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Person-Centered Case Formulation: A Culturally Responsive and Trauma Informed Reconceptualization for Psychotraumatology Practice

Charlotte O'Brien[1] | Divine Charura[2]

[1]John Wiley & Sons, London, UK | [2]York St John University, York, UK

Correspondence: Charlotte O'Brien (cobrien@wiley.com)

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ABSTRACT

This is a conceptual-practice paper proposing a person-centered formulation, illustrated with a clinical case study derived from qualitative research data. This paper aims to update and promote the use of a culturally responsive and trauma-informed model of a person-centered formulation for individuals seeking refuge and asylum, utilizing accessible language and a holistic approach. It adopts two methods, namely, (i) a qualitative case study approach to collaboratively explore a client's narrative of trauma and displacement, (ii) it develops a new person-centered formulation based on a culturally responsive and trauma-informed model. This paper demonstrates how a person-centered approach may facilitate a more holistic conceptualization of trauma, relational distress, and systemic adversity amongst refugee and asylum-seeking populations, enabling a more effective, nonpathologizing therapeutic exploration and process. It advocates for the inclusion of a person-centered formulation in psychotraumatology practice with individuals seeking refuge and asylum as part of a culturally responsive and trauma informed approach to psychotherapy. Finally, it highlights the potential clinical implications for working with clients from various cultural contexts, and the importance of language considerations and a holistic therapeutic approach.

1 | Introduction

The field of counseling psychology has its philosophical grounding and core values radically rooted in humanism with a relational stance (Jones Nielsen and Nicholas 2016; Maslow 2013; Paul et al. 1996; Rogers 1951, 1957a, 1957b, 1959, 1961, 1963, 1965, 1970, 1971, 1980). It draws on phenomenology to understand human experience, taking a nonpathologizing approach to psychological distress, which acknowledges the importance of the intersubjective and the dangers of labeling (Martin 2006). Above all, it prizes the potentially curative properties of the therapeutic relationship, which is now recognized as central for therapeutic success (Martin 2006; O'Brien and Charura 2026; Orlinsky et al. 2004).

A key competency required of Counseling Psychologists is formulation of their client's presenting distress within their chosen therapeutic model (British Psychological Society [BPS] 2011; Health and Care Professions Council [HCPC] 2023; Lane and Corrie 2026; Simms 2011), which is either idiosyncratically and collaboratively applied according to the individual's therapeutic needs, or used as part of an integrative model based on the practitioner's training and expertise. Johnstone and Dallos (2014) acknowledge that different therapies take different positions on what is included in formulation, with Simms (2011) arguing that formulation within the realm of person-centered theory is in itself a contentious issue, as assessment and diagnosis are typically associated with the medical model and have been repeatedly rejected by person-

centered practitioners (Mearns 1997). Yet, Rogers (1957a, 1957b) himself has noted the value of an increased understanding of a client's distress, which can result in greater empathy and congruence (Berghofer 1996; Simms 2011).

Rogers (1951, 1961) stated that psychological distress can be better understood by phenomenologically exploring a person's subjective meaning, relational contexts, and lived realities, rather than utilizing diagnostic categorization. By applying a phenomenological lens, a meaningful response to adverse or constraining relational conditions, which are often shaped by conditions of worth and disruptions to the individual's organismic valuing process can be formulated (Joseph 2015; Mearns and Thorne 2013). However, formulation within a person-centered framework is therefore not a fixed explanatory model, but an emergent, dialogical process that is co-constructed within the therapeutic relationship and continually refined through attuned empathic engagement (Schmid 2007a, 2007b). When viewed through a trauma-informed lens, person-centered formulation further recognizes the pervasive impact of trauma on a person's sense of self, trust, embodiment, and relational safety, while maintaining a nonpathologizing stance that resists reducing trauma responses to symptoms or deficits (Charura et al. 2024; Purton 2014). Indeed, Hipolito (2019) notes that the concept of trauma from a person-centered perspective is complex and can have more than one meaning across psychoaffective development. Even from within the womb, a fetus remains vulnerable to trauma that can affect its potentialities up to the moment of birth (e.g., anoxia, blood type incompatibility), yet trauma can also act as a possible optimum condition for the actualization of potentialities (Hipolito 2019). Hipolito (2019) purported that it is therefore essential when developing a therapeutic project with a client that a diagnostic system approach is taken into consideration which explores the six necessary and sufficient conditions, including how to overcome possible deficits stemming from trauma which require special measures (e.g., careful use of medication, special education or modifying eating habits).

In alignment with Hipolito's (2019) views on the complexity of trauma from a person-centered perspective, we have proposed in our own research on conceptualizing trauma that it can be experienced by and impact any individual across any one or combination of their bio-psycho-social-sexual-spiritual-existential and cultural or *holistic* realms of existence. We therefore propose the preferred use of the term *embodied trauma* to illustrate the agreed absence of dualism between the body and the psyche, and instead define it as follows:

> Embodied trauma is the whole body's response to a significant traumatic event, where mental distress is experienced within the body as a physiological, psychological, biological, cultural, or relational reaction to trauma. Embodied trauma may include psychosomatic symptoms alongside the inability to self-regulate the autonomic nervous system and emotions, resulting in states of dissociation, numbing, relational disconnection, changed perceptions, or nonverbal internal experiences which affect every-day functioning.
>
> (O'Brien and Charura 2023, 1120)

We also assert that trauma happens in the context of relationship and therefore any approaches to therapeutic support or healing need to be considered in the context of relationships. Hence, the centrality of the therapeutic relationship, interconnectedness and community (Charura et al. 2024; Rogers 1957a, 1957b).

Contemporary person-centered thinkers argue that formulation must remain ethically grounded, relationally responsive, and sensitive to power, culture, and intersubjectivity, particularly when working with trauma and marginalized experiences (Charura and Paul 2015; Uphoff and Charura 2016; O'Brien and Charura 2026). In this way, person-centered formulation functions as an ongoing relational understanding that honors lived experience, supports psychological integration, and prioritizes safety, agency, and meaning-making over explanation or control. Indeed, if psychotherapeutic practitioners are to be authentically person-centered, then valuing each person and respecting their culture, difference and diversity is key (Schmid 2007a, 2007b).

Whatever the practitioner's stance, there cannot be any doubt that the competency of formulation is required by professional bodies across the United Kingdom (UK) and that it needs to be ethically included as part of psychological assessment and treatment planning with the client. If formulation is indeed a given in the field of counseling psychology, the question then remains as to how we do it well, bringing it up to date for psychotraumatological practice today, and more specifically, how we revolutionize it in a culturally informed way for individuals seeking refuge and asylum in the United Kingdom.

1.1 | A Holistic Approach to Psychological Distress

Recent literature has pointed toward the need for a holistic approach to conceptualizing and assessing the psychological distress of individuals seeking refuge and asylum, considering it across the realms of its biological-psychological-social-sexual-spiritual-existential presentations (O'Brien and Charura 2023). However, no comprehensive model has yet been proposed considering these holistic aspects of an individual, despite its urgent requirement in order to provide specific, targeted, relevant, and expedient access to appropriate therapeutic care services in the United Kingdom. Although some therapeutic models of formulation, such as Cognitive Behavioral Therapy [CBT] (Beck 2019; Dudley and Kuyken 2006), which use a longitudinal case formulation approach, feed in to specific systems and services within the UK such as the National Health Service [NHS] and National Institute for Health and Care Excellence guidelines for particular diagnoses, such as psychosis and schizophrenia (National Institute for Health and Care Excellence [NICE] 2026), they often fail to take into account the specific needs of individuals seeking refuge and asylum beyond

psychological distress. This may include, for example, the need for relational belonging, the benefit of spiritual support, or embodied expressions of distress shown through body mapping (O'Brien and Charura 2024).

We also take this one step further and advocate for a holistic approach to psychological distress which includes using a trauma-informed and culturally-informed lens. Trauma-informed practice is defined by the UK Government (2022, 1) as "... an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development ... trauma can affect individuals, groups and communities ... [and] aims to increase practitioners' awareness of how trauma can negatively impact on an individual and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff." Applying a culturally informed lens is also essential as "the [practitioner] is always informed by social and cultural contexts and is never culturally neutral. Moreover, the [practitioner] has a clinical responsibility to make explicit [their] own assumptions, premises and categories in relation to the [clients'] to prevent misunderstandings and misdiagnoses. Culturally informed [practice] cannot be defined once and for all; it is not a quick-fix technique or manual. It is rather the continuous development of a professional attitude, perceiving all human beings, including the [practitioner], as cultural bearers and cultural learners ... we need culturally reflexive [practitioners] ..." (Leseth 2015, 190).

1.2 | Formulation and Culture

Johnstone and Dallos (2014) note the inherent problem within the current models of formulation which do not allow for individual cultural identities or ethnicities in the process of formulation. In fact, taking this one step further, we would suggest that these aspects are seemingly entirely absent from most globally westernized conceptualizations of formulation, where formulation has arisen, and is inherently imbedded in, a globally westernized model of individuals and psychological care. Contemporary or traditional models of formulation such as CBT (Beck 2019), Psychodynamic (Malan 1979) or Compassion Focussed Therapy (CFT) (Gilbert 2009) have historically underemphasized cultural identity, value systems, expressions of distress, aspects of intersectionality or language considerations which resoundingly echo the profound absence of multicultural training and competencies and colonization across pedagogical scholarship, research and psychological profession as a whole to date (Charura and Lago 2021).

Uphoff and Charura (2016), however, considered formulation within the person-centered approach as an emergent, relational, and ethically grounded process rather than a fixed or technical product. They argued that traditional notions of formulation, often shaped by diagnostic and expert-led frameworks, sit uneasily with person-centered values unless they are fundamentally reconceptualized. From their perspective, person-centered formulation is implicit in the therapeutic relationship itself, arising through phenomenological attunement, dialogical understanding, and sensitivity to context, power, and culture. They emphasized formulation as tentative, coconstructed, and continually evolving, serving not to explain or categorize the client but to deepen shared understanding and support relational presence. They noted that the type of formulation they outlined (following Simms 2011) is a simplified version of that which Speierer (2013) proposed in his Differential Incongruence Model. It gave practitioners a means to analyze and formulate client incongruence collaboratively, with both client and therapist focus. They drew also on Schmid's work stating that "It is exactly this collaboration that distinguishes the person-centered approach from other modalities: it is relational, meaning that "it is and must be co-operative, collaborative, cocreated and coexperienced" (as cited in Uphoff and Charura 2016, 316). However, we argue that these revision have not yet gone far enough to incorporate a holistic, culturally and trauma-informed approach to formulating therapeutic work with clients in the field of psychotraumatology.

1.3 | Formulation and Language

A central issue regarding the formulation of psychological distress with individuals who are seeking refuge and asylum is language, especially what is lost in translation (Uphoff and Charura 2016; O'Brien and Charura 2023). Not only are interpreters urgently needed to facilitate a more accurate understanding of a displaced individual's presentation of distress, but there is also a question as to whether our current models of formulation can truly support culturally diverse expressions of distress, such as our recent findings which note Ethiopian expression of worms in the ear (Grisaru et al. 2016), or Congolese descriptions of a boiling hot brain (Murphy et al. 2021; O'Brien and Charura 2023). There is arguably not space in the existing models of formulation to conceptualize and document these culturally specific expressions of distress or to consider language requirements of each individual.

2 | Method

This paper adopts a qualitative case study methodology, drawing on McLeod's (2010) articulation of case study research as a practice-based, reflexive, and contextually grounded approach within counseling and psychotherapy. McLeod (2010) emphasizes the value of case studies in illuminating the complexity of lived experience, relational processes, and meaning-making that are often marginalized by nomothetic designs. This approach is particularly suited to person-centered formulation which privileges phenomenological understanding, ethical sensitivity, and responsiveness to social and cultural context. The case which we draw our formulation ideas from, involves a research participant, a man seeking sanctuary in the United Kingdom and is used illustratively rather than representationally. The focus is not on generalization, but on theoretical and experiential resonance, enabling a nuanced exploration of how cultural location, trauma, and power shape the formulation processes. The case study allows formulation to be examined as emergent and dialogical, embedded within the therapeutic relationship and wider socio-political realities, thereby offering a rigorous and transparent methodology aligned with person-centered and trauma-informed values.

2.1 | Ethical Approval

Ethical approval was gained from York St John University's School of Education, Language and Psychology Ethics Committee. Approval Code: RECCOUN00025. Informed consent was sought from each participant in the study via a paper consent form and through verbal consent. This included consent for anonymized data sharing for research, publication and dissemination purposes.

2.2 | A New Approach to Formulation

Integrating the latest theoretical literature from our recent comprehensive scoping review of individuals seeking refuge and asylum and their experiences of embodied trauma (O'Brien and Charura 2023), we propose a new culturally informed model of formulation using a person-centered approach (see Figure 1). This new approach values each individual client's ability to voice what it is that hurts, and to decide in which direction to orient their organismic tendencies toward therapeutic growth, change and self-actualization (1951, 1957a, 1957b, 1959, 1961). We, as researchers and therapeutic practitioners, believe that the person-centered approach is best positioned to support the individualized model required for displaced individuals, and have culturally re-envisioned Simms' (2011) model of person-centered formulation specifically for this client group. We also draw on Lane and Corrie (2026, 100) writing on assessment, formulation and therapeutic engagement, in which they argued that The main function of holistic assessment then "is to develop an approach for hearing the client's story and to collect information that will support an understanding of the client's needs. The needs to develop that understanding it's partly why it is important to avoid jumping straight into therapy. It is not possible to be certain at the outset if your offer makes sense for the client or even if a psychological intervention is the most appropriate for the challenges they face." The sections that follow will present our new model of Culturally Informed Person-Centered Formulation and explicate the model further by using an anonymized research participant example roughly based on our own research experiences and therapeutic practice for educational and demonstrative purposes only.

We now present a case formulation based on a qualitative semistructured interview with a real research participant whose identity has been anonymized (see Figure 2). The participant has been pseudonymized "Ade," which is not their real name, and some details have been changed to uphold confidentiality. The client's consent was given as part of a doctoral thesis research study and the full paper of this study can be read via the subsequent publications (O'Brien and Charura 2023, 2024). However, using the raw data answers from the semistructured interview (see full raw data set in Appendix A) we have suggested how an updated version of this culturally and trauma informed, holistic formulation can be used to Ade, his interpreter and his therapeutic practitioner.

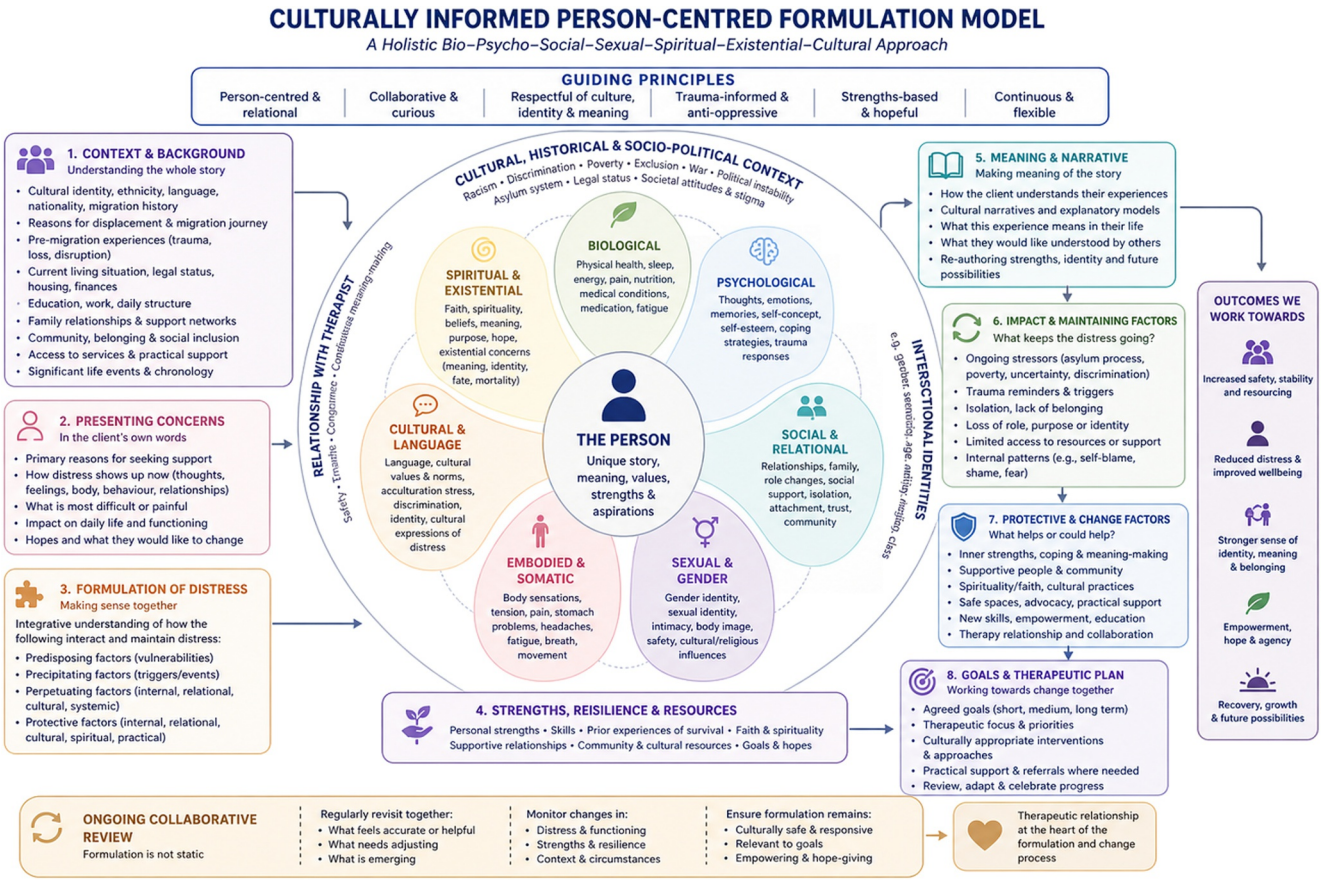

FIGURE 1 | Culturally and trauma informed person-centered formulation model.

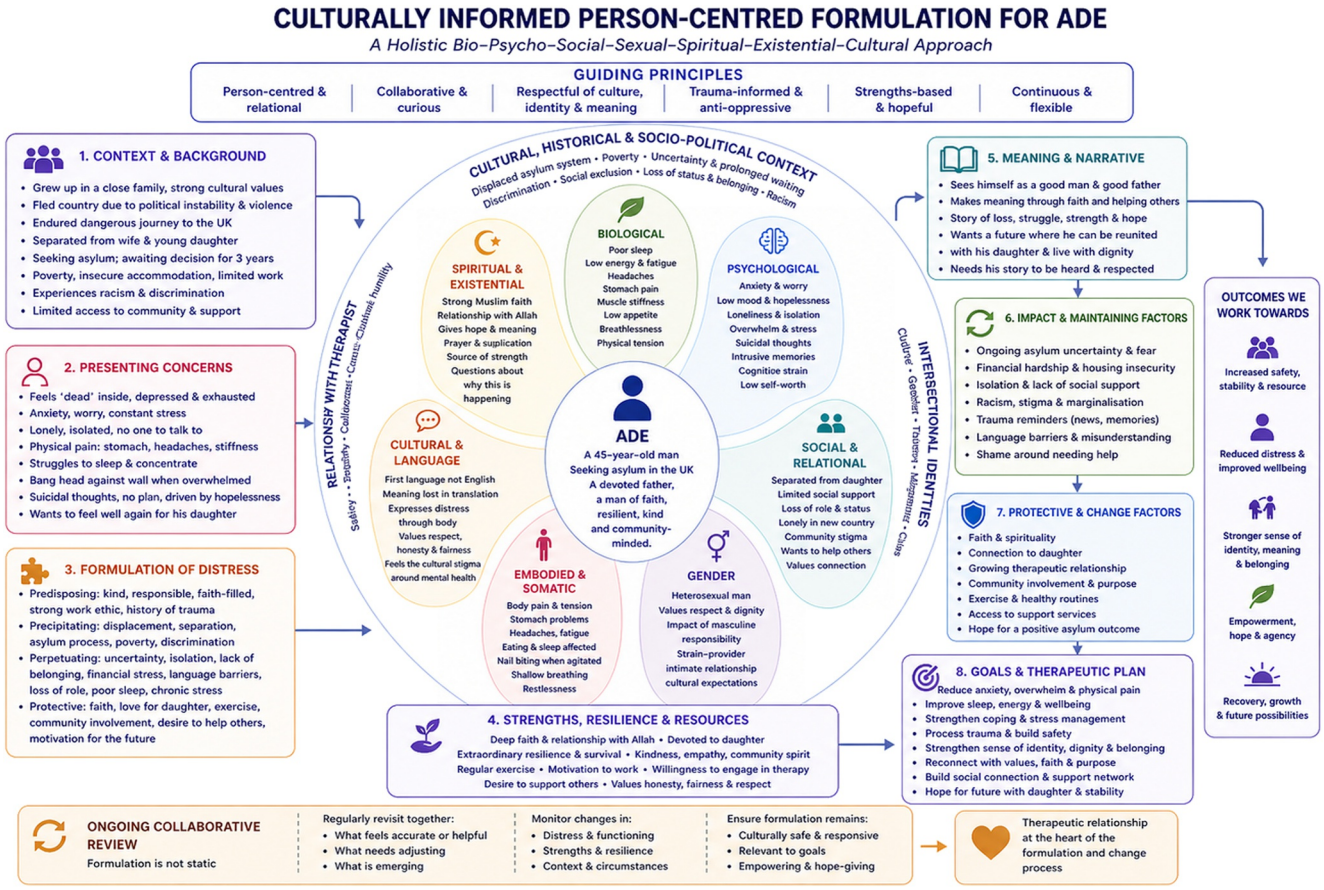

FIGURE 2 | Culturally and trauma informed person-centered formulation for Ade.

2.3 | Participant Information

Ade came to take part in a doctoral thesis study exploring refugee and asylum seeker's perspectives of embodied trauma (O'Brien and Charura 2024). Ade was a man of Pakistani heritage, aged between 45 and 54 years-old, unemployed and divorced, and seeking refuge in Northern England with his daughter. Ade scored 10 out of a possible 10 on the Trauma Screening Questionnaire (TSQ) (Brewin et al. 2002) signifying likely Post Traumatic Stress Disorder (PTSD).

2.4 | Research Method

The research method employed in this study asked Ade to take part in a qualitative semistructured interview where the structured section was made up of the TSQ (Brewin et al. 2002). The semistructured section was then a series of open questions, using prompts where necessary (Jacob and Furgerson 2012). There was a total of seven open questions covering the subtopics, including embodied trauma and its psychological impact(s), the relationship to the body and self-concept, and the impact of the refuge or asylum-seeking process and being dislocated from their own cultural context. This was followed by a body mapping exercise. Afterward, reflexive thematic analysis (Braun and Clarke 2022) was used to analyze the data collected from a sample of 13 participants. Ade's data can be found in Appendix A.

3 | Results

The formulation presented in Figure 2 demonstrates how the proposed culturally and trauma-informed person-centered model can be applied in practice to collaboratively understand the experiences of individuals seeking refuge and asylum. Rather than functioning as a diagnostic tool, the model offers a structured yet flexible framework for developing a shared understanding of psychological distress that remains grounded in person-centered values, cultural responsiveness, and trauma-informed care. Our approach here aligns with Rogers' (1951) assertion that theory should not be a rigid structure or dogma, but rather a tentative framework to stimulate further thinking and development.

The logic of the model follows an interconnected eight-stage process. The formulation begins with an exploration of the client's context and background, recognizing that experiences of migration, displacement, family relationships, culture, language, faith, social position, and exposure to trauma shape the individual's current experiences. These stages reflect the person-centered commitment to collaboratively exploring the client's phenomenological world rather than imposing external interpretations and staying with the client's frame of reference.

The eight stages are not intended to be followed as a rigid linear sequence. Rather, they operate as an interconnected and re-

flexive process. Offering a space to collaboratively explore the client's context and background utilizing this formulation allows for a process and relational orientated approach. This facilitates a depth of moment-by-moment meaning making and contextualized formulation of distress, which also identifies and prizes strengths and resources alongside the client's challenges or difficulties. Exploration of meaning and narrative helps clarify how the client understands their experiences, which in turn illuminates the factors maintaining distress and those supporting change. These understandings collectively inform an articulation of what the client experiences as hurting, as well as the direction they feel they need to move toward growth, healing, and self-actualization (Rogers 1957a, 1957b, 1959). Throughout the process, the formulation remains open to revision as new experiences, insights, and meanings emerge within the therapeutic relationship.

The second stage focuses on presenting concerns as described by the client in their own words. Consistent with Rogers' emphasis on subjective experience, distress is understood through the client's lived reality rather than through diagnostic categorization. In Ade's case, experiences of anxiety, exhaustion, loneliness, hopelessness, bodily pain, and suicidal thoughts emerged as central concerns. Importantly, these experiences were expressed through culturally meaningful narratives and embodied descriptions rather than solely through psychological language.

The third stage involves collaboratively formulating distress by integrating presenting, predisposing, precipitating, perpetuating, and protective factors. Unlike many traditional formulations that focus primarily on intrapsychic processes, the current model incorporates cultural, relational, systemic, and sociopolitical influences. For Ade, distress appeared to emerge from the interaction between previous trauma exposure, ongoing asylum uncertainty, social exclusion, poverty, family separation, and reduced access to meaningful social roles. This broader understanding reflects a trauma-informed recognition that psychological distress often develops within adverse relational and environmental conditions.

The fourth stage identifies strengths, resilience, and resources. This component is particularly important within a person-centered framework because it acknowledges the individual's actualizing tendency and capacity for growth despite adversity. Ade's relationship with his daughter, religious faith and engagement with a spiritual community and practice, commitment to helping others, engagement with exercise, and willingness to engage in therapy all represented important sources of resilience that could be incorporated into therapeutic work.

At the center of the model sits the person within a holistic bio-psycho-social-sexual-spiritual-existential-cultural framework. This represents a significant development beyond earlier person-centered formulations. Rather than focusing exclusively on cognitive, emotional, or relational processes, the model explicitly recognizes that trauma and distress may be experienced across multiple interconnected domains of human experience. In Ade's formulation, psychological distress was inseparable from embodied symptoms, spiritual beliefs, social relationships, cultural identity, language experiences, and existential concerns regarding meaning, belonging, and future hope.

The fifth stage explores the client's meaning and narrative. This reflects the person-centered emphasis on phenomenological understanding and seeks to explore how clients make sense of their experiences. Ade understood his self-concept as a caring father and a person of faith, despite adversity. His story was not solely one of trauma and loss but also one of perseverance, responsibility, and hope. The formulation therefore prioritizes the client's own explanatory framework and cultural narratives rather than relying exclusively on professional interpretations.

The sixth stage identifies impact and maintaining factors. Here, the model examines the processes that continue to sustain distress over time. In Ade's case, ongoing uncertainty surrounding his asylum claim, financial hardship, social isolation, language barriers, and experiences of discrimination appeared to maintain psychological suffering long after the original traumatic events had occurred. This highlights trauma-informed principles which suggest that current environments may continue to perpetuate distress and systemic retraumatization.

The seventh stage identifies protective and facilitative factors of change. These are the elements that may support recovery, resilience, and psychological growth. Within the current formulation, these factors emerge from the client's own strengths, values, relationships, cultural resources, spirituality, and community connections. This approach aligns with person-centered principles by emphasizing empowerment, agency, and self-determination rather than therapist-directed solutions.

The eighth stage translates the formulation into an articulation of the incongruence (or psychological maladjustment) that the client experiences, thwarting of their actualizing tendency, as well as identifying what they need to move toward growth and healing (Rogers 1957a, 1957b, 1959). Unlike prescriptive treatment models, the therapeutic aim(s) emerge moment-by-moment from the collaborative understanding developed throughout the formulation process. For Ade, this included reducing distress, strengthening social connections, processing traumatic experiences safely, rebuilding a sense of dignity and belonging, and supporting hope for the future. The formulation therefore functions as a bridge between understanding the client's experiences and identifying meaningful therapeutic priorities.

Importantly, the model differs from traditional person-centered formulations in several ways (Simms 2011; Uphoff and Charura 2016). While maintaining the core person-centered principles of empathy, collaboration, phenomenological understanding, and nonpathologisation, it explicitly incorporates cultural identity, language considerations, spirituality, community belonging, embodied expressions of distress, and sociopolitical context. The model also extends contemporary person-centered thinking by integrating trauma informed and culturally responsive principles, recognizing the impact of trauma on embodiment, relationships, identity, safety, and meaning-making.

The case of Ade illustrates how these domains interact dynamically rather than operating independently. His embodied symptoms, psychological distress, spiritual beliefs, cultural values, family relationships, social exclusion, and experiences of displacement formed an interconnected network of experiences that could not be adequately understood through symptom-focused or diagnostic approaches alone. The formulation therefore provides a holistic map of distress, resilience, and strengths that support recovery which can guide therapeutic engagement while remaining responsive to the client's evolving experiences.

In practice, the model can be used collaboratively during assessment, ongoing therapy, multidisciplinary discussions, supervision and care planning (see Appendix B for an example formulation worksheet that could be used in practice). The formulation remains provisional and open to reflexive revisions as new meaning and experiences emerge. In this way, it reflects the person-centered view that understanding is always relational, evolving, and coconstructed rather than fixed or definitive.

4 | Discussion

This paper has proposed an updated, culturally informed, person-centered formulation model for use in psychotraumatology practice with individuals seeking refuge and asylum. Drawing on person-centered theory, contemporary literature on embodied trauma, and the illustrative case formulation of "Ade," the paper demonstrates how psychological distress cannot be adequately understood through reductionist or exclusively symptom-focused frameworks alone. Instead, the findings presented here suggest that distress experienced by displaced individuals is relational, embodied, cultural, spiritual, existential, and systemic in nature, requiring a holistic and collaborative approach to formulation. This position aligns with broader critiques of dominant psychiatric and diagnostic paradigms, which have historically individualized distress while neglecting the socio-political and cultural contexts in which suffering occurs (Summerfield 2001; Watters 2010; Johnstone and Boyle 2018).

This proposed model, in contrast, extends existing person-centered formulations by explicitly integrating cultural identity, language, spirituality, community belonging, and culturally specific expressions of distress into the formulation process. This addresses an important gap identified within existing formulation literature, where dominant westernized models often fail to adequately conceptualize the lived experiences of individuals from diverse cultural backgrounds (Johnstone and Dallos 2014). Fernando (2017) similarly argues that many mainstream mental health frameworks remain rooted in Eurocentric assumptions about selfhood, pathology, and healing, often marginalizing nonwestern understandings of distress. In the case of Ade, for example, distress could not be meaningfully understood without considering the intersection of displacement, loss of cultural belonging, separation from family, poverty, exclusion from community networks, and prolonged uncertainty associated with the asylum process. His presentation of anxiety, exhaustion, loneliness, embodied pain, and suicidal ideation emerged not as isolated psychopathology, but as understandable responses to prolonged relational, social and systemic adversity.

The findings further reinforce recent literature which conceptualizes trauma amongst refugee and asylum-seeking populations as embodied and culturally mediated (Murphy et al. 2021; O'Brien and Charura 2023). Ade repeatedly described distress through physical and embodied experiences, including stomach pain, headaches, low energy, stiffness, disturbed sleep and feelings of being "dead." Such experiences highlight the limitations of traditional western diagnostic frameworks which may privilege cognitive or behavioral symptoms over embodied and culturally situated expressions of suffering. Kirmayer and Young (1998) note that cultural variations in the expression of distress challenge the universality of western psychiatric categories, particularly in trauma-related presentations. Similarly, Summerfield (1999, 2008) has criticized the global exportation of western trauma frameworks, arguing that concepts such as PTSD may inadequately capture the lived realities of displaced populations whose suffering is inseparable from social rupture, collective violence, and ongoing uncertainty.

Importantly, Ade's culturally embedded expression of "banging one's head against the wall" when overwhelmed illustrates how emotional distress may be communicated through culturally specific metaphors that are not readily accommodated within conventional formulation approaches. The inclusion of these narratives within formulation is therefore essential in avoiding misinterpretation, pathologization, or clinical oversimplification. Kleinman (1988) has long argued that clinicians must attend to patients' "explanatory models" of illness and suffering in order to avoid imposing culturally incongruent interpretations of distress. Without such consideration, there is a risk that culturally normative expressions may be misunderstood as evidence of psychopathology, further perpetuating experiences of marginalization and epistemic injustice within mental health systems (Hook et al. 2017).

Considering the embodied, Uphoff and Charura (2016, 317) in their writing on person-centered formulation noted that "... in line with our views on formulation and diagnosis ..., we assume that in the future, along with all orientations person-centered practitioners will need to take neuroscience more actively into account possibly informing their understanding by deconstructing clinical features into neural biological constructs.."

Uphoff and Charura (2016) approach neuroscience with a cautious interest, positioning it as a complementary rather than determinative influence on person-centered formulation. They suggest that developments in interpersonal neurobiology may offer a shared language for understanding embodied, relational, and affective processes that occur within therapy. However, they are clear that neuroscience should inform but never replace phenomenological, relational understanding. Within person-centered formulation, neurobiological ideas are therefore held tentatively and ethically, used to enrich empathy and attunement rather than to explain away meaning or reinstate expert-led authority. Although formulation remains relational, dialogical, and grounded in lived experience with neuroscience held as a supportive rather than guiding framework, this relational

commitment also foregrounds the central role of language, culture, and meaning-making in how experience is understood and communicated within the therapeutic encounter.

Language emerged as another critical component of culturally informed formulation. Ade frequently struggled to understand questions even when supported by an interpreter, suggesting that translation alone may not sufficiently bridge differences in meaning-making, cultural assumptions, and conceptualizations of distress. Tribe and Thompson (2008) argue that interpreters working within mental health contexts occupy highly complex relational positions, where emotional nuance, cultural meaning, and power dynamics may significantly shape therapeutic communication. This finding supports previous work highlighting the risks of "what is lost in translation" within psychological assessment and therapy for displaced populations (O'Brien and Charura 2023). Consequently, culturally informed formulation requires more than interpreter access; it requires clinicians to remain reflexively aware of linguistic nuance, practitioner assumptions, culturally shaped narratives, and differing understandings of mental health and suffering. Formulation therefore becomes not merely an assessment task, but a collaborative and dialogical process of meaning-making between practitioner, client and, where relevant, interpreter.

The formulation of Ade's experiences also demonstrates the importance of recognizing strengths, resilience, and protective factors alongside distress. Consistent with person-centered principles, the model intentionally avoids reducing the individual to pathology alone. Ade's relationship with his daughter, his faith, his engagement with exercise, and his efforts to support others within the refugee community all emerged as significant protective resources. His spirituality and connection with God appeared to provide continuity, meaning, and hope amidst prolonged uncertainty and exclusion. Previous research has similarly demonstrated the protective role of spirituality, religion, and community belonging among displaced populations coping with trauma and forced migration (Ai et al. 2005; Nickerson et al. 2017). From a person-centered perspective, these strengths may also be understood as expressions of the individual's actualizing tendency and capacity toward growth despite adverse conditions (Rogers 1961, 1963). However, it is equally important to critically acknowledge that discourses of "resilience" can sometimes obscure the structural injustices and systemic harms experienced by displaced individuals if interpreted uncritically (Ecclestone and Lewis 2014). Practitioners must therefore avoid romanticizing resilience while recognizing the profound adversity within which such strengths emerge.

The culturally informed formulation model also highlights the importance of understanding distress within broader systemic and sociopolitical contexts. Ade's difficulties were closely linked to structural experiences including the asylum system, poverty, housing instability, social exclusion, and community stigma. This supports critiques of individualized models of psychopathology, which may overlook the impact of social injustice, immigration systems, and ongoing adversity on mental health. Patel et al. (2018) argue that global mental health approaches must move beyond biomedical reductionism toward frameworks that account for social determinants of mental health, inequality, and structural violence. Likewise, Miller and Rasmussen (2017) suggest that ongoing postmigration stressors, such as poverty, insecure immigration status, and social isolation, are often more predictive of psychological distress amongst refugees than premigration trauma exposure alone.

This is particularly significant given evidence suggesting that asylum systems themselves may function as sites of retraumatization (Carswell et al. 2011; Silove et al. 1997). Ade's narratives of uncertainty, exclusion, and fear illustrate how psychological distress may persist or intensify long after the initial traumatic events due to hostile systemic environments and prolonged instability. A culturally informed person-centered approach therefore requires practitioners not only to attend to intrapsychic processes, but also to recognize how systems of power, discrimination, and displacement contribute to psychological suffering. In this sense, formulation may function as an antipathologizing and socially contextualized clinical tool that positions distress as understandable within the context of forced migration and ongoing adversity rather than solely as individual dysfunction.

At the same time, there are important tensions in attempting to integrate person-centered philosophy with formalized formulation practices. As Simms (2011) notes, some person-centered practitioners may view formulation itself as contradictory to nondirective and antidiagnostic principles. There remains a risk that formulation could inadvertently impose professional interpretations onto clients' lived experiences, particularly when shaped by institutional requirements or dominant psychological discourses. The current model therefore requires clinicians to engage reflexively and collaboratively, ensuring that formulations remain tentative, evolving, and coconstructed rather than fixed explanatory frameworks. This resonates with broader critiques within counseling psychology regarding the balance between professional expertise and respecting clients' phenomenological realities (Cooper 2008).

Although the proposed model offers an important conceptual contribution, several limitations should also be acknowledged. First, the paper presents a theoretical and practice-oriented framework illustrated through a single case example, limiting generalizability. Experiences of displacement, trauma, and cultural identity are highly heterogeneous, and no single formulation framework can fully encompass the complexity of all refugee and asylum-seeking populations. Second, although the model attempts to move beyond westernized assumptions, it remains situated within counseling psychology discourse and may still reflect certain western epistemological foundations. Decolonial scholars have argued that even culturally adapted western models may unintentionally reproduce unequal power relations if they fail to fully engage with indigenous and non-western epistemologies of healing and wellbeing (Gone 2010; Mills 2014). Continued collaboration with culturally diverse communities, interpreters, and practitioners is therefore essential in refining and evaluating the model further.

Finally, empirical research examining the clinical utility, acceptability and therapeutic outcomes associated with this formulation approach remains necessary. Future studies could explore how culturally informed formulations impact

therapeutic alliance, client engagement, intervention planning, and treatment outcomes across various displaced populations and clinical contexts. Longitudinal research may also help determine whether holistic formulations improve continuity of care, multidisciplinary communication, and service accessibility for refugee and asylum-seeking populations. In addition, future work should explore how practitioners are trained in culturally informed formulation and reflexive practice, particularly given longstanding concerns regarding insufficient multicultural competencies within psychology training programs (Charura and Lago 2021; Sue et al. 2009).

Overall, this paper argues that culturally informed person-centered formulation offers a meaningful and ethically responsive framework for psychotraumatology practice with individuals seeking refuge and asylum. By integrating cultural identity, spirituality, embodiment, language, relational experiences, and systemic adversity into collaborative formulation processes, practitioners may be better positioned to understand the complexity of displaced individuals' distress and provide more humane, contextually sensitive and effective care.

5 | Conclusion

This paper has argued for a culturally and trauma informed reconceptualization of person-centered formulation within psychotraumatology practice for individuals seeking refuge and asylum. Drawing together person-centered philosophy, contemporary trauma literature, cultural psychiatry, and embodied understandings of distress, we have proposed a holistic formulation model that moves beyond reductionist and westernized conceptualizations of psychological suffering. In doing so, the paper responds to a significant gap within existing formulation practices, where culture, spirituality, language, systemic oppression, displacement, and embodied expressions of distress have often remained peripheral or insufficiently conceptualized.

In concluding, we are drawn to Simms' (2011) question and exploration of whether case formulation sits uncomfortably within a person-centered framework, Gillon (2012) offered a nuanced critique that challenges the assumption that formulation is inherently incompatible with person-centered values. Gillon (2012) argued that the perceived tension arise largely from medicalized, expert-driven understandings of formulation, rather than from formulation per se. When formulation is reconceptualized as a tentative, collaborative, and phenomenological process, it can function in ways that remain faithful to person-centered principles of nonpathologization, relational depth, and respect for the client's subjective frame of reference (Gillon 2012; Uphoff and Charura 2016). This critique highlights that Simms' position risks reconceptualizing formulation as a static product, rather than recognizing it as an emergent and coconstructed process embedded within the therapeutic relationship. From this perspective, the discomfort identified by Simms may reflect broader professional anxieties regarding power, accountability, and legitimacy, rather than an intrinsic incompatibility between person-centered therapy and formulation. Gillon's (2012) response thus reframes formulation as ethically viable when grounded in dialogical, relational, and process-oriented practice.

Using the case formulation of "Ade," this paper has demonstrated how distress amongst displaced individuals may be more accurately understood as relational, embodied, existential, cultural, and socio-political in nature, rather than solely as intrapsychic dysfunction or symptomatology. The proposed model therefore positions formulation not as a static diagnostic exercise, but as a collaborative, culturally responsive and meaning-making process grounded in the client's lived experience, identity, values, relationships, and context. Importantly, the framework seeks to preserve the core values of person-centered practice including empathy, collaboration, phenomenological understanding, and nonpathologization, while responding to the increasing need for culturally informed and clinically applicable approaches within contemporary psychological services.

The paper further highlights the crucial importance of language, interpretation, spirituality, community belonging, and systemic context when working therapeutically with refugee and asylum-seeking populations. Without such considerations, there remains a risk that practitioners may inadvertently misunderstand, pathologize or decontextualize culturally situated experiences of distress. As global displacement continues to rise, the need for psychologically, culturally and ethically responsive models of formulation becomes increasingly urgent. The implications extend beyond psychotraumatology alone and are relevant to broader counseling psychology, psychotherapy, psychiatry, and multidisciplinary mental health practice.

At the same time, this paper acknowledges the tensions inherent in integrating formulation practices within person-centered traditions, as well as the limitations of attempting to develop culturally responsive models from within historically western psychological frameworks. The proposed formulation should therefore be understood as evolving, tentative, and open to ongoing critical reflection, refinement, and coconstruction alongside displaced communities, practitioners, and researchers. Future empirical research is now required to evaluate the clinical utility, cultural acceptability, and therapeutic impact of this formulation approach across diverse settings and populations.

Based on the arguments advanced throughout this paper, we make the following recommendations:

i. There is a profound and urgent need for culturally informed and antioppressive approaches to psychological formulation within counseling psychology, psychotherapy, and psychotraumatology practice.
ii. Practitioners should adopt holistic bio-psycho-social-sexual-spiritual-existential-cultural approaches to formulation, which explicitly incorporate language needs, interpreter dynamics, embodiment, systemic adversity, and culturally situated expressions of distress.
iii. Psychology training programs and professional bodies should strengthen multicultural, decolonial, and culturally responsive competencies within formulation teaching and clinical supervision.
iv. Services working with refugee and asylum-seeking populations should prioritize collaborative, culturally safe, and trauma-informed approaches to assessment and

intervention planning which recognize the ongoing impact of displacement, poverty, uncertainty, and social exclusion.

v. Future research should undertake empirical evaluation and clinical trials of this culturally informed person-centered formulation model to assess its efficacy, acceptability and capacity to improve therapeutic engagement, intervention planning and psychological outcomes for displaced individuals.

5.1 | Limitations

- We have employed a qualitative in-depth case study for one participant using research data, and the domains that have been conceptualized within our formulation example are specific to this participant and are not generalizable to all clients. However, informed by person-centered theory, the example questions that we have formulated in each of the domains facilitate the possibility of working idiosyncratically in therapy with different clients (see Appendix B). This is in line with a person-centered perspective that theory should not be used as a dogma but only as a stimulus to further thinking (Rogers 1951). We also recommend further exploration and evidencing of the model in practice.
- We are drawing on person-centered theory as our intentionality is for the application of the formulation model within different contexts. As such we have used the term "person-centered" rather than purely limiting our approach to classical "client-centered" psychotherapy. We acknowledge the limitation that broadening our approach beyond classical client-centered psychotherapy may dilute the potency of a puristic approach.

5.2 | Reflexivity Statement

Both authors approached this work from a person-centered and trauma-informed philosophical position, grounded in counseling psychology, relational practice, and an ethical commitment to culturally responsive care. Our clinical, research, and teaching experiences working with refugee and asylum-seeking populations have shaped our awareness of the limitations of dominant westernized models of psychological formulation, particularly where culture, language, embodiment, spirituality, systemic adversity, and displacement may remain insufficiently conceptualized.

We recognize that formulation is never a neutral process and is inevitably influenced by the practitioner's own theoretical orientation, cultural positioning, assumptions, and lived experiences. Throughout the development of this paper, we therefore sought to remain reflexively attentive to issues of power, interpretation, representation, and epistemic authority, particularly when working with the experiences and narratives of displaced individuals. In keeping with person-centered principles, we approached formulation as tentative, collaborative, and coconstructed rather than objective or fixed.

The illustrative case material presented within this paper derives from previous qualitative research conducted by the first author as part of doctoral research exploring embodied trauma amongst refugee and asylum-seeking populations. The formulation presented does not claim to represent the participant's definitive experience, but rather demonstrates one possible culturally and trauma-informed understanding developed through phenomenological and relational interpretation. We remain mindful that all interpretation is partial and situated, and that alternative understandings may emerge from various cultural, relational, or theoretical perspectives.

Both authors engaged in ongoing dialogue, critical reflection, and collaborative discussion throughout the writing process in order to challenge assumptions, deepen reflexive awareness, and ensure that the proposed formulation framework remained aligned with person-centered, antipathologizing, and culturally responsive values.

Author Contributions

Charlotte O'Brien: conceptualization, investigation, writing – original draft, methodology, writing – review and editing, formal analysis, project administration, data curation. **Divine Charura:** conceptualization, writing – original draft, methodology, writing – review and editing, supervision.

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Ethics Statement

Ethical approval was gained from York St John University's School of Education, Language and Psychology Ethics Committee. Approval Code: RECCOUN00025.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that supports the findings of this study are available in the appendices of the article.

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Appendix A: Raw data results from qualitative interview for "Ade."

Time	Quote/reflection	Code/label
5.20	Okay, so I cannot explain this in words. I don't have enough words to explain this. But I can say that whatever circumstances I'm having those circumstances when I have my daughter, it's not less than a blessing for me. She is a blessing for me	Children bringing hope/happiness
6.54	So I've been through a lot and I'm still suffering a lot but my daughter is like a center of my life. I'm already 50 so I am always trying that whatever time I have I can	Children at the center of my life

(Continues)

(Continued)

Time	Quote/reflection	Code/label
	do the best for her. So she keeps me going	
11.44	Yes some broken dreams	Difficulty sleeping
11.45	(Interpreter) Acting or feeling as though the events were happening again. He didn't understand it	Difficulty understanding TSQ statements (even with interpreter)
12.40	(Interpreter) He's saying that it's a constant thing. Constant thought constants, like memories. So with the with that, like he feels his energy is down. He doesn't have any energy in the body. He doesn't feel good	Overthinking and rumination
14.19	(Interpreter) He says, I mentioned this thing to my doctor as well. And he said it's because of the stress you are suffering from	Doctor helps
14.19	[Charity anonymized] caseworker, they suggested to me that I should keep myself busy, because the more busy I am, the less I'll be thinking about it	Charities help
16.15	(Interpreter) So he's saying yes because it's interconnected because when you are too much stress you think a lot and you think a lot and you have physical symptoms	Overthinking and rumination causes stress
17.40	(Interpreter) He has been having these counseling sessions for a long time, through different agencies like he was in contact with the [Charity anonymized] and [Charity anonymized] like, and he's also researching on internet himself about different mental health conditions like anxiety and other conditions	Therapy helps
17.40	So while reading about different conditions, he thinks that he is autistic also. So he just wanted to mention this because especially when his sleep is so disturbed when he's having these broken dreams, so he thinks that he's autistic	Disturbed sleep Neurodiversity
18.51	Even if it's a normal days, like my mind was still like continuously processing things like it's not stopping	Overthinking and rumination

(Continues)

(Continued)

Time	Quote/reflection	Code/label
19.37	Okay, so I've tried to keep myself busy during the day. But at the same time, I feel that my body doesn't have enough energy. It's getting lower and lower energy	Keeping busy to stop over thinking
20.34	Now like even, like most of the time, I feel like I want to sleep. And that's why I sleep more	Disturbed sleep
21.55	(Interpreter) So he does feel frustrated sometime when he's trying to sort out something. So try to get help from some professionals if possible. He does feel agitated sometimes. But he try not to be angry	Frustrated
24.08	(Interpreter) So the answer to your question is yes, in a sense that he says sometimes when the situation will get so tense and he will be so anxious that sometimes in our like in our culture, there is a saying meaning of the thing is that people try to like bang their head on the wall, because they don't know what to do	Cultural expression of distress. Bang head on wall when don't know what to do
26.53	(Interpreter) Okay, so he's saying that in regards to the effect of those sufferings in this whole process, I have been through It's immense. And it's immense not only like it's not only physical effect, it's mentally it's emotionally and it's physically so it's quite a lot. I'm I'm not able to explain it in words	Home office causing distress
30.15	Okay, so physically as I mentioned, low energy, tiredness, weakness and emotionally I feel quite a lot down because my circumstances are similar to many of the people out there but it's also different. So, overall the effect is quite strong on my body on my emotion	Low energy, embodied emotions and experience
31.08	How would you describe your physical or mental health in relation to what you have been through? Sorry can you repeat again?	Difficulty understanding statements/questions
34.01	So when he has been through those incidents in	Strong impact of trauma initially

(Continues)

(Continued)

Time	Quote/reflection	Code/label
	the start, obviously, the effect was quite strong because it was fresh	
34.11	(Interpreter) Now with the passage of time, because he's having treatments and he's trying to keep himself busy. And he's also struck some exercise. So it's not, it hasn't disappeared, or it's not gone completely. It's still there and it's still concerned, but it's not so intense like before	Keeping busy helps, exercise helps
34.11	(Interpreter) He's not able to like mix up in his own community because people are quite busy with their own lives, but still they do not mix with people like them. So all in all they can do is to go to the mosque and meet a couple of people there. Or go to the places like meeting point or some other like places where people can. These people can meet each other and have some time together. So it's also one of the factors that people like in the normal community do not mix with them	Normal community do not want to mix with him. Religious community exclude him
36.07	So, it's not very easy to even mix up with asylum seekers and refugees because everybody is so scared that they don't want to share a lot of information with any other person. So everybody is sort of like, like, restricted to himself. So even with asylum seekers, you will hardly be able to mix up with one or two people no more than that	Strong feeling of fear in refuge and asylum community
38.08	(Interpreter) So answer is yes. Because he thinks maybe because when I was in a normal situation, normal circumstances, maybe I was more stronger at that time. Now after suffering obviously it's not the same level of strength anymore	Stronger in home country Impact of cultural belonging
38.58	(Interpreter) I'm wondering if it feels quite hard to trust people? Yes	Lack of trust
39.35	Everybody connected	Hard to trust cultural and religious community as everyone is connected

(Continues)

(Continued)

Time	Quote/reflection	Code/label
42.23	So I thank my God every night I go to bed, and I thank my God because I feel that I'm much better than many people out there. And when I think about my daughter, I thank my god, so all my connection with my god is quite strong	Importance of religion in everyday life.
43.48	So it's it's okay. In the sense because I'm still in contact with my family. It was very strong when my father was alive, but he has passed away now. My mom is there she is old and she's ill, but I still try to keep contact with her. I have very less contact with my brothers because everyone is so busy in their own life. So and plus I have been in this country for 16 years now. So I have developed my own life here	Importance of connection with family
45.21	So things keep changing in life, nothing stays the same. So I had a time when I used to doubt myself that I'm going to stay alive that I was so much in a tense situation	Transient lifestyle
45.21	But now with the because I've been blessed with this blessing in my life which is my daughter. So it gives me hope it gives me like it keeps me alive and because now my priority is to spend time with her to do the best for her to provide everything for her which I can so now she's my my like my reason to keep going	Blessing of children
48.21	(Interpreter) (On seeing birthday cards) Because it gives him the nice feeling that people love him and people care for him	Love
49.18	She she's really lovely. She combs every, she combs my hair and I think that this is the best relationship in the world	Importance of connection family
49.57	Sometimes when the circumstances were like very intense or trying sometimes people do think like harm themselves or suicidal thoughts come, but I don't think about this because I have her in my life and now	Suicidal

(Continues)

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Time	Quote/reflection	Code/label
	everything is on one side. My priority is just my daughter	
52.35	Stress anxiety depression, occasionally quite bad but then he started meeting other people and volunteers help them a lot	Stress
53.32	(Of shoulders) Stiff, stiffness	Stiffness in shoulders
53.59	Distress in his stomach	Distress in stomach
54.24	Ok so I cannot understand it properly but there is some issue with my stomach	Stomach issues
54.26	So it could be stress related. It could be hernia related or it could be food related. I don't know. But there is some issue with them stomach	Stomach issues
54.50	(Interpreter) He has diabetes and joints pain now as well	Joint pain
55.53	(On choosing brown) I'm using a color with my color	Brown for skin color
57.05	Stress, what other people have been through is stress	Stress
57.38	(Interpreter) Ok so he says when I am coloring with my daughter she likes pink and purple	Colors remind him of daughter (pink purple)
58.45	(Interpreter) So he says head is the most important one because it takes effect because of the stress and when head is affected it affects the body	Head is affected by stress
58.45	A couple of people who ask me and I advise them to start gym because it affected me in a good sense. So it might work for them. So because when people exercise it release some sort of hormones or something which affects the brain and you feel better	Exercise helps
1.00.12	(Interpreter) So he's just trying to explain that I tried to help by providing awareness to the people. Because sometimes people are like avoiding things like when I had my corona vaccine, I used to go people meet people in meeting points and I was telling them that go to the center in church. There is a vaccine nurse coming there you can have your vaccine easy	Impact of COVID

(Continues)

(Continued)

Time	Quote/reflection	Code/label
	there. But people are scared that if we do a vaccine, we'll have a blood clot and we'll die and I used to try to convince them that no I'm here in front of you	
1.00.49	But people choose not to do it because they think that we will die	Impact of COVID
1.03.20	It's, if you have you know what happened I think this this or related sometime we are related in this this word because I think it's related for our community	Feeling connected/related to refugee/asylum community because of what's happened
1.03.32	I go to you know for community so they will ask me a question and it needs not ask a lot of question but he will think about if I'm belong to the Pakistan. But there is families or something like that. Like that time I will not talk too much because of my family, because I have some you know difficult circumstances or this in my personal so I not cheer for everybody	People questioning where he's from
1.03.32	But I think maybe I'm dead, listen maybe I don't know why but sometimes I feel it's people avoid me	Feeling dead
1.04.32	They don't listen to me. So they don't want to you know sir, same like me to communicate. Hello Hi. So I think they don't try to close me they avoid me	Not feeling listened to
1.04.46	I not feel good. Because I feel I'm I'm that's how I feel I'm lonely. Not all people sometimes a little bit tough, but most of people I feel I'm lonely because of people who have I feel they have ...	Feeling lonely
1.05.10	Yes a wall up. They have not it's not risky, and share my, I not ask for their personal, or not asked for too much person, but I think about that, not I think because I feel, after feeling I think about they put up the wall because you don't want to close me	Others don't want to get close to me (put wall up)
1.05.33	I don't know is I think he's a problem for the heart, mental or something like that, or maybe cultural, I	Feeling judged

(Continues)

(Continued)

Time	Quote/reflection	Code/label
	don't feel I am not is maybe equal to them	
1.05.52	Yeah, yes because they think about me is this man, they don't have car, what happened because our family didn't know they don't know where they living, he come to the mosque but ignored	Feeling judged (no car, family)
1.06.30	If I think about that one thing because also [Charity anonymized] guy he told me because if he if you go to the one one word you think about that, but he starts talking about that you're going to be very deep and dig and dig and dig you don't try this you try to stop	Over think and ruminating
1.06.54	Every day because of single you know a lot of challenges, circumstance, by my circumstances because I need some money because I take my daughter to outside so I have no source agenda. So I do a lot of things to my daughter, but I can't because I can't buy things	Poverty or destitution
1.08.42	I'm not you know I'm I'm very lucky because a lot of people have support me or also my my daughter she loves me and I love my daughter	Love
1.08.54	I thanks to the God or also lot of, because is that experience because I also have you know before I homeless and I have a lot of seemed like a district your life is not easy. I spend time with my daughter I'm that time and destitute. So a lot of challenges	Thanking God
1.08.54	So I also have a lot of difficulties is still to, to sort out, but I think it's sometimes I feel upset because you know, also is very difficult to managing	Difficulties of everyday life
1.08.54	But I'm still hoping so I tried to enter some time very frustrated because you have no money nothing we take to my daughter if she asked me Daddy, I want ice cream. I seem like this is a little irritating, what do you have	Difficulties of everyday life

(Continues)

(Continued)

Time	Quote/reflection	Code/label
	after we feel you know, because we can't go there, you know, because of you know these things. So it's not easy to live at the moment. So I have a different, especially what I most of think about my daughter	
1.08.54	But I'm, I'm happy with it, I know I'm struggling, but I try to manage to is my good thing now, if I feel a lot of pressure, so I'm going to the people to ask for the thing. And good thing. After that I can receive conversation and communicate to the people. So most of my depression or stress is released	Difficulties of everyday life
1.11.05	I'm now you know, I'm very weak	Feeling weak
1.11.05	So I think, I think is before I'm very scared about that for anxiety, anxiety is not easy, is a very dangerous, it's dangerous means it's not good for health is a very complicated thing. You know, I don't know why because longtime clients suffer. So, I do a lot of things to you know, for a lot of people involved I go to the exercises, I managed to go to outside	Anxiety
1.11.05	So, I invest specially I go to out every night walk for 40 min	Anxiety
1.11.05	So also I am happy with that with my daughter	Children bring happiness
1.11.05	At the moment I have something you know child arrangements Order in the court. So I have a lot of stress about this	Stress
1.11.05	I think sometime I think you know for try to another people is not just for me, it's for another people, every people have same problems is not easy processes, very difficult for everybody	Being treated differently to others
1.13.49	Thinking is very strong because of my condition	Overthinking and ruminating
1.13.49	But I'm very positive, you know, especially for my daughter	Children as a protective factor
1.13.49	So I'm also I'm happy with that because a lot of people	Happy

(Continues)

(Continued)

Time	Quote/reflection	Code/label
	involved me what my mental health also in physical health	
1.14.44	We have some what we have ongoing, I have a lot of pressure for the ongoings. If the if I'm talking to the another person, I feel more relaxed	Feeling more relaxed after the research

Appendix B: Person-centered formulation worksheet.

MY STORY, IDENTITY & CONTEXT	WHAT IS HURTING /WHY HAVE I COME TO THERAPY RIGHT NOW?	EXPERIENCES THAT HAVE SHAPED OR IMPACTED ME
e.g. Story of Who I Am • Culture • Language • Faith • Family • Community • Where I Belong • Who I am Being and Becoming	e.g. Needs • Challenges • Thoughts • Feelings • Body Experiences • Relationships • Daily Life • Spiritual Life	e.g. Trauma • Loss • Adversity • Discrimination • Critical Incidents • Relational or Emotional Difficulties

CONDITIONS OF WORTH	INTROJECTED VALUES, BELIEFS, POWER	INCONGRUENCE	DISTRESS OR MALADJUSTMENT
What did I learn from childhood that I needed to be or to do in order to be accepted, loved or to feel safe?	What messages from others have I taken inside myself? How do I experience power?	Who I am: Who I feel I should be: Gap:	What am I feeling, what am I experiencing and how is this affecting my holistic wellbeing, relationships, body and life?

STRENGTHS, WAYS OF COPING	MEANING & NARRATIVE	HOPE, GROWTH, EXPERIENCES OF LOVE & CONNECTION
e.g. Strengths • Values • Relationships • Spirituality • Community • Hope • Resources	How do I understand my story? What meaning does this experience hold?	What would healing, congruence, belonging love, connection and growth look like?

COLLABORATIVE UNDERSTANDING
Distress may be connected to experiences of trauma, conditions of worth, identity, culture, relationships, oppression, loss, uncertainty and life circumstances. What challenges and strengths have we recognized? What experiences need to be given voice and narrative? This formulation remains tentative, collaborative and open to reflexive revision. **Review Question:** Does this formulation feel accurate, culturally meaningful, respectful and hopeful?