National Institute for Health and Care Excellence (NICE) guidelines for trauma (2018), they fundamentally do not fit with displaced clients. Practitioners felt that this was because displaced individuals were not generally aware of what the medications do, due to common barriers including language, literacy, unfamiliarity with the health system, cultural beliefs and practices, and also noted the impact of their unaffordable costs (Filmer et al., 2023).

Filmer et al. (2023) noted that the responsible provision of medication is for the purpose of improving patient outcomes and quality of life, asserting that medications should be provided to displaced individuals in a patient-centred, culturally responsive way, with a need to alleviate barriers that inhibit them from accessing culturally appropriate pharmaceutical care. The issue of cultural power was also noted by practitioners as impacting displaced individuals' access to psychopharmacological services. They stated that displaced individuals were commonly given medications for seemingly clinical diagnoses, such as hearing voices, which may be common experiences in their culture (King, 2021). Similarly, practitioners reported that displaced individuals look to doctors or shaman in their culture to help them manage problems, taking prescriptions without a full understanding to respect cultural positions of power.

Practitioners in this study were also generally opposed to having prescribing rights in practice, a topic that is still being explored

by the BPS by request from NHS England (BPS, 2020a). The BPS (2020a) noted that having prescribing rights as psychologists could have the potential to improve the experiences of clients and service users, as well as provide the profession the opportunity to progress. However, the BPS (2020a) also noted three main concerns from their consultation with practitioners, which are also found in this study. They included the need for additional training in order to prescribe medications, and this also included the need for mentoring and governance from the Royal Pharmaceutical Society and HCPC to ensure competency, and the expectation to work within an MDT and not in isolated practice (BPS, 2020a). The BPS (2020a) also noted that other professions have taken up to 10 years to obtain non-medical prescribing rights; therefore, there will be little impact for displaced individuals via this route for the next decade, with many practitioners also wanting to opt out.

4.6 | Transcultural training is not part of the curriculum

This theme explored the findings of our study which highlighted the urgent need for a transcultural modality, competencies and training. It also revealed that half of practitioners received little or no transcultural training apart from occasional workshops. Instead, practitioners cited their own factors which they felt contributed to their transcultural competencies or training. These included travel, personal reading, learning from interpreters, keeping up to date with current affairs, or studying videos of other cultures, and their own intersectional lived experiences. Practitioners also asserted throughout the data set that they did not want transcultural training to become just another online health training module.

Edge and Lemetyinen (2019) made three main suggestions in their paper for approaches to working across cultures in therapeutic practice. They noted the importance of upskilling practitioners to work with difference and diversity for effective delivery of psychological treatments, increasing the availability of culturally adapted interventions with competent practitioners and co-production of appropriate means of responding to cross-cultural mental health difficulties, including staff training and service methods that use alternative explanatory models of mental health or perceptions illness (Edge & Lemetyinen, 2019). This reflects the wider conversation found within this study that there is a need for a transcultural modality for therapeutic practice, not just add-on training sessions (Charura & Lago, 2021), as the White, Westernised, classical models of the profession do not fit vulnerable, culturally diverse displaced individuals.

I've missed the guidelines if they're there? also highlighted the lack of available guidelines or professional frameworks for working transculturally with clients. Practitioners noted feeling ashamed that they were not aware of any professional transcultural guidance or frameworks, and most mentioned that they would need to actively root out any documentation that might be available from professional bodies. Lago (2016) attempted to operationalise a set of humanistic transcultural competencies. These included practitioners being vigilant to their own perceptions, projections and behaviours towards clients who are perceived to be diverse or different, being aware of othering the client and their identity, not reducing the client's experiences to a set of Westernised theories, therapies or assumptions and co-creating a good enough relationship with the client to foster a transcultural therapeutic capability. Together, these competencies may be summarised as transcultural skills, awareness, knowledge and relationships (Lago, 2016; Sodowsky et al., 1994), which could begin to build a framework or guidelines for professional humanistic transcultural practices.

This study, therefore, recommends that as part of these person-centred qualities aspired to within the NHS, a professional, person-centred, transcultural framework and corresponding set of guidelines should be provided, particularly including transcultural competencies and skills required for working with displaced individuals. These transcultural concepts have been echoed across time (Lago, 2016) and yet are still notably absent in practice.

4.7 | Facilitators

The main facilitators to successfully treating displaced individuals with embodied trauma were covered by two major themes, which we will discuss below:

4.8 | Embodied trauma—what is in a name?

In this study, we found that using the term embodied trauma enabled a bottom-up, humanistic, transculturally informed and non-pathologising exploration of the *dis-ease* of displaced individuals. This was in contrast to the medical model in which diagnosis requires compliance to strict codification of mental health symptomology (Murphy et al., 2021; Pilgrim, 2016). Its purpose and function were to allow practitioners to open up and enable a non-judgemental dialogue with clients, exploring each displaced individual's holistic experiences of embodied mental distress, which was not constricted or fragmented by the medical model (Pilgrim, 2016).

These experiences of embodied trauma may be much more wide ranging and idiosyncratic across the holistic realms of human experience (O'Brien & Charura, 2023) than a medical model may allow, with their means of manifestation often being transculturally diverse due to differences in the displaced individual's cultural context, worldview or racial identity development (Charura & Lago, 2021). This novel term therefore aimed to holistically embrace these aspects of diversity, difference and intersectionality of human experiences, and transcultural manifestations of embodied mental distress (Charura & Lago, 2021; Crenshaw, 1991; Rogers, 1965). The use of this expansive term has been facilitative in creating a powerful paradigm shift, moving away from the classic top-down medicalised approach to categorising psychological distress, towards a humanistic conceptualisation of *dis-ease* within the psychological professions.

We assert that this is more befitting for the times we inhabit, valuing of an outward looking stance that facilitates hope and ethical psychological care in times of crisis (Charura, 2021). We now discuss what this holistic constellation of care could look like.

4.9 | A holistic constellation of care

This study highlights the desire from practitioners to create a more holistic response to therapeutic treatment and care of displaced individuals. They noted in the sub-theme *Joining the dots of coordinated, culturally-informed care* that working therapeutically with displaced individuals is complex work, requiring flexibility and an MDT, which enabled them to focus on therapeutic treatment.

Practitioners reflected on the usefulness of referring clients to *A holistic constellation of care*, which would meet a displaced individual's basic needs on Maslow's (2013) hierarchy, including food, housing and physical health, which they said could contaminate the therapeutic process if not managed in parallel. Practitioners also noted a need to take Home Office processes out of the therapy room, and having competent lawyers and interpreters available in the service to help minimise the impact on mental health (WHO, 2015).

A recent randomised control trial of an integrated care intervention using an MDT and employment services for trauma-affected refugees (Bruhn et al., 2022) has showcased the effectiveness of integrated care using a medical doctor, psychologist and add-on interventions with employment services in Denmark, which has promise for scalability and sustainability for other healthcare and employment sectors. However, limitations included accommodation and visa status stressors, which were challenging to amend, with no legal support provided to participants (Bruhn et al., 2022). There was also a set offering of psychological therapies, which might not be effective for all displaced individuals, including psychopharmacological treatment, psychoeducation and manual-based CBT (Bruhn et al., 2022).

Thinking further into the realms of holistic care, practitioners in this study also noted the need to incorporate spiritual or religious support from faith leaders, and the need to build bridges to community-based organisations, such as mosques and churches, and also to charity organisations and universities, to understand how we can become more psychologically minded and transculturally informed to our clients' needs. They also noted that displaced individuals do not necessarily need to come straight to therapeutic services but may benefit from being in direct contact with charitable organisations or religious centres who provide a sense of cultural community, religious coping and mental well-being (Maier et al., 2022).

Exploring an MDT approach within the NHS, practitioners noted the key role that non-medical staff play in making links with displaced individuals, especially patient ambassadors, care coordinators and the social prescribing team, who can also link into pharmacists to organise medication reviews. Whilst these staff play a crucial role in the care of displaced individuals, this study found that there is still a requirement to join up the dots and strengthen those links in practice, accessing the right team members with the right skill sets at the right time. The UK Government (2021) also noted the vital role that social prescribers play for the refugee population, who may require a greater range of prescribed activities and interventions than the general population to address their well-being and health needs.

This study also highlighted the importance of social justice in accessing equitable, transcultural treatments and mental health care (Gushue et al., 2022). Practitioners often spoke of the easily disposable nature of displaced individuals, who can be lost within a healthcare system due to a collusion of anonymity which gets played out. Without connection to, or navigation skills for, the healthcare system, displaced individuals can become disengaged or problematised to the advantage of the system, which is overbooked and understaffed, and where 'did not attend' (DNA) patients are often a cost-saving. Systemic racism was also seen to have a significant impact within the UK health services (Tonkin, 2022), in which practitioners noted an awareness of helping White-skinned displaced individuals, for example Ukrainians, whilst often neglecting the Afghans and Syrians, due to a discomfort with difference. An anti-immigrant sentiment also still faces displaced individuals who have experienced increasing racism since Brexit (Adebowale, 2020).

5 | REFLEXIVITY AND LIMITATIONS

The authors note, in the words of Braun and Clarke (2022, p. xxviii), that 'this is our mapping', acknowledging that we are informed in this research by our own individual perspectives, intersectional lenses, world view and point in time of writing this paper. We acknowledge that we are also vulnerable to biases, and to seeing what we subconsciously want to see (Harris et al., 2020). Yet, reflexively, we may also consider these individual lenses a strength, echoing the need for individualised humanistic care for displaced individuals as no one lens or approach can ever fit all. However, in order to address these potential pitfalls, we have also utilised Gibbs's (1988) reflective cycle following each interview, to reflexively engage with our reactions, assumptions or biases.

As authors from different cultural backgrounds, although from mutually Westernised academic origins, we held up a reflexive mirror to one another during the analytic process to ensure that we explored non-Westernised approaches to psychological care. These reflexive inclusions, for example, helped us to explore and integrate the use of traditional and indigenous healing concepts, explore therapy beyond the traditional westernised dyad and consider the spiritual and cultural meaning of psychological wellness, which, in turn, helped us formulate a holistic conceptualisation of mental health across the bio-psycho-social-sexual-spiritual-existential realm of humanism (O'Brien & Charura, 2023).

We also considered power reflexively in our analytic approach (Proctor, 2021). This included that held within the medical model, sitting in this case with GPs, who, in their words, hold the keys to a self-named collusion of anonymity in the system. It caused us to reflect on the differential levels of power within practitioner groups,

for example, between counsellors, psychotherapists, psychologists and medical doctors, and how this could be engaged with more equitably and holistically in a constellation of care for the benefit of all (i.e. the client, practitioner and systems of care).

Some limitations included the lack of culturally diverse practitioners that we interviewed in generally White, Westernised services. This also included a lack of diversity in languages spoken, and lack of culturally different lenses available with which to consider the type and success of care provided to displaced individuals.

Reflexively, we acknowledge that good qualitative research is robust, well-documented and well-informed, and through the extensive use of the rich data set in this study we have allowed for a thorough and in-depth exploration of the topics observed in this naturalistic setting (Nassaji, 2020).

6 | CONCLUSION AND FUTURE AVENUES

Based on the findings of this study, it is proposed that the following transculturally informed, humanistic therapeutic practices should be used with displaced individuals experiencing embodied trauma, and are the basis of a recommendation for future research.

1. Transculturally-Informed Assessment (including body mapping approaches).
2. Transculturally-Informed Screening of Embodied Trauma Symptoms (see O'Brien & Charura, 2024).
3. Transculturally-Informed, Person-Centred, Humanistic Psychological Formulation.
4. Transculturally-Informed, Person-Centred Treatment Plan.
5. Regular Psychopharmacology Review.
6. Transculturally-Informed Activities and Groups.
7. Transculturally-Informed Routine Outcome Measures & Client Feedback.

POSITIONALITY STATEMENT

With a reflective and reflexive awareness of the positionality and lenses that we bring to this research (Braun & Clarke, 2022) and how they intrinsically influence our work, we share with the reader that we are a White, British female, and a black, British male of African heritage.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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