

The Crisis of Representation
in the Refugee Resettlement Sector in New Zealand

Marieke Jasperse

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Abstract

Resettlement practitioners are powerful advocates for resettling individuals but are often accused of relying on representational practices that promote inaccurate assumptions of psychopathology. The preoccupation with post-traumatic stress disorder and vicarious traumatisation that characterises such representations can result in resettling communities being subjected to two levels of stigmatisation within society. They are thereby simultaneously at risk and a risk in their new society of settlement and their resilience and opportunities for vicarious resilience in the sector are potentially silenced.

Informed by the transformative paradigm, this thesis recognises that positivist psychological research reinforcing assumptions of psychopathology has historically been promoted throughout the resettlement sector. The transformation anticipated in this research was to raise awareness of the range of responses to trauma and trauma work by sharing critical reflections from resettlement practitioners, obtained through socially constructed semi-structured interviews, together with recently published positivist psychiatric research. This approach to research was chosen to explore identified concerns of local resettling communities and challenge practitioners to reconsider how they represent resettling individuals and resettlement work.

The primary aim of this research was to explore how psychopathological representations are resisted and/or reproduced by practitioners working within the resettlement sector in Wellington, New Zealand. A total of 25 interviews with a cross section of resettlement practitioners (psychiatrists, psychologists, social workers, interpreters and volunteers) were conducted. Six interconnected themes were identified; “They’re people”, “This is not paradise”, “Psychotherapy”, “Pretty damaged people”, “Oh, those poor people” and “People have no idea”. The first three themes resisted the three assumptions of

psychopathology which imply that the vast majority of resettling individuals suffer from PTSD, caused by their pre-displacement trauma, and require specialist psychological intervention. The remaining three themes corresponded with the implications of these assumptions, such as, promoting the 'at risk' status of resettling individuals and resettlement practitioners and reliance on the assumptions of psychopathology in advocacy. The conclusion of the analysis was that practitioners are potentially caught in a crisis of representation. Central to this crisis is the way in which resettling communities' psychological wellbeing was represented and the assumptions made about the type of assistance they should receive. Subsequently, practitioners felt compelled to continue to rely on psychopathological representations of resettling communities and resettlement work, in order to obtain recognition and resources for the services they provided. Importantly, in some cases, they continued to do this, knowing that these representations did not accurately reflect the resilience of resettling communities or the realities of supporting them to settle in New Zealand. In addition, they acknowledged that such representations could compromise successful settlement outcomes by perpetuating stigma, societal prejudice and service provision that reinforces passive styles of resettlement. Such critical reflections corroborate the concerns of representatives of resettling communities as well as clinical research published during the course of this research.

The secondary aim of this thesis was to raise awareness of the assumptions of psychopathology that resettlement practitioners tend to rely on and to promote the resilience of resettling communities and realities of supporting them to successfully settle in New Zealand. My approach to sharing my research resulted in a constructive collaboration with the New Zealand Red Cross. As part of this collaboration, I conducted a regional training tour that enabled me to sensitise approximately 500 practitioners to the assumptions of psychopathology being promoted in the resettlement sector and encourage them to critically

reflect on the ways in which they represent their work and resettling clients. While the research resonated with most practitioners across the country, a critical incident with one specialist mental health service, revealed contrasting perspectives consistent with the crisis of representation I had conceptualised. It also highlighted the significance of the relational context in the reception of critical research.

In light of the pervasiveness of the assumptions of psychopathology that inform service provision and pragmatism required of practitioners, the recommendation from this research is that practitioners receive ongoing professional development in order to be as critically reflexive and culturally responsive as they are required to be by their professional associations. This research also recommends future participatory research initiatives in collaboration with local resettling communities to identify alternative interventions that acknowledge their resilience and respond to their priorities for resettlement and recovery.

The first contribution of this research has been to identify and illustrate the implications of the crisis of representation within the New Zealand resettlement context during the period 2014 - 2018. The second contribution of this research has been to go beyond simply recommending initiatives to increase critical reflexivity and to actually create opportunities to do so throughout the sector. The third contribution of this research has been to conduct reciprocal research informed by the transformational paradigm – a first in the Department of Psychological Medicine at the University of Otago, Wellington.

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Thesis outputs

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Chapter 1

Introduction

“Issues of representation are central to the alleviation of suffering and critical to efforts refugees make to improve their lives. Those seeking protection and assistance continuously rely on lawyers, case workers, interpreters, aid workers, governmental and non-governmental organizations and campaigning groups to represent them [...] In forced migration research, it is acknowledged that the interests of refugees may not be represented by the primarily middle-class, elite, and often white European research community, and that the claims of different groups may themselves compete.”

(Dona, 2007, p. 220)

This thesis critiques the psychopathological response to the refugee crisis and subsequent ‘crisis of representation’ in the refugee resettlement sector. The starting point for this thesis is recognising that while resettlement practitioners are powerful advocates for resettling communities, they are often accused of perpetuating the stigmatised status of resettling communities as they attempt to acquire recognition and resources for the services they provide. Practitioners’ reliance on psychopathological representations, characterised by a preoccupation with pre-displacement trauma, post-traumatic stress disorder (PTSD) and specialist psychological intervention, attracts sympathy and support in the short term. However, such psychopathological representations also risk sabotaging successful settlement by silencing resettling communities’ priorities for resettlement and recovery (Colic-Peisker & Tilbury 2003; Harrel-Bond, 2002; Miller & Rasmussen, 2017; Pupavac, 2002; Watters, 2001).

Despite the preoccupation with psychopathology observed in psychological resettlement research (Miller et al., 2006; Patel, 2003; Summerfield, 1999), psychiatric epidemiological research has revealed that the majority of resettling individuals do not actually develop PTSD (Blackmore et al., 2020; Charlson et al., 2019; Henkelmann et al., 2020; Turrini et al., 2017). The absence of PTSD in most resettling individuals means that the assumptions of psychopathology and associated representations often reproduced by resettlement agencies are inaccurate. In light of these concerns from scholars, resettling communities and corresponding clinical research, the aims of this thesis are to explore how these representations are reproduced and/or resisted by practitioners in Wellington, New Zealand and to raise awareness of the potentially problematic psychopathological representations perpetuated by practitioners in the resettlement sector.

The ‘refugee crisis’

The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as:

“a person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his [sic] nationality and is unable or, owing to such fear, is unwilling to avail himself [sic] of the protection of that country; or who, not having a nationality and being outside the country of his [sic] former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.”

(UNHCR, 1979, p. 29).

At the time of initiating this research there were approximately 19.5 million refugees registered with the UNHCR. However, the total number of people forcibly displaced worldwide, as a result of conflict, generalised violence and gross human rights violations, including those that were internally displaced people (individuals who have yet to cross a

border) and asylum seekers (individuals who arrive independently to a new country and apply for asylum), was 59.5 million (UNHCR, 2015). Over the course of this research this number rose to 79.5 million individuals. Such an unprecedented level of displacement is commonly referred to as the “refugee crisis”¹ (Chouliaraki & Stolic, 2017; Silove et al, 2017; UNHCR, 2020).

The UNHCR was established in 1951 after the Second World War and is responsible for providing international refugee protection and seeking permanent solutions to refugee issues (Goodwin-Gill, 2014). The UNHCR can implement three different strategies to achieve this: local integration, voluntary repatriation and resettlement to a third country. Of these, resettlement is the only durable solution, given local integration and voluntary repatriation is often not possible in protracted politically unstable situations (UNHCR, 2000). Less than one percent of the world’s refugees get the opportunity to resettle in a third country, with the majority of refugees continuing to live in challenging situations in neighbouring countries (UNHCR, 2020).

The psychopathological response to the refugee crisis

The UNHCR and other humanitarian agencies responsible for refugees have been criticised for perpetuating “crisis-imposed identities of powerlessness” (Zetter, 1991, p. 60) and assumptions of psychopathology that imply all refugees develop PTSD, from their pre-displacement trauma, and require specialist psychological support (Pupavac, 2002; Summerfield, 1999; Watters, 2001). These assumptions are reflected in media responses to

¹ References to such a “*crisis*” are a contentious issue with scholars such as Chouliaraki and Zaborowski (2017) who criticise the Eurocentrism informing it. References to the “*refugee crisis*” are primarily used by Western media to sensationalise the arrival of people seeking asylum in Western countries and such media coverage often ignores the systemic issues that force people to flee in the first place (See also Franquet Dos Santos Silva, Brurås, & Beriain bañares, 2018).

the refugee crisis (Article 19; Chouliaraki & Stolic, 2017; Ongenaert & Joye 2019; Slade, 2019). Headlines such as: “Refugees go from fleeing war to fighting PTSD” (Brenner, 2016), are not uncommon and perpetuate pervasive assumptions of psychopathology associated with becoming a refugee.

The primary psychopathology associated with refugees and resettling individuals is PTSD (Miller et al., 2006; Silove et al, 2017; Summerfield, 1999). PTSD is characterised by a number of symptoms in response to a traumatic event that causes clinically significant impairment. The DSM-5 definition of a traumatic event requires exposure to actual or threatened death, serious injury and/or sexual violence. Symptoms include re-experiencing the traumatic event, avoidance of things associated with the traumatic event, negative alterations to mood, and increased arousal. The symptoms must last for at least one month and cannot be attributed to substance abuse or medical illness (American Psychological Association, 2013). For a complete list of DSM-5 criteria for PTSD see Appendix A.

The diagnostic criteria for PTSD were first published in 1980 in the third edition of The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (Young, 1995). Young has argued that the creation of this psychiatric diagnosis was a sociopolitical response to veterans returning from the Vietnam War suffering from psychological distress whilst being subjected to severe public scrutiny. A diagnosis of PTSD was viewed as providing recognition of the psychological effects of the atrocities the veterans had executed on behalf of the US military and enabled the veterans to access resources previously unavailable to them (Summerfield, 1999; Young, 1995).

As the diagnosis of PTSD gained popularity and started to be applied to survivors of other potentially traumatic events such as child abuse, rape, and other crimes (Miller et al., 2006). It was also applied to the influx of South East Asian refugees fleeing the Vietnam War

and genocide in Cambodia (Miller et al., 2006). It has since become the primary psychopathology associated with refugees and resettling individuals and psychological research is dominated by studies identifying the prevalence of PTSD in these populations (Miller et al., 2006; Silove et al, 2017; Summerfield, 1999).

Some scholars have, however, raised significant concerns regarding the popularity of PTSD and imposition of such diagnoses across cultures (Muecke, 1992; Miller et al. 2006; Patel, 2003; Pupavac, 2008; Summerfield, 1999; Watters, 2001). Psychiatrists, such as Derek Summerfield (1999), have gone so far as to suggest that PTSD is a “pseudo-condition” (p. 1449). Other psychiatrists are not quite so critical but raise concerns over the imposition of interventions developed in Western clinical contexts, particularly when refugees and resettling individuals continue to experience potentially traumatic or highly stressful situations in their society of settlement (Nickerson et al., 2011; Miller et al. 2006; Patel, 2003). While the process of displacement is defined by persecution and characterised by exposure to violence, human rights violations, and extreme living conditions, the assumption that PTSD (or any psychological distress) originates exclusively from these experiences is problematic.

Such an assumption fails to acknowledge the significance of on-going stressors in one’s immediate environment. These stressors can include, but are not restricted to, insecurity, social isolation, poverty, perceived discrimination, issues acculturating and intimate partner violence (Chu et al., 2013; Li et al., 2016; Miller & Rasmussen, 2010; Nickerson et al., 2011; Schweitzer et al., 2011; Steel et al., 2011; Vaage et al., 2010). Scholars have encouraged psychological practitioners and researchers to distinguish between pre-displacement and post-displacement experiences and to consider psycho-social focused interventions that move beyond the specialist psychological interventions popularised in the West. Such interventions incorporate a range of approaches such as resettlement assistance

and advocacy, which provide necessary practical and social support, in addition to access to pharmacotherapy and psychotherapy (Nickerson et al., 2011).

Pharmacotherapy refers to the use of pharmaceutical drugs to treat psychological distress. Selective serotonin reuptake inhibitors (SSRIs) or selective serotonin and norepinephrine reuptake inhibitors (SNRIs) are often prescribed for PTSD to reduce the psychological and physiological effects of prolonged distress (National Institute for Clinical Excellence, 2005). It takes six to eight weeks for individuals to respond to SSRIs and SNRIs and this response must be monitored by a psychiatrist and/or general practitioner. Pharmacotherapy is often prescribed in combination with psychotherapy.

Psychotherapy, commonly known as ‘talk therapy’, refers to a range of treatments that involve discussing psychological distress with a psychiatrist, psychologist, or other sufficiently qualified mental health professionals. Cognitive behavioural therapy is the primary psychotherapy recommended for PTSD (American Psychological Association, 2017). It promotes stress management, mindfulness, and strategies to challenge and change inaccurate and intrusive thoughts about the trauma, as well as behavioural strategies to overcome avoidance of stimuli and/or situations associated with the trauma (National Institute for Clinical Excellence, 2005). Cognitive behavioural therapy is the primary psychotherapy recommended for refugee and resettling clients (Nickerson et al., 2011; Silove et al., 2017).

Clinicians critical of the imposition of psychological diagnoses and intervention on resettling populations maintain that access to specialist psychological support should be available to those who desire it. However, observations from their own practice have indicated that ongoing psychological procedures that support individuals in processing the painful memories associated with their pre-displacement trauma are often not a priority for resettling communities (Miller et al. 2006; Patel, 2003; Pupavac, 2008; Summerfield, 1999).

Such interventions have also been reported to be perceived by resettling clients as “individualistic”, “self-indulgent”, and “shame-inducing” (Patel, 2003, p. 29), prompting a number of clinicians to reflect on the “spirit of humility” required when considering what they can offer resettling clients (Bracken et al., 1997, p. 441). Throughout this thesis, references to “specialist psychological support” refer primarily to psychotherapy that attends to pre-displacement trauma.

Whilst this research aims to contest the representational practices associated with the psychopathological response to the refugee crisis, it is important to acknowledge that this research does not dismiss the genuine distress experienced by resettling individuals. This research is designed to respond to local resettling communities’ concerns regarding how their distress is represented, and responded to, by raising awareness of the representational practices that resettlement agencies and practitioners rely on. These practices promote the assumption that the majority, if not all, resettling individuals suffer from PTSD, from their pre-displacement trauma, and require, desire and respond to specialist psychological support. Challenging such assumptions of psychopathology is important not just because they compound the stigmatised status of resettling individuals, but also because they are inaccurate. Psychological research available at the time of initiating this research (Fazel et al., 2005; Steel et al., 2009), and published during my PhD candidature (Blackmore et al., 2020; Charlson et al., 2019; Henkelmann et al., 2020; Turrini et al., 2017), has consistently indicated that the majority of resettling individuals do not develop PTSD or any other psychopathology.

For instance, a systematic review and meta-analysis published just prior to submitting this PhD reported that the prevalence of post-traumatic stress disorder, depression, and/or anxiety was 22% at any point in time in the conflict-affected populations assessed (Charlson et al., 2019). Furthermore, the analysis differentiated between mild, moderate and severe

forms of psychopathology and identified that approximately 9% of conflict-affected populations suffer from moderate to severe psychopathologies that require clinical intervention. This is significantly less than previously published studies citing prevalence rates of PTSD as high as 99% in communities exposed to conflict (de Jong et al., 2000).

Whilst prevalence rates of psychopathology (particularly PTSD, depression and anxiety) identified in resettling communities vary significantly across studies, it is important to acknowledge that resettling individuals are significantly more likely to suffer from PTSD than other populations (Charlson et al., 2019; Henkelmann et al., 2020; Steel et al., 2009). For instance, the meta-analysis by Charlson et al. (2019) identified that the prevalence of PTSD and depression in post-conflict settings is more than five times higher than the existing global mean burden of disease. This thesis recognises that whilst the majority of resettling individuals do not develop PTSD or any other psychopathology, published prevalence rates still represent a significant number of individuals (potentially millions) who require psychological consideration and care. Furthermore, this thesis maintains that symptoms of psychopathology, such as PTSD, are an understandable (as opposed to pathological) response to abhorrent experiences. A sentiment shared by the psychiatrists (Summerfield, 1999), psychologists (Patel, 2003) and scholars (Watters, 2001) who inspired this PhD research.

The ‘crisis of representation’ in the resettlement sector

Resettling individuals and communities are often reliant on others to represent them. Representation in this instance refers to practitioners speaking on behalf “of” and “for” resettling individuals and communities and scholars have raised concerns that the field of Refugee Studies is subject to a “crisis of representation” (Dona, 2007, p. 221). The concept of a crisis of representation originated in anthropology with Marcus and Fischer (1986) raising concern over the inability of academics, in this case anthropologists, to accurately interpret the social reality of others (Schwandt, 2007). In the context of refugee resettlement, the crisis

of representation refers to the observation that, despite the best of intentions, the interests of those responsible for representing resettling refugees can be in conflict with the interests of resettling individuals and/or communities (Dona, 2007; Harrell-Bond, 2002; Pupavac, 2002; Summerfield, 1999; Watters, 2001). A significant area of conflict is the way in which resettling communities' psychological wellbeing is represented and the assumptions made about the type of assistance they should receive.

Scholars and resettling communities are critical of popular representations reproduced by resettlement agencies and advocates in their attempts to acquire recognition and resources for the services they provide. The reliance on assumptions of psychopathology that these representations have has significant implications for service provision and societal perceptions of resettling communities (Pupavac, 2002; Summerfield, 1999; Watters, 2001). Inappropriate resettlement support, in addition to societal prejudice and stigma, has the potential to sabotage the ability of resettling individuals and/or communities to settle successfully and participate in their new society of settlement.

Refugee resettlement in New Zealand

New Zealand signed the 1951 UN Convention Relating to the Status of Refugees in 1960 (and its 1967 Protocol of Refugee Conventions) and until the late 1980s, New Zealand refugee resettlement was based on an ad hoc quota system without any specific policies or structures in place (Marlowe & Elliott, 2014). This changed in 1987 when the Labour Government established the Immigration Act. This Act set an annual resettlement quota of 800 places, which was decreased to 750 in 1997. The quota remained unchanged until a campaign, "Double the Quota" (Stephens, 2018) was initiated during the course of this research. The advocacy associated with this campaign resulted in an increase to 1000 places in 2018 by the National Government. This quota was set to increase again to 1500 in July

2020 under the current Labour Government (Immigration New Zealand, 2020a). Overall, approximately 50,000 refugees have been resettled in New Zealand since the Second World War from a diverse range of countries across Europe, the Middle East, Africa, Asia and South America (Beaglehole, 2013; Immigration New Zealand, 2020b; Marlowe & Elliot, 2014).

The actual composition of the refugee quota is determined annually by the Ministers of Immigration and Foreign Affairs and Trade, following consultation with the UNHCR and relevant government departments, NGOs and refugee communities in New Zealand (Gray, 2008). In the last five years NZ has accepted refugees from 46 countries, with the majority of refugees originating from Afghanistan, Bhutan, Colombia, Myanmar and Syria (Immigration New Zealand, 2020b).

The settlement guidelines recognise several different categories of refugees. Quota refugees make up the largest numbers and include emergency protection cases (up to 600 places), women at risk (up to 75 places) and medical cases (up to 75 places). The next largest group consists of refugees who are sponsored by family members resident in New Zealand under the family reunification programme (up to 300 places). A much smaller group of refugees consists of convention refugees or asylum seekers, with many more applications than are granted. For instance, in 2018 there were approximately 510 applications for asylum and 153 of these were granted (Immigration New Zealand, 2020b). The UNHCR can also request resettlement of additional refugees under exceptional circumstances in response to humanitarian crises; a recent example of this would be the emergency intake of Syrian refugees that occurred during the course of this research (Immigration New Zealand, 2020a).

Another recent development has been the introduction of a new community sponsorship pilot which provided an opportunity for four churches (Caritas Aotearoa, South

West Baptist Church, Glenniti Baptist Church and Society of Vincent de Paul) to assist a number of families resettle in four regions throughout New Zealand (Wellington, Nelson, Christchurch, and Timaru respectively, Ministry of Business, Innovation & Employment, 2019).

The majority of resettling individuals entering New Zealand spend an initial six weeks at Mangere Reception Centre, in Auckland, where they are provided with an orientation to life in New Zealand. Individual needs assessments are also conducted during this time to evaluate: previous education, past employment experience, housing needs and family groupings, physical and mental health needs, social needs and any other special considerations. After the initial six weeks, individuals or families are sent to one of eight resettlement centers in Auckland, Hamilton, Palmerston North, Wellington, Nelson, Christchurch, Dunedin or Invercargill. Additional resettlement centres are currently being established in Ashburton, Blenheim, Levin, Masterton, Timaru and Whanganui (Immigration New Zealand, 2020a).

The primary agency responsible for assisting resettling individuals in New Zealand is the New Zealand Red Cross. The New Zealand Red Cross is funded by the New Zealand government to provide initial settlement support for 12 months. Churches throughout New Zealand had historically been responsible for providing initial settlement support (Binzegger, 1980). In 1990 the Inter-Church Commission on Immigration and Refugee Resettlement became an incorporated society: The Refugee and Migrant Service Aotearoa New Zealand (Beaglehole, 2013; Department of Labour, 2011). This service was renamed Refugee Services Aotearoa New Zealand in 2008 before becoming a programme within the New Zealand Red Cross in 2012 (New Zealand Red Cross, 2020).

The New Zealand Red Cross provides a “Pathways to Settlement” programme that provides settlement support from social workers, case workers, cross cultural workers and trained refugee support volunteers who work closely with other government and non-governmental organisations. Such organisations include social services such as Work and Income and Housing New Zealand and settlement specific services such as Interpreting New Zealand and English Language Partners New Zealand. The agenda of all agencies is to ensure that all resettling individuals receive the assistance they require and are able to settle successfully within New Zealand society as soon as possible. According to New Zealand’s Resettlement Strategy successful settlement is defined as:

“Refugees are participating fully and integrated socially and economically as soon as possible so that they are living independently, undertaking the same responsibilities and exercising the same rights as other New Zealanders and have a strong sense of belonging to their own community and to New Zealand.”

(Immigration New Zealand, 2012, p. 3)

Successful settlement and sense of belonging can be compromised by the context in which individuals are settling and the characteristics of New Zealand society. New Zealand can be considered a diverse society with the latest census identifying that approximately a quarter (27.4%) of New Zealanders were born overseas (Stats NZ, 2018). Despite this, New Zealand is a post-colonial society with the majority of the population originating from Europe (70.2%). Maori are the indigenous people of New Zealand and comprise only 16.5% of the population and individuals of Asian (15.1%), Pacific (8.1%) and Middle Eastern, Latin American and African (combined 1.5%) descent are also in the minority (Stats NZ, 2018). The census also identified that almost half of New Zealanders (48.2%) do not identify with a religion and those that do are likely to identify as Christian (Stats NZ, 2018). Individuals who

follow other religions such as Islam are therefore also in the minority in New Zealand society. Whilst politicians, the press and public awareness campaigns regularly express pride in such diversity (Spoonley & Butcher, 2009), research indicates that racial and religious prejudice is prevalent in New Zealand society and individuals identifying as a racial and/or religious minority regularly report experiences of discrimination (Human Rights Commission, 2013). At the time of initiating this PhD research the New Zealand General Social Survey (2014) identified that one in ten New Zealanders had experienced some form of discrimination. Experiences of discrimination are also reported by individuals resettling in New Zealand. This is not surprising as many resettling individuals are of a racial and religious minority in New Zealand (Beaglehole, 2013; Butcher, Spoonley & Trlin, 2006; Marlowe et al., 2014).

Instances of discrimination against resettling individuals are often attributed to prejudice informed by international and national media coverage that constructs refugees as a threat to their new society of settlement (Slade, 2019; Spoonley & Butcher, 2009; van Dijk, 2000). Perceptions of threat can range from threatening the Western 'ways of life' to an increased risk of terrorism and are often referred to as unsympathetic representations (Slade, 2019). Sympathetic representations of resettling individuals on the other hand can sometimes construct these individuals as powerless victims of war and persecution and likely suffering some form of psychopathology.

Whilst media coverage in New Zealand is significantly more sympathetic than other resettlement countries such as Australia (Slade, 2019; Sulaiman-Hill et al., 2011; Spoonley & Butcher, 2009), studies have identified the tendency of the New Zealand media to promote New Zealand as progressive whilst relying on overwhelming statistics and "the trauma story" to prompt sympathy and solidarity in an increasingly cautious and cynical society

(Greenbank, 2014; Slade, 2019). For instance, the following headlines were characteristic of the New Zealand media coverage of the “Syrian crisis” in 2015: “New Zealand has pledged to take Syrian refugees but we could be doing more” (nzherald.co.nz, Sep 15, 2015, Slade, 2019, p. 136) and “The Forgotten Millions: Syrian kids find peace at last after the horrors of war” (nzherald.co.nz, Sep 8, 2015, Slade, 2019, p. 129).

At this stage it is important to acknowledge that such sympathetic representations are not as problematic as unsympathetic representations; however this thesis maintains representations that rely on assumptions of psychopathology disregard the societal context that so often compromises successful settlement. Sympathetic representations also influence sanctioned responses to supporting resettling individuals suffering significant distress.

Specialist psychological services for resettling individuals in New Zealand

In 1989, shortly after the Immigration Act and inception of the annual quota, New Zealand hosted its First Refugee Mental Health Conference. At this time, practitioners questioned the capacity of local health services to provide culturally responsive care and adequate settlement support to resettling communities in New Zealand (Abbott, 1989). Practitioners at this conference were particularly concerned about the psychological wellbeing of resettling individuals and importance of specialist services that understood the complexities of resettlement.

Refugees as Survivors New Zealand was the first specialist mental health service established in New Zealand for resettling refugees in Auckland in 1995. It was set up as a non-denominational, politically-neutral, not-for-profit charitable trust and was funded by the Ministry of Health, philanthropic organisations and donations from the community (Refugees as Survivors New Zealand, 2018). It was situated at the Mangere Reception Centre and its staff of psychiatrists, psychologists and psychotherapists worked closely with interpreters to

conduct the initial psychological screening, assessment and treatment of resettling individuals entering New Zealand under the annual quota system.

Two years later a similar specialist service was established in Wellington, Wellington Refugees as Survivors Trust, to provide specialist support for resettling individuals in the Wellington region. This service was renamed Refugee Trauma Recovery in 2012 and became a programme within New Zealand Red Cross during the course of this research (Scoop, 2017).

Over time, both specialist services have incorporated multidisciplinary support from physical therapists, social workers and cross-cultural workers and providing professional development to other practitioners wanting to work more effectively with resettling clients experiencing psychological distress (Refugees as Survivors New Zealand, 2018; Refugee Trauma Recovery, 2018).

Impetus for this research

The impetus for this research came from my own experiences supporting resettling individuals in Wellington, as a refugee support volunteer with the New Zealand Red Cross (2006 - 2010), whilst I completed an MSc in Cross-Cultural Psychology (2008 - 2009) and worked for ChangeMakers Refugee Forum, a rights-based refugee-led NGO representing local resettling communities in Wellington (2010 - 2012). During the course of my studies, I became increasingly interested in the psychological resettlement research I was reviewing, particularly what appeared to be a preoccupation with pre-displacement trauma, prevalence rates of PTSD and persistent endorsement of specialist psychological intervention. This research and the associated assumptions of trauma did not align at all with my own observations of the sector. I had been supporting individuals and families from Africa, the Middle East and South East Asia settle in Wellington for eight years and had witnessed with

admiration how they approached the challenges of resettlement with dignity and determination. I had also developed an appreciation for how distressing and disempowering the process of resettlement could be. I became increasingly concerned that the ‘at risk’ representations of resettling communities, in research and the resettlement sector, failed to acknowledge their resilience and the challenges associated with creating a new life in a foreign country and culture.

My postgraduate study in cross-cultural psychology had sensitised me to some of the limitations of positivist psychological research, such as the methodological issues associated with documenting the prevalence of Western psychological diagnoses in culturally diverse contexts and the ability of such research to inform appropriate interventions. For instance, for my MSc in cross-cultural psychology I conducted a nationwide survey and subsequent statistical analysis to identify the psychological impact of Islamophobia on Muslim women in New Zealand (Jasperse et al., 2012). In hindsight, the research was informed by a preoccupation with psychopathology and assumptions around the association between experiences of Islamophobia and indices of depression and anxiety. Whilst it was important to document and draw attention to women’s experiences of Islamophobia and the negative impact of such discrimination, there was little scope to acknowledge the women’s resilience or what they would recommend in terms of interventions to reduce Islamophobia in New Zealand. My MSc also sensitised me to how susceptible conclusions of such research could be in terms of the characteristics of participants sampled and the instruments and statistical techniques utilised. In the context of this research, this was particularly relevant when critically reviewing research reporting prevalence rates of PTSD from small clinical samples that rely on self-report symptom checklists (Fazel et al., 2005).

This concern intensified when I began to work with ChangeMakers Refugee Forum in 2010 and became aware of rights-based approaches to resettlement and local resettling communities' concerns over how they were being represented. ChangeMakers Refugee Forum was established in response to resettling communities' desires to no longer be passive recipients of resettlement policies. ChangeMakers Refugee Forum's motto is "nothing about us without us" (2008) and reflects resettling communities' resentment over government agencies and NGOs addressing their concerns without adequate consultation. A consistent criticism to come from communities was the way in which they felt they were positioned within representations that prompted pity, assumptions of powerlessness, and policies that failed to address their priorities for resettlement. Working closely with ChangeMakers Refugee Forum sensitised me to the power dynamics within the sector and discontent from communities regarding New Zealand's resettlement policies, practices and perceived prejudices.

It was at this time that I became aware of a systematic review, published in *The Lancet*, that addressed the methodological issues associated with psychological research reporting prevalence rates of PTSD in resettling populations (Fazel et al., 2005). In their review the authors acknowledged that the majority of psychological studies reporting prevalence rates of PTSD were based on small clinical samples and once they controlled for this in their analysis, the overall prevalence of PTSD, recorded as high as 99% in some studies (de Jong et al., 2000), dropped down to 9%. I was astounded by this finding and on further investigation found that prevalence rates from psychological screening conducted at Mangere Refugee Reception Centre, published in the same year, indicated that only 7% of resettling individuals entering New Zealand met the diagnostic criteria for PTSD (McLeod & Reeve, 2005). These two publications captured the remarkable resilience of resettling

communities and challenged the assumptions of psychopathology and associated representations, circulating in the sector. I was intrigued by this discrepancy and interested in researching alternative representations of resettling individuals and communities in New Zealand.

In addition to the assumptions of psychopathology applied to resettling communities, I became increasingly critical of the assumptions of risk associated with resettlement work. The psychological research I had reviewed, and resettlement training I had received, had a tendency to focus on the risks for resettlement practitioners of becoming vicariously traumatised. Again, this preoccupation with psychopathology did not align with my own experiences of assisting families settling in Wellington. I found the work incredibly rewarding and was constantly inspired by the people I was supporting. It was also rare for individuals to display distress or disclose the details of their pre-displacement trauma(s). I was concerned that these assumptions of risk not only pathologised resettling communities but suggested they were a risk to those supporting them. I was therefore interested in researching alternative representations of resettlement work in New Zealand.

My time at ChangeMakers Refugee Forum also drew my attention to the reluctance of local resettling individuals to participate in resettlement research. Many people had concerns about the conduct of researchers and reported numerous unethical and exploitative encounters. These concerns prompted my colleagues at ChangeMakers Refugee Forum to publish guidelines encouraging researchers to reflect on their anticipated approach and accountability to resettling communities (ChangeMakers Refugee Forum, 2009). Aware of these concerns and guidelines I decided to conduct research that did not rely on the perspectives of resettling individuals; particularly, the perspectives of individuals suffering from PTSD and/or seeking specialist psychological intervention. While I recognised the need

for psychological research that acknowledges resettling individuals' responses to trauma and priorities for recovery, obtaining a PhD from this process felt inappropriate to me. It also risked being experienced as just as unethical and exploitative as other research by potential participants. I therefore chose to use my research to raise awareness of the responsibility resettlement practitioners have for representing resettling communities and their role in perpetuating assumptions of psychopathology. For instance, at the time of initiating this research the website of the specialist mental health service supporting resettling individuals in Wellington was reproducing the assumptions of psychopathology I was becoming increasingly critical of (see Figure 1).

Figure 1

Screenshot of the Refugee Trauma Recovery website at the time of initiating this research, 2014. Reproduced with permission (See Appendix B).

Please help one former refugee who has experienced torture and trauma, to settle successfully in New Zealand

None of us can help everyone whose life has been shattered by war, torture, trauma or rape as a weapon of war.

But, imagine how one former refugee will feel, knowing someone as caring as you reached out when they needed you most.

Can you see their face as they realise someone does care?

Click here to make your kind donation

Now living in New Zealand

Post traumatic stress after witnessing the horrific murder of his family

Getty iStock image to preserve client confidentiality

In an apparent attempt to prompt pity and donations from the public, the homepage of the website provided alternating profiles of hypothetical clients suffering from PTSD from their pre-displacement trauma, using phrases such as: “Now in New Zealand: Post traumatic stress after witnessing the horrific murder of his family” and “Suicidal thoughts after unspeakable trauma”. Whilst elsewhere on the website the assumption that resettling individuals are a risk to those supporting them was also reproduced:

“This work is specialised. It’s hard to provide insights without being too shocking [...] the counselling work is too draining for anyone to do it five days a week. A counsellor can themselves become traumatised from empathic engagement with traumatised clients.”

The way in which the website represented resettling individuals and resettlement work felt disrespectful to me. It failed to acknowledge the individuality, agency and aspirations of resettling individuals I had supported, including those suffering from post-traumatic stress. I was aware that international agencies such as the UNHCR, International Committee of the Red Cross, Médecins Sans Frontières and Oxfam had been accused of reproducing similar psychopathological representations in their attempts to attract recognition and resources in the past and analysis of internal documents indicated that many practitioners in these organisations attempted to resist such representations (Chouliaraki, 2013; Harrel-Bond, 2002; Malkki, 1995; Pupavac, 2002, 2008; Rajaram, 2002; Summerfield, 1999; Walkup, 1997).

Consequently, I wanted to know whether or not practitioners working for this specialist mental health service, and other local resettlement agencies in Wellington, were aware of and resisting such assumptions of psychopathology. I was interested in capturing any alternative accounts aligning with the resilience of resettling communities and the realities I had observed of supporting them settle in New Zealand. These positive accounts

could then be used to raise awareness of the issues of representation in the sector and challenge common misconceptions of resettling individuals and resettlement work.

The primary aim of this research was therefore to explore how psychopathological representations are resisted and/or reproduced by practitioners working within the resettlement sector in Wellington, New Zealand. The secondary aim of this research was to conduct reciprocal research that raises awareness of the assumptions of psychopathology resettlement practitioners tend to rely on and to promote the resilience of resettling communities and realities of supporting them settle in New Zealand.

Such a research agenda aligns with the transformative paradigm. The transformative paradigm acknowledges the politics of knowledge production and maintains that the pursuit of knowledge should help people improve society (Mertens, 1999). The transformative paradigm doesn't prescribe a specific methodology but encourages researchers to reframe their research around a number of parameters. More specifically, to conduct research that responds to historically marginalised communities' concerns, recognise the power of combining quantitative and qualitative data, and the responsibility researchers have to tie this data to socio-political transformation (Mertens, 2007).

In the context of this research it is acknowledged that psychological research reinforcing assumptions of psychopathology has historically been promoted throughout the resettlement sector. The transformation anticipated in this research is to raise awareness of the range of responses to trauma and trauma work by sharing critical reflections from practitioners, obtained through socially constructed semi-structured interviews, together with recently published positivist psychiatric research, which is not widely acknowledged or accessible outside of academia. Such an approach could corroborate the concerns of local resettling communities and challenge practitioners to reflect on how they represent resettling individuals and resettlement work. As a graduate in cross-cultural psychology, former

resettlement practitioner and PhD candidate in Psychological Medicine I considered myself ideally placed to conduct this type of research. I was armed with my own observations of the sector, was aware of local resettling communities' concerns, and I was able to access and critically interpret published positivist psychological research.

Reviewing the literature

A narrative approach was taken to reviewing the literature in this thesis. Despite the growing popularity of systematic reviews, narrative reviews still play an important role in informing clinical research and practice and allow for the individual interpretation of a range of clinical concepts and concerns (Baethge et al., 2019; Ferrari, 2015). Within the context of this research, it was important to review research that corresponded with the concerns of local resettling communities regarding the intersection of positivist psychological research, assumptions of psychopathology, and representational practices of resettlement agencies. It is important to acknowledge that the review of the literature was never intended to be a systematic review of all perspectives, but rather a review of the published critical perspectives from resettling communities, researchers and practitioners. Such a narrative review reflects the principles of the transformative paradigm (see Ch 3, p. 61) and intention of this thesis to contest the representations of risk that dominate discussions of refugee resettlement.

An initial review of the literature was conducted in 2014 to establish the context of the research and inform the content of Chapter 2 - Issues of representation in the refugee resettlement sector (see p. 28). Four distinct literature searches were conducted for this chapter. The first literature search focused on identifying published concerns from psychiatrists and psychologists regarding the pathologisation of distress, subsequent assumptions of psychopathology that circulate in the humanitarian sector and implications for

successful settlement. The initial search terms were “refugee”, “resettlement”, “PTSD”, “pathologisation”, “psychiatrist”, “psychologist”.

The second literature search focused on identifying positivist psychiatric research on the prevalence of PTSD in resettling communities, models of pre and post displacement trauma on subsequent indices of PTSD and efficacy of specialist psychological interventions. Research that aligned with the three assumptions of trauma regarding the constant ‘at risk’ representation of resettling communities being contested in this thesis. The initial search terms were “refugee”, “resettlement”, “PTSD”, “pre-displacement trauma”, “post-displacement trauma”, “psychological intervention”.

The third literature search focused on identifying all available studies documenting resettlement practitioners’ experiences of vicarious traumatisation, vicarious resilience and/or vicarious post-traumatic growth. Reviewing these studies allowed me to reflect on the representations of risk associated with resettlement work. The initial search terms were “refugee”, “resettlement practitioners”, “vicarious trauma”, “vicarious resilience”, “vicarious post-traumatic growth”.

The fourth literature search focused on identifying published concerns regarding the representational practices of resettlement agencies and implications for societal perceptions, stigma and successful settlement. I was particularly interested in identifying studies incorporating the perspectives of representatives from resettling communities. The initial search terms were “refugee”, “resettlement”, “resettlement agencies”, “representation”, “successful resettlement”.

A corresponding review of the literature was conducted to inform the content of Chapter 3 - Calls for reciprocal resettlement research (see p. 51). The first literature search identified published critique of positivist psychological research conducted on refugee and resettling communities (search terms: “refugee”, “resettlement”, “psychological research”, “trauma”).

The second literature search identified published concerns regarding research conducted on refugee and resettling communities in general (search terms: “refugee”, “resettlement”, “research”, “ethics”, “best practice guidelines”).

After each search I also reviewed references cited within publications of interest and set up corresponding alerts in Google Scholar, PubMed, and PsychINFO which alerted me, on a monthly basis, to potentially relevant studies published during the course of my candidature.

Representation in this thesis

I would like to acknowledge a number of choices I have made in this thesis regarding the representation of “refugees”. Throughout this thesis I have chosen to refer to “resettling individuals”, “resettling communities” and/or “resettling clients”. This is an attempt to acknowledge that resettlement in New Zealand is an ongoing, often protracted process (Awad, 2011; Bloom, 2014; Ministry of Business, Innovation & Employment, 2012) and that individuals are granted residence on arrival in New Zealand and thus are technically no longer refugees (Immigration New Zealand, 2020). Such representation also reflects recent changes to how local resettling communities have chosen to represent themselves. For instance, during the course of this research ChangeMakers Refugee Forum changed its name to Changemakers Resettlement Forum (Changemakers Resettlement Forum, 2019). In addition, I have chosen to refer to research participants as having a “refugee background”. This is also a preference of local resettling communities and established practice within the resettlement sector in New Zealand (ChangeMakers Refugee Forum, 2009).

I have also chosen to prioritise, where possible, the perspectives of resettling individuals who have participated in previous resettlement research. I recognise that this is not common practice, however, it is an attempt to acknowledge that this research is responding to genuine concerns of resettling communities. The inclusion of resettling individuals’ critical perspectives is also a response to observations that they are often

excluded from psychological research that purports to support them and their communities (Miller et al., 2006; Patel, 2003; Summerfield, 1999).

Outline of Chapters

This thesis is composed of seven chapters. The following is a brief summary of what the reader can expect from each.

Chapter 2: Issues of representation in the refugee resettlement sector

This chapter provides a critical overview of the psychopathological response to the ‘refugee crisis’ and subsequent ‘crisis of representation’ in the resettlement sector. In this chapter, I reference published critique from a range of practitioners (i.e. psychiatrists, psychologists and social workers), representatives of resettling communities and corresponding clinical studies (i.e. meta-analyses and clinical trials) available at the time of initiating this research. This chapter sets the scene for the primary aim of this research: to explore how psychopathological representations are resisted and/or reproduced by practitioners working within the resettlement sector in Wellington, New Zealand. The concepts covered in this chapter will correspond with the analysis and discussion in Chapter 5.

Chapter 3: Calls for reciprocal resettlement research

This chapter provides an overview of the critique of previously published psychological research conducted on resettling communities. In this chapter, I review critical reflections from researchers (i.e. psychiatrists, psychologists and social workers) and ‘the researched’ (i.e. refugee background participants and representatives) and acknowledge their calls for reciprocal research. This chapter sets the scene for the secondary aim of this research: to conduct reciprocal research that raises awareness of the problematic psychopathological representations often perpetuated by practitioners and responds to criticism that PhD research conducted in the resettlement sector is rarely ‘passed on’. The

concepts covered in this chapter will correspond with the analysis and discussion in Chapter 6.

Chapter 4: Methodology

In this chapter I discuss the methodological decisions I made throughout this research, decisions informed by a transformative approach to research. I describe the initial relational context of the research, as well as the participants and procedures that resulted in the reflections analysed in this thesis. I outline the six stages of constructivist thematic analysis I conducted on these reflections. I also describe the approach I took to analysing my attempts to raise awareness of the issues of representation within the resettlement sector with a reflexive case study.

Chapter 5: Reflections on the psychopathological representations of resettling individuals and resettlement work

In this chapter, I describe the critical analysis I conducted to explore how practitioners working within the resettlement sector in Wellington, New Zealand resist and/or reproduce psychopathological representations of resettling individuals and resettlement work. This analysis is a response to published accusations that resettlement agencies reproduce inaccurate psychopathological representations of resettling individuals and resettlement work.

I describe the analysis I conducted on interviews with a cross section of resettlement practitioners. I identify how participants consistently resisted, and resented, the psychopathological representations of resettling individuals, and resettlement work, but few recognised their responsibility in the reproduction of such representations. I identify the personal and professional pride participants took in advocating for resettling communities and isolated instances where this advocacy was associated with reproducing the assumptions of psychopathology. I identify instances where participants reflected on the implications of

these representations and suggest that the sector suffers from a ‘crisis of representation’. Throughout this chapter I refer to published critique from clinicians and representatives from resettled communities, corresponding clinical studies and conclude with considerations for critical reflexivity in the resettlement sector.

Chapter 6: Reflections on stimulating critical reflexivity in the resettlement sector

In this chapter, I address the secondary aim of this research: to conduct research that raises awareness of the problematic psychopathological representations potentially perpetuated by practitioners within the refugee resettlement sector in New Zealand. This aim is in response to published criticism regarding the perceived appropriateness, and practical application, of positivist psychological refugee research conducted on resettling communities.

In a reflexive case study, I reflect on my influence as a researcher and the impact of this research by analysing my attempts to share the analysis covered in the previous chapter (Chapter 5) and stimulate critical reflexivity within the resettlement sector through collaboration, and subsequent consulting, with the New Zealand Red Cross. I also reflect on a critical incident that occurred during the regional training tour which offered an additional opportunity to reflect on a potential ‘crisis of representation’ in the resettlement sector in New Zealand.

Chapter 7: Conclusion

In the concluding chapter I summarise the impetus and transformative agenda of this PhD research. I reflect on my analysis and its consistency with recent clinical research conducted in the general population. I acknowledge the limitations of this research and suggest future research initiatives that prioritise participatory approaches with resettling and indigenous communities. I conclude this chapter by discussing the clinical implications of this PhD research and original contribution to Psychological Medicine.

Chapter 2

Issues of representation in the refugee resettlement sector

“It is difficult because we are dealing with ever-changing community issues, government policies, and NGOs that have been representing us for so long on their own.”

(Awad, 2011, p.45)

Introduction

Inspired by critique from Adam Awad, the co-founder of ChangeMakers Refugee Forum, former colleague and representative of resettling communities in New Zealand, this chapter reviews critical scholarship on the representational practices of resettlement agencies and the ramifications of the ‘at risk’ representations on which they tend to rely. Published critique from psychiatrists and psychologists, and corresponding clinical research that challenges the assumptions of psychopathology, and associated representations, reproduced by resettlement agencies will also be reviewed, as well as the assumptions of ‘risk’ associated with resettlement work. The chapter concludes with a summary of corresponding critique from resettling communities, selected researchers, and clinical research available in New Zealand at the time of initiating this research.

A single pathologised identity

“Refugees tend to be encapsulated within the ubiquitous designations of PTSD or trauma-related problems [...] Without an opportunity to articulate their own experiences in their own terms and to identify their own priorities in terms of service provision, refugees may be the subject of institutional

responses that are influenced by stereotypes and the homogenising of refugees into a single pathologised identity.”

(Watters, 2001, p.1710)

As noted in Chapter 1, resettlement agencies are powerful advocates for resettling communities, but they are often accused of relying on psychopathological representations that reduce resettling individuals to a “single pathologised identity” (Watters, 2001, p. 1710). Pathologising the refugee experience is often done in an attempt to acquire recognition and resources, and agencies are funded accordingly (Pupavac, 2002; Rajaram, 2002; Szczepanikova, 2010; Watters, 2001, Westoby & Ingamells, 2010). Reliance on psychopathological representations characterised by a preoccupation with pre-displacement trauma, PTSD and specialist psychological intervention, can attract sympathy and support in the short term. However, critique from scholars, and resettling communities, suggest these representations can sabotage successful settlement by perpetuating the stigmatised status of resettling communities, silencing their priorities for resettlement and recovery, and subjecting them to specialist psychological support that fails to account for the socio-political context in which they are settling (Colic-Peisker & Tilbury 2003; Harrel-Bond, 2002; Miller et al., 2006; Patel, 2003; Pupavac, 2008; Rajaram, 2002; Summerfield, 1999; Watters, 2001; Westoby & Ingamells, 2010).

Representational practices of resettlement agencies

Resettlement agencies play a crucial role in representing the rights of resettling communities and securing the resources they require to settle successfully. Resettlement agencies have however been accused of relying on particular representational practices that stigmatise resettling individuals and communities (Chouliaraki et al., 2017; Ongenaert & Joye, 2019; Slade, 2019). One of the most obvious representational practices is the

imposition of “crisis-imposed identities of powerlessness” (Zetter, 1991, p. 60), accompanied by visual images of vulnerable women and children in precarious situations. Numerous scholars have criticised the West’s preoccupation with “damaged lives from distant lands” (Phillips, 2010, p. 273) and process of “othering” (Said, 1978) that pervades the way in which these lives are represented (Chouliaraki et al., 2017; Dona, 2007; Harrel-Bond, 2002; Ongenaert & Joye, 2019; Pupavac, 2008; Rajaram, 2002; Slade, 2019).

Othering is defined as “the process that makes the other” (Mountz, 2009, p. 2) and has been criticised extensively by post-colonial scholars identifying how the colonising powers created the ‘other’ in their pursuit to “save”, “civilise” and “control” (Mountz, 2009, p. 2). Edward Said (1978) was one of the first post-colonial scholars to draw attention to ‘othering’ and how this process was achieved by three representational practices; homogenisation (i.e. “they are all the same”), feminisation (i.e. “they are inferior”) and essentialism (i.e. “they possess similar traits”) (Mountz, 2009). In the context of representing resettling individuals and communities, agencies and advocates have been accused of relying on similar representations that imply that all resettling individuals are similar, powerless and their distress is pathological. These representational practices are accused of perpetuating the stigmatised status of resettling individuals and communities in their new societies of settlement.

Social stigma refers to “the disapproval of, or discrimination against, a person based on perceivable social characteristics that distinguish them from other members of a society” (Goffman, 1963, p. 3). In this case, a person’s present and/or past refugee status. The stigma associated with being ‘a refugee’ has been identified as one of the most pervasive barriers to successful settlement and is associated with low self-esteem and poor psychological and physical health (Miller & Rasmussen, 2010; Schweitzer et al., 2011; Steel et al., 2011; Vaage et al., 2010). The stigmatisation of resettling communities is strongly associated with the

othering stereotypes described above and such stereotypes are often widely shared, overly simplified and extremely difficult to shift. This issue with stigmatisation is further compounded by the fact that resettling individuals often do not have the opportunity to represent themselves.

Article 19 (2003), a British human rights agency, conducted a research project in collaboration with the School of Journalism at Cardiff University and other supporting agencies on media representations of resettling refugees in the United Kingdom and identified that the majority of the time politicians and resettlement practitioners are speaking for resettling communities. In depth interviews with resettling individuals revealed how popular representations of their communities in this coverage left them feeling “alienated”, “ashamed” and “attacked” (p. 9). A number of individuals expressed their frustration over the constant misrepresentation but felt powerless to do anything about it: “Sometimes I feel the urge to take the initiative to respond but I do not know how, what to do and where to go” (p. 40).

Alice Szczepanikova (2010) conducted interviews with individuals resettling in the Czech Republic and identified that many perceive resettlement agencies’ advocacy and assistance as problematic. They particularly resented the ways in which agencies represent them as passive, powerless, apolitical victims and the ways in which they were often required to produce associated “performances of refugee-ness” (p. 461) in order to receive assistance. The individuals Szczepanikova interviewed also identified that such performances were often promoted by agencies in their public awareness campaigns and that they relied primarily on resettling women:

“There were a few things I didn’t like so much. For example, when someone was doing some research or it was for a radio programme, they would call us [refugee women] [...] A woman is able to lower herself, to ask for help. I shed a tear, if

needed [...] They sort of exploited us, you know, but it is hard to say it in this way.

I know how I felt about it and I know how other women felt.”

(Szczepanikova, 2010, p. 472)

The interviewees also acknowledged that their performances of refugee-ness had to conform to the agency’s agenda, as opposed to their own, and that this symbiotic relationship wasn’t acknowledged: “We need them as well as they need us, but they will not admit it and that’s what I don’t like” (p. 472).

Reflections on the lack of accountability towards resettling communities in the sector have been published by a number of scholars (Harrell-Bond, 2002; Pupavac, 2002; Walkup, 1997). Mark Walkup captured a particularly damning reflection from a consultant working for the UNHCR in his investigation:

“We work for no other organization in the political, governmental, or commercial world which has such an absence of mechanisms for determining citizen or consumer satisfaction.”

(Walkup, 1997, p. 52).

A particularly contested area of accountability is the way in which resettling individuals’ crisis-imposed identities are associated with assumptions of psychopathology. Resettlement agencies have been accused of “pathologising populations” (Pupavac, 2002, p. 489) with their reliance on representations that imply all resettling individuals suffer from PTSD and require specialist psychological intervention. As noted in Chapter 1, psychiatrists, such as Summerfield (1999), have gone so far as to suggest that PTSD is a “pseudo-condition” that prioritises Western interests:

“For the vast majority of survivors’ posttraumatic stress [PTSD] is a pseudo condition, a reframing of the understandable suffering of war as a technical problem to which short-term technical solutions like counselling are applicable.

These concepts aggrandise the western agencies and their “experts” who from afar define the condition and bring the cure. There is no evidence that war affected populations are seeking these imported approaches.”

(Summerfield, 1999, p. 1449)

Indeed, other scholars have highlighted the preoccupation with psychopathology that pervades the sector and assumptions made about the assistance resettling individuals require. Watters (1998) conducted a study of mental health services for resettling refugees throughout Europe and identified that only 2 of 18 countries had mechanisms for receiving feedback from resettling clients.

In addition to the lack of accountability, Watters (2001) expressed concern that resettlement services are influenced by the assumptions of psychopathology and ignore the significance of socio-political contexts in which communities are resettling. Other scholars have echoed this sentiment and suggest that resettlement policies and practices can also undermine the resilience of resettling individuals and reinforce “passive resettlement styles” (Colic-Peisker & Tilbury, 2003, p. 72).

Val Colic-Peisker and Farida Tilbury (2003) conducted a comprehensive research project in Western Australia which identified that the assumptions of psychopathology that inform resettlement support can reinforce passive styles of resettlement. The research was informed by interviews and focus groups with 200 resettling individuals from the former Yugoslavia (e.g. Bosnia, Serbia, Croatia) and the Horn of Africa (e.g. Ethiopia, Eritrea, Somalia and Sudan), in addition to 40 resettlement professionals, including interpreters, counsellors, and community workers.

In their analysis they identified that an individual’s approach to resettlement could be differentiated into “active” or “passive” resettlement styles (p. 61). Active resettlement styles

were characterised as “future-oriented” (p. 67) with resettling individuals pursuing education, employment and relationships within and beyond their community. In contrast, passive resettlement styles were characterised as “loss-oriented” (p. 73) with resettling individuals consumed by the loss of their society and status. These individuals were likely to be unemployed, or underemployed, and live in relative isolation from others. These individuals were also more likely to subscribe to the “sick role” (p. 74), designated by service providers. Colic-Peisker and Tilbury (2003) argue that the sector’s preoccupation with psychological screening, diagnosis and treatment can convince resettling individuals that they are “damaged” and “disabled” (p. 80) and contribute to passive resettlement styles. They also argue that the preoccupation with psychopathology results in unsuccessful settlement being attributed to resettling individuals and their inability to process their pre-displacement trauma as opposed to reflecting on the shortcomings of their new society of settlement.

Published critique from clinicians and clinical research

Consistent with the critique regarding the representational practices of resettlement agencies, a significant number of psychiatrists and psychologists have historically also challenged the representations and associated assumptions of psychopathology that circulate in the resettlement sector. The consensus among these clinicians is that, whilst a percentage of resettling individuals may develop PTSD and desire specialist psychological support, the majority do not (Bracken et al., 1995; Miller et al., 2006; Patel, 2003; Papadopoulos, 2007; Summerfield, 1999). Indeed, in clinical guidelines for managing PTSD, published in The National Institute for Health and Clinical Excellence by The Royal College of Psychiatrists and The British Psychological Society, it states: “Being a refugee is not a diagnosis. Refugees may present with any of the psychiatric disorders or none at all” (2005, p. 120).

In line with these observations, systematic reviews of clinical studies reporting the prevalence rates of PTSD in displaced populations also suggest that resettling individuals may not be as at risk as assumed (Charlson et al., 2019; Fazel et al., 2005; Henkelmann et al., 2020; Steel et al., 2009). The following section describes these systematic reviews in detail and discusses the methodological issues that have influenced the inflated rates of PTSD prevalence often published in the literature.

The original systematic review conducted by Fazel, Wheeler and Danesh (2005), over a decade ago and published in *The Lancet*, is the only review to focus exclusively on studies reporting the prevalence rates of PTSD in refugees (n = 5,499 from Africa (i.e. Ethiopia & Rwanda), Southeast Asia (i.e. Cambodia & Vietnam), Eastern Europe (i.e. Bosnia-Herzegovina & Kosovo), The Middle East (i.e. Afghanistan & Iran) and Central America (i.e. Cuba & Haiti) resettling in Western countries (the UK, Italy, Norway, the USA, Canada, Australia and New Zealand). The review identified 17 studies that determined prevalence rates of PTSD and reported prevalence rates between 3% and 86%. However, subsequent analysis, based on studies with at least 200 participants (n = 9) showed an overall prevalence of 9%.

At the time of initiating this research, the most recent systematic review was conducted by Steel et al., (2009). This review identified 161 studies reporting the prevalence rates of PTSD in 81,866 “conflict-affected persons” (p. 537) from 40 countries. The majority of these studies (122, n = 62,069) were conducted in low to middle income countries throughout Africa (i.e. Somalia & Sierra Leone), Asia (i.e. Cambodia & Vietnam), the Middle East (i.e. Afghanistan & Iraq) and Eastern Europe (i.e. Bosnia-Herzegovina & Kosovo), while 59 studies (n = 19,797) were conducted with resettling individuals in high income countries throughout Western Europe (i.e. Austria, Sweden & the UK), North America (i.e. the USA & Canada) and Oceania (Australia & New Zealand). The range of

reported prevalence rates of PTSD was 0% to 99% with an overall prevalence rate of 30.6%. Subsequent analysis identified significantly higher reported rates of PTSD in studies conducted in clinical contexts, with small clinical samples. Once adjusted for these methodological factors, the overall prevalence rates of PTSD decreased from 30.6% to 15.4%. A similar trend was documented for depression in this study with the prevalence rate dropping from 30.8% to 17.3%.

The major methodological issues associated with inflated prevalence rates of PTSD in resettling populations include the propensity to use PTSD checklists not validated in non-Western contexts, reliance on self-report measures and use of small clinical samples. Studies that conduct psychiatric interviews in community samples consistently produce lower prevalence rates of PTSD that are much more representative of resettling communities (Fazel et al., 2005; Holifield et al., 2002; Steel et al., 2009).

During the course of my PhD candidature, additional systematic reviews were published and continued to indicate that the majority of refugee (Blackmore et al., 2020; Bogic et al., 2015; Charlson et al., 2019) and resettling individuals (Giacco et al., 2018; Henkelmann et al., 2020) do not develop PTSD or any other psychopathology. In each review the authors also acknowledge the methodological issues associated with obtaining accurate indications of psychopathology in refugee and resettling communities. I discuss these studies in more depth in Chapter 5 (p. 119).

Responses to trauma

In addition to the observation that the majority of resettling individuals do not develop PTSD, a number of psychiatrists and psychologists have identified that there are a range of responses to traumatic events. Papadopoulos (2007) developed a “trauma grid” (Figure 2) for practitioners that takes into account different levels of distress experienced by resettling

refugees (negative effects), their resilience (neutral effects) and possibilities for positive development (positive effects).

Figure 2

Trauma Grid proposed by Papadopoulos (2007, p. 309).

The Trauma Grid			
Negative effects		Neutral effects	Positive effects
Psychiatric disorders e.g. PTSD	Psychological distress	Resilience	Adversity-activated development

In the trauma grid Papadopoulos (2007) distinguishes between “psychological distress” and “psychiatric disorders such as PTSD”, with distress being the most common response that does not require specialist psychological support. The neutral response to trauma is ‘resilience’, which is characterised by the ability to retain functionality in the face of adversity. The positive response to trauma is referred to as “adversity-activated development”, characterised by enhanced or positive perceptions of oneself, one’s relationships and one’s purpose in life. According to Papadopoulos, these different responses to trauma can be experienced simultaneously and practitioners have a responsibility to recognise and promote the range of responses.

Currently, no empirical studies have been conducted to measure adversity-activated development in resettling individuals. However, a similar positive response to trauma, called post-traumatic growth, has received some attention in the literature. Post-traumatic growth is defined as “the positive psychological changes experienced as a result of the struggle with highly challenging life circumstances” (Tedeschi & Calhoun, 2004, p. 1). Post-traumatic growth is characterised by changes such as an increased appreciation for life, awareness of personal strength and spirituality, changed priorities and more meaningful relationships. Both adversity-activated development and post-traumatic growth describe similar changes.

However, the two concepts differ as post-traumatic growth assumes that exposure to trauma will result in traumatisation and post-traumatic growth, whereas adversity-activated development does not (Papadopoulos, 2007).

Tedeschi, Calhoun and colleagues in Sarajevo identified the co-existence of PTSD and post-traumatic growth in a cohort of former refugees from the former Yugoslavia (Powell, Rosner, Butullo, Tedeschi & Calhoun, 2003). The co-existence of PTSD and post-traumatic growth has since been documented in resettling communities in Africa (Ssenyonga, Owens & Olema, 2013), Asia (Hussain & Bhushan, 2011), Europe (Kroo & Nagy, 2010; Sutton et al., 2006), and the USA (Ai et al., 2007) providing empirical evidence of the range of responses to trauma.

Pre- and post-displacement trauma

In addition to acknowledging the range of responses to trauma, Papadopoulos (2007) also stressed the importance of acknowledging the context in which people are resettling and the stressors associated with this process. He was particularly critical of the assumption that resettling individuals develop PTSD due to their pre-displacement experiences. This observation has since been reported by other clinicians and researchers: at the time of initiating this research (Chu et al., 2013; Miller & Rasmussen, 2010; Nickerson et al., 2011; Porter & Haslam, 2005; Schweitzer et al., 2011; Steel et al., 2011; Vaage et al., 2010) and throughout my PhD candidature (Bogic et al., 2015; Li et al., 2016; Nickerson et al., 2019; Silove et al., 2017).

Historically, clinicians focussed on the direct effects of pre-displacement trauma (i.e. exposure to violence and human rights violations), arguing that the distress experienced by displaced people could be alleviated by specialist psychological interventions that support individuals to process their pre-displacement trauma (Neuner, 2010).

However, the distress experienced by displaced people can also be attributed to stressors in their current resettlement environment and alleviated by interventions that directly address these stressors. Post-displacement stressors identified in previous studies include insecurity, social isolation, poverty, perceived discrimination, issues acculturating and intimate partner violence (Li et al., 2016; Miller & Rasmussen, 2010; Nickerson et al., 2019). Psychosocial-focused interventions therefore typically include a range of approaches such as resettlement assistance and advocacy, which provide necessary practical and social support, in addition to access to psychotherapy (Nickerson et al., 2011).

Specialist psychological intervention

Whilst the consensus seems to be that specialist psychological support should be available to all resettling individuals who desire it, some clinicians have raised concerns regarding the imposition, and possible iatrogenesis, of interventions developed in Western clinical contexts (Bracken et al., 1995, 1997; Patel 2003, Papadopoulos, 2007; Summerfield, 1999). Iatrogenesis is defined by the American Psychological Association as "a disorder precipitated, aggravated, or induced by the physician's attitude, examination, comments, or treatment" (1994, p. 103). A number of clinicians have expressed concern that their interventions may undermine the resilience of resettling clients by promoting a sense of victimhood that can become self-perpetuating (Bracken et al., 1995, 1997; Patel 2003, Papadopoulos, 2007; Summerfield, 1999), particularly when the assumptions of psychopathology in the resettlement sector require clients to perform their "refugee-ness" (Szczepanikova, 2010, p. 461) or reward "passive resettlement styles" (Colic-Peisker & Tilbury, 2003, p. 62).

At the time of initiating this research, the latest meta-analysis evaluating the efficacy of psychological interventions for resettling individuals identified 19 studies plagued by methodological issues that prevented any "definitive inferences" (Nickerson et al., 2011, p.

399). Methodological issues identified by Nickerson et al., (2011) included the absence of control conditions, small sample sizes, and the lack of long-term follow-up assessment. These factors limit the ability to accurately assess the efficacy of specific interventions.

During the course of my PhD candidature, additional meta-analyses were published that indicated that specialist psychological intervention was associated with a modest decrease in symptomology for resettling individuals suffering from significant distress (Kip et al., 2020; Nose et al., 2017; Patel et al., 2016; Turrini et al., 2019). For instance, Nose and colleagues (2017) performed a meta-analysis of randomised controlled trials (RCTs) evaluating the efficacy of psychological interventions. Interventions included Narrative Exposure Therapy (NET), Cognitive Behavior Therapy (CBT) and Trauma Focused Psychotherapy (TFP). The resettling individuals were originally from Africa and the Middle East and sought specialist support for PTSD in the USA and Europe (Austria, Denmark, Germany, Netherlands and Norway). These researchers identified that only one in five individuals receiving treatment showed an improvement compared to the before treatment condition. While this outcome is considered clinically significant, it does suggest that specialist psychological intervention is not effective for all resettling individuals seeking specialist psychological support.

Nose et al., (2017) also acknowledged the significant methodological limitations associated with the RCTs included in their analysis and the requirement for more rigorous evaluation of psychological intervention for resettling individuals and communities. This sentiment was shared by Patel et al. (2016) who concluded that despite increasing efforts to evaluate the effectiveness of psychological intervention for resettling individuals, “the results are inconclusive” (p. 2). The review by Patel et al., (2016) also raised concerns regarding the ethnocentrism of such evaluations. The reliance on Western derived psychiatric diagnosis

such as PTSD, psychiatric interventions, and psychiatric assessments focused on symptom reduction as opposed to perceived quality of life or other indices of wellbeing.

Meta-analyses published towards the end of my candidature have continued to identify clinically significant improvements for psychological interventions which are maintained after one month (Turrini et al., 2019) and six months (Kip et al., 2020). Consistent with previous reviews, the authors of these reviews acknowledged the limitations of evaluating psychological interventions for individuals with refugee or resettling status. These limitations include the small number of available studies to evaluate, significant variation across the different studies and spontaneous recovery in some control conditions. Whilst the authors of these reviews endorse psychological intervention, they caution against assuming that psychological interventions will be effective for everyone.

At the time of initiating this research there was also a notable absence of published studies documenting the perspectives of resettling communities on the perceived appropriateness of psychological intervention, with the exception of a small study conducted in Denmark with resettling refugees, therapists and interpreters (Mirdal et al., 2012). The perspectives of 16 refugee background patients from Iraq, Bosnia, Lebanon, and Afghanistan (seven women and nine men) who had received psychotherapy were captured in this study. A number of participants reported that psychotherapy had helped them to make sense of their experiences and provided an opportunity to vent and receive validation. Other participants maintained that talking made things worse and expressed a preference for physical therapy, prescription medication and practical support. One of the themes from the analysis was “the perceived unsuitability of the psychological treatment” (p. 437) and several of the interpreters participating in the study observed that psychotherapy could keep clients “in a state of illness and dependency” (p. 453), thus echoing the concerns of clinicians cited earlier in this section. In light of these observations of iatrogenesis and methodological issues interfering with

systematic evaluation of psychological intervention, the assumption that all resettling individuals will require, desire and recover from such intervention is problematic.

Professional and personal risk

“Accounts suggest working with asylum seekers’ and refugees’ extreme experiences involves a significant level of professional and personal risk [...] As a result, discourses of ‘risk’ have constitutive power over the psychological life of practitioners and produce an experience of ‘trauma.’”

(Apostolidou, 2014, p. 281)

An additional assumption of psychopathology produced in psychological research, and subsequently reproduced in the resettlement sector, is that of the “professional and personal risk” (Apostolidou, 2014, p.281) associated with resettlement work. This ‘risk’ refers to the assumption that practitioners supporting resettling individuals will become vicariously traumatised and experience symptoms of PTSD similar to their clients (MacIan & Pearlman, 1990). The promotion of this assumption constructs resettling individuals as a substantial risk to those supporting them and can perpetuate further stigmatisation of resettling communities (Bogen & Marlowe, 2014; Hernandez-Wolfe et al., 2007; Pupavac, 2002; Reynolds, 2011).

A significant number of studies have been published over the last decade documenting the experiences of psychiatrists, psychologists, counsellors, social workers, doctors, nurses, interpreters, and advocates working with resettling individuals in the United Kingdom (Century, Leavey, & Payne, 2007; Green et al., 2012; Guhan & Liebling-Kalifani, 2011; Miller, Martell, Pazdirek et al., 2005; Munday, 2009; Splevins, Cohen, Joseph, Murray, & Bowley, 2010), Denmark (Holmgren, Søndergaard, & Elklit, 2003), Sweden (Kjellenberg et al., 2014), Australia (Barrington & Shakespeare-Finch, 2013 & 2014; Farley et al., 2014; Surawski, Pedersen, & Briskman, 2008) and New Zealand (Bloom, 2014). The majority of

these studies have focused on the psychological consequences for practitioners providing specialist psychological support (i.e. psychologists and counsellors) and the interpreters who facilitate this process.

The primary psychological consequence referenced in these studies is the risk of becoming vicariously traumatised. Vicarious traumatisation refers to “the negative transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients’ traumatic experiences” (Pearlman & McCaen, 1995, p. 558). It is considered an inevitable consequence of therapeutic work. Vicarious traumatisation can have a profound impact on the way practitioners perceive themselves, their relationships, and the world, and can result in practitioners experiencing symptoms of PTSD (McCaen & Pearlman, 1990).

Indeed, all studies documenting the experiences of practitioners supporting resettling individuals describe the detrimental impact of clients’ “extreme experiences” (Apostolidou, 2016, p. 281) that can induce symptoms of vicarious traumatisation such as intrusive thoughts, insomnia, anxiety, anger, avoidance and a variety of somatic complaints (Barrington & Shakespeare-Finch, 2013 & 2014; Bloom, 2014; Century et al., 2007; Farley et al., 2014; Green et al., 2012; Guhan & Liebling-Kalifani, 2011; Kjellenberg et al., 2014; Holmgren et al., 2003; Miller et al., 2005; Munday, 2009; Splevins et al., 2010; Surawski et al., 2008).

In addition to documenting instances of vicarious traumatisation, all of these studies acknowledge the complex and challenging nature of working within resettlement contexts. The perception is that these challenges exceed those encountered when working in other contexts for psychologists and counsellors (Century et al., 2007 and Schweitzer et al., 2015), for GPs and nurses (Farley et al., 2014), for social workers and support staff (Guhan and Liebling-Kalifani, 2011) and for refugee advocates (Surawski et al., 2008). These challenges

often came down to feeling overwhelmed by the spectrum of resettlement stressors that their clients faced and a sense of responsibility to address these stressors with scarce resources. This type of distress corresponds more with the concept of burnout, which is characterised by exhaustion, cynicism, and lack of efficacy from ongoing organisational stressors associated with one's occupation (Maslach, Schaufeli & Leiter, 2001).

In spite of these challenges, practitioners from these studies maintained that supporting resettling individuals was rewarding and perceived as promoting significantly more personal and professional satisfaction than other professional contexts they had worked in (Apostolidou, 2016; Barrington & Shakespeare-Finch, 2014; Bloom, 2014; Guhan & Liebling-Kalifani, 2011; Hernandez-Wolfe et al., 2014; Surawski et al., 2008). The rewards of resettlement work documented in these studies were often referred to as vicarious post-traumatic growth (Barrington & Shakespeare-Finch, 2013, 2014; Bloom, 2014; Century et al., 2007; Crezee et al., 2011; Gomez, 2012; Green et al., 2012; Kjellenberg et al., 2014; Miller et al., 2005; Munday, 2009; Splevins et al., 2010; Staite, 2012), and vicarious resilience (Apostolidou, 2016; Bloom, 2014; Hernandez-Wolfe et al., 2014).

Vicarious post-traumatic growth (Arnold et al., 2005) is the vicarious version of post-traumatic growth and is characterised by positive changes in self-perception, life philosophy and interpersonal relationships (see discussion on p. 37). Vicarious post-traumatic growth is the most commonly referenced reward of resettlement work, potentially illustrating the pervasive assumptions of risk in the sector in that practitioners will experience vicarious traumatisation. Vicarious resilience on the other hand, is defined as the positive transformation that occurs in response to clients' resilience (Hernandez et al., 2007). Vicarious resilience can account for similar positive changes as vicarious post-traumatic growth, and allows researchers to recognise that the rewards of resettlement work can occur in the absence of vicarious traumatisation (Hernandez et al., 2007).

Regardless of whether they attend to vicarious traumatisation or vicarious resilience, all of the studies mentioned above suggest that practitioners are initially inspired by the resilience of resettling clients and their capacities to cope. These inspiring interactions with resettling clients offer practitioners opportunities to reflect on, and re-evaluate, their own lives. Over time, practitioners have reported becoming more aware, and appreciative, of their own privilege and some become more politically active. The combination of client progress and advocacy is associated with profound personal and professional satisfaction that allows practitioners to make sense of, and sustain, their practice.

Research published during the course of my candidature continued to record accounts of vicarious resilience and/or vicarious post traumatic growth in resettlement practitioners in Australia (Long, 2019; Roberts et al., 2018; Schweitzer, van Wyk & Murray, 2015), the United Kingdom (Apostolidou, 2016), and the United States (Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). In addition to acknowledging the opportunities for vicarious resilience in the resettlement sector, these studies also reported that practitioners were more likely to report instances of burnout as opposed to vicarious traumatisation. Such research continues to challenge the assumption that resettling clients' pre-displacement trauma is the primary source of practitioners' distress.

Reflecting on the research outlined above, practitioners appear to report a similar range of negative, neutral, and positive responses to trauma work as their resettling clients as shown in Figure 3, which I have based on the trauma grid proposed by Papadopoulos (2007). There also seems to be a parallel between the significance of resettlement stress for resettling refugees and resettlement practitioners with practitioners attributing the majority of their distress to their attempts to address their clients' post-displacement stress.

Figure 3

Documented range of responses to trauma and trauma work in the resettlement context, inspired by Papadopoulos (2007).

Responses to trauma				
		Negative	Neutral	Positive
Resettling clients	PTSD	Distress	Resilience	Adversity activated development Post-traumatic growth
Resettlement practitioners	Vicarious trauma	Distress	Resilience	Vicarious resilience Vicarious post-traumatic growth

Representational practices in New Zealand

Local resettling communities in New Zealand (Awad, 2011; ChangeMakers Refugee Forum, 2008; Elliott, 2015; Mugadza, 2012; Rother, 2008) and resettlement researchers (Bloom, 2014; Greenbank, 2014; Ford, 2012; Fraser, 2011, Mortensen, 2008; Slade, 2019) also acknowledge the issues discussed so far in this chapter. As illustrated in the opening quote of this chapter (p. 28), Adam Awad, a representative of local resettling communities, identified similar issues of representation in the resettlement sector in New Zealand at the National Refugee Health and Wellbeing Conference in 2009. In his keynote speech, “The Voice of the Community”, he acknowledged that resettling communities resent that agencies continue to represent them “on their own” and that despite communities creating a “collective voice” the resettlement sector refuses to “hear this voice” (Awad, 2011, p.45).

In his speech Awad (2011) called for the sector to adopt a “strength-based approach” (p. 46) that acknowledged the resilience and resources of resettling communities, prioritised genuine collaboration, and enabled everyone to “play their part” (p. 46). According to Awad the “lack of listening” (p. 46), combined with the sector’s preoccupation with “deficits” (p. 46), was compromising the wellbeing of resettling communities by diminishing their self-esteem, restricting their autonomy, and allocating scarce resources to specialist psychological services that leave resettling individuals feeling “more damaged than when they arrived” (p. 47).

The limitations of specialist psychological intervention for resettling individuals have also been acknowledged in “Therapies for Refugees, Asylum Seekers and New Migrants: Best and Promising Practice Guide for Mental Health and Addiction Services”, prepared by Te Pou in 2010. The guidelines acknowledge that psychological intervention is often not a priority for resettling individuals and available services are not always accessible or culturally appropriate. The guidelines also acknowledge the lack of refugee mental health research conducted in New Zealand and a reliance on “limited international evidence” (p. 27).

Published prevalence rates from psychological screening conducted at Mangere Refugee Reception Centre over a five year period (1995-2000) involving 2992 resettling individuals (46.9% female and 53.1% male) from 34 nationalities, indicated that only 7% met the criteria for PTSD and were referred on to specialist psychological services (McLeod & Reeve, 2005). The only published psychiatric study concentrating on a specific resettling community was conducted by psychiatrist Peter Cheung with the resettled Cambodian community in Dunedin (N = 239; 53.4% female and 46.6% male) in 1994. This study identified that while the majority of participants had survived multiple traumas, such as the

loss of loved ones, forced labour, and torture, only 12% met the diagnostic criteria for PTSD and only one individual (.05%) had sought specialist psychological support (Cheung, 1994).

These studies provide compelling evidence that the psychopathological representations reproduced by resettlement agencies in New Zealand are inaccurate. However, as post-graduate resettlement research in New Zealand has shown, resettlement agencies, and advocates, continue to rely on assumptions of psychopathology in their approaches to advocacy (Fraser, 2011; Mugadza, 2012; Slade, 2019).

For instance, Rebecca Fraser (2011) conducted interviews with 10 advocates from resettlement agencies across Auckland, the Waikato and Wellington. In her analysis she identified that agencies and advocates consistently represented resettling refugees as “at risk”, “damaged”, and “difficult” (p. 99). The ways in which resettling communities are represented by resettlement agencies, and advocates, has significant implications for societal perceptions of resettling communities and this was confirmed by Vimbi Mugadza (2012) who identified that resettling communities were acutely aware of their stigmatised status and the assumptions of psychopathology circulating in society. Participants in her study spoke of feeling “parasitic” and “pitied” (p. 153) and expressed a strong desire for strength-based approaches to resettlement which would shift society’s perceptions of them.

Similar issues of representation have also been identified in refugee-related media coverage in New Zealand. Emily Greenbank (2014) conducted an analysis of articles published in *The New Zealand Herald*, *The Dominion Post* and *The Press* in the lead up to the general elections in 2005, 2008 and 2011, and identified that resettling individuals are consistently portrayed as “passive victims” (p. 35). Only 32% of the articles included perspectives from resettling individuals and further analysis revealed that these perspectives accounted for only 26% of the text. Furthermore, these perspectives tended to replicate

“performances of refugee-ness” (Szczepanikova, 2010, p. 461, cited earlier, see p. 31) with expressions of gratitude, whilst “expert” perspectives, often NGO practitioners, would provide authoritative accounts of the issues and responses required.

During the course of my PhD candidature, an additional study was conducted by Natalie Slade (2019) who analysed media coverage of the Syrian refugee crisis in *Stuff* and *The New Zealand Herald*. Consistent with the previous study, Slade identified that the media coverage continuously portrayed refugees as “passive victims” (p. 125). She also identified that only 17.1% of the articles included the perspectives of resettling individuals and when they did, they were there to illustrate “the trauma story” (p. 131).

An additional assumption of psychopathology reproduced in the resettlement sector in New Zealand is the assumption of risk associated with supporting resettling individuals. As noted in Chapter 1 (p. 20) at the time of initiating the research the local specialist psychological service for resettling refugees was promoting its work as “shocking” and “specialised” and focused exclusively on the risks of vicarious traumatisation. While there are no published studies documenting the experiences of resettlement practitioners in New Zealand, a post-graduate study conducted by Alia Bloom (2014), explored the experiences of five resettlement practitioners (counsellor advocates and case workers) in Wellington at the time of initiating this research. Bloom identified that while practitioners discussed distress associated with their work, they rarely attributed this distress to their clients. In fact, three of the five participants maintained they had never experienced vicarious trauma, but often felt stressed by “structural sector challenges” (p. 30). Such challenges included working with restricted resources and collaborating with social services they experienced as having little to no compassion and/or cross-cultural competence.

Practitioners in Bloom's study also identified the importance of institutional support, supervision and self-care, in addition to a "strength-based professional philosophy" (p. 35) in order to sustain their practice and experience the "rewards" (p. 33) of resettlement work. These 'rewards' included being "inspired by clients" (p. 32), an "increased sense of contribution and self-worth" (p. 33) and "changed perspective of personal challenges" (p. 31) and reflect the concepts of vicarious resilience and vicarious post-traumatic growth discussed earlier.

Conclusion

Resettlement agencies are powerful advocates for resettling individuals but they may also rely on representational practices that promote exaggerated assumptions of psychopathology. The preoccupation with PTSD and vicarious traumatisation that characterises such representations results in resettling communities being subjected to two levels of stigmatisation within society. They are simultaneously at risk and present a risk in their new society of settlement and their resilience and opportunities for vicarious resilience in the sector are disregarded. At the time of initiating this research there were indications that the way in which specialist agencies were promoting their work to the public reproduced assumptions of psychopathology. These representations did not accurately reflect the perceptions of practitioners working in the sector (Bloom, 2014) or the resettling communities they support (Awad, 2011). In light of these observations, the primary aim of this thesis was to explore how psychopathological representations are resisted and/or reproduced by practitioners working within the resettlement sector in Wellington, New Zealand. The following chapter identifies how the assumptions of psychopathology originated from positivist psychological research and considers the necessity of conducting reciprocal social constructivist research.

Chapter 3

Calls for reciprocal resettlement research

“Refugee background communities have been soft targets for researchers who come with their own terms and methodologies [...] We get interviewed over and over. What changes?”

(Awad, 2011, p. 45)

Introduction

This chapter provides an overview of the critiques that have historically been made of psychological research conducted on resettling communities (Mackenzie et al., 2007; Marlowe, 2010; Miller et al., 2006; Patel, 2003; Pittway et al., 2010; Sukarieh & Tannock, 2012; Summerfield, 1999). I review critical reflections from researchers (e.g. psychiatrists, psychologists and social workers) and ‘the researched’ (e.g. refugee background participants and representatives) which call for social constructivist research that attends to the relational context and concept of reciprocity. I discuss how local resettling communities have raised similar concerns and how I responded to these concerns by conducting reciprocal PhD research that raises awareness of the problematic psychopathological representations often perpetuated by practitioners in the resettlement sector in New Zealand.

Refocus research efforts

“Social constructivism, can serve as a bridge by helping to refocus research efforts in ways that are both conceptually and methodologically more attuned to the needs of war-affected communities and the organizations working to address their mental health needs [...] A constructivist approach encourages us to ask (rather than assume we already know) how communities are affected [...] and what their priorities are.”

(Miller et al., 2006, p. 410)

In addition to being critical of a perceived preoccupation with psychopathology pervading the resettlement sector and informing the representational practices of resettlement agencies and advocates, as discussed in the previous chapter, selected psychiatrists (Bracken et al., 1995; Nickerson et al., 2011, Summerfield, 1999), psychologists (Miller et al., 2006, 2010; Papadopoulos, 2007; Patel, 2003; Steel et al., 2009) and other scholars (Harrel-Bond, 2002; Muecke, 1992; Pupavac, 2002; Watters, 2001; Westoby & Ingamells, 2010) have identified how this stems primarily from positivist psychological research.

Positivist research aims to discover the nature of reality and to identify its universal truths (Lincoln & Guba, 2000; Miller et al., 2006). Commonly referred to as “the scientific paradigm” (Miller et al., 2006, p. 410), positivist research is deductive and hypothesis-driven whereby a priori assumptions are tested through experimental design or retrospective analysis of existing quantitative data. Quantifying observable phenomena via statistical techniques is assumed to produce an unbiased result that can be generalised to larger populations and the prescribed stance of the researcher is one of objectivity (Lincoln & Guba, 2000; Miller et al., 2006).

In the context of psychological research, this approach has historically attempted to identify universal patterns of psychological distress and/or dysfunction and generalise these patterns across diverse contexts. The same underlying mechanisms are assumed to be at work within all individuals, with some authors arguing that it pays little attention is paid to the social context (Berry et al., 2002; Miller et al., 2006; Willig, 2013). In the context of psychological resettlement research, the precedent has been to identify the prevalence of PTSD in resettling populations with symptom checklists and infer the necessity of specialist psychological intervention (Bracken et al., 1995; Hollifield et al., 2002; Miller et al., 2006; Nickerson et al., 2011, Summerfield, 1999).

Whilst it is important to identify the psychological implications of displacement, numerous psychiatrists (Bracken et al., 1995; Nickerson et al., 2011, Summerfield, 1999) and psychologists (Miller et al., 2006, Papadopoulos, 2007; Patel, 2003) have raised concerns over the perceived ethnocentrism of positivist psychological research. The first concern is that the presence of PTSD symptomology does not necessarily have the same subjective significance for resettling individuals. Indeed, several psychiatrists have published reflections from fieldwork in Africa (e.g. Uganda) and Central America (e.g. Nicaragua) that individuals may have PTSD symptoms but are not functionally impaired – a crucial component of a diagnosis of PTSD (Bracken et al., 1995; Summerfield, 1999). Furthermore, many of these individuals considered their symptoms of distress to be normal and were more concerned about the restoration of their social and political worlds (Summerfield, 1999).

Another concern is that the preoccupation with psychopathology diverts funding towards research that continues to identify the prevalence of PTSD in resettling populations and promote specialist psychological services to treat PTSD. This is viewed as giving psychiatrists and psychologists “unrivalled credibility” (Patel, 2003, p. 25) to address the perceived ‘needs’ of resettling communities. A number of practitioners have further reflected on the “popularity” and “prestige” (Miller et al., 2006, p. 419) of PTSD research and how this self-perpetuating cycle leaves little room to acknowledge the resilience of resettling communities, let alone their priorities for resettlement and recovery.

To counter these concerns, psychologists such as Miller et al., (2006) have called for a “refocusing” (p. 409) of psychological resettlement research that relies on a social constructivist approach. Social constructivist approaches to research avoid the identification of universal truths and attend to the socially-constructed nature of reality (Burr, 2015). Such an approach to research is more likely to utilise inductive qualitative methods, such as interviewing, focus groups or observational field work and ethnography. Such methods

provide insights into how people make sense of their reality and include reflections on the interpersonal nature of research and subjective experience of the researcher (Holloway, 1997; Lincoln & Guba, 2000; Miller et al., 2006).

In the context of psychological research, a social constructivist approach means attending to the diverse ways in which psychological wellbeing and distress are understood and expressed across, and within, different cultural contexts (Berry et al., 2002; Burr, 2015; Miller et al., 2006; Willig, 2013). With respect to psychological resettlement research it provides an opportunity to challenge the assumptions of psychopathology produced by positivist psychological research. A powerful illustration of this comes from a study Jay Marlowe (2010) conducted with Sudanese men resettling in Australia. The men shared their resentment towards the assumptions of psychopathology in Australian society and recognised the role of positivist psychological research in reproducing such assumptions:

“A Sudanese man stated that he had refused to participate in a previous research project that intended to document the level of trauma his resettling community had sustained. He explained his reply to the researcher for that project as follows: I told him, ‘If you already know that [we] are traumatised, why do you have to do the research? You have already answered your question, so I do not think that I will participate. We do research because we do not know, in order to find. But if you already know what you are going to find, why do you do it? You are wasting your time.’ [...] As a refugee, we are concerned about how refugees are portrayed. One of these problems is that people assume that refugees are traumatised people.”

(Participant 13, Marlowe, 2010, p. 176)

By utilising a social constructivist approach, Marlowe (2010) was able to establish relationships with the Sudanese men and create space for them to share their reflections on

displacement. Such an approach enabled the men to resist the assumptions of psychopathology and share their individual interpretations of trauma:

“Trauma has two sides to me. I am sure this is true for other people. One is that these experiences are teaching them to think, to think hard, and to know what life is and what are the possible ways of dealing with it [...] I know at the moment other people say [about refugees], ‘Oh, trauma, their mind is lost, their personality, they have lost a lot of things, they have nothing.’ It is not completely horrible the way it was.”

(Participant 23, Marlowe, 2010, p. 183).

In addition to being able to identify culturally-specific concerns and individual interpretations of trauma, a social constructivist approach to psychological research has the potential to produce research that is more relevant to resettling communities and the services that support them. Research informed by social constructivism has the potential to identify culturally-specific explanations of suffering (e.g. spiritual, social, political, and/or psychosomatic), help-seeking behaviour and desired support (Miller et al., 2006). In the context of this research, a social constructivist approach has the potential to capture reflections from practitioners on the resilience of resettling communities and realities of supporting them settle in New Zealand, in effect creating a space for resettling individuals to be represented as more than at risk and a risk.

Nothing changes

Critique of resettlement research is not restricted to positivist psychological research (Mackenzie et al., 2007; Pittaway et al., 2010; Sukarieh & Tannock, 2012). Increasingly, researchers and the ‘researched’ (refugee background participants) have also expressed concerns over the relevance of research informed by social constructivism. Research conducted in the Shatila refugee camp in Lebanon captured the following criticism from

residents: “We always get visited; get asked questions and nothing changes. Why do you keep researching?” (Sukarieh & Tannock, 2012, p. 500).

Research conducted between 10 and 15 years ago, indicates that residents of refugee camps and resettling communities were becoming increasingly critical of claims that their participation in research projects will give them a voice and contribute to positive changes for their communities (Awad, 2011; ChangeMakers Refugee Forum, 2009; Mackenzie et al., 2007; Marlowe, 2009; Pittaway et al., 2010; Sukarieh & Tannock, 2012). Such cynicism is captured in the following reflection from another resident of the Shatila refugee camp:

“At least twenty researchers have given me voice. My voice was given in English, French, Arabic, Dutch, Swedish, and Spanish. But I haven’t heard it back and I will never do.”

(Sukarieh & Tannock, 2012, p. 500).

The primary concern is that people never hear back from the researcher after participating in their research. This lack of feedback has resulted in people feeling exploited, reduced to an analysis that advances the career of the researcher (ChangeMakers Refugee Forum, 2009; Mackenzie et al., 2007; Pittaway et al., 2010; Sukarieh & Tannock, 2012). This is particularly so for PhD students: “They get their PhDs and funding from our stories and they cannot even be bothered to send us a report and a thank you letter” (Mackenzie et al., 2007, p. 305).

Referred to as “fly in and fly out researchers” (Pittaway et al., 2010, p. 236), refugee and resettling communities have expressed additional concerns regarding the conduct of researchers, the relevance and repetition of research projects, and the reluctance to participate in further research (ChangeMakers Refugee Forum, 2009; Mackenzie et al., 2007; Pittaway et al., 2010; Sukarieh & Tannock, 2012). Some researchers have gone so far as to suggest the

only response to these concerns is to cease conducting research in certain communities altogether (Sukarieh & Tannock, 2012).

Despite such criticism, many residents of refugee camps and resettling communities still recognise the potential value of research (ChangeMakers Refugee Forum, 2009; Dyregrov et al. 2000; Sukarieh & Tannock, 2012). Kari Dyregrov et al. (2000) asked a cohort of resettling individuals in Norway who had participated in a previous research project for their reflections on participation. All participants rated their experiences positively. Many expressed an appreciation for the opportunity to reflect on their experiences and felt relieved afterwards. They also reported a sense of responsibility to other resettling individuals and belief that their participation would improve resettlement outcomes for others.

This belief was often cited in a systematic review documenting the overestimation of risks associated with participating in trauma research (Legerski & Bunnell, 2010). This review of ten trauma studies (primarily interviews with veterans, survivors of interpersonal violence, or terrorism in the USA) revealed that the majority of participants viewed their participation in trauma research positively. The perception that participation could improve outcomes for others was a consistent theme and instances of distress instigated by the research were reported as dissipating quickly. Legerski and Bunnell (2010) concluded that it is unethical not to conduct trauma research and this has been confirmed by researchers conducting research with refugee background communities (Harrell-bond & Voutira 2007; Marlowe, 2010; Miller et al 2006; Rousseau & Kirmayer, 2010).

While researchers agree that they have a responsibility to act ethically and attend to the unequal power dynamics inherent in resettlement research, many researchers have also argued that it is necessary to move beyond harm minimisation. In other words, “the issue is not simply how research is done but what is done with it” (Rousseau & Kirmayer, 2010, p. 66).

Reciprocal research

The consensus amongst researchers is that they have a responsibility to conduct reciprocal research with refugee and resettling communities (Dona, 2007; Harrell-Bond & Voutira, 2007; Jacobsen & Landau, 2003; Mackenzie et al., 2007; Pittway et al., 2010; Rousseau & Kirmayer, 2010). Indeed, researchers such as Catriona Mackenzie and colleagues (2007) state that “research with refugees can only be justified if it provides reciprocal benefits” (p. 316). Reciprocal research acknowledges that researchers rely on the generosity of research participants to generate data for their projects. It also acknowledges that researchers have the most to gain from the research and so have a responsibility to conduct themselves ethically and ensure that the research project provides reciprocal benefits, not only for participants but for the communities they represent. Most resettlement research has been criticised for documenting the difficulties refugee and resettling communities face. Mackenzie et al. (2007) maintain that researchers have a responsibility to respond to these difficulties and offer solutions, such as increasing capacity within communities, improving health outcomes, or changing social attitudes.

Mackenzie et al. (2007) acknowledge that this type of research exceeds the time and resources required of traditional approaches to research and that this can be “in tension” (p. 316) with academic institutions. Others have referred to this tension as “the dual imperative”:

“The dual imperative: to satisfy the demands of the academy and to ensure that the knowledge and understanding our work generates are used to protect refugees, influence governments, and improve the ways institutions like the United Nations or Non-Governmental Organizations do their work.”

(Jacobsen & Landau, 2003, p.1)

Whilst the concept of reciprocity is often discussed in the context of disseminating research, psychological researchers such as Miller (2004) have stressed the importance of

reciprocity in the initial relational context of resettlement research. The relational context refers to the relationship that develops between the researchers and participants and is considered crucial in accessing authentic accounts that accurately reflect the perspectives of refugee and resettling communities. Miller acknowledges the reluctance of these communities to participate in psychological research and describes the risk of superficial relational contexts capturing strategic, self-protective performances. Miller maintains that researchers must invest in the relational context of their research (i.e. transparency around the intentions of the research and investing time and resources to earn the trust of potential participants), in order to access authentic accounts that capture the complexity of communities' experiences. Acknowledging the relational context, he argues, contributes to the rigour of the research and confidence in the conclusions drawn from it. Miller has acknowledged that such reflections are rarely published in psychological research and attributes this to the dominance of positivist approaches to research (Miller, 2004, p. 219).

Research practices in New Zealand

International critique of resettlement research and calls for reciprocal research are consistent with concerns expressed by local resettling communities in New Zealand (Awad, 2011; ChangeMakers Refugee Forum, 2009; Fraser, 2011; Ministry of Business, Innovation and Employment, 2012; Mugadza, 2012; Rother, 2008). Concerns of being “soft targets” (Awad, 2011, p.45) prompted ChangeMakers Refugee Forum to publish guidelines on conducting research with resettling communities in New Zealand:

“These guidelines are designed to assist you [researcher] in your interactions with refugee background communities; to reduce demands on our communities and to ensure that the outcomes of any research benefit our communities.”

(ChangeMakers Refugee Forum, 2009, p.1).

The guidelines echo the concerns of refugees, resettling communities and researchers expressed earlier in this chapter (Mackenzie et al., 2007; Miller et al., 2006; Patel, 2003; Pittaway et al., 2010; Sukarieh & Tannock, 2012; Summerfield, 1999). They specifically state that researchers should “work with us, not on us” (ChangeMakers Refugee Forum, 2009, p.1) and encourage researchers to reflect on the type of research they are intending to conduct, ensuring they prioritise respect, relationships, recognise the diversity within resettling communities and avoid duplicating previous research. The guidelines recommend researchers also refer to priorities previously identified by resettling communities and conclude with the following challenge: “Can you produce results that acknowledge our issues and needs in a way that strengthens us, and perceptions of our communities?” (ChangeMakers Refugee Forum, 2009, p. 4).

As discussed in the previous chapters, resettling communities are concerned about how they are represented and the resulting stigma, societal prejudice and poor resettlement outcomes associated with such representations. They are also increasingly reluctant to participate in resettlement research and have requested strength-based approaches that draw attention to their resilience, dignity and desire to contribute to New Zealand society (Awad, 2011; ChangeMakers Refugee Forum, 2009; Fraser, 2011; Ministry of Business, Innovation and Employment, 2012; Mugadza, 2012; Rother, 2008). Thus, this PhD research is an attempt to respond to published criticism, local concerns and ChangeMakers Refugee Forum’s challenge by conducting reciprocal research that raises awareness of the problematic psychopathological representations potentially perpetuated by practitioners in the resettlement sector in New Zealand.

The transformative paradigm

Such an agenda aligns with the transformative paradigm. The transformative paradigm acknowledges the politics of knowledge production and maintains that the pursuit of knowledge should help people improve society (Mertens, 1999). According to Donna Mertens (2007) the transformative paradigm is informed by four philosophical assumptions (See Figure 4).

The first philosophical assumption relates to ontology and the nature of reality. In accordance with social constructivism the transformative paradigm poses these questions: “How is reality defined?”, “By whom?”, and “Whose reality is given privilege?” (2007, p. 216). These questions echo the concerns by critical psychiatrists, psychologists and resettling communities regarding the privileging of Western perspectives informed by positivist psychological research: Perspectives which in some instances have not only pathologised resettling individuals’ responses to extreme violence and human rights violations but silenced their reality of resettling and recovering in a new society of settlement.

The second philosophical assumption relates to epistemology and the relationship between researchers and participants. The transformative paradigm poses the following question: “If I am to really know if something is real, how do I need to relate to the people from whom I am collecting data?” (Mertens, 2007, p. 218). According to Mertens, establishing trust and partnerships throughout the research process is paramount and echoes the concerns and calls for reciprocal resettlement research summarised earlier in this chapter (Harrell-Bond & Voutira, 2007; Jacobsen & Landau, 2003; MacKenzie et al., 2007; Miller, 2004; Pittaway et al., 2010; Rousseau & Kirmayer, 2010; Sukarieh & Tannock, 2012).

Figure 4

Philosophical assumptions behind the Transformative Paradigm (Mertens, 2007, p. 216).

Ontology: There are multiple realities that are socially constructed, but it is necessary to be explicit about the social, political, cultural, economic, ethnic, racial, gender, age, and disability values that define realities. Different realities can emerge because different levels of unearned privilege are associated with characteristics of participants and researchers. Transformative researchers need to be aware of societal values and privileges in determining the reality that holds potential for social transformation and increased social justice.

Epistemology: To know realities, it is necessary to have an interactive link between the researcher and the participants in a study. Knowledge is socially and historically located within a complex cultural context. Respect for culture and awareness of power relations is critical.

Methodology: A researcher can choose quantitative or qualitative or mixed methods, but there should be an interactive link between the researcher and the participants in the definition of the problem, methods should be adjusted to accommodate cultural complexity, power issues should be explicitly addressed, and issues of discrimination and oppression should be recognised.

Axiology: Three basic principles underlie regulatory ethics in research: respect, beneficence, and justice. The transformative axiological assumption pushes these principles on several fronts. Respect is critically examined in terms of the cultural norms of interaction within a community and across communities. Beneficence is defined in terms of the promotion of human rights and an increase in social justice. An explicit connection is made between the process and outcomes of research and furtherance of a social justice agenda.

The third philosophical assumption relates to methodology and the decisions made to adequately address the concerns of marginalised communities. The transformative paradigm poses the following question: “How can I collect data about the reality of human experiences in such a way that I can feel confident that I have indeed captured that reality?” (2007, p. 215).

While the transformational approach prioritises the insights of marginalised communities gained through qualitative approaches, the power of integrating these insights with quantitative demographic and/or epidemiological data is recognised. This is particularly the case as quantitative data are still perceived by many decision-makers as more credible (Mertens, 2007). In the context of this research, I recognise that combining critical reflections from practitioners with recent clinical research has the potential to corroborate the concerns of resettling communities and challenge the assumptions of psychopathology promoted in the resettlement sector (Awad, 2011; ChangeMakers Refugee Forum, 2009; Fraser, 2011; Greenbank, 2014; Mugadza, 2012).

The fourth philosophical assumption relates to axiology and the ethical principles of respect, beneficence, and justice. Respect is required within and across communities at all stages of the research process and requires a sensitivity to power dynamics and prioritising the perspectives of individuals and communities who are repeatedly denied the opportunity to represent themselves. Beneficence refers to the researcher’s responsibility to protect and promote the rights of participants while justice is the ultimate agenda of the transformational paradigm.

In the context of this research, respect is reflected in my decision to develop a PhD research project that responds to resettling communities’ concerns over representation and reluctance to participate in research. Benevolence is demonstrated by the desire to raise awareness about assumptions of psychopathology in the resettlement sector. Finally, justice is

indicated by my commitment to disseminate the research findings to decision makers throughout the resettlement sector as a means to encourage them to change the representational practices they tend to rely on. I discuss these dimensions in more detail in the following chapters.

Donna Mertens developed the transformative paradigm in her work with deaf and hard of hearing communities in the USA. The work sought to improve the experience of the court system for defendants who identify as deaf or hard of hearing (Mertens, 1999). Whilst the transformational approach prioritises the insights of marginalised communities, Mertens also acknowledged the importance of including those responsible for their concerns. She advocated for designs that bring the two sides together to inspire action and reiterated that while researchers are not decision makers they have a responsibility to disseminate their research and recommendations to decision makers.

With its emphasis on investigating issues raised by marginalised communities, mixed methods and commitment to disseminating the research to facilitate change, the transformative paradigm was ideally placed to respond to the critique outlined in this chapter and corresponding calls for reciprocal research.

Conclusion

In response to published criticism regarding the perceived appropriateness, and practical application, of positivist psychological research conducted on resettling communities, this thesis aims to conduct reciprocal, social constructivist psychological research. This approach has the potential to produce outcomes that are more relevant to resettling communities and the services that support them. Informed by the transformative paradigm, the secondary aim of this thesis was to raise awareness of the assumptions of psychopathology resettlement practitioners have tended to rely on and to promote the resilience of resettling communities and realities of supporting them settle in New Zealand.

The transformation anticipated here was to create opportunities for resettling individuals to be represented as more than just at risk and a risk. The methodological decisions I made in my attempt to conduct transformative research will be described in detail in the next chapter.

Chapter 4

Methodology

“Methodologically, the transformative paradigm not only leads us to reframe the understanding of our worldviews but also to understand that subsequent methodological decisions need to be reframed as well.”

(Mertens, 2007, p. 219)

Introduction

In this chapter I describe the methodological decisions I made to produce the data analysed in this thesis. I describe my decision to conduct in-depth semi-structured interviews with local resettlement practitioners and the distinct stages of the thematic analysis to which I subjected the interview transcripts. I also describe my decision to document my attempts to disseminate this analysis to decision makers in the resettlement sector with a reflexive case study. Further I discuss how this approach allowed me to respond to published critique and calls for reciprocal research that addresses the potential preoccupation with psychopathology in the resettlement sector in New Zealand.

Methodological decisions

In the previous chapter I identified that the transformative paradigm was ideally placed to respond to criticism of psychological resettlement research and calls for reciprocal research. The transformative paradigm does not prescribe a specific methodology but encourages researchers to reframe their research around a number of parameters. More specifically, to conduct research that responds to local resettling communities' concerns, recognise the power of combining a range of quantitative and qualitative data, and to take responsibility to tie this data to socio-political transformation (Mertens, 2007).

Responding to local resettling communities' concerns

As discussed in the previous chapters, the impetus for this PhD research was the uncomfortable realisation that while resettlement agencies are powerful advocates for resettling communities, they are also accused of perpetuating the stigmatised status of resettling communities by relying on representations that promote assumptions of psychopathology. Representatives of resettling communities have argued that such representations can sabotage successful settlement so, with that in mind, I set out to conduct research that raised awareness of the responsibility resettlement practitioners have for representing resettling individuals and their potential role in perpetuating assumptions of psychopathology.

This research was also influenced by the reluctance of local resettling communities to participate in psychological research at the time of initiating this research, and published criticism regarding the perceived appropriateness and practical application of psychological resettlement research. I was, however confident that I would be able to interview a number of practitioners with refugee backgrounds and made a commitment to integrate the perspectives of resettling individuals who had participated in previous research in New Zealand.

Recognising the power of combining quantitative and qualitative data

I recognised that my position as a cross cultural psychology graduate and PhD candidate in Psychological Medicine put me in a strong position to question any psychopathological representations being reproduced in the sector. I had observed how easily critical perspectives from resettling communities could be dismissed. I realised I could capture similar critique from former colleagues and corresponding clinical research that could not be so easily dismissed. I therefore chose to conduct in-depth semi-structured interviews with resettlement practitioners to capture their critical reflections (qualitative data) and combined these critical reflections with corresponding clinical and academic research

published during the course of my candidature (quantitative data). Such an approach could corroborate the concerns of local resettling communities and challenge practitioners to reflect on how they were representing resettling individuals and/or communities and resettlement work.

Responsibility of researchers to tie data to socio-political transformation

As previously stated, the anticipated socio-political transformation was raising awareness of the issues of representation in the resettlement sector in New Zealand. More specifically, the responsibility that resettlement practitioners had in representing resettling communities and their potential reliance on assumptions of psychopathology. At the time of initiating this research, I anticipated that this transformation would occur primarily in the practitioners who participated in an interview with me. However, in line with the transformative paradigm, I was also committed to disseminating the research and associated recommendations to decision makers within the sector (Mertens, 1999). In an attempt to be accountable, I anticipated documenting the entire research process to provide evidence of how my approach as a researcher and my attempts to raise awareness in the resettlement sector were perceived by others throughout the course of my candidature. In addition, I wanted to document what, if any, socio-political change my research may have been able to catalyse. A critical aspect of such a case study would be my commitment to critical reflexivity.

Critical reflexivity

Critical reflexivity is a crucial aspect of social constructivist research (discussed on p. 52) that acknowledges that researchers co-construct the research they produce with participants. While there is little consensus as to what constitutes critical reflexivity, it generally involves “locating the researcher” (Finlay & Gough, 2003, p. 22) in the design, data

collection, data analysis, and dissemination of the research. Scholars committed to critical reflexivity have acknowledged that such “self-aware analysis” (Finlay & Gough, 2003, p. ix) is rarely published (see also Probst, 2015) and this sentiment has historically been shared by practitioners conducting research with refugee and resettling communities (Mackenzie et al., 2007; Marlowe, 2009; Miller, 2006, 2004; Patel, 2003; Pittaway et al., 2010; Szczepanikova, 2010).

As critical reflexivity was relatively uncharted territory for a PhD candidate trained primarily in positivist research methods, I sought inspiration from other researchers’ reflections on reflexivity (Braun & Clarke, 2013; Denzin & Lincoln, 2013; Finlay & Gough, 2003; Parker, 1992; Waitt, 2016), including an exploratory study of reflexive research conducted by Barbara Probst (2015).

Probst interviewed 34 qualitative researchers from eight countries (the United States, the United Kingdom (England, Ireland, and Scotland), Australia, New Zealand, Canada, and Israel) who maintained that a commitment to critical reflexivity can enhance the rigour of research, ethical treatment of participants and personal growth of the researcher. The researchers participating in this study also acknowledged a number of issues associated with critical reflexivity. The most frequently cited issue was the tension between the time needed for reflexivity and tight research schedules. Other researchers reflected on the self-doubt and anxiety that the process could prompt and recognised the potential risk of “narcissistic distortion” (Probst, 2015, p.45), which refers to the inappropriate or decontextualised emphasis on the researcher’s experience. The main recommendations to come from this study were the importance of documenting the agenda of the researcher, transparency around the analytical process and an audit trail.

Importance of documenting the agenda of the researcher

Probst (2015) recommended that researchers document the agenda of their research, acknowledge their subjectivity and answer the following questions: “Why was the study undertaken? Why does it matter, and to whom?” (p. 47). As cliché as it sounds, my responses to such questions ultimately came down to a sense of responsibility and belief that I was uniquely placed to conduct this research due to my experience and “unearned privilege” (Mertens, 2007, p. 216). Unearned privilege is a product of the social, political, cultural, ethnic and economic values that inform a given society, in addition to sexuality, gender, age and disability (Mertens, 2007). My sense of responsibility stemmed from recognising the unearned privilege and associated advantages afforded to myself and my family as we settled in New Zealand because of the socio-political, economic and ethnic forces that influenced the successful settlement of visibly European migrants.

As a first generation New Zealander of Dutch and Indonesian descent, my early years were spent in what would be considered a deprived community attending a public school. It was the type of community where resettling families are located after their initial stay in Mangere. I have really fond memories of this time. I had a diverse range of friends but also developed an awareness that not everyone had what I had. Over time, my parents achieved the success many European migrants achieve in New Zealand and we moved to an affluent area where I attended a private school. Again, I have fond memories of this time but the diversity of my friends decreased and I developed an awareness of what others had that I didn't. I therefore grew up being exposed to a wide spectrum of New Zealand society and the substantially different ways in which ‘different’ New Zealanders experience New Zealand.

Our family travelled regularly overseas to visit relatives throughout my childhood and at the age of 17 I started travelling independently with the ambition to travel to 30 countries

before the age of 30. This pursuit exposed me to many different cultures and different ways of living. It also exposed me to the realities of forced migration as I observed asylum seekers existing across Europe and visited refugee camps in South East Asia. The same year that I started travelling independently, I started studying psychology at university and volunteering at a local resettlement agency. As I progressed through my undergraduate psychology degree, I developed an interest in the ethnocentrism of psychology and choose to do an MSc in cross-cultural psychology: a discipline that sensitised me to the limitations of psychological research and allowed me to conduct meaningful research documenting Muslim women's experiences of Islamophobia in New Zealand (Jasperse et al., 2012).

Shortly after I completed my MSc in cross-cultural psychology, I started working at ChangeMakers Refugee Forum with local resettling communities. This experience sensitised me further to the shortcomings of New Zealand society and the unrelenting challenges resettling communities must navigate. It also prompted me to consider what psychological research could realistically do to address these challenges (Awad, 2011; ChangeMakers Refugee Forum, 2008, 2009).

I had the privilege of working with many outstanding individuals but one client stood out in particular. His name was Abdalla and at the time I got to work with him (2011) he had been participating in a poetry project with Refugee Trauma Recovery. One afternoon he entered the office with a poem he wanted to share with me called "Silence":

*"Perhaps one day I shall go out into the city and recognise myself amongst the crowd of souls. I will say to them, "Hey look! There goes the man I really am".
Will they dare to acknowledge me?
No one responds. There is silence in the atmosphere, silence on the mountain top,
silence beneath the universe. The world moves on minding its own business.*

Shamefully, I close my eyes and rest my mouth. Silence is the only language that does not need an interpreter.”

(Gabriel, 2010, p. 19)

Abdalla so eloquently expressed the stigma associated with having been a refugee, the bravery required throughout the resettlement process, and the lack of recognition from an indifferent society. I had been considering pursuing a PhD and this was the moment that catalysed my sense of responsibility to conduct transformative resettlement research. I wanted to use my experience, power and privilege to challenge issues of representation in the sector so resettling individuals could be seen and heard, instead of silenced. Then and there, I committed myself to utilising my unique position as a privileged first generation migrant, Pakeha², cross-cultural psychology graduate and resettlement practitioner to catalyse change in the New Zealand resettlement sector.

Transparency around the analytical process and an audit trail

In an attempt to catalyse such change, I wanted to raise awareness of issues of representation that originated in psychiatry, were being reproduced in the resettlement sector and contributed to the stigma Abdalla spoke of. I was also aware that I needed to be transparent about my complicity in the challenges I sought to address. The reflexivity reference that resonated the most for me during my candidature came from Claire Ballinger (2003), an occupational therapist who conducted social constructivist research in rehabilitation units for her own PhD research. I appreciated her reflections on navigating multiple research identities and recommendation to reflect on the following:

² Pakeha refers to a New Zealander of European descent in Te Reo (Te Aka Online Maori Dictionary, 2020).

“How do you represent yourself as a researcher?”

How is your discipline or profession implicated in this [research]?”

What assumptions about disciplinary or professional knowledge are reinforced by this [research]?”

How could this [research] be challenged?”

Who might benefit from this [research] and for whom might this [research] pose a threat?”

(Ballinger, 2003, p. 76).

Her prompts encouraged me to reflect on my own positioning as a former resettlement practitioner and PhD candidate in Psychological Medicine, two identities implicated in the critique that I was intending to raise awareness of. I anticipated that my research would resonate with resettlement practitioners and reassure resettling communities, but might also pose a threat for agencies responsible for providing specialist psychological support given their indicated reliance on the assumptions of psychopathology I sought to challenge. In response, I decided to reflect on Ballinger’s prompts throughout the research process, documenting them in a research journal and integrating them into this thesis, all while acknowledging that “the act of reflexivity is never complete” (Ballinger, 2003, p. 67).

Acknowledging the necessity of providing a transparent account of all methodological and analytical decisions (Probst, 2015), the rest of this chapter describes the decision to conduct semi-structured interviews with local resettlement practitioners and a constructivist thematic analysis of the transcripts. In addition to documenting my approach to disseminating my research in a reflexive case study.

Semi-structured interviews

With initial evidence that the local specialist mental health service was reproducing popular psychopathological representations of resettling individuals and resettlement work on

their website as illustrated in Chapter 1 (see p. 19), I decided to conduct in-depth semi-structured interviews with a cross section of their practitioners in order to obtain their reflections on working in the resettlement sector. I wanted to identify how practitioners from Refugee Trauma Recovery represented their work and resettling clients in a one-on-one conversation and bring them “into” the research process (Dunn, 2016, p. 185).

Interviews allow researchers to obtain a diverse range of perspectives from a diverse range of participants (Dunn, 2016). Described as “conversations with purpose” (Holloway, 1997, p. 94), semi-structured interviews consist of a predetermined set of questions designed to address a specific research question or aim. The major strength of semi-structured interviews is that they allow the participant to share what is most relevant from their perspective and the researcher has the opportunity to clarify answers and pursue unanticipated areas of insight. This flexibility is particularly important when conducting research with members of marginalised communities whose insights can differ significantly from mainstream society (Dunn, 2016). The major drawback of interviewing is that participants will only share what they are willing to share (which is their right) or may say what they think the researcher wants to hear (Dunn, 2016; Holloway, 1997; Fontana & Frey, 2000). Researchers can also be accused of “cherry picking” (Morse, 2010, p. 3) specific quotes from interviews that confirm their assumptions and research agenda. These limitations however also apply to other methods such as observation and questionnaires (Denzin & Lincoln, 2000).

After reviewing the literature, I drafted an initial interview schedule asking participants to share their experiences of working in the resettlement sector (Appendix C questions 1-3). I included specific prompts which would provide an opportunity for participants to reflect on popular representations of resettling refugees, and resettlement work, within New Zealand society (Appendix C questions 4-5). An additional question at the

end of the interview would capture any reflections the participants felt were important that I may not have anticipated (Appendix C question 6).

I then recruited a former colleague engaged in the resettlement sector at the time to pilot test the interview schedule. I requested feedback regarding the structure and interview style. On reflection we decided that I should move the initial demographic questions from the beginning of the schedule to the end as it felt intrusive to start the interview asking about a person's age and potential refugee background. It felt better to start the interview by asking: "I am interested in your experiences working in a refugee resettlement NGO in New Zealand. Tell me about your role and the organisation you work for?" allowing participants to offer information on their own terms.

The order of questions in the interview schedule can have a significant impact on the initial rapport with the participant and that is one of the benefits of pilot testing interview schedules (Dunn, 2016). Other benefits include ensuring the schedule prompts an adequate range of responses and rules out issues of ambiguity (Dunn, 2016; van Teijlingen & Hundley, 2010). I reviewed my colleagues' responses afterwards with my academic supervisors and was satisfied that the interview schedule had prompted a range of reflections that would allow me to analyse the issues of representation in the resettlement sector in New Zealand.

Participant characteristics

In response to initial evidence that the local specialist mental health service was reproducing popular psychopathological representations of resettling individuals and resettlement work on their website (Chapter 1, see p. 19), I initially intended to interview practitioners from Refugee Trauma Recovery. I was interested in investigating the way in which practitioners responsible for providing specialist psychological support would represent their work and resettling clients. However, after recruiting all practitioners from Refugee Trauma Recovery, I decided to expand my criteria to interview a cross section of

practitioners and volunteers working for the local branch of the New Zealand Red Cross and Interpreting New Zealand. It seemed pertinent to also identify how practitioners who do not provide specialist psychological support represent resettling individuals and resettlement work. This approach provided a cross section of practitioners who were responsible for providing initial practical and psychosocial support to the majority of resettling individuals in the area, as opposed to the minority who required specialist support. I was curious to see if these practitioners shared different reflections compared with their colleagues at Refugee Trauma Recovery and were more likely to engage with the public through the course of their work. Therefore, the ways in which they represent their work and clients arguably has wider reaching implications in terms of societal perceptions of resettling communities.

This approach is considered a form of purposeful sampling, more specifically criterion sampling whereby participants are recruited because they meet specific criteria (Denzin & Lincoln, 1994; Stratford & Bradshaw, 2016). In this instance, the inclusion criterion was to be currently working or volunteering for Refugee Trauma Recovery, New Zealand Red Cross and Interpreting New Zealand in the Wellington region. The choice to recruit additional practitioners who did not provide specialist psychological support was also a form of theoretical sampling as it was intended to reflect the aims of the research, create opportunities for comparison and greater heterogeneity amongst participants (Robinson, 2014).

There was also a practical consideration that if had I stuck with my original plan to only interview practitioners at Refugee Trauma Recovery, I would have had only eight interviews to analyse. I was concerned that this might not have been enough as the scholars informing my analytical approach recommended 20-30 interviews for a PhD research project (Braun & Clarke, 2014). Sample size is a contested area in qualitative research (Robinson, 2014; Stratford & Bradshaw, 2016) and after amending my inclusion criteria to invite

practitioners from other agencies, I decided I would interview every eligible individual who expressed an interest in participating in this research. Such a decision leaves this study susceptible to self-selection bias (Dunn, 2016) with participants volunteering to participate in an interview because the agenda of the research resonated with them. A certain degree of self-selection bias is unavoidable in voluntary research.

While participant characteristics are usually reported in the results section of psychological research, I have chosen to report the characteristics of participants here. I do this because I intend to quote participants' reflections later in this chapter. This choice is also in accordance with the transformative paradigm and my epistemological position where I do not consider participants as 'data' but rather individuals who co-constructed the critical reflections analysed in this thesis with me. Furthermore, standard practice in psychological research usually requires the tabulation of participant characteristics and provision of pseudonyms. However, given the size of the sector, associating an individual's gender, country of origin and professional position could compromise the confidentiality I had promised participants. Thus, in the interests of confidentiality, I have chosen to report the characteristics of participants collectively below.

Twenty-five individuals, involved in the Wellington resettlement sector in 2014, volunteered to participate in an in-depth semi-structured interview. Fifteen participants identified as professional practitioners: psychiatrists, psychologists, counsellors, social workers, case workers, cross cultural workers, and interpreters, with a range of 2 - 25 years' experience ($M = 9$ years). Ten participants identified as volunteers, with 0.5 - 14 years' experience ($M = 3$ years). Twelve participants identified as New Zealand born. Eight participants identified as migrants from Europe, South East Asia or South America (length of residence in New Zealand spanning 2 - 48 years ($M = 15$)). Five participants identified as former refugees from Europe, the Middle East, Africa or South East Asia (length of residence

in New Zealand spanning 6 - 20 years ($M = 13$ years)). Of the participants, fifteen were female and ten were male, with ages ranging from 23 – 73 years ($M = 44$ years). Despite the small size of the local resettlement sector, I was able to interview a diverse range of participants in terms of their respective professional positions, experiences, gender, age, and migratory status. In spite of this heterogeneity, it is important to acknowledge the restricted ability to generalise the perspectives from these practitioners to other regions of resettlement. For further discussion of this limitation see Chapter 7 (p. 197).

In terms of integrating individual reflections in this thesis, I chose to indicate the gender of each individual, whether they were born in New Zealand, migrated to New Zealand or resettled under the refugee quota programme and in what capacity they engaged with resettling refugees. For instance, ‘Male, migrant, practitioner’ and ‘Female, refugee background, volunteer’. I acknowledge the limitations of this classification as individuals can identify as having a migratory or refugee background despite having been born in New Zealand. Furthermore, many migrants working in the resettlement sector have come from the same regions as resettling communities but had the means to migrate voluntarily. In the context of this study however participants did not identify with more than one category and I was able to acknowledge the potential contribution of participant characteristics without compromising confidentiality. I was conscious that making an individual’s participation public could have detrimental personal, professional and political implications for participants (Dunn, 2016).

Initial relational context and recruitment

In addition to being aware of the reluctance of local resettling communities to participate in postgraduate psychological research (see Ch 3, p. 59), I knew resettlement agencies shared similar sentiments. During my time at ChangeMakers Refugee Forum I had collaborated on a number of interagency initiatives and attribute the access I was granted by

management from Refugee Trauma Recovery and New Zealand Red Cross to the relationships I established during that time. As a former resettlement practitioner, I was able to schedule face to face meetings with management, describe my anticipated PhD project and assess their interest in participating. I knew I would need their support in order to proceed.

I have included an entry from my research journal after my initial meeting with management from Refugee Trauma Recovery where, informed by Ballinger's prompts, I reflected on how I represented myself, their reservations regarding the research and invitation to an upcoming staff meeting to recruit potential participants:

“Today I met with management at Refugee Trauma Recovery. [NAME] and [NAME] acknowledged that they do not typically participate in research, particularly postgraduate research, but could see the potential of this research. They referred to my reputation and how this was the reason they were open to exploring the possibility of participating in this research. They reiterated the need to protect their staff and clarified the time commitment required to participate. I reiterated my desire to produce research that has perceived benefits for resettling refugees and resettlement practitioners, and promised I would approach this piece of research differently. I have been invited to attend a staff meeting to introduce myself and my anticipated research project. I will take this opportunity to prepare a presentation that will provide an overview of recent resettlement research that will hopefully resonate with everyone, regardless of whether they decide to participate or not. An attempt to demonstrate respect and reciprocity from the outset of the research.”

(Research Journal 13.03.14)

Once ethical approval was granted from the Otago University Human Ethics Committee (Reference number 14/109: Appendix D), I liaised with management from Refugee Trauma Recovery to select an appropriate staff meeting to attend. In addition to the intention to promote the research and recruit participants, I prepared a presentation on the latest research on vicarious responses to resettlement work and recently published concept of vicarious resilience (Hernandez-Wolfe et al., 2014, see Ch 2, p. 44). Preparing such a presentation was an attempt to raise awareness of issues of representation within the team, regardless of whether they chose to participate in my research or not, and to give them a sense of the type of research I was intending to conduct. I distributed Information Sheets (Appendix E) at the end of the session and asked staff to contact me directly to express their interest in participating. This approach to recruitment seemed to be appreciated and I ended up receiving emails from every practitioner in the team, including the following:

“I was very engaged in your presentation. It was like having a mini training and allowed me to develop another frame of reference when thinking about clients. I would be happy to engage in your research.”

(Female, NZ born, practitioner, P7)

I adopted a similar approach to recruiting participants from the New Zealand Red Cross. Again, this was facilitated by my relationships with management formed over the years as a refugee support volunteer and researcher. I was also able to ask the volunteer coordinator of New Zealand Red Cross to distribute a recruitment email (Appendix F) to all volunteers on the network. Again, I immediately started to receive email responses illustrating the perceived value of the research and interest in participating: “Your research seems very interesting and valuable. I'd love to help” (Female, migrant, volunteer, P22).

After recruiting participants from Refugee Trauma Recovery and New Zealand Red Cross, I approached other resettlement agencies to participate in the research by email. A number of agencies did not acknowledge this invitation but Interpreting New Zealand did and distributed the recruitment email across its network. I received emails from two interpreters. The contrast between this experience and the relative ease of recruitment with Refugee Trauma Recovery and New Zealand Red Cross was my first insight into the significance of the relational context and how my relationships with management and their endorsement of my research influenced the research process.

Co-constructing interview reflections

Once I received emails from individuals expressing interest in participating in an interview, we made arrangements to meet at a mutually agreeable time and location. The majority of interviews with practitioners were conducted onsite at the resettlement agencies whilst the majority of interviews with volunteers were conducted at cafes in the city centre. At the beginning of each interview, I asked participants if they had read the information sheet and had anything they would like clarified. At this point I reiterated that participants were free to stop the interview at any stage without consequences and asked for their written consent (Appendix G). Taking the time to discuss the impetus for the research and inform participants of what was going to be required of their participation was a fundamental aspect of respecting their autonomy (Dunn, 2016; Fontana & Frey, 2000; Holloway, 1997). After receiving written consent I initiated the semi-structured interview which was approximately an hour in length.

Towards the end of each interview, participants were asked whether there was anything that they had not discussed that they felt was important to add and were encouraged to take this opportunity to reflect on their experience of the interview. Every participant

reflected on the perceived value of the research and expressed a desire to receive a report of the findings. For example, one participant said:

“This kind of research is just really important for us as professionals in the sector but also for our society as a whole. Trying to change how we think and talk about refugee background communities is important on so many levels [...] I really want to see the end result.”

(Female, NZ born, practitioner, P12)

At the end of the interview, I presented each participant with a card acknowledging that without their participation and insights I would not be able to pursue my PhD. Within the card was a \$30 grocery voucher; a koha³ to acknowledge their time. I applied for this funding through the University of Otago post-graduate research office.

The interviews were conducted over a four month period (September – December, 2014), audio recorded and transcribed verbatim over four months (January – April, 2015). In light of my anticipated analytical approach, constructivist thematic analysis within a transformative paradigm, a simplified transcription scheme was all that was required (see Appendix H). Such an analysis does not attend to technical linguistic details of speech so these are not acknowledged in the transcription scheme either (Braun & Clarke, 2006; Parker, 1992).

It was important to me to provide participants with an opportunity to receive and review a copy of the transcript of their interview, a process referred to as “participant checking” (Dunn, 2016, p. 173). This process is considered particularly important when

³ Koha refers to a contribution in Te Reo and has connotations of reciprocity (Te Aka Online Maori Dictionary, 2020).

interviews are conducted in a language of which participants are not native speakers and can improve the accuracy of subsequent interpretation and analysis. Twelve of the 25 participants chose to review a copy of their transcript, including all participants who were not native English speakers. While I received no requests to change anything, all the participants who had chosen this option expressed their appreciation for this opportunity to review their transcript, as illustrated by the following comment:

“Thank you for this. I have nothing to change. It is a great reflection for myself [...] I am sorry that it must be really hard to transcribe my English [...] Best wishes for the report.”

(Male, refugee background, practitioner, P13)

In addition to such self-conscious comments on their ability to communicate in English, a number of participants with refugee or migrant backgrounds also expressed concerns regarding the confidentiality of their transcripts:

“I’m not really that comfortable with, how can I say, with expressing that I got these conclusions from working with the [NATIONALITY] community [...] it could not only give too much away about me or the community but professionals too. I understand that quite a lot of my views could be a bit challenging for other people to accept [...] I really enjoy being able to contribute to your research but anonymity at all levels is so important to me.”

(Female, migrant, practitioner, P9)

In these instances, I was able to reassure them that I would do everything I could to make sure no one would be able to attribute what they had shared back to them. I also received a number of responses that indicated the interview process had inspired participants to consider initiatives in their own communities:

“Thank you Marieke, that was really great to read. It's also served as a reminder to me about ideas I'd had about possibly doing things within my community to increase understanding about refugees. It was actually quite inspiring to read through! Best of luck!”

(Female, migrant, volunteer, P22)

Analytical approach

“Thematic analysis offers a toolkit for researchers who want to do robust analyses of qualitative data, but yet focus and present them in a way which is readily accessible to those who aren't part of academic communities.”

(Braun & Clarke, 2014, p. 2)

Thematic analysis is an analytical approach popularised by Virginia Braun and Victoria Clarke (2006) in their publication, “Using thematic analysis in psychology” which provides a six-stage process for systematically identifying, analysing and reporting patterns across a data set. These patterns, known as themes, can be identified in one of two ways in thematic analysis: an inductive or deductive way (Braun & Clarke, 2006). An inductive approach to thematic analysis is a “bottom-up” approach and is driven by what is in the data. In contrast, a deductive approach analysis is a “top-down” approach, where the researcher brings specific concepts and concerns to the data. In reality, thematic analysis often uses a combination of both approaches and the approach taken by a particular researcher will ultimately rest on their research question.

As outlined in earlier chapters I have chosen to take a transformative approach to this PhD research. Such an approach is informed by social constructivism and attention to issues of representation in the resettlement sector. The agenda of the research is applied and the intended audience of the research are resettlement practitioners in New Zealand. I therefore

determined that the most appropriate form of analysis for this project was constructivist, acknowledging that themes are socially produced and can have socio-political consequences (Braun & Clarke, 2006). Constructivist thematic analysis often utilises a combination of deductive and inductive approaches and in this case, I was interested in identifying any reproduction of assumptions of psychopathology (deductive) whilst anticipating resistance to such assumptions and unanticipated aspects that participants felt were important to share (inductive).

Constructivist thematic analysis has similarities with critical discourse analysis (van Dijk, 1993). Indeed, both attend to the productive influence of language and interplay between power, discourse and dominance. van Dijk (1993) positions critical discourse analysis as a political act that addresses the abuse of power by “power elites” (p. 252) and the ability of these elites to maintain their dominance through their access to discourse. According to van Dijk, individuals and institutions have “discourse access profiles” (p. 256) which determine “who is allowed to speak, to whom, where, when and how” (p. 257). Power is a product of access to discourse and dominance is produced directly, by participating in particular discursive contexts, and indirectly, by influencing particular public discourse(s).

In the context of this research, it is acknowledged that resettlement agencies are recognised authorities on refugee resettlement and have considerable access to resettlement discourse. These agencies have direct access to resettlement discourse by engaging directly with resettling communities, practitioners, policymakers and the public. They also have indirect access to the public through their engagement with the media and public awareness campaigns.

Resettlement agencies are responsible for representing resettling individuals and the representations (re)produced by practitioners affiliated with these agencies have significant implications for the societal perceptions of resettling communities and resettlement work.

This is of great significance as the stigma associated with particular societal perceptions can have significant implications for resettling individuals and their ability to settle successfully in their new society of settlement (Colic-Peisker & Tilbury 2003; Watters, 2001; Westoby & Ingamells, 2010; Zetter, 1991).

It is also acknowledged that the assumptions of psychopathology, that originated in psychiatry, are institutionalised and inform the structure of service provision. Practitioners are therefore likely to be invested in promoting such assumptions in order to continue receiving recognition and resources (Colic-Peisker & Tilbury 2003; Miller et al., 2006; Watters, 2001). According to van Dijk (1993; 2000) such promotion is often characterised by particular representational practices. More specifically, the promotion of specialist perspectives and statistics that reinforce resettling individuals “deficits” and “dependence” (p. 34) whilst promoting the “apparent acceptance” towards resettling communities and “vigorous action” (p. 48) to address their psychopathology.

van Dijk (1993) posits that representations are “the ‘missing link’ between discourse and dominance” (p. 251) and allow certain versions of reality to “appear natural” and “acceptable” to others in society (p. 254). This thesis acknowledges that representations that promote the assumptions of psychopathology do appear natural and acceptable given that persecution defines the process of becoming a refugee. However, as stated earlier, I also share the concerns of resettling communities and scholars who maintain that there are a range of responses to such persecution such as perseverance, pride and post-traumatic growth (Ai et al., 2007; Hussain & Bhushan, 2011; Kroo & Nagy, 2010; Papadopoulos, 2007; Ssenyonga, Owens & Olema, 2013; Summerfield, 1999; Sutton et al., 2006) and resettling individuals often have other priorities during the resettlement process than addressing their pre-displacement trauma (Bracken et al., 1995; Miller et al., 2006; Patel, 2003; Summerfield, 1999; Watters, 2001).

While critical discourse analysis and constructivist thematic analysis both critically analyse the representational practices of power elites, constructivist thematic analysis does not attend to, or attempt to analyse, the complex linguistic features as most forms of critical discourse analysis do. Many scholars have commented on the lack of consensus on how to conduct critical discourse analysis (Parker, 1992; van Dijk, 1993; Waitt, 2016; Willig, 2013) and constructivist thematic analysis is considered to be a much more accessible analytical approach (Braun & Clarke, 2014). This is particularly relevant as the intended audience of this research are resettlement practitioners who may not be interested in academic discussions of ‘discourse’. Braun and Clarke (2014) have acknowledged that some scholars have challenged the “sophistication” (p. 1) of thematic analysis, particularly in doctoral research projects. In response to this, they acknowledge that thematic analysis, like any analysis, can be done well or poorly and reiterate the importance of PhD candidates being transparent about their analytic choices and consistent with their chosen theoretical orientation. Below I attempt to achieve such transparency with a description of the six stages of constructivist thematic analysis I conducted. I also referred to Braun and Clarke’s (2006, p. 96) 15-point checklist of criteria for good thematic analysis (See Appendix I).

Familiarising self with data

The first stage of the analysis was initiated when I transcribed the interviews. Whilst time-consuming, this transcription process provided an opportunity for me to immerse myself in the interview data critically and take note of initial reflections that were relevant to my research questions. Once I had transcribed each interview, I imported it into Hyper RESEARCH. Hyper RESEARCH is a software programme which allows researchers to organize their qualitative data and subsequent analysis (ResearchWare, 2020). Once I had transcribed and imported all the interviews, I was able to re-read each transcript and proceed with the second stage of the analysis.

Generating codes

The second stage of the analysis involved systematically coding all the interview transcripts in Hyper RESEARCH. Codes can be descriptive and interpretative and should correspond with the research questions. Descriptive codes reflect the content of participant accounts, whereas interpretative codes provide an interpretation of the content. Extracts from an interview transcript are allocated one or multiple codes and Hyper RESEARCH allows the researcher to subsequently isolate specific coded extracts across all the interview transcripts, otherwise known as the data set.

Initial codes in my analysis included; “refugees”, “at risk representation”, “risk representation”, “resilient representation”, “resettlement work”, “risks of resettlement work”, “rewards of resettlement work”, “responsibility for resettlement”, “responsibility for representation”, “frustration over representation”, “media representation”, “societal perceptions and prejudice”, “stigma”, “socio-political context”, “advocacy and lack of awareness”, “trauma”, “powerlessness”, “pity”, “performances of refugeeness”, “pride”, “PTSD”, “pre-displacement trauma”, “post-displacement trauma”, “psychological intervention”.

Generating initial themes

The third stage of the analysis involved collating codes into coherent patterns across the data set. According to Braun and Clarke (2006) a theme “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (p. 82). Contrary to popular opinion, themes do not “emerge” from the data and Braun and Clarke (2012, p. 63) stress the importance of acknowledging the active role researchers take in interpreting and identifying themes. Braun and Clarke (2012) also state that there is “no magic formula” (p. 65) to determine the number

of themes required of a given data set. The emphasis is rather on the analyst and their ability to “tell a particular story” (p. 65) that captures the complexity of the dataset.

The initial deductive themes I identified corresponded with participants’ resistance and/or reproduction of the assumptions of psychopathology (i.e. “PTSD”, “pre-displacement trauma” and “psychological intervention”). Participant reflections on the resilience of resettling individuals, the significance of resettlement stress and/or ethnocentrism of psychotherapy were interpreted as instances of resistance. Participant reflections on the severity of resettling clients’ PTSD from their pre-displacement trauma and requirement of specialist psychological support were interpreted as instances of reproduction. Participant reflections on the ramifications of reproducing assumptions of psychopathology were identified as initial inductive themes. (i.e. “societal perceptions”, “stigma” and “service provision”)

Reviewing initial themes

The fourth stage of analysis involved reviewing the initial themes to confirm that they reflected the coded extracts and captured the most relevant aspects of the data set in relation to the research question. At this stage of the analysis it is common to collapse a number of initial themes and/or split a theme and that is what I did. For instance, I ended up combining initial themes that captured participant reflections on; pre-displacement trauma, post-displacement trauma, societal perception and prejudice, service provision and the socio-political context, together in one theme challenging the tendency to attribute resettling individuals’ distress to their pre-displacement trauma. In contrast, I chose to separate reflections on the responsibility for issues of representation in New Zealand society according to whether they attributed it to the media, or their own attempts to advocate for resettling clients. This distinction was crucial and informed my conclusion of a crisis of representation in the sector.

Defining and naming themes

The fifth stage of the analysis involved reviewing the overall story of the analysis and ensuring there was sufficient evidence to support each theme. This stage of the analysis also involved naming each theme. Braun and Clarke (2012) acknowledge that naming of themes may seem trivial but endorse “concise” and “catchy” (p. 68) names, preferably informed by the reflections from participants. I therefore selected an extract to capture the essence of each theme and isolated a phrase from each extract to be the corresponding theme name (see Figure 5).

Figure 5.

Overview of thematic analysis.

Theme	Corresponding participant quote	Description of theme
“They’re people”	“I guess what I’d like people to know about refugees is that they’re not helpless individuals who we should all pity and wrap in cotton wool. They’re people. People with skills. People with attributes. People who would like to have a life and be independent [...] Some of them do have textbook PTSD with the nightmares, flashbacks and all the rest of it but the resilience really is remarkable. They’re looking after their kids. They’re working [...] I guess that goes back to the stories people have. What has already been overcome.”	This theme captures participants’ resistance against the preoccupation with psychopathology, powerlessness, and pity to acknowledge the resilience of resettling individuals and range of responses to trauma.
“This is not paradise”	“I find that there is not enough encouragement about what they are actually achieving here. Often, they are validated on “Oh and then you came to New Zealand” and then also this perception about New	This theme captures participants’ resistance against the preoccupation with pre-displacement trauma to acknowledge

	Zealand being some kind of heaven. I see it across all professionals, particularly Kiwis, “Oh it was so horrible there and now you arrived to paradise”. This is not paradise.”	the significance of post-displacement stress for resettling individuals.
“Psychotherapy”	“Not all refugees are traumatized. They've had traumatic things happen in their lives but a lot of them are remarkably resilient. Although we are nominally Refugee Trauma Recovery, by no means are all the interactions I've had with people here been trauma focused. There is an assumption here that some people are really badly traumatised and need specialist trauma treatment. That needs to be recognised but there isn't one approach that fits all people. Some of the really traumatized people are not remotely interested in any trauma type therapy and they present wanting help with practical stuff and if that's what they want, that's what they should get. The idea that trauma should be opened up and resolved by psychotherapy is a Eurocentric kind of idea. It's unclear how well it works.”	This theme captures participants' resistance against the assumption that all resettling individuals require, desire, and respond to specialist psychological support.
“Pretty damaged people”	“You can't have too higher hopes. I'm sort of getting to the stage where I don't think we can really get them [resettling clients] totally out of their PTSD. Ours are pretty damaged people. When you've been hung upside down and water boarded, day after day, that has a pretty strong effect on you. The tortured ones are different.”	This theme captures participants' reproduction of representations that rely on assumptions of psychopathology and instances where participants reflected on the stigmatising

		implications of such representations.
“Oh, those poor people”.	“There is the reaction of “Oh, those poor people”. “Oh, you're just amazing helping them”. “Oh, how do you cope?”. It's disempowering for everybody. It's disempowering for the refugee communities. It's disempowering for people working in the sector. It's disempowering for me [...] the people I work with have helped me observe my own life. It's made me a richer person and it keeps people here. I've got colleagues who have been here for 15, 20, 25 years.”	This theme captures participants' resistance against the assumption of risk that accompanies resettlement work to acknowledge the opportunities for vicarious resilience in the sector.
“People have no idea”	“I quite like the socially educating side of it [resettlement work]. People make comments “We shouldn't be taking in refugees” and I quite like to actually be able to put a story behind it. Illustrate why there is the need and what these people have been through. Most people have no idea, no idea at all.”	This theme captures participants' pride in advocating for resettling clients and communities, the necessity of such advocacy, and reliance on representations that perpetuate assumptions of psychopathology.

Producing the report

The sixth stage of the analysis involved preparing the analysis to be shared with participants and participating agencies. Braun and Clarke (2006) discuss this stage primarily in terms of preparing a final report, constructing an analytic commentary, selecting compelling themes and extracts and relating the analysis back to the research question and peer reviewed research. In my case I prepared a one hour PowerPoint presentation to share with participants and participating agencies.

The preparation of the presentation allowed me to practice the “story of the dataset” I provide in Chapter 5, albeit a condensed version. I chose to address the assumptions of psychopathology first, as that was the basis of my research and combined participants’ critical reflections with corresponding clinical data and recent resettlement research. I went on to share instances of practitioners reproducing representations that rely on such assumptions. I concluded with reflections from refugee background practitioners on the ramifications of such inaccurate representations.

In the following section, I reflect on the process of sharing my initial analysis with participating agencies, a priority within the transformative paradigm.

Sharing the initial analysis with participants and participating agencies

Once I had completed the initial round of analysis I pursued opportunities to present it back to participants and management from participating agencies. This is an additional aspect of participant checking that involves sharing the analysis with some or all participants, creating opportunities for clarification, critique, and potential collaboration (Braun & Clarke, 2013). Again, as with the transcripts (Dunn, 2016), participant checking is conducted to minimise issues of misrepresentation and is important when working with historically misrepresented communities and/or controversial concepts.

The first participating agency to respond was Refugee Trauma Recovery. It took approximately two months between re-initiating contact with management (August, 2015) and actually returning to present at another staff meeting (October, 2015). As the extract from my research journal illustrates, this initiative provided confirmation of my analysis and powerful feedback regarding the perceived value of the research and research process:

“Today I presented my initial analysis back to the staff at Refugee Trauma Recovery. My impression was that the initial analysis I presented captured their critique of the sector. Everyone confirmed the instances of resistance and

reproduction I had identified and no one asked for clarification. Interestingly, participants were more interested in reflecting on their experiences participating in the research itself. They all expressed appreciation for my “respectful” approach and ability to communicate complex concepts in an accessible way. One participant, with a refugee background, said “You see and hear and I can’t wait for you to share”. From the inception of this research I promised management (and myself) that I would do research differently and it is great to hear participants describing the perceived value of the research and research process.”

(Research journal, 11.10.15)

This feedback was particularly significant given the agency’s previous reluctance to participate in post-graduate research. It also provided evidence for Miller’s (2004) argument about the importance of investing in the initial relational context of research. The positive response from Refugee Trauma Recovery’s practitioners also confirmed the accessibility of thematic analysis for applied research initiatives that aspire to transform policy and/or practice (Braun & Clarke, 2014).

The second agency to respond to my offer to share my research was Interpreting New Zealand. I met with the CEO of Interpreting New Zealand and she invited me to speak at their upcoming AGM where a significant number of interpreters and other stakeholders would be present. I prepared a 20 minute presentation and afterwards a number of attendees shared their own observations of the sector. I received the following email from the CEO the day afterwards acknowledging the perceived relevance of the research and offer of on-going support:

“Thank you so much for coming and speaking at our AGM last night. Your presentation obviously struck a chord with the audience [...] I hope the message

[resilience of refugees and opportunities for vicarious resilience in the resettlement sector] gets out to the wider population – including the media and government! Please keep in touch and if you need any more input, just let us know.”

(CEO INZ, 11.11.15)

In contrast, my attempt to reconnect and share my analysis with New Zealand Red Cross was initially unsuccessful. I emailed the New Zealand Red Cross Client Services Manager with whom I had initially liaised and she responded with enthusiasm:

“Thanks for following up and exciting that you are at the point of being able to share your initial findings. It would be great to have you come along and talk to our team – how long do you think you need to do this well? I want to make the time to do justice to the topic. We are very busy here.”

(Client Services Manager, 19.10.15)

However, after sending an email every fortnight over five months and receiving no further response, I had to recognise that my research was no longer a priority for practitioners at the New Zealand Red Cross at that particular time. I was aware that the increased media coverage of the ‘refugee crisis’ had created an influx of volunteers for the team to coordinate and that they were busy preparing for the arrival of additional families from Syria. I therefore decided to approach New Zealand Red Cross Head Office directly (See Chapter 6 for reflections on this process), with the intention to liaise with the local team once things had slowed down for them. I had to acknowledge and respect that my PhD research was not a priority for these practitioners at this time.

The reflections I had read on conducting reciprocal resettlement research had stressed that significance of respect, the renegotiation of research relationships and consideration of issues that arise after the research (Dona, 2007; Jacobsen & Landau, 2003; Mackenzie et al,

2007; Pittaway et al., 2010; Rousseau & Kirmayer, 2010). I was also reminded by Barbara Harrell-Bond and Eftihia Voutira (2007) that the freedom to conduct research is “neither automatic nor absolute” (p. 285) and sought solace in the fact that the I could not be accused of not pursuing opportunities to “pass on” my PhD research (Pittaway et al., 2010, p. 229).

Refining the analysis

After conducting the initial analysis of the interviews and presenting this analysis back to several participating agencies in 2015, the socio-political climate changed, with increasing media coverage of the ‘refugee crisis’ and initiatives to increase New Zealand’s refugee quota (Stephens, 2018; Slade, 2019). I was able to refine my analysis after observing how local resettlement agencies who had participated in my research were representing resettling communities and resettlement work in the media during this time.

The differences in the ways resettling individuals were represented in the media and interviews provided a powerful opportunity to reflect on the relational context of the interviews I had conducted with practitioners. I found the discrepancy between what was acknowledged privately in an interview with me and publicly in the media intriguing. This discrepancy also aligned with the discrepancy between the representations reproduced on Refugee Trauma Recovery’s website (see Chapter 1, p. 19) and resistance of these representations in the reflections of many Refugee Trauma Recovery practitioners in their interviews. This opportunity for reflection inspired my conclusion that practitioners are potentially caught in a ‘crisis of representation’ in the resettlement sector. It also informed my recommendation that the sector requires initiatives that stimulate critical reflexivity and sensitise practitioners to how they represent their work and resettling clients (see Chapter 5 for this analysis and discussion).

Reflecting on stimulating critical reflexivity in the resettlement sector

The secondary aim of this PhD research was to conduct reciprocal research that raised awareness of the problematic psychopathological representations that have been perpetuated by some practitioners in the resettlement sector in New Zealand. At the time of initiating my research there was evidence that local resettlement agencies were relying on representational practices that promoted assumptions of psychopathology and I anticipated raising awareness of this issue with practitioners from these agencies.

The analysis from the practitioner interviews indicated that while practitioners attempted to resist the assumptions of psychopathology circulating in society, very few practitioners recognised their role in potentially promoting such assumptions. The recommendation from my analysis was that the resettlement sector required initiatives that stimulate critical reflexivity and sensitise practitioners to how they represent their work and resettling clients. Informed by the transformational paradigm and the responsibility researchers have to disseminate their research and recommendations to decision makers (Mertens, 1999), I decided to document my approach and how practitioners responded in a critically reflexive case study.

Case studies are considered a “critical tool” in qualitative psychological research (Moglia et al., 2011, p. 2895) and allow researchers to develop “an in-depth, multifaceted understanding of a complex issue in its real-life context” (Crowe et al., 2011, p. 1). Case studies can have implications for both theory development and theory testing (Baxter, 2016; Crowe et al., 2011). In the context of this study, the use of a case study approach enabled me to be accountable to the secondary aim of my research (raising awareness of problematic representational practices practitioners often rely on), whilst also testing the themes and concept of a crisis of representation I had constructed from my analysis of practitioner

interviews (the primary aim of this research). Seeking such validation and verification from stakeholders in the research context is considered best practice (Moglia et al., 2011) and aligns with the priorities of the transformational paradigm (Mertens, 2007). It also aligns with Ballinger's (2003) prompts to reflect on how a researcher represents themselves, their research and others' responses to them (see previous discussion on p. 73).

According to Moglia et al., (2011) data in case studies can include email correspondence, conversations and presentations. This approach aligns with the work of Mountz et al., (2015) and their suggestion that the pursuit of personally and politically meaningful research requires a reconsideration of what "counts":

“What if we counted differently? Instead of articles published or grants applied for, what if we accounted for thank you notes received, friendships formed, collaborations forged? [...] Slow scholarship is about engaging different publics, engaging in activism and advocacy, and generally amplifying the potential impact of our scholarship rather than moving on to the next product that ‘counts.’”

(Mountz et al., 2015, p. 1245)

In light of the concerns regarding the perceived relevance and application of psychological resettlement research (see Chapter 3, p. 51), and my desire to produce personally and politically meaningful PhD research, I documented my research dissemination to different audiences, as well as my efforts for advocacy, and collaborations to amplify its impact. I wanted my PhD to offer an alternative example of what can 'count' in psychological resettlement research. I therefore amended my ethical approval and gained consent to incorporate conversations and email correspondence into my reflexive case study

(Reference number 14/109: Appendix J), in addition to copyright permission for training resources and websites (Appendix B).

When I initiated my PhD research, I never anticipated that I would have the opportunity to collaborate with the New Zealand Red Cross to address the secondary aim of this research across the country. I was able to document this development in the reflexive case study and I sought copyright permission to reflect on the resources and regional training tour associated with this (see Appendix L, M, N). After the regional training tour I was invited to present my research to other agencies and this resulted in critical feedback from a number of practitioners responsible for providing psychological support to resettling individuals. This critical incident provided opportunities for further reflection and refinement of my concern of a crisis of representation.

Reflecting on critical incidents is a recommended practice in case study design (Crowe et al., 2011) and aligns with Ballinger's prompts for reflexivity where she encourages researchers to reflect on the ramifications of their research and ask, "for whom may this pose a threat?" (Ballinger, 2003, p. 76). I also reviewed published reflections from researchers attempting to disseminate their research in other resettlement contexts. Attempts were made to anonymise the agency and practitioners involved in this incident. It is also important to acknowledge that integrating my interactions with them was not an attempt to present these practitioners in a negative light but rather to illustrate the issues I was exploring in my analysis and attempting to address with my PhD research.

Analytically, I draw on my own observations in addition to email correspondence, PowerPoint presentations, conference posters, media articles, websites and training resources collected between 2016 and 2018. I stored these different data points in Hyper RESEARCH, along with the interview transcripts, and was able to code each to identify the consistencies

with the original constructivist thematic analysis I conducted (see p. 84). I was also able to identify new concepts and considerations that lead to an additional review of the literature (search terms: “refugee”, “resettlement”, “research”, “relational context”, “research dissemination”) and refinement of my analytical interpretation (i.e. the significance of the relational context in the reception of critical research).

I present this critically reflexive case study in Chapter 6 in the form of a descriptive narrative that documents the iterative process of disseminating the research and recommendations to decision makers. Such an approach allowed me to provide evidence of the way in which my iterative attempts to raise awareness of the issues of representation in the resettlement sector were perceived by a selection of practitioners across the country. It also allowed me to validate my constructivist thematic analysis and corresponding concept of a crisis of representation in the resettlement sector. Conducting a critically reflexive case study also allowed me to provide evidence of the perceived socio-political change my research was able to catalyse.

Conclusion

Inspired by the transformative paradigm and recognising my unique position as a privileged cross cultural psychology graduate, former resettlement practitioner and PhD candidate in Psychological Medicine, I chose to conduct in-depth semi-structured interviews with 25 resettlement practitioners in Wellington, New Zealand. I conducted a constructivist thematic analysis to identify how these practitioners represented their work and resettling clients and integrated their reflections with recently published clinical research. I then conducted a reflexive case study documenting my approach to disseminating this integrated analysis to decision makers in the resettlement sector. Such an approach was chosen to corroborate the concerns of resettling communities and raise awareness of the

psychopathological representations of resettling communities and resettlement work historically perpetuated in the resettlement sector in New Zealand. The integrated analysis of the interviews with practitioners and recent clinical research is provided in the following chapter.

Chapter 5

Reflections on the psychopathological representations of resettling individuals and resettlement work

“We have only certain images about refugees. When you hear ‘refugee’ it looks like somebody is scared, it means somebody escaped and they have no options.”

(Male, refugee background practitioner, P14)

Introduction

This chapter addresses the primary aim of this PhD research: to explore how psychopathological representations are resisted and/or reproduced by practitioners working within the resettlement sector in Wellington, New Zealand. In this chapter I identify how participants consistently resisted and resented the psychopathological representations of resettling communities and resettlement work but few recognised their responsibility in the reproduction of such representations. I identify the personal and professional pride participants took in advocating for resettling communities and I isolated instances where this advocacy was associated with reproducing the assumptions of psychopathology. I also identify instances where participants reflected on the implications of these representations, such as perpetuating the stigmatised status of resettling individuals and reinforcing passive styles of resettlement.

The chapter is organised into six interconnected themes; “They’re people”, “This is not paradise”, “Psychotherapy”, “Pretty damaged people”, “Oh, those poor people” and “People have no idea”. The first three themes correspond with the three assumptions of psychopathology which imply that resettling individuals typically suffer from PTSD, from their pre-displacement trauma, and require specialist psychological intervention. The

remaining three themes correspond with the implications of these assumptions, such as, promoting the ‘at risk’ status of resettling individuals and resettlement practitioners and reliance on the assumptions of psychopathology in advocacy. Each theme is discussed in relation to published research, critique from clinicians and/or representatives from resettled communities and corresponding clinical studies. The chapter suggests that there is a crisis of representation in the New Zealand resettlement sector and concludes with considerations for stimulating critical reflexivity.

“They’re people”

“I guess what I’d like people to know about refugees is that they’re not helpless individuals who we should all pity and wrap in cotton wool. They’re people. People with skills. People with attributes. People who would like to have a life and be independent [...] Some of them do have text book PTSD with the nightmares, flashbacks and all the rest of it but the resilience really is remarkable. They’re looking after their kids. They’re working [...] I guess that goes back to the stories people have. What has already been overcome.”

(Male, migrant, practitioner, P1)

Participants in the present study were highly critical of popular perceptions of refugees and resettling individuals, particularly the systematic association with assumptions of powerlessness and psychopathology and the pity that often accompanies such associations. Participants took care to acknowledge that many aspects of the refugee journey can have such characteristics but emphasised how focusing exclusively on these ignores the resilience, aspirations and initiative of refugee and resettling individuals. Practitioners responsible for conducting psychological assessments of resettling individuals were also adamant that a diagnosis of PTSD should not define an individual or diminish their resilience and

resourcefulness. Other practitioners and volunteers shared similar reflections and criticised common references to “poor refugees”:

“The whole dialogue around ‘poor refugees’ frustrates me. I want people to see ‘refugees’ as skilled, intelligent, talented people who come from really diverse backgrounds. People that have things to offer to New Zealand.”

(Female, New Zealand born, practitioner, P12)

“It’s like ‘those poor refugees’ and they [New Zealanders] assume they’re [resettling individuals] going to stay that way [...] I’m sure a lot of people would have come across people who came here as refugees but if they were to find out that they came as refugees then it would challenge what they thought refugees were [...] You don’t hear the success stories much, for people no longer associate them with being refugees.”

(Female, migrant, volunteer, P22)

In these reflections, participants consistently emphasised the contribution resettling individuals can make, in an attempt to counterbalance the assumptions of diminished capacity that accompany assumptions of psychopathology. Participants expressed a strong desire to promote positive success stories and shift attention away from perceptions perpetuated by “the media”:

“You have all these images; the innocent baby crying, his mother having nothing to eat or to drink, trying to escape the war [...] Whenever we hear the word ‘refugee’ we remember these images because these are the only images provided by the media [...] We need to change that idea about refugees. We need to focus on the positive side of their lives. How they managed to survive. How they were able to succeed here in New Zealand.”

(Male, refugee background, practitioner, P14)

“The media plays a role, you never see anything good on the news [...] A lot of people are working hard to build a life outside their country in this new country and achieve something but there’s always that stigma, they can’t get away from it.”

(Male, refugee background, volunteer, P16)

In addition to the stigma associated with sympathetic representations of “poor refugees” produced by the media, participants in the present study also acknowledged the stigma associated with unsympathetic representations that portray refugee and resettling communities as “a problem”:

“When things get reported in the media about refugees they’re portrayed as a problem. The ‘refugee crisis’ is the problem. At the end of the day they’re just people trying to survive.”

(Male, migrant, practitioner, P1)

“All of the dialogue around asylum seekers I find incredibly upsetting. The whole “They’re queue jumpers”, “Their taking advantage of the system”, you know? People don’t get on a dangerous boat in Indonesia for no reason. People don’t flee their country for no reason. People don’t put themselves and their family at that level of risk if there isn’t a really good reason.”

(Female, New Zealand born, practitioner, P12)

Similar issues of representation have also been identified in refugee related media coverage in New Zealand. Emily Greenbank (2014) conducted a critical analysis of articles published in The New Zealand Herald, The Dominion Post and The Press in the lead up to the elections in 2005, 2008 and 2011, and identified that resettling communities are consistently portrayed as “passive victims” or a “policy issue” (p. 35).

Similarly, Natalie Slade (2019) analysed media coverage of the Syrian refugee crisis in Stuff and The New Zealand Herald, in 2015, and identified that the coverage consistently portrayed refugees as “passive victims” (p. 125) and the refugee crisis as an “issue New Zealand could not ignore” (p. 123). She also interviewed 17 representatives from resettling communities who expressed their resentment over the preoccupation in the media with their “vulnerability” and “problems” (p. 198 - 202) and expressed a strong desire for the promotion of positive success stories to counter the assumptions circulating in New Zealand society. In the words of one of the women participating in Slade’s research:

“You see a lot of comments on those media articles that go on about how refugees just come here and they’re not going to do anything. So, if we can somehow change that image from vulnerable people who are escaping for x y z reasons, but then they come to New Zealand and look at all the positive benefits they have and how they can contribute to our society. I think that message is really important.”

(Rez cited in Slade, 2019, p. 202)

In addition to local research, a local resettling community organisation, the Auckland Resettled Community Coalition (ARRC), launched an initiative with photographer Nando Azevedo, “New Zealanders Now - From Refugees to Kiwis”, to resist the problematic representations of their communities. The photographic exhibition, later published as a book, contained portraits of resettling individuals from 18 different ethnicities with commentary about their experiences resettling in New Zealand. The initiative was described in the following way:

“Many people from refugee backgrounds have made New Zealand their home. Their past may be in another country, but their present and future is here. This

project is about those people [...] New Zealand benefits enormously from resettling refugees yet when people think of refugees it's often in negative terms. They see them as a term 'refugee' and forget about the people behind the word [...] Many people forget that being a refugee is only a temporary classification – one stage in the journey to safety. It is not a permanent status but merely a label. The 'New Zealanders Now' project came about through the need to peel back that label and redefine the word 'refugee.'

(ARCC, 2017)

The criticism that resettling individuals are constantly represented as passive victims or a problem in the media is also consistent with international research. According to analyses of media coverage of the refugee crisis across Europe, media representations of refugees and resettling individuals are also split into sympathetic or unsympathetic representations (Berry et al., 2016; Chouliaraki & Stolic, 2017; Chouliaraki & Zaborowski, 2017; Franquet Dos Santos Silva et al., 2018; Georgiou & Zaborowski, 2017). Sympathetic representations tend to focus on the plight of the persecuted and the assumptions of powerlessness and psychopathology that accompany that whilst unsympathetic representations tend to focus on the potential threat to the sovereignty and/or security of the societies of settlement. Research has identified that media coverage of the refugee crisis in New Zealand is significantly more sympathetic than in other Western countries (Greenbank, 2014; Slade, 2019; Sulaiman-Hill et al., 2011). However, there is recognition that while sympathetic representations are arguably better than unsympathetic representations, sympathetic representations are still stigmatising.

Furthermore, Baranik and colleagues (2018) recently published a paper “The stigma of being a refugee” in which they reported the insights of 159 individuals resettling in Western

countries such as the UK, France, and Germany. In their study the authors asked individuals to fill in a questionnaire to identify their primary sources of stress and indices of psychological wellbeing. The results of the study indicated that the stigma associated with one's former refugee status was perceived as one of the most significant stressors and was associated with increased anxiety, depression and sleep disturbance. In the words of one participant: "The most difficult part of being a refugee is the negative stigma that comes with it" (participant cited in Baranik et al., 2018, p. 121).

In light of the significance of the stigma associated with one's refugee status, the desire to redefine the word 'refugee' by promoting positive success stories was the recommendation from many, including practitioners participating in this PhD research. However, scholars such as Chouliaraki (2013) and Pupavac (2008) have cautioned against initiatives that rely exclusively on positive representations of resettling communities as it can prompt apathy and inaction by ignoring the actual, often systemic issues and suffering that occur. Reflections on such systemic issues and suffering are discussed in the next theme: "This is not paradise".

"This is not paradise"

"I find that there is not enough encouragement about what they are actually achieving here. Often, they are validated on "Oh and then you came to New Zealand". I see it across all professionals, particularly Kiwis, "Oh it was so horrible there and now you arrived to paradise". This is not paradise."

(Female, migrant, practitioner, P9)

In addition to being highly critical of the ways in which resettling communities are represented in the media, participants in the present study were also highly critical of New Zealand society. Participants constantly referred to the preoccupation people have with resettling individuals' pre-displacement experiences and the expectation that their distress

would cease once they arrived in New Zealand. As the opening quote above suggests, participants were keen to dispel the perception that New Zealand is “paradise”. The observation that this assumption was particularly pronounced in New Zealanders was also evident by the surprise expressed by a number of local volunteers who described their experiences supporting resettling individuals as “eye-opening”:

“It’s been an eye-opening experience learning from what they [resettling individuals] come from but also the environments that they’re placed in here in New Zealand. They [New Zealand Red Cross] said it was going to be full on at the start but it didn’t really dawn on me how full on it was going to be [...], just all the hassles with structural stuff like government requirements, it’s good for me to become aware of those things [...] They really step into a different world when they get here and they can get quite isolated in the communities, low socioeconomic communities. It’s not an environment that I’ve spent a whole lot of time in.”

(Male, New Zealand born, volunteer, P17)

New Zealand born volunteers interviewed for this study acknowledged that resettling individuals experience New Zealand very differently to how they do. Volunteers reflected on how they had underestimated how demanding the process of resettlement would be for resettling individuals and how much would be required of them as volunteers. These volunteers referred to the initial culture shock that resettling clients experience and the many processes involved with supporting them to settle into an entirely new society. For instance, learning to navigate public transport, grocery shopping, paying bills and attending appointments, all whilst pursuing educational and employment opportunities. A number of these volunteers also acknowledged the expectations of many resettling individuals themselves in terms of the ease of settling:

“I think he [resettling client] really saw New Zealand as the Promised Land [...] when he got here he had a whole lot of expectations that it was just going to be easy living but you know there’s a lot of difficulties people have to face here as well.”

(Male, New Zealand born, volunteer, P17)

Practitioners participating in this research made similar observations, noting the impact of issues that plague the resettlement process and how an awareness of these issues leads to an inability to “see New Zealand the same again”:

“You never see New Zealand the same again. I mean you learn a lot about who we are and actually some of those things you can’t let go. It’s not okay to bring people here and not support them to actually be contributing and connected to New Zealand [...] I think some of the systemic stuff that goes on is terrible. The difficulties to access support, like Work & Income, we don’t have a well thought out system. I mean a lot of our work is around telling organisations their own policies and getting them to apply their own policies. There’s no accountability [...] I’m in awe of the people that we work with. I mean the situations that they come from and often the stuff that they face here [...] your neighbours harass you, your house might be burgled, in Auckland there was an attempted mugging of a newly arrived person. I think if really bad things happen to you when you’ve come to a place that’s supposedly safe then that sets you back a lot more.”

(Female, New Zealand born, practitioner, P11)

This reflection captures the shame expressed by many New Zealand born practitioners who acknowledged the impact of systemic issues such as difficulty accessing services and appropriate support. They also expressed concerns over safety in the communities in which resettling communities are placed. These practitioners further observed that such experiences

can set clients back when they expect to be safe in their new society of settlement. The practitioner cited above also acknowledged that many of these experiences were not specific to resettling communities:

“It’s not just hard for refugees, it’s also hard for ordinary New Zealanders who are not managing [...] it’s very hard to argue your way with an 0800 number to get your needs met.”

(Female, New Zealand born, practitioner, P11)

Indeed, New Zealand “is not paradise” for many New Zealanders, including “New” New Zealanders (ARRC, 2017). New Zealand has some of the highest rates of drug and alcohol addiction (He Ara Oranga, 2018; Ministry of Health, 2018), suicide (He Ara Oranga, 2018; Ministry of Health, 2018), domestic abuse (Ministry of Social Development, 2020), poverty (Ministry of Health, 2018), and issues regarding inadequate housing and homelessness (Ministry of Health, 2018) of all the OECD countries.

Whilst the New Zealand government has attempted to respond to these issues with initiatives such as “He Ara Oranga”, the inquiry into Mental Health and Addiction (He Ara Oranga, 2018), “Are you ok?” ,the family violence campaign (Ministry of Social Development, 2020) and “Healthy Homes” initiative (Ministry of Health, 2020), many New Zealanders require support and have difficulty accessing such support. The practitioner cited above, as well as others, acknowledged the responsibility the New Zealand government has to provide accessible social services, including sustainable settlement support, whilst others referred to resettlement as a “mutual task”:

“New Zealand is not a perfect society [...] for me it’s very important I try to pass on this message, that for people who come to New Zealand as refugees, it’s not just their task to resettle, it’s our mutual task.”

(Female, refugee background, practitioner, P2)

While New Zealand has relatively progressive politics with a commitment to human rights and little to no conflict or corruption, participants in the present study consistently resisted representations of New Zealand as “paradise”. Participants constantly referred to the detrimental impact of resettlement stressors such as issues accessing support services, prejudice, and poverty on resettling individuals’ subsequent psychological wellbeing. This attention to resettlement stress challenges the tendency to attribute unsuccessful settlement outcomes to resettling individuals and their inability to process their pre-displacement trauma and integrate. Instead, it points to the shortcomings of the society of settlement and its responsibility to provide adequate resettlement support and safety.

The critical reflections from participants on the perceived shortcomings of New Zealand society and its associated resettlement policies and practices is consistent with resettlement research conducted by the New Zealand government. In 2012, the Ministry of Business, Innovation and Employment published a longitudinal research project entitled: “New Land, New Life: Long-term Settlement of Refugees in New Zealand”. The project included face to face interviews with 512 resettled individuals who arrived in New Zealand under the Refugee Quota Programme between 1993 and 1999, from Ethiopia, Iraq, Somalia, and Vietnam.

The interviews revealed that many individuals still required assistance accessing government support, bringing their family into New Zealand, and finding work. Furthermore, one in five of these individuals felt that Work and Income New Zealand and Immigration New Zealand had not treated them fairly. Many individuals reported that they were often the target of discrimination fuelled by ignorance and felt that they were unable to participate fully in New Zealand society; the ultimate goal of New Zealand Resettlement Strategy (see Ch 1, p. 18). The report concluded:

“It is very evident that the process of resettlement is ongoing. On the evidence of this research, some may never get to the place where they can participate in this country’s life to the same extent as other residents.”

(Ministry of Business, Innovation and Employment, 2012, p.19)

The same year Vimbi Mugadza published her post graduate research critically reviewing resettlement practices in New Zealand (Mugadza, 2012). She conducted interviews and focus groups with community leaders representing 10 different resettling communities and identified that many resettling individuals felt that New Zealand’s resettlement practices are disempowering and result in a dependency on welfare that leave them feeling helpless and humiliated. This disempowering dynamic was eloquently expressed by one of the men Mugadza interviewed:

“I think for us as people, where we come from, we’ve got some kind of pride and we’re used to living out of our sweat, you know? You work to eat. That’s how we’re used to. And you come here, you’re sitting – first of all, you’re doing nothing, and it becomes boring at some stage and you lose your value, your passion as a human being. And we’ve got children and we need to set a good example for them. And they see you doing nothing. They go to school and one day the teacher asked, “What does your father do?” and your child is there saying, “My father is unemployed”. They come home and say this, and I didn’t know what to say. You know, it breaks your heart.”

(Mugadza, 2012, p. 120-121)

Participants in Mugadza’s study also shared their experiences of racism, how they were perceived as “parasitic” (p. 153), and how community education was required to shift society’s perception of resettling individuals and increase awareness of their desire to contribute to their new society of settlement. Mugadza also identified that some individuals

required substantial support before they are in a position to be able to contribute to New Zealand society:

“One participant talked about coming to a third country of resettlement as the last hope for refugees and if this did not work well, all the resilience and strength just crumbles leading to cases of mental illness; “Just help us, like, make a plan for us, help us, support us. Nothing was in place like that. We are not here for another challenge, we’re past that, we don’t have much energy, we need some help and support.”

(Mugadza, 2012, p. 132)

A couple of years later Jay Marlowe and colleagues (2014) published an analysis of the New Zealand Resettlement Strategy. In their analysis they acknowledged the “aspirational” (p. 65) status of the Resettlement Strategy. They also noted that the success of such a strategy will be a reflection of both the resilience of resettling communities, as well as the New Zealand government’s ongoing commitment to providing sustainable resettlement support. Marlowe and colleagues identified the importance of attending to the social context in which individuals and communities are resettling and the necessity of prioritising initiatives in New Zealand society that address issues of discrimination and/or indifference that prevent the genuine participation to which this strategy aspires.

The implications of the shortcomings of New Zealand society for the successful settlement of resettling people have been identified by national resettlement research (Marlowe et al., 2014; Ministry of Business, Innovation and Employment, 2012; Mugadza, 2012). Such findings also support the critical reflections of participants in the present study regarding the preoccupation people have with resettling individuals’ pre-displacement trauma. These reflections are consistent with published concerns from psychiatrists (Bracken et al., 1995/1997; Silove et al., 2017), psychologists (Miller & Rasmussen, 2010, 2017; Patel,

2003) and social workers (Marlowe, 2010; Westoby & Ingamells, 2010), all of whom draw attention to the significant impact of post-displacement stress and the need for psychosocial approaches to resettlement support. Post-displacement stressors identified in these previous studies include insecurity, social isolation, poverty, perceived discrimination, unemployment or underemployment, issues acculturating and intimate partner violence (Miller & Rasmussen, 2010). Psychosocial interventions therefore typically include a range of approaches such as resettlement assistance and advocacy, which provide necessary practical and social support, in addition to psychotherapy (Nickerson et al., 2011).

The negative effects of post-displacement stress on successful resettlement have also been identified in clinical research. For instance, a meta-analysis of 56 studies documenting the mental health of 22,221 displaced people from Africa, Asia, Central and South America, Europe, and the Middle East, identified that post-displacement stressors such as temporary accommodation and restricted employment opportunities were associated with significantly poorer mental health (Porter & Haslam, 2005). Clinical studies conducted since have continued to identify the significance of post-displacement stress (Bogic et al., 2015; Chu et al., 2013; Li et al., 2016; Schweitzer et al., 2011; Steel et al., 2011; Vaage et al., 2010) with many concluding that the impact of post-displacement stress can surpass the impact of pre-displacement trauma.

For instance, during the course of my PhD candidature Li and colleagues (2016) published a narrative review summarising studies investigating the relationship between post-migration stress and psychopathology in resettling individuals and asylum seekers. In their review they analysed approximately 80 studies from resettlement countries such as Australia, the United Kingdom and the United States and distinguished between socioeconomic stressors, social and interpersonal stressors, and stressors related to the resettlement process and policies. The conclusion of their review was that post-migration factors are consistently

associated with indices of psychopathology and in many instances are interpreted as having an adverse effect “over and above” (p. 81) the impact of pre-migration trauma.

In response to the increasing recognition of the significance of post-displacement stress on the subsequent psychological wellbeing of resettling individuals, psychologists Kenneth Miller and Andrew Rasmussen (2017) have suggested that practitioners subscribe to an “ecological model of refugee distress” (p. 129). This model was inspired by the social ecological model (Bronfenbrenner, 1977) that acknowledges that individuals are influenced by circumstances within their family, community and the wider society. The ecological model of refugee distress acknowledges that a resettling individual’s distress can also be attributed to the stressful conditions in their new society of settlement. In the words of Miller and Rasmussen (2017): “Our point is simply that war exposure, for all of its destructive power, should not be assumed to be the sole, or even primary, source of distress among refugees” (p. 130).

The implications of this ecological model, and the clinical research informing it, Miller and Rasmussen (2017) argue is that it should be possible to improve the wellbeing of resettling individuals with interventions that do not rely on psychotherapy to address pre-displacement trauma. Indeed, addressing post-displacement stressors may be enough to promote natural recovery (Miller & Rasmussen, 2017). The practitioners responsible for providing psychotherapy who participated in this PhD research shared similar (unprompted) reflections which are discussed in the next theme; “Psychotherapy”.

“Psychotherapy”

“Not all refugees are traumatised. They've had traumatic things happen in their lives but a lot of them are remarkably resilient. Although we are nominally Refugee Trauma Recovery, by no means are all the interactions I've had with people here been trauma focused. There is an assumption here that some people

are really badly traumatised and need specialist trauma treatment. That needs to be recognised but there isn't one approach that fits all people. Some of the really traumatized people are not remotely interested in any trauma type therapy and they present wanting help with practical stuff and if that's what they want, that's what they should get. The idea that trauma should be opened up and resolved by psychotherapy is a Eurocentric kind of idea. It's unclear how well it works."

(Male, New Zealand born, practitioner, P3)

The majority of practitioners responsible for providing psychotherapy in the present study resisted the assumptions of psychopathology that imply all resettling individuals suffer from PTSD from their pre-displacement trauma and require psychological intervention. They constantly referred to the resilience of resettling individuals and in line with the previous theme, "This is not paradise", also reflected on the preoccupation people have with resettling individuals' pre-displacement trauma. They all reiterated the significance of post-displacement stress on clients' subsequent psychological wellbeing and acknowledged clients' preference for receiving practical support to address these "hassles":

"I think people have kind of quite extreme ideas about what the nature of the work is. I think in their minds we're just sitting here hearing people recounting these horrible tales of being displaced and dreadful things that they've seen [...] Often people's hassles might seem kind of mundane stuff to do with housing and finding it really hard to learn English, worrying about relatives overseas, not being able to find work [...] A lot of people we see are very clear they don't want to talk about the past and you quickly learn that it's not going to be perceived as helpful either."

(Male, migrant, practitioner, P1)

A number of practitioners admitted that there was “a bit of trial and error” when providing psychotherapy to resettling clients and acknowledged that “one treatment modality doesn't fit all”:

“I think in all clinical work, there’s a bit of trial and error [...] Trying to understand the person from their cultural perspective, their difficulties and really trying to match that up with something that might be appropriate to help them move forward [...] One treatment modality just doesn't fit all.”

(Female, New Zealand born, practitioner, P5)

Several practitioners responsible for providing psychotherapy reflected on the perceived appropriateness of their speciality and suggested that psychotherapy may not be suitable for all resettling individuals. This suggestion was also shared by a number of practitioners with a refugee background who reflected “maybe the Western model doesn’t work”:

“You know for us from a different culture, we don't have any counselling so maybe the Western model doesn’t apply or doesn't work. They need to come up with a different way to really support the client if they come with [a] post traumatised issue or depression or something.”

(Male, refugee background, practitioner, P8)

“Some fields are more specialised than others and we happen to be in this specialised field [...] Isn’t that a form of limitation? There is no one person who knows everything.”

(Female, refugee background, practitioner, P2)

The reflections from practitioners working for Refugee Trauma Recovery are consistent with the national mental health guidelines for refugees, asylum seekers and new migrants (Te Pou, 2010) which acknowledge that psychological intervention is often not a

priority for these individuals and available services are not always accessible or culturally appropriate. The guidelines also acknowledge the lack of refugee mental health research conducted in New Zealand and reliance on limited international evidence. The reflections from practitioners were also consistent with concerns from representatives from local resettling communities:

“I want to talk specifically about mental health and mental illness for refugees. This is a huge issue for our communities. It is no surprise to anyone. But when we approach the mental health system in New Zealand we find we do not fit... they mess with our mana⁴. So we can leave the system more damaged than when we arrived.”

(Awad, 2011, p.47)

The reflections from participants responsible for providing psychological intervention also correspond with clinical research published during the course of my PhD candidature. Psychiatric epidemiological studies consistently indicate that the majority of resettling individuals do not develop PTSD or any other psychopathology and acknowledge that inflated prevalence rates of PTSD are associated with small clinical studies utilising self-report symptom checklists (Bogic et al., 2015; Charlson et al., 2019; Fazel et al., 2005; Henkelmann et al., 2020; Steel et al., 2009).

For instance, during the course of my PhD candidature Bogic and colleagues (2015) published a systematic review of 29 studies documenting the long term (five or more years since displacement) mental health of refugee and resettling individuals in Africa, Asia, the Middle East, Europe and the United States. In their review they identified that prevalence

⁴ Mana is a multi-faceted word in Te Reo that refers to the supernatural force in a person, place or object. In this instance, it most likely refers to a person's sense of power, status and spirituality (Te Aka Online Maori Dictionary, 2020).

rates of psychopathology varied significantly across studies. For instance, prevalence rates of PTSD ranged from 4.4% to 86% and studies considered to be more methodologically rigorous were consistently associated with lower prevalence rates. Such studies relied on representative, random samples with diagnostic interviews conducted in the individual's native language and were likely to produce prevalence rates of approximately 20%. This review and its associated acknowledgement of methodological variation corresponds with the reflections of participants in the present study and provides clinical evidence against the assumption that all resettling individuals develop PTSD.

Towards the end of my candidature, Charlson et al., (2019) published updated prevalence estimates of mental disorders in conflict settings for the World Health Organisation. This meta-analysis included 129 studies from countries throughout Africa, Asia, the Middle East and Europe and indicated that the prevalence of post-traumatic stress disorder, depression, and/or anxiety was 22% at any point in time in the conflict-affected populations assessed. Furthermore, the analysis differentiated between mild, moderate and severe forms of psychopathology and identified that approximately 9% of conflict-affected populations suffer from moderate to severe psychopathology (including PTSD, depression, anxiety, bipolar disorder and schizophrenia). This rate is significantly less than previously published studies citing prevalence rates of PTSD as high as 99% in communities exposed to conflict (i.e. de Jong et al., 2000).

At the time of submitting this PhD, a meta-analysis was also published focusing specifically on the prevalence of psychopathology in resettling individuals in Western countries (Henkelmann et al., 2020). Henkelmann and colleagues (2020) conducted a systematic review and meta-analysis of 66 studies documenting the prevalence PTSD, depression and anxiety in resettling communities in high income countries in Europe, North America and Australia. The pooled prevalence rates of PTSD identified in this analysis was

29% for diagnosed PTSD and 37% for self-reported PTSD. The pooled prevalence rates of depression were 30% for diagnosed depression and 40% for self-reported depression. The pooled prevalence rates of anxiety were 13% for diagnosed anxiety and 42% and self-reported anxiety. In their discussion Henkelmann and colleagues (2020) acknowledge that the prevalence rates identified in their analysis are higher than prevalence rates identified in studies identifying the prevalence of psychopathology in individuals living in conflict and discuss how this is likely due to the detrimental influence of post-displacement stress. Again, this is consistent with the reflections in the current and previous theme (“This is not paradise”). The significant variation across studies and methodological limitations such as the inclusion of studies that rely on small, non-random samples and self-report measures are also acknowledged in this discussion.

In light of the relatively low prevalence of PTSD (and other psychopathology) in individuals in conflict settings (including resettling individuals), psychiatrists and psychologists working in this area have started to refer to “potentially traumatic events” (PTEs; Steel et al., 2009, p. 538) in their publications to acknowledge the assumption that specific experiences cause traumatisation (Silove et al., 2017; Steel et al., 2009; Nickerson et al., 2019). Recent research conducted by these practitioners have also identified that while resettling individuals have often survived multiple PTEs, such as exposure to conflict, extreme living conditions and the ‘disappearance’ of loved ones, the predominant psychological response is resilience (Nickerson et al., 2019).

The study by Nickerson et al., (2019) also identified the significance of post-displacement stress for individuals resettling in Australia and suggested that the effect of these stressors can exert an effect “over and above” (p. 10) pre-displacement PTEs. This is consistent with the studies cited earlier regarding the significance of post-displacement stress

on subsequent indices of mental health (Bogic et al., 2015; Chu et al., 2013; Li et al., 2016; Miller & Rasmussen 2010, 2017; Nickerson et al., 2011; Porter & Haslam, 2005; Schweitzer et al., 2011; Steel et al 2009). All of these studies support the emerging consensus that multidisciplinary psychosocial support should be provided to resettling individuals to address these post-displacement stressors (Miller & Rasmussen 2010, 2017; Nickerson et al., 2011, Silove et al., 2017). Whilst all participants in the present study emphasised the significance of post-displacement stress (see second theme “This is not paradise”), the reflections from practitioners providing psychological interventions mentioned above went one step further by acknowledging the perceived inappropriateness of specialist psychological intervention and efficacy of such support.

Concerns over the ethnocentrism of psychological intervention for resettling individuals have been raised by numerous clinicians (Miller et al., 2006; Patel, 2003; Summerfield, 1999) and scholars (Colic-Peisker & Tilbury, 2003; Pupavac, 2002; Watters, 2001). Whilst the consensus is that psychological intervention should be available to those who desire it, the conclusions from research evaluating the efficacy of psychological intervention for resettling populations are cautious (Kip et al., 2020; Nose et al., 2017; Patel et al., 2016; Turrini et al., 2019).

For instance, during the course of my candidature Patel et al., (2016) published a systematic review of evaluations estimating the efficacy of psychological intervention for resettling individuals. In their review the authors raised concerns regarding the methodological issues associated with such studies such as the reliance on small non-random samples and self-report symptom checklists. Patel et al., (2016) also raised concerns regarding the ethnocentrism of such evaluations. For instance, the specific focus on the Western derived psychiatric diagnosis of PTSD, psychiatric over psychosocial intervention,

and psychiatric assessments focused on symptom reduction over perceived quality of life or other indices of wellbeing.

Nose et al., (2017) conducted a systematic review and meta-analysis of randomised controlled trials (RCTs) evaluating the efficacy of specialist trauma treatments for resettling individuals, originally from Africa and the Middle East, seeking specialist support for PTSD in the United States and Europe (Austria, Denmark, Germany, Netherlands and Norway). The meta-analysis identified that one in five individuals receiving treatment showed greater improvement relative to the control condition. While this is considered clinically significant, this does suggest that specialist psychological intervention is not effective for all resettling individuals seeking support.

Another systematic review and meta-analysis (Turrini et al., 2019) conducted since with displaced people receiving treatment in low and high income countries (e.g. Jordan, Thailand & Uganda, as well as, the USA, Denmark & Australia) identified a similar reduction in PTSD, in addition to depression and anxiety. While the conclusion of this systematic review was that there was “moderate evidence” (p. 9) that interventions reduce symptoms of PTSD, depression and anxiety in displaced populations, the authors also acknowledged that “spontaneous recovery” (p. 9) was observed in some of the control conditions, indicating that some individuals recover without such intervention.

Meta-analyses published towards the end of my candidature have continued to identify clinically significant improvements for psychological interventions which are maintained after one month (Turrini et al., 2019) and six months (Kip et al., 2020). Consistent with previous reviews the authors acknowledged the methodological issues associated with evaluating psychological interventions for individuals with asylum, refugee, or resettling status and call for more rigorous research.

This clinical research aligns with the critical reflections from practitioners responsible for providing psychological support to resettling clients in the present study and resists the third assumption of psychopathology that all resettling individuals require and respond to specialist psychological intervention. Again, the consensus and corresponding clinical research maintain that such support should be available for those who desire it, as this has been shown to be effective for some individuals, but there is also a need to investigate and invest in alternate interventions.

During the course of my candidature, there has been an emerging emphasis on the perceived efficacy of traditional healers for addressing psychiatric issues in culturally diverse populations with a series of systematic reviews recently published in psychiatric journals (Nortje et al., 2016; van der Watt, 2018). These studies are subject to similar methodological limitations as the RCTs described above, in terms of their sample size and rigour, but a review of 32 quantitative studies (Nortje et al., 2016) in 20 countries (e.g. high income countries such as the UK, USA and Canada as well low income countries such as Indonesia, Nigeria and Zimbabwe) and a review of 16 qualitative studies (van der Watt et al., 2018) in 12 countries (e.g. high income countries such as the USA, Canada and New Zealand and low income countries such as Indonesia, India and Ghana) indicated that treatments from traditional healers who attribute disease and distress to spiritual, magical or religious explanations are associated with positive outcomes and could be considered as an complementary psychosocial intervention.

These reviews also identified the significance of the perceived personal qualities of the healer, in addition to expectations regarding the efficacy of the treatment. This has also been acknowledged in a number of the reviews of RCTs mentioned above (Nickerson et al., 2011; Patel et al., 2016; Turini et al., 2019), as well as a study conducted in Denmark evaluating the perceptions of resettling individuals receiving psychological treatment (Mirdal

et al., 2012). The authors of this study concluded; “The relationship between the therapist, patient, and interpreter, and the development of trust and a good working alliance was seen by all as the most important curative factor” (Mirdal, 2012, p. 432).

The suggestion that the quality of the therapeutic relationship is as important as the type of therapeutic approach has also been acknowledged in some of the reviews of the RCTs discussed above (Nickerson et al., 2011; Turini et al., 2019). Such an acknowledgement also raises questions about the therapeutic effects of positive relationships with other practitioners in the sector (i.e. social workers and volunteers).

At the time of initiating this PhD research, there was a paucity of published studies documenting the perspectives of resettling communities on the appropriateness of psychological intervention. An exception was a study by Mirdal and colleagues (2012). In addition to identifying the significance of the therapeutic relationship, these authors also identified the significance of post-displacement stress and preference for practical support, as well as perceptions such as; “I do not need to talk” and “It makes things worse” (p. 454).

Similar observations have been documented in a number of studies published since. For instance, Shannon and colleagues (2015) conducted a series of focus groups with 111 resettling refugees (57% male and 43% female) from Burma, Bhutan, Somali, and Ethiopia in the USA to explore why they were not accessing local mental health services. Participants in the study consistently expressed concerns that “talking does not help” (p. 289), and the perception that it could make things worse. Nevertheless, the authors of the study concluded that stigma and a lack of information were the primary barriers to accessing mental health services as opposed to reflecting on the perceived suitability of the available services.

Resettling individuals’ preference for coping strategies other than specialist psychological support was also identified in a recent study conducted by Baranik et al., (2018) who explored resettling individuals’ perspectives on stress, coping and psychological

wellbeing with an online questionnaire. A total of 159 individuals (68% male and 32% female) from the Middle East and Africa resettling in Western countries such as the USA, UK, and Germany responded and the most commonly reported coping strategies were positive thinking, persistence and patience, prayer and pursuing educational and employment opportunities. Seeking specialist psychological intervention was not reported in this study.

In summary, the critical reflections participants shared in their interviews with me strongly resisted the assumptions of psychopathology that imply that all resettling individuals suffer from PTSD from pre-displacement trauma, and require, desire and respond to psychological intervention. These critical reflections also correspond with published concerns from representatives of local resettling communities, clinicians and recent clinical research.

After I conducted this initial analysis and presented it back to participating agencies such as Refugee Trauma Recovery, in 2015 the socio-political climate had changed with increasing media coverage of the 'refugee crisis' and initiatives to increase New Zealand's refugee quota. All of a sudden everyone seemed to be talking about refugees and attending to issues of representation became increasingly relevant. This provided me with a unique opportunity to observe how local resettlement agencies, who had participated in my research, represented resettling communities and resettlement work in the media.

Shortly after the first increase to the annual quota and arrival of families from Syria, the following article was published: "Fears underfunding of Wellington health services will 're-traumatise' Syrian refugees" (Appendix K). The article illustrated issues of representation I had been interrogating in my analysis. It opened with the following statement: "Syrian refugees scarred by torture, war and the loss of loved ones may be re-traumatised because our health system is underfunded, health leaders say", before citing a spokesperson from Refugee Trauma Recovery, "the overstretched, specialised regional counselling service". The spokesperson claimed that "up to a third" of the Syrians resettling in Wellington will be

suffering “severe trauma, depression and anxiety” and will require “therapy” before arguing that if Refugee Trauma Recovery did not receive additional funding, these individuals will be “re-traumatised” as “it's not like they can go off and be 'fixed' elsewhere, they're torture victims”.

This narrative perpetuated the assumptions of psychopathology this research is so critical of: the psychopathologisation of resettling communities, preoccupation with their pre-displacement trauma, and indiscriminate endorsement of specialist psychological support.

This instance in the media provided the perfect opportunity to reflect on van Dijk's (2000) analysis of the ways in which power elites use the media to influence public opinion and maintain their power. In this instance, the journalist and spokesperson from Refugee Trauma Recovery had used a number of representational practices identified by van Dijk. For instance, they represented resettling individuals as “deficient” and “dependent” (van Dijk, 2000, p. 34) whilst representing themselves as “taking vigorous action” (p. 48) in response to such deficiencies (“the specialised regional counselling service is already overstretched ... they're torture victims... we have major concerns”). The use of hyperbole (“it's not like they can go off and be 'fixed' elsewhere), statistics (“up to a third”) and privileging of ‘specialist’ perspectives (“manager” of a “specialised regional counselling service”) are also common representational practices.

Despite the critical reflections from practitioners working at Refugee Trauma Recovery on the ways in which others perceive resettling communities and resettlement work, as well as, receiving confirmation of my analysis from them just months earlier, the spokesperson for the agency continued to publicly reproduce assumptions of psychopathology in their attempts to appeal to donors and acquire additional funding.

I found the discrepancy between what was acknowledged privately in an interview with me and publicly in the media intriguing. It also aligned with the discrepancy between

the Refugee Trauma Recovery website (Chapter 1, p. 19) and the reflections of many of its practitioners during our interviews. This disjuncture prompted me to revisit the interview transcripts to identify instances of reproduction and any potential reflections on their ramifications. Instances of reproduction are reviewed in the next theme; “Pretty damaged people”.

“Pretty damaged people”

“You can't have too higher hopes. I'm sort of getting to the stage where I don't think we can really get them [resettling clients] totally out of their PTSD. Ours are pretty damaged people. When you've been hung upside down and water boarded, day after day, that has a pretty strong effect on you. The tortured ones are different.”

(Female, New Zealand born, practitioner, P5)

In spite of the resistance from the practitioners from RTR I interviewed, one interview stood out in particular. I realised it was the only interview I conducted with a practitioner with whom I did not have a previous relationship. Despite my interest in capturing alternative representations of resettling communities and resettlement work, they proceeded to reproduce all the assumptions of psychopathology their colleagues were so critical of. They referred repeatedly to resettling clients’ PTSD and poor prognosis. They also used possessive paternalistic pronouns that positioned them and their colleagues as responsible for their clients’ potential recovery; “I don't think we can really get them totally out of their PTSD [...] ours are pretty damaged people”. They described resettling clients as “damaged” and “different” and provided vivid detail of their pre-displacement experiences as evident in the quote above. At no stage in their interview, did they acknowledge the resilience of resettling clients, the significance of the therapeutic relationship or the stressors associated with resettling in New Zealand.

While this practitioner's reflection most likely captured how they genuinely felt about their work with resettling clients at the time, this analysis suggests that their reflection was influenced by the fact that they work exclusively with resettling individuals suffering significant distress and that this may skew their perception of resettling individuals' resilience (discussed further on p.142). It is also possible that their reflection was an indication of vicarious traumatisation (discussed further on p.137) or burnout (discussed further on p.139). Regardless, this analysis attends to the responsibility that resettlement practitioners have for representing resettling communities accurately. In this instance, the way in which this practitioner described their work and resettling clients could have significant implications for how others perceive resettling individuals and communities. The implications of these psychopathological representations could be identified in a number of the volunteer interviews. Several comments suggested that volunteers were primed to expect psychopathology to dominate their interactions with resettling clients from the training they had received. One participant enthusiastically described identifying post-traumatic stress in one of the individuals he was assisting:

"Pretty early on one of the guys was exhibiting some symptoms of post-traumatic stress. When we'd done the training, they'd given us a pamphlet for a refugee trauma society and I was just looking through a bullet point of symptoms of PTSD and I was like "yip, yip, yip", ticking all the boxes."

(Male, New Zealand born, volunteer, P17)

Another volunteer expressed concern over resettling individuals' lack of traumatic disclosure and sought confirmation whether this was usual or not:

"None of them ever talk about what they've been through. I certainly don't ask them, but they never talk about it. I was just wondering, when you see people like this that have been through trauma, is it usual that they don't talk about it?"

(Female, New Zealand born, volunteer, P19)

While this analysis is critical of these particular reflections and the preoccupation with psychopathology reflected in them, it is important to acknowledge that these perspectives are legitimate and may in some instances be accurate. Whilst this PhD contests the preoccupation with psychopathology that characterises popular representations of resettling individuals, there does need to be acknowledgment of the impact of pre-displacement trauma and an awareness of PTSD (or other psychopathology) within the sector to ensure resettling individuals who are struggling with significant distress are referred on for further support. Volunteer training should prepare volunteers to identify individuals who may be struggling with significant distress. However, this analysis suggests that focusing exclusively on pre-displacement trauma, PTSD and specialist psychological intervention can be stigmatising and skew perceptions of the type of support that is required.

For example, several practitioners expressed concern that the preoccupation with psychopathology influenced the perceptions of practitioners at other agencies that should be assisting resettling communities:

“Services say, “Oh the refugees are too hard, we don't work with them, Refugee Trauma Recovery does that work”. I want those agencies to actually say that being able to work with refugee background communities develops their skills and strengths [...] If you've got a professional who can work well with a refugee background person, with all of the diversity and complexity that might come with that, isn't that a strength that they can bring to their practice? I think it is really important so it doesn't become only a special set of people who can work with refugee background communities.”

(Female, New Zealand born, practitioner, P12)

Such reflections suggest that perceptions of resettling individuals promote the assumption that only practitioners from specialist psychological services can provide them with adequate support. Such assumptions are concerning considering the previous themes, “This is not paradise” (p. 108) and “Psychotherapy” (p. 116), which acknowledge the detrimental effect of resettlement stress and desire for practical resettlement support.

The perception that, “refugees are too hard, we don't work with them”, is also concerning as it could have significant implications for resettling individuals attempting to access additional support, as well as the quality of that support. Interviews with a number of practitioners with refugee backgrounds revealed that this type of perception was not lost on them or other resettling individuals either:

“If I hear myself referred to all the time as a “refugee”, “refugee”, “refugee”, I feel a kind of weight, a kind of pressure. If I’ll be referred to all the time as a “refugee” it means I’m something they need to work harder with, you know? None of us want to feel like that.”

(Male, refugee background practitioner, P14)

Such insights suggested that the assumptions of psychopathology reproduced by practitioners in the resettlement sector promoted the perception that resettling communities are “damaged” and “different” and therefore “too hard”. Such perceptions also placed additional “pressure” on resettling individuals and the practitioners who support them.

An interesting observation from one practitioner was that these types of perceptions play a significant role in the provision of support. More specifically, support that requires performances of refugee-ness and reinforces the development of passive styles of resettlement:

“Everybody has this talk of helping, “We want to help you with this”, “We want to assist you with that” but that language is not very appropriate for their

resilience [...] For me it is difficult to see the loss of resilience [...] You have no money and all these people come and write these letters and then you get all this and that but at the same time that's the only way to get this and that so I will say how hopeless I am [...] Some people talk the talk that they are expecting. They are adapting by doing the hopeless thing because I think in a sense they are given more opportunities by being hopeless.”

(Female, migrant, practitioner, P9)

The reflection on the “loss of resilience” due to resettling clients “adapting to the hopeless thing” is consistent with concerns from Colic-Peisker and Tilbury (2003) suggesting that resettlement policies and practices, informed by assumptions of psychopathology, undermine the resilience of resettling individuals and reinforce “passive resettlement styles” (p. 72). While the style of resettlement is partly determined by an individual’s personality and personal resources, Colic-Peisker and Tilbury suggest such styles are also a product of the style of service provision. Passive styles of resettlement are often associated with poorer resettlement outcomes such as unemployment, isolation and poor physical and psychological health and characterised by an internalised sense of hopelessness.

Although some resettling individuals adopt more “active” styles of resettlement, research conducted by Szczepanikova (2010) has identified that resettling individuals often feel compelled to produce strategic “performances of refugee-ness” (p. 461), playing up their “powerlessness” (p. 470) in order to receive assistance from support services. Such performances were resented by these individuals but were often seen as their only option. Similar reflections have been documented in other resettlement research projects such as the study Marlowe conducted with Sudanese men resettling in Australia (See Chapter 3, p. 54). The catalyst for Marlowe’s research was when one of the Sudanese men stated: “I had to prove that I was damaged goods” in order to access services (Marlowe, 2010, p. 1).

An additional issue was raised by a practitioner in the present study regarding the expectations of service providers and the issues when resettling communities fail to “fit the patterns” associated with popular perceptions of resettling communities:

“A couple several service providers mentioned that to me that it was difficult to work with [nationality] and I think that is because in a way [nationality] are Westerners [...] I think that's one of the difficulties that they encounter [...] they [the national group] didn't quite fit the patterns they had before with refugees [...] They're vocal and they know what they want [...] What would you expect from a European client? Just think about a European client, not a refugee, just a client?”

(Male, migrant, practitioner, P10)

Such a reflection acknowledges the pernicious implications of representations that rely on assumptions of psychopathology and powerlessness (Mallki, 1996; Pupavac 2002; Summerfield 1999; Zetter, 1991). Not only do representations produced in the sector perpetuate perceptions that resettling individuals are “damaged” but they become “difficult” and “demanding” if they assert themselves and their priorities for resettlement. Aspects of this dynamic were present in an interview with one of the volunteers in the present study who said:

“I was never involved with the [nationality x] for example and people have said, “Oh they were hard to work with”, and now I've seen the [nationality y] and I say, “Oh they're hard to work with”. I knew one woman who had one family and it was [nationality y] and she said, “Oh they're so demanding” and I said, “Oh what a shame you got them”. Some of the groups are more demanding whereas others have taken a much more humble approach.”

(Female, New Zealand born, volunteer, P20)

Such reflections raise interesting questions about the intersection of issues of representation in the sector and subsequent service provision to resettling communities. The ways in which agencies represent and respond to resettling clients and the associated performances of refugee-ness required to receive adequate support, have further implications for societal perceptions of resettling communities and resettlement work. A significant number of participants reflected on how disempowering these perceptions can be for resettling individuals and those supporting them and these are discussed in the next theme; “Oh, those poor people”.

“Oh, those poor people”

“There is the reaction of “Oh, those poor people”. “Oh, you're just amazing helping them”. “Oh, how do you cope?”. It's disempowering for everybody. It's disempowering for the refugee communities. It's disempowering for people working in the sector. It's disempowering for me [...] the people I work with have helped me observe my own life. It's made me a richer person and it keeps people here. I've got colleagues who have been here for 15, 20, 25 years.”

(Female, New Zealand born, practitioner, P12)

The majority of participants in the present study acknowledged that when they disclosed to others that they were worked in the resettlement sector, they were consistently met with two reactions: pity (“Oh, those poor people”) and concern (“Oh, how do you cope?”). Many participants recognised how the assumptions of psychopathology circulating in New Zealand society subjected resettling communities to two levels of stigmatisation within society constructing them as simultaneously at risk and a risk. Participants reflecting on this issue resisted such stigmatisation by emphasising the resilience of resettling clients and referring to their work as a “rewarding”:

“People say, “Why would you want to do that kind of work? It must be very awful”. Or people start perceiving you like you’re some kind of saint, “Wow that’s really amazing that you’re doing that work”. It really is out of proportion to what we do [...] Everybody we see just has some incredible tale of adversity and resilience to tell [...] It is a horrible cliché, but it really does feel like a privilege to hear these stories from people [...] I find it rewarding and it helps me to keep perspective.”

(Male, migrant, practitioner, P1)

Instead of indulging in others’ assumptions regarding the “awful” aspects of resettlement work, practitioners discussed how they actively reframed their work as a “privilege” and described how they were constantly inspired by clients, derived significant satisfaction from supporting them, and had a strong desire to continue to do so. Such sentiments were also shared by many of the volunteers, one of whom told me:

“In all honesty it’s just been a joy, an absolute joy [...] It brings me down to earth when I get frustrated with what’s going on in the world. To be with people who can come through these experiences with such grace and humility. It calms me down [...] I’ll continue to put my name down for other intakes.”

(Male, New Zealand born, volunteer, P25)

These reflections are consistent with research documenting the experiences of practitioners supporting resettling clients in Western countries (Apostolidou, 2016; Barrington & Shakespeare-Finch, 2013 & 2014; Bloom, 2014; Century, Leavey, & Payne, 2007; Farley et al., 2014; Green et al., 2012; Guhan & Liebling-Kalifani, 2011; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015; Holmgren, Søndergaard, & Elklit, 2003; Kjellenberg et al., 2014; Long, 2019; Mehus & Becher, 2015; Miller, Martell, Pazdirek et al., 2005; Munday, 2009; Roberts et al., 2018; Schweitzer, van Wyk & Murray, 2015;

Splevins, Cohen, Joseph, Murray, & Bowley, 2010; Surawski, Pedersen, & Briskman, 2008), including New Zealand (Bloom, 2014). Such studies have identified that practitioners report significant personal and professional growth associated with supporting resettling individuals and is referred to as vicarious resilience (Hernandez, Gangsei, & Engstrom, 2007) or vicarious post-traumatic growth (Arnold et al., 2005).

As discussed in Chapter 2, vicarious resilience and vicarious post-traumatic growth are referred to as the “rewards” of resettlement work (Guhan & Liebling-Kalifani, 2011, p. 216) and participants in this study also described their work as “rewarding”. As noted above, they described how they are inspired by clients, derive significant satisfaction from supporting them, and have a strong desire to continue doing so. Participants also spoke of how their work offered them opportunities to “observe” their own lives. These rewards are identical to those identified by Alia Bloom (2014) in her pilot study of practitioners’ vicarious experiences in the resettlement sector in New Zealand. The five practitioners in her study reported being inspired by clients, having an increased sense of contribution and self-worth, and a change in perspective.

This said, while participants in the present study readily described the resilience of resettling clients and rewarding aspects of their work, they were often reluctant to discuss the negative emotional impact of clients’ traumatic pre-displacement experiences. The following extracts are from the practitioners cited above who resisted the assumptions of ‘risk’ associated with resettlement work:

“I should talk about it, the toughest part of the work [...] The hardest thing to hear is somebody talking about an experience of being tortured [...] I think everyone on the team would agree [...] It can make you feel pretty useless.”

(Male, migrant, practitioner, P1)

“It takes a big toll personally in terms of what you're holding, in terms of hearing people's stories [...] One of the big challenges is not being able to do anything to resolve a lot of the pain.”

(Female, New Zealand born, practitioner, P12)

Feeling “pretty useless” and “unable to do anything” aligns with descriptions of powerlessness reported in research documenting experiences of vicarious traumatisation in resettlement practitioners (Apostolidou, 2016; Barrington & Shakespeare-Finch, 2013 & 2014; Bloom, 2014; Century, Leavey, & Payne, 2007; Farley et al., 2014; Green et al., 2012; Guhan & Liebling-Kalifani, 2011; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015; Holmgren, Søndergaard, & Elklit, 2003; Kjellenberg et al., 2014; Long, 2019; Mehus & Becher, 2015; Miller, Martell, Pazdirek et al., 2005; Munday, 2009; Roberts et al., 2018; Schweitzer, van Wyk & Murray, 2015; Splevins, Cohen, Joseph, Murray, & Bowley, 2010; Surawski, Pedersen, & Briskman, 2008). It is also consistent with the observation in many of these studies that vicarious traumatisation and vicarious resilience/vicarious post-traumatic growth can be experienced simultaneously.

The reluctance of participants to disclose their experiences of vicarious traumatisation could be interpreted as an act of resistance. Many participants were invested in resisting the psychopathological representations of resettling individuals and referred to the potential of this research to improve perceptions of resettling communities during their interviews: “Trying to change how we think and talk about refugee background communities is important on so many levels” (Female, New Zealand born, practitioner, P12). Aware that resettling refugees are simultaneously perceived as at risk and a risk in their new society of settlement, participants may have been concerned that disclosing instances of vicarious traumatisation in more detail might reinforce this perception. A recent study documenting the experiences of

psychologists supporting resettling clients at a not-for-profit refugee trauma and rehabilitation agency in Australia identified a similar trend:

“There was less focus on the experiences of vicarious trauma in the current study. Participants rarely discussed listening to stories of the past as an issue. When clients’ stories of the past were brought up, participants focused on the strengths and inspiration.”

(Roberts et al., 2018, p. 7)

The psychologists in the study by Roberts et al., (2018) were much more likely to attribute any personal distress to Australia’s restrictive resettlement policies and practices and indeed that is what participants in the present study did also. Participants repeatedly acknowledged their frustration with the shortcomings of the resettlement process and how this impacted their ability to effectively support clients. For example, one practitioner said:

“All things being equal we could do good work with our clients - if we’re not having to hassle all the time about Housing, WINZ [Work and Income], family reunification [...] I often use the therapy triangle with clients. There’s safety and stabilization at the bottom of the triangle, then there’s the trauma work, then there’s the reconnection with ordinary life. We just get stuck down the bottom of the triangle. It frustrates the hell of out of me.”

(Female, New Zealand born, practitioner, P6)

“I’ve been knocked more by institutional stuff than clients. I’m often frustrated by the limitations in the service we offer people. They say “you don’t solve the problem by throwing money at it” but it would be a bloody good start at supporting people at such a critical juncture in their lives.”

(Male, New Zealand born, practitioner, P3)

While these participants didn't shy away from acknowledging the “*challenges*” associated with resettlement work, the majority of them went to pains to attribute these challenges to systemic issues such as unresponsive social services and insufficient resourcing to adequately address clients' resettlement stress. In the words of one participant, “the clients aren't the problem”:

“It's a challenging role [...] For me the challenges are actually more working with other agencies within New Zealand and having to advocate for things that I thought were basic rights for our clients [...] The clients aren't the problem.”

(Female, New Zealand born, practitioner, P12)

The frustration associated with instances when resettling clients' basic rights were not being acknowledged, the advocacy required, and inadequate resourcing of the sector were particularly pronounced in comments from participants born in New Zealand. Similar reflections were captured by Alia Bloom (2014) who acknowledged that resettlement practitioners in New Zealand unanimously attributed their distress to structural challenges in the sector. Similar ideas have been documented in studies documenting the experiences of a range of practitioners internationally, for instance, psychologists and counsellors (Century et al., 2007, Roberts et al., 2018 and Schweitzer et al., 2015), GPs and nurses (Farley et al., 2014), social workers and support staff (Guhan and Liebling-Kalifani, 2011) and refugee advocates (Surawski et al., 2008).

The observation that the policies and practices of the society of settlement undermine the resilience of practitioners and the recovery of clients was also reported recently by Stephanie Long (2019). Long interviewed clinical supervisors about their perceptions of vicarious traumatisation and vicarious post-traumatic growth in practitioners supporting resettling clients in Australia. The participants suggested that the symptoms of distress often associated with vicarious traumatisation and attributed to the content of clients' pre-

displacement stories, actually stem from the socio-political context constantly undermining their clinical work and recovery of clients. Predictability, stability, consistency, respect and dignity are considered the key components of recovery and the supervisors participating in this study reflected on how current resettlement policies and practices prevent such conditions. In the words of one supervising practitioner:

“Nothing addresses the context of the worker and the work. It is all about what they see with the client. But you go to work on a day when the government has made a decision that has an effect on the client population as a whole; that can be the thing that shatters perception and shocks the worker, not the client trauma.”

(Long, 2019, p.10)

Participants in the present study were invested in resisting the assumptions of risk associated with resettlement work and shared the personal and professional satisfaction they derive from supporting resettling clients. Participants also seemed reluctant to discuss instances of vicarious traumatisation and were more inclined to attribute their distress to burnout from a dysfunctional sector. Their reflections were consistent with international studies documenting the experiences of resettlement practitioners and illustrate the significance of the socio-political climate for resettling clients and practitioners, as well as the observation that a range of responses of resettlement work can be experienced simultaneously (i.e. vicarious traumatisation and/or burnout and/or vicarious resilience). Furthermore, whilst participants were quick to criticise the assumptions of psychopathology associated with resettling communities and resettlement work, few acknowledged their reliance on such assumptions in their attempts to advocate for resettling clients. The implications of such approaches to advocacy are discussed in the next theme; “People have no idea”.

“People have no idea”

“I quite like the socially educating side of it [resettlement work]. People make comments “We shouldn't be taking in refugees” and I quite like to actually be able to put a story behind it. Illustrate why there is the need and what these people have been through. Most people have no idea, no idea at all.”

(Female, New Zealand born, practitioner, P5)

All the participants in the present study described the personal and professional pride they took in advocating for resettling clients and communities. Participants acknowledged that such advocacy was necessary given the lack of awareness of refugee resettlement in New Zealand society and the discrimination and/or indifference associated with this:

“I think a hell of lot of people in New Zealand don't realise that refugees are coming and probably don't want to know.”

(Female, New Zealand born, volunteer, P19)

“I think most people in New Zealand are totally unaware of what refugees are [...] You say to people, ‘Oh we have this refugee thing’ and they say, ‘Oh that's good’, maybe [...] The perception even from people who have an idea of refugees they have this perception that the refugees coming here are absolutely cradled right the way through and that's not the case at all.”

(Male, New Zealand born, volunteer, P25)

The necessity of advocating for resettling clients has been acknowledged in several of the previous themes (“This is not paradise” (p. 108) and “Oh, those poor people” (p. 134) and was a consistent theme in other studies documenting the experiences of resettlement practitioners overseas. Studies documenting the experiences of psychologists have continually acknowledged that the advocacy required transcends traditional clinical practice but the sense of contribution associated with advocacy can “counterbalance” the sense of

powerlessness that can accompany supporting resettling clients (Apostolidou, 2016, p. 277; Bloom, 2014; Century et al., 2007, Roberts et al., 2018; Schweitzer et al., 2015).

Advocacy can, however, rely on or perpetuate the assumptions of psychopathology. For instance, the practitioner quoted at the beginning of this theme stating that “people have no idea”, is the same practitioner who is quoted at the beginning of the theme “pretty damaged people”. Further on in the interview, this practitioner did reflect on the fact that she worked for a specialist mental health service and therefore was working only with the proportion of resettling clients who struggle with significant distress; “We’re the worst end, these are very damaged people” (Female, New Zealand born, practitioner, P5).

This reflection aligns with the concept of a clinician’s bias which has been discussed by George Bonanno (2004) and his reflections on resilience and role of psychology in undermining individuals’ innate capacity for recovery. Bonanno’s argument was that psychologists rely on knowledge gleaned from psychological research conducted primarily on individuals who experience significant distress and seek treatment after a traumatic event. Bonanno also observed that resilience was often perceived as rare or pathological by many psychologists but he argued that this “unexpected resilience” (p. 24) was much more common than acknowledged.

It was therefore understandable that if one’s psychological (or volunteer) training was informed by such psychological research and if one proceeds to work with the minority of resettling individuals who do suffer significant distress and seek treatment, then that may skew one’s perception of all resettling individuals, their resilience and priorities for recovery. This clinician’s bias has implications for practitioners who go on to represent resettling clients in the advocacy that is required in the New Zealand resettlement sector and society.

While all practitioners I interviewed consistently criticised the media for promoting assumptions of psychopathology to prompt pity, no one acknowledged that the media often

approaches resettlement practitioners to provide ‘expert’ comments (see analysis of Refugee Trauma Recovery spokesperson in the media article on p. 126) and that resettlement organisations regularly produce press releases for the media.

David Ongenaert and Stijn Joye (2019) recently published a paper, “Selling displaced people”, which examined the communication strategies of international refugee organisations such as the UNHCR. In their analysis, they identified a preoccupation with ‘vulnerability’ (p. 487) in 91.7% of all press releases from the UNHCR published from 1 January 2014 to 31 December 2015 with recurrent representations such as “This plan [...] can help us [...] support those who are desperate and traumatised” (p. 495). In interviews with press officers from the UNHCR, many acknowledged that press releases are “reactive stories” that “rarely, have the space to individualise people” (p. 495). Indeed, further analysis of the press releases identified an absence of perspectives from displaced people (1.3%) with the organisation (87.2%), employees (47.4%), celebrities (10.3%) or others (8.3%) speaking for them. If the perspectives of displaced people were present they implied vulnerability. Similar observations have been made of the communications strategies of other agencies such as the International Rescue Committee, International Committee of the Red Cross, Oxfam, and The United Nations Children's Fund (Ongenaert & Joye, 2019; Pupavac, 2002; Rajaram, 2002), including local initiatives to increase the annual refugee quota in New Zealand (Slade, 2019).

As discussed earlier in Slade’s (2019) work, she identified that the media coverage of the Syrian ‘refugee crisis’ in New Zealand consistently portrayed refugees as “passive victims” (p. 125). Her analysis also identified that only 17.1% of the newspaper articles included the perspectives of refugees themselves. With the exception of one interview, all emphasised “the trauma story” (p. 131). Politicians, resettlement practitioners and academics (82.9%) were responsible for representing resettling communities and in her interviews with representatives from resettling communities many reflected on this issue:

“I’m really tired of seeing the white Pākehā male or female talk about somebody else’s story, you know, and then they get the respect and all of that to be able to be invited to the table, when actually why aren’t you inviting that very person who’s story it is?”

(Slade, 2019, p. 219)

Slade (2019) also interviewed a number of these advocates and while many were conscious of not perpetuating stereotypes and were committed to creating opportunities for resettling communities to share their perspectives in their campaigns, several reflected on their responsibility for these issues of representation in the past:

“We didn’t talk about people - people are fleeing, we talked about refugees fleeing [...] We talked about people as refugees even once they were here. We didn’t talk about the positive aspect. These are people who are seeking to rebuild their lives, who are looking for a new start and future for their family. We talked about these are people fleeing terror, these are people who are fearful, these are people who need safety. So, we talked about victims rather than survivors.”

(Slade, 2018, p. 143)

Such a reflection aligns with the insights shared by practitioners in the present study regarding their frustration with constant references to “refugees” as opposed to “people” (“They’re people”), preoccupation with their precarious pre-displacement experiences (“This is not paradise”) and assumed psychopathology (“Psychotherapy”). In spite of this frustration, only one practitioner acknowledged their responsibility for relying on such representations in their own attempts to advocate:

“I might be responsible for some of that stuff. When we were trying to set up places like Refugees as Survivors [now Refugee Trauma Recovery] it was really

important to actually get the message to different people of influence that trauma did exist. That it was sort of a normal part of being a refugee. That there needed to be services available. That's stereotyping isn't it?"

(Female, New Zealand born, practitioner, P11)

This participant was referring to the inception of Refugee Trauma Recovery, a specialist mental health service, where it was necessary to represent resettling individuals in a specific way. The reflection on trauma being “a normal part of being a refugee” was consistent with critique from psychiatrists and psychologists who have accused PTSD of being a “pseudo-condition” that pathologises the “understandable suffering of war” (Summerfield, 1999, p. 1449 see also Bracken et al., 1995; Miller et al., 2006; Patel, 2003; Watters, 2001). These scholars argued that challenging the assumptions of psychopathology does not intend to dismiss the genuine distress experienced by resettling individuals. By definition, they have all been subjected to persecution, displaced and resettled into a third, often unknown, country so will require significant support to resettle. The issue is however what that support looks like, the assumptions that inform it, and the observation that obtaining recognition and resources can be compromised if advocates deviate from representations that do not align with these assumptions.

Scholars such as Watters (2001) who raised concerns about the reduction of resettling individuals to a “single pathologised identity” (p. 1710, see discussion in Ch 2, p. 28) also spoke about the ways in which the assumptions of psychopathology underpin service provision and compel practitioners to be pragmatic when representing resettling clients:

“Agencies concerned with the social welfare of refugees may have to identify the problems in the context of clinical categories in order to assist [...] The agency may feel an overwhelming sense of responsibility to act and may eschew critical analysis in favour of a pragmatism [...] Either present the refugees' problems in

terms that highlight the range of social, political and economic concerns of the refugee but that may not mobilise any resources to support the refugee, or, alternatively, in full knowledge of the broader complexities, nevertheless present the refugee as a traumatised victim and mobilise support.”

(Watters, 2001, p. 1710)

Such pragmatism was present in the reflection from the practitioner responsible for acquiring resources for Refugee Trauma Recovery, and arguably the representations reproduced by the Refugee Trauma Recovery spokesperson in the media (p. 126), as well as the Refugee Trauma Recovery practitioner who spoke of “pretty damaged people”. Although Watters (2001) published his concerns two decades ago, they remain just as relevant today. The requirement for such pragmatism, however, is concerning given that clinical research published since disputes the assumptions of psychopathology that underpin service delivery. Practitioners participating in the present study also readily identified the inaccuracy and implications of such assumptions. I therefore suggest that the resettlement sector suffers from a crisis of representation.

The crisis of representation in the resettlement sector

In the context of refugee resettlement, the crisis of representation refers to the observation that, despite the best of intentions, the interests of those responsible for representing resettling refugees can conflict with the interests of resettling individuals and/or communities (Dona, 2007; Harrell-Bond, 2002; Pupavac, 2002; Summerfield, 1999; Watters, 2001). The central conflict is the way in which resettling communities’ psychological wellbeing is represented and the assumptions made about the type of assistance they should receive. The discrepancy between what practitioners who knew me shared with me privately in their interview and what they stated publicly in the media and on the website suggests that they are caught in this crisis of representation. These practitioners felt compelled to continue

relying on psychopathological representations of resettling communities and resettlement work in order to obtain recognition and resources for the services they provide. Importantly, they continued to do this, knowing that these representations do not accurately reflect the resilience of resettling communities or realities of supporting them to settle in New Zealand.

In addition, they acknowledged that such representations can compromise successful settlement outcomes by perpetuating stigma, societal prejudice and service provision that reinforces passive styles of resettlement. The reflections from participants from Refugee Trauma Recovery in particular suggested that practitioners providing specialist psychological support are particularly compromised. Alternative approaches to representing their work and clients could compromise the resourcing of their services and their ability to support the subsection of resettling individuals, who do require, desire, and may be responsive to this form of psychological support.

In light of this crisis of representation, the recommendation from this analysis is to stimulate critical reflexivity in the sector by sensitising practitioners to their responsibility for the issues of representation. Critical reflexivity has been referred to as the “constant self-conscious scrutiny of the self” (England, 2004, cited in in Dowling, 2016, p. 34). My interpretation is that the process of critical reflexivity involves reflecting on one’s assumptions and actions and the implications of these for oneself and others. In the context of refugee advocacy, critical reflexivity has been described as a commitment to being “more self-reflective and accountable to the people and the situations they represent” (Ambrose et al., 2015, p. 1). My hope was that by disseminating the critical reflections shared by practitioners in the interviews, alongside corresponding clinical research, practitioners would have an opportunity to reflect on the assumptions of psychopathology they may hold, their investment in these assumptions, and the implications of these assumptions for resettling communities. This may prompt them to reconsider how they represent their resettling clients.

Indeed, many practitioners who participated in an interview with me commented on appreciating the opportunity for critical reflection:

“Talking in this context has allowed me to be able to reflect [...] I feel grateful to actually undergo this process [...] To stop for a minute and really think about what we’re doing here [...] I think working in this area we can get a bit precious. That we are the people that know. That we are the specialists. We need to watch that.”

(Female, New Zealand born, practitioner, P7)

The suggestion that the resettlement sector requires initiatives to increase critical reflectivity is not a new one (Dona, 2007; Harrell-Bond, 2002; Patel 2003; Walk-Up, 1997; Watters, 2001). Similar calls for critical reflexivity have also come from researchers (Bloom, 2014; Fraser, 2011; Slade, 2019) and resettling communities (Awad, 2011; CRF, 2009) in New Zealand.

Conclusion

The analysis in this chapter suggests that the resettlement practitioners interviewed in this study may be caught in a crisis of representation. Despite many practitioners resisting the assumptions of psychopathology that are associated with resettling individuals and resettlement work, there was an indication that some practitioners continued to rely on these assumptions in their advocacy. Furthermore, practitioners were quick to criticise the media for perpetuating the assumptions of psychopathology, as opposed to critically reflecting on the origins of these assumptions. The recommendation from this analysis is that the resettlement sector requires initiatives that sensitise practitioners to the issues of representation and inspire them to reconsider how they represent their work and resettling clients to others. The following chapter documents my attempts to stimulate critical reflexivity in the sector and address the secondary aim of this PhD research: to conduct

reciprocal research that raises awareness of the problematic psychopathological representations often perpetuated by practitioners within the refugee resettlement sector in New Zealand.

Chapter 6

Reflections on stimulating critical reflexivity in the resettlement sector

“Marieke’s research was quite a challenge to us [...] It has forced us to stop and reflect.”

(New Zealand Red Cross National Migration Programme Manager, 2017)

Introduction

This chapter addresses the secondary aim of this PhD research: to conduct reciprocal research that raises awareness of the problematic psychopathological representations often perpetuated by practitioners within the refugee resettlement sector in New Zealand. In this chapter I critically reflect on my approach to disseminating the analysis covered in the previous chapter (see Chapter 5) and my attempt to stimulate critical reflexivity within the resettlement sector through collaboration, and subsequent consulting, with the New Zealand Red Cross. I also reflect on a critical incident that provided a powerful opportunity for reflection on the potential crisis of representation in the resettlement sector in New Zealand.

This critically reflexive case study is an attempt to reconsider what can ‘count’ in psychological resettlement research (see discussion in Chapter 4, p. 98) and is a descriptive narrative that draws on my experience, email correspondence with practitioners, PowerPoint presentations, conference posters, media articles, websites and training resources to provide an audit trail of the way in which my iterative attempts to raise awareness of the issues of representation in the resettlement sector were perceived by practitioners across the country, in addition to the perceived socio-political change associated with these attempts.

The chapter is organised into four sections; 1. reflections on disseminating my research and recommendations to New Zealand Red Cross National Office, 2. reflections on

the development and training associated with an induction manual for New Zealand Red Cross, 3. reflections on a regional training tour conducted for New Zealand Red Cross and 4. reflections on a critical incident that occurred with a number of practitioners from a service providing specialist psychological support to resettling individuals. The chapter concludes with reflections on the significance of the relational context in the reception of resettlement research and attempts to stimulate critical reflexivity in the sector.

New Zealand Red Cross National Office

In light of my inability to schedule and share my initial analysis with the practitioners from the local branch of the New Zealand Red Cross who participated in my research, as discussed in Chapter 4, I decided to initiate contact with National Office directly. I called the Communications Manager, introduced myself and my research, and requested a meeting to share some of the recommendations of my research. I followed the call with an email summarising what we had talked about and she responded later that day to schedule a meeting:

“What a pleasure hearing from you! My job can be a real slog sometimes, I am forever harping on about people being people and not ‘refugees’, portraying hope, dignity and people as resilient survivors. I am stoked that you have picked up on this rhetoric”.

(New Zealand Red Cross Communications Manager, 04.02.16)

The introduction of her email illustrated her immediate interest in my research and confirmation that I had conducted research that reflected a genuine concern in the sector. Her response was also consistent with the critical reflections shared by the practitioners I interviewed. In addition, her reference to “people being people and not ‘refugees’” aligned

well with the first analytical theme in my previous analytical chapter “They’re people” (See Chapter 5, p. 103).

During our meeting the following week we were able to discuss my research and associated recommendations in more depth. I was also able to describe how I had shared my initial analysis with Refugee Trauma Recovery and had recently presented my findings at a national refugee research symposium. I offered to prepare a presentation for National Office and she agreed to arrange it with her colleagues.

The presentation occurred approximately two months later and was attended by a range of practitioners; social workers, cross cultural workers, volunteer coordinators, the media team and management. At the end of the presentation, several practitioners shared how this research resonated with their own observations of the sector. A reflective discussion developed in the audience around appropriate approaches to awareness raising, representation and advocacy. I was able to offer additional insights from the interviews I conducted with their colleagues, in addition to the insights from international resettlement research.

Afterwards, the National Migration Programmes Manager approached me asking if I was interested in assisting her to implement some of the recommendations from my research. In the following section I will reflect on how I represented myself and my research in this presentation (Ballinger, 2003) and avoided the defensive responses towards external resettlement researchers documented elsewhere (Krause, 2017; Harrell-Bond 2002; Szczepanikova, 2010; Walkup 1997).

In the process of preparing my presentation for the National Office I was mindful of communicating my research, and recommendations, as respectfully as possible. I wanted to be transparent about the impetus for my PhD research and implicate myself for relying on ‘at risk’ psychopathological representations in my previous resettlement work. I also wanted to

acknowledge the shortcomings of positivist psychological research conducted on resettling communities. I was acutely aware that I was trying to raise awareness of issues of representation in the resettlement sector, whilst simultaneously trying to model respectful representation of the research participants, some of whom would be present in the audience.

Aware of the fact that academics in the resettlement sector have a reputation for being arrogant (Krause, 2017; MacKenzie et al., 2007; Pittaway et al., 2010), I wanted to be as approachable as possible. I chose to be seated and moved a table and chair to the front of the room so it felt more like a conversation. Rather than begin with the usual formal type of introductions, my opening comments were about expressing my appreciation of the opportunity to discuss my research and inviting questions or discussion at any point of the presentation.

In the first section of my presentation I shared the following disclaimer:

“Before I start, I would like to acknowledge that my research runs the risk of being misinterpreted as minimising the impact of trauma and I want to say that this is absolutely not my intention. I’m acutely aware of the profound physical, psychological and spiritual implications associated with becoming, and being, a refugee but I personally believe it is dangerous and disrespectful to focus exclusively on the detrimental consequences and my research is an attempt to acknowledge the resilience, dignity and determination of those I’ve met.”

The disclaimer was an attempt to demonstrate my own reflexivity, the intentions of my PhD research and awareness of potential unintended interpretations of the research findings. It was also an opportunity to refer to my own experience in the sector and align myself with the audience. I referred to the impetus for my PhD research again in the body of the presentation:

“The impetus for my research really came from my concern over the representation of refugees and resettlement work and our preoccupation with trauma. I really feel like this pathologises resettling refugees and by extension resettlement workers [...] I felt like it conflicted with my own personal and professional experiences engaging with resettling refugees [...] so that was where I was coming from.”

I also took care to include myself in the critique:

“People often have no idea that they’re describing their clients in this way and it’s something I’ve been responsible for in the past also. It’s important for me to acknowledge that.”

and continued to do this throughout the presentation (i.e. “our preoccupation with trauma” & “we have a tendency”).

I also acknowledged the limitations of psychological resettlement research by summarising the methodological issues surrounding inflated prevalence rates of PTSD in resettling communities, critiquing the other salient aspect of my identity as a PhD candidate in Psychological Medicine.

In terms of my PowerPoint presentation, I chose a simple black and white colour palette and an identical image along the bottom of every slide (Figure 6). This image is of silhouettes of individuals walking in single file. The silhouettes depict men, women and children, the young, elderly, and disabled without an identifiable country of origin. I did this in an attempt to challenge the popular refugee representations of vulnerable women and children from particular parts of the world (Chouliaraki, 2013; Dona, 2007; Harrel-Bond, 2002; Malkki, 1996; Pupavac, 2008; Rajaram, 2002).

Figure 6.

Format of PowerPoint presentation prepared for New Zealand Red Cross National Office.



I also chose to incorporate audio recordings of colleagues from the Department of Psychological Medicine repeating reflections from the participant interviews that captured the concepts I wanted to communicate (matching for gender and accent). In this way, it felt like the participants were present and personally reflecting with the audience. This was also an attempt to acknowledge that the analysis and associated critique was not just an ‘academic’ exercise but genuine concern expressed by their colleagues and would address concern over the perceived relevance and practical application of psychological resettlement research, and PhD research in particular (Awad, 2011; Mackenzie et al., 2007; Marlowe, 2010; Miller et al., 2006; Patel, 2003; Pittway et al., 2010; Sukarieh & Tannock, 2012; Summerfield, 1999). I said:

“I got colleagues of mine to say these quotes so you get a sense of what people had to say [...] This is what one of your colleagues had to say” - “I think we have

only certain images about refugees. When you hear 'refugee' it looks like somebody is scared, it means somebody escaped and they have no options. We need to change that idea about refugees. We need to focus on the positive side of their lives. How they managed to survive. How they were able to succeed here in New Zealand."

I also chose to incorporate instances where participants had reproduced the problematic psychopathological representations I was attempting to raise awareness of by playing audio recordings of quotes from the theme "Pretty damaged people" in Chapter 5 (p. 128). I was then able to discuss why this type of representation was problematic and follow it with an alternative representation from another participant in a similar professional position that acknowledged the resilience, agency and aspirations of resettling individuals in spite of their psychopathology, "They're people" (Chapter 5, p. 103).

After playing the alternative representation I was able to summarise corresponding clinical research to illustrate the inaccuracy and implications of the assumptions of psychopathology circulating in the sector. For instance, studies indicating the relatively low prevalence of PTSD in resettling populations (Bogic et al., 2015; Charlson et al., 2016; Fazel et al. 2005; Steel et al., 2009), significance of post-displacement stress (Bogic et al., 2015; Porter & Haslam, 2005; Steel et al., 2009) and shortcomings of specialist psychological intervention (Bracken et al., 1997; Nickerson et al, 2011; Patel, 2003; Summerfield, 1999).

I also made a point of ensuring the first and last audio-recorded reflections came from a practitioner with a refugee background. This ordering was an attempt to acknowledge that resettling individuals are often spoken for (Mackenzie et al., 2007; Malkki, 1996; Marlowe, 2010; Miller et al., 2006; Patel, 2003; Pittway et al., 2010; Rajaram, 2002; Sukarieh & Tannock, 2012; Summerfield, 1999), and that I wanted to counter this tendency. Working

within a transformational paradigm I wanted to prioritise their perspectives throughout the presentation.

It is generally accepted that criticism is more likely to be positively received when the person offering the criticism is perceived to be similar to those at whom the criticism is directed. Psychologists term this the “intergroup sensitivity effect” (Hornsey et al., 2004, p. 499) and I would have benefited from this effect as I am a privileged Pakeha woman, a demographic shared with the majority of the audience at New Zealand Red Cross National Office. That said, the perceived psychological investment of the critic in the issues that are raised also matters, as Hornsey et al., (2004) documented in their publication, “You can criticise because you care”. The authors identified that pre-empting criticism with concern and using inclusive language to implicate the critic within the criticism are powerful strategies to minimise defensiveness and promote constructive conversations and change. That is what I had intuitively done by introducing myself as a former resettlement practitioner, being transparent about the impetus of the research and implicating myself in the critique throughout my presentation.

The approach outlined above enabled me to communicate a critique which combined my own observations of the sector with critical reflections from their colleagues (who had participated in my interviews) and corresponding clinical studies. This approach created an opportunity for the practitioners in attendance to reflect on, and reconsider, how they represented their work and resettling clients, in particular, the implications of promoting inaccurate assumptions of psychopathology. As discussed in the previous chapter, numerous scholars have identified the need to stimulate critical reflexivity in the resettlement sector and have observed that humanitarian organisations do not often offer such opportunities (Harrell-Bond, 2002; Krause, 2017; Lokot, 2019; Slade, 2019; Walk-Up, 1997; Watters, 2001). At the

end of my presentation, the National Migration Programmes Manager asked if I could assist her in raising awareness of these issues of representation within the organisation and shortly afterwards formally contracted me to contribute to a staff induction manual that was under development.

New Zealand Red Cross induction manual

I developed two modules for the induction manual (Appendix L). The modules included reflections from practitioners who participated in my PhD research, in addition to published research. Both modules replicated the approach I had taken in the initial research presentation to Head Office. I worked with staff at National Office to incorporate perspectives from resettling clients, previous public communication initiatives such as the “Get to know me” campaign and their internal policies such as their employment assistance programme. Prompts for critical reflexivity were positioned throughout each module under “Research & Reflect”.

The first module was entitled “Stereotypes and stigma in the resettlement sector” and was described in the following way:

“The aim of this module is to sensitize you to the stereotypes and stigma within the resettlement sector and suggest ways for you to critically reflect on your role in resettlement and ways you represent refugee background clients.”

The following exercise is an example of a reflexivity prompt associated with this module:

“Now, take a moment to write, in your own words, a description of clients with a refugee background:_____.

Review your description: How would you feel being described this way? How do you think a resettling refugee would feel being described this way? How do you

think a person, with little to no knowledge of refugees, would feel about resettling refugees after reading this?”

The second module was entitled “Strengthening resilience in the resettlement sector” and was described in the following way:

“This module aims to introduce you to the concepts of resilience and vicarious resilience within the resettlement sector and suggest ways in which you can acknowledge the resilience of refugee background clients while enhancing your own personal and professional resilience.”

The following exercise is an example of a reflexivity prompt associated with this module:

“If you have been working in the resettlement sector for a while, can you identify your own experiences of vicarious resilience? If you are new to the resettlement sector, can you anticipate any experiences of vicarious resilience you may experience? You may like to approach an experienced colleague and ask them about their personal and professional experiences of vicarious resilience.”

I was invited to deliver a presentation at the launch of the induction manual the following year at the New Zealand Red Cross National Hui and repeated the strategies I had utilised in the initial presentation at National Office. I continued to implicate myself in my critique and play audio recordings of critical reflections from practitioners to introduce each concept before summarising corresponding clinical and resettlement research and suggesting prompts for critical reflexivity.

Shortly after the launch of the induction manual, I asked the National Migration Programmes Manager if she could provide a reflection on my PhD research. Acquiring her perspective on the perceived relevance of my research, in addition to her description of the

application of the research into the sector, was an attempt to be accountable to my claims of conducting transformative research (Mertens, 2007, see Chapter 4). This request was met with appreciation: “Thanks for the opportunity to comment on how we've engaged with your research - please see attached” (See Appendix M).

In her reflection she acknowledged the initial presentation I gave at National Office and described how I sensitised those present to their role in perpetuating stereotypes and stigma in the resettlement sector:

“We became very interested in her [Marieke’s] findings after a short presentation she gave on the importance of language and the resettlement process [...] She provided us with a challenge around our role in reinforcing stereotypes simply through our use of language [...] Her message was quite a challenge to us and at times not an easy one to hear. It has forced us to stop and reflect on how we communicate both internally and externally.”

The reflection went on to describe the application of my research findings into the New Zealand Red Cross resettlement programme and how these findings continue to inform their practice:

“She [Marieke] completed two modules on stereotypes and resiliency which have now been rolled out to all 150 staff. The material is also now being integrated into our volunteer training programme which trains 600 people each year [...] The research was also timely as we integrated a regional mental health service into our team. We are working through a process of updating comms materials related to this service and have been able to use Marieke’s findings and recommendations as a guide.”

The reflection concludes:

“I’m very grateful for the willingness with which Marieke has shared her research and findings. It has made a very real and meaningful impact in the refugee settlement sector.”

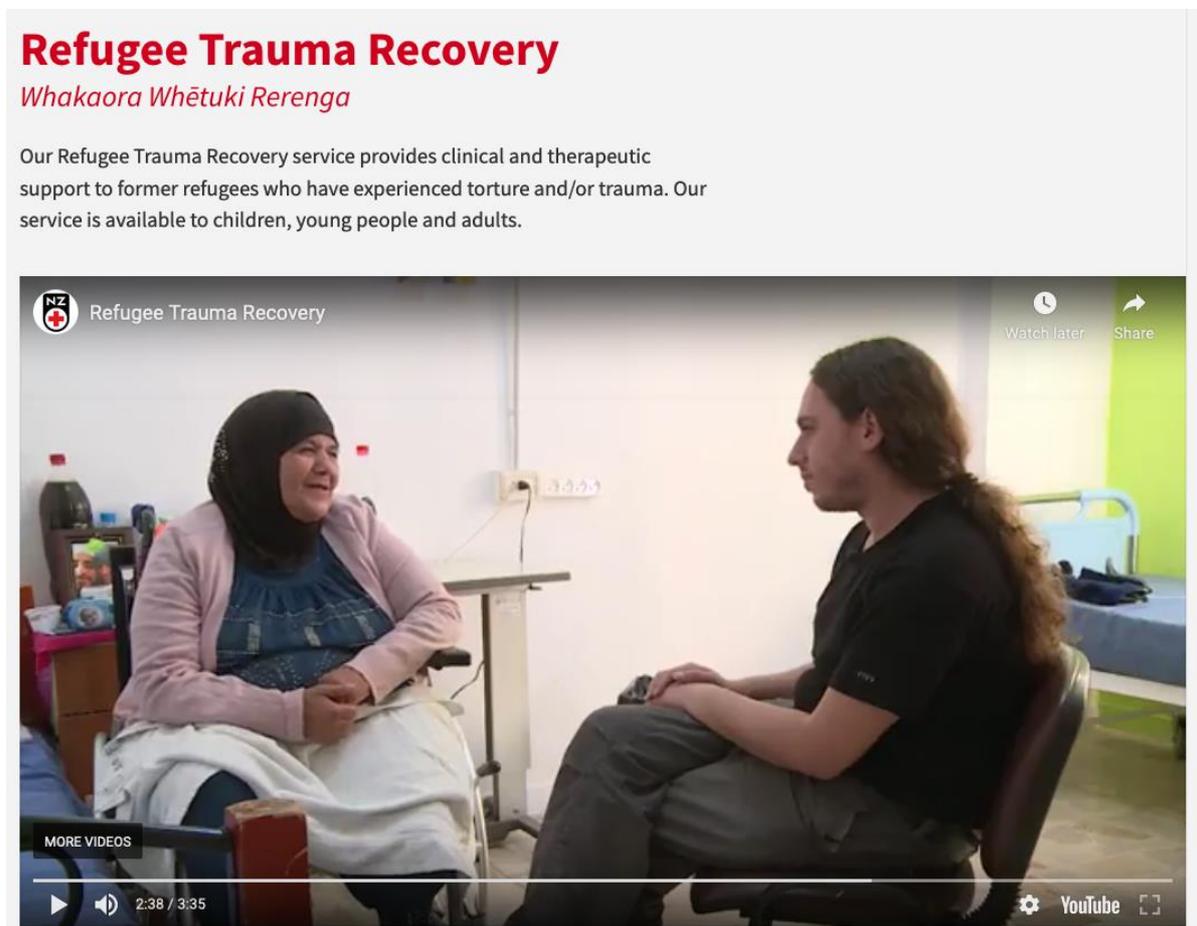
(New Zealand Red Cross National Migration Programmes Manager, 11.12.17)

Receiving this reflection was a significant moment for me and indicated that I had succeeded in stimulating critical reflexivity within the primary agency responsible for resettling individuals in New Zealand. My research aim of raising awareness of the issues of representation in the sector became institutionalised within the staff induction manual. This transformation was further extended when the integration of the local mental health service occurred and a new website was created for Refugee Trauma Recovery.

I was relieved to see that the representational practices on the new website had taken into account many of the issues I had raised with New Zealand Red Cross. The homepage of the website has a video following the journey of recovery for Hamda, a refugee background woman from Syria (see Figure 7). The video portrays Hamda with dignity. Hamda describes her distress in her own words and is shown receiving psychotherapy and physiotherapy from a multi-disciplinary team of practitioners. In addition to her sewing and socialising with family and friends. The video captures the complexity of trauma and the resilience and resources resettling individuals bring to their recovery.

Figure 7.

Screenshot of the Refugee Trauma Recovery website towards the end of this research, 2018. Reproduced with permission (see Appendix B).



Beneath the video is a brief description of Refugee Trauma Recovery’s “core clinical service” that acknowledges their multidisciplinary team and that they work closely with other agencies to provide “holistic support”. The description also acknowledges that the support provided by Refugee Trauma Recovery is voluntary and individuals can opt out if they desire.

In contrast to the website at the time of initiating this PhD research (see discussion Ch 1, p. 19) the new version of the website does not reproduce the assumptions of psychopathology. More specifically, the website no longer implies that all resettling

individuals suffer from PTSD and are powerless to settle in New Zealand without specialist psychological support.

New Zealand Red Cross training tour

A few months after the launch of the induction manual, the National Migration Programmes Manager contacted me to see if I was interested in traveling to the regional offices to personally train staff. I immediately agreed as it was another opportunity to raise awareness of assumptions of psychopathology potentially being promoted by practitioners in the resettlement sector. It also provided further indication of the perceived value of my PhD research and personal approach to sharing it. The manager wrote:

“The team leaders loved your session last year and we think there is real value in inducting all staff on these topics in person.”

Shortly afterwards I started receiving invitations from the regional team leaders. I have included one such invitation to illustrate the genuine enthusiasm expressed by practitioners in response to my research and further training:

“I met you in Wellington at the national hui and was very impressed by your research in the area of resettlement, stereotypes and stigma [...] I am very excited to hear that we can look at getting you to do some training around the country!”

(New Zealand Red Cross Team Leader, 01.05.18)

Also attached to the previous invitation was the original email the National Migration Programmes Manager had sent to all area managers (See Appendix N) regarding the training. I sought consent to include it here as it provides unprompted evidence of my engagement with the NZRC:

“Some of you will be familiar with Marieke who wrote our module 3 & 4 on resiliency and stereotypes, she also presented at our Team Leaders hui late last year. Since then we’ve had lots of requests from team leaders who have wanted her to travel to their areas and do it with the whole team [...] so we’ve contracted Marieke to deliver regional training.”

In addition to the endorsement of my research and recommendations:

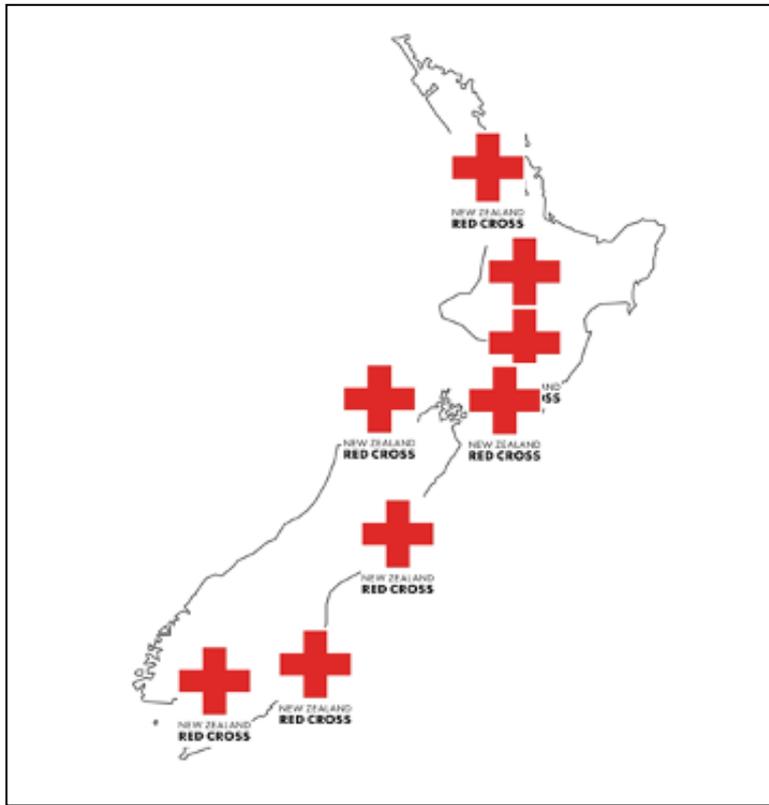
“Her message is fantastic – all about taking a strengths based approach to how we talk and think about resettlement, refugees and our roles [...] I’d strongly encourage each area to make use of this training as the principles underlie how we want to approach our work.”

(New Zealand Red Cross National Migration Programmes Manager, 30.04.18)

Over the course of two months, I travelled to all eight regional offices (Auckland, Hamilton, Palmerston North, Wellington, Nelson, Christchurch, Dunedin & Invercargill) and trained a range of New Zealand Red Cross resettlement staff (client services managers and case workers, cross-cultural workers, volunteer trainers and co-ordinators, the communications team, fundraising team and pathways to employment team). Staff from other agencies such as Interpreting New Zealand, English Language Partners, Regional Public Health, Community Law Centre, and the Refugee Quota Branch from Immigration New Zealand also attended. I ran separate sessions for the two specialist mental health services supporting resettling individuals in New Zealand, in addition to the agencies based at Mangere Refugee Reception Centre. I also returned to ChangeMakers Refugee Forum and the colleagues who inspired this research. At the conclusion of the national training tour, I had delivered 12 sessions and personally trained approximately 500 practitioners (See Figure 8).

Figure 8.

The regional offices of New Zealand Red Cross where I conducted training.



At the end of each session, I asked the practitioners to share an insight from the session that was significant for them and made notes on their reflections. Their responses consistently acknowledged an increased awareness of the implications of representing resettling clients a certain way and appreciation for the opportunity to critically reflect with their colleagues. As stated earlier it is uncommon for agencies to offer such opportunities for critical reflection (Harrell-Bond, 2002; Krause, 2017; Lokot, 2019; Walk-Up, 1997; Watters, 2001).

Practitioners admitted that they were unaware of the clinical research I shared in the presentation and were particularly shocked by the low prevalence rates of PTSD identified in resettling populations ("They're people", Chapter 5, p. 103). They also expressed interest in the concept of vicarious resilience and admitted that they were only aware of the concept of vicarious traumatization ("Oh, those poor people", Chapter 5, p. 134). These responses

confirmed the pervasiveness of the assumptions of psychopathology in the resettlement sector and lack of access to clinical research that does not reproduce these assumptions (Patel, 2003; Miller et al., 2006).

Practitioners also shared how the critical reflections captured in my PhD research resonated with their own observations, particularly the preoccupation with pre-displacement trauma and significance of resettlement stress (“This is not paradise”, Chapter 5, p. 108). A number of practitioners expressed relief that my research reinforced the significance of settlement support and the suggestion that they didn’t have to be ‘specialists’ (i.e. psychiatrists or psychologists) to effectively support resettling individuals (“Psychotherapy”, Chapter 5, p. 116). Such relief corresponded with concerns raised by some of the participants in the present study, in addition to, scholars such as Summerfield (1999), regarding the psychopathologisation of resettling communities and subsequent ‘specialist’ status of psychiatrists and psychologists in the resettlement sector (Miller et al., 2006; Patel, 2003; Watters, 2001).

At the end of every session a reflexive discussion developed with practitioners reflecting on the requirement for constant advocacy in their roles and their reliance on assumptions of psychopathology. Many practitioners confirmed that they felt “caught” in the crisis of representation I had raised with them. A number of practitioners acknowledged their reliance on sympathetic representations that rely on assumptions of powerlessness and psychopathology and that this was preferable to other unsympathetic representations that associate asylum seekers and resettling communities with perceived threats to New Zealand’s sovereignty and security. Such unsympathetic stereotypes were attributed to the media and seen to create additional cynicism within the communities resettling individuals are settling in. Practitioners attending the workshops readily acknowledged the issues and implications I

had raised with them but many felt frustrated that I was unable to provide a straightforward solution.

In spite of this frustration, in every session, practitioners with a refugee background expressed appreciation that I had conducted critical research that captured the concerns of their communities. They shared their frustrations regarding the psychopathological assumptions made about their communities (“They’re people”, “Pretty damaged people”, “Oh, those poor people”, “People have no idea”, Chapter 5, p. 103, 128, 134 and 141), the perceived appropriateness of specialist psychological services (“Psychotherapy”, Chapter 5, p. 116) and significance of resettlement stress (“This is not paradise”, Chapter 5, p. 108).

Whilst these frustrations have been documented in research conducted with resettling communities in other Western countries such as Australia (Marlowe, 2010), Denmark (Mirdal et al., 2012), the United Kingdom (Fish & Fakoussa, 2018) and the United States (Baranik et al., 2018; Ferriss & Forrest-Bank, 2018; Shannon et al., 2015), receiving the endorsement from a range of practitioners who have resettled in New Zealand and been subjected to misrepresentation and subsequent marginalisation is considered the most important “point of reference within the transformative paradigm” (Mertens, 2007, p. 223).

I also received a number of unprompted emails from attendees reiterating the perceived relevance of my research and ability to “bridge” research and practice:

“Unanimously all staff enjoyed your presentation, thought it was hugely relevant and would have liked it to be a full day [...] We appreciated your facilitation style [...] It is very important to be able to bridge the academic world with the “on the field” work.”

(New Zealand Red Cross Team Leader, 27.06.18)

Receiving such correspondence suggested that I had successfully responded to the call of Miller et al., (2006) for reciprocal social constructivist resettlement research that bridges research and practice and is perceived as relevant for resettling communities and the agencies assisting them (See Chapter 3, p. 51). In saying that, it is important to acknowledge that conducting such research and pursuing opportunities to stimulate critical reflexivity in the sector would not have been possible within a three-year (full-time) PhD programme. Transformational research inevitably exceeds traditional academic timeframes (Jacobsen & Landau, 2003; Mackenzie et al., 2007; Pittway et al., 2010) and the success of this research in sensitising practitioners to the issues of representation in the sector can be attributed to my part-time PhD status and ability to collaborate with New Zealand Red Cross over the course of five years (Figure 9).

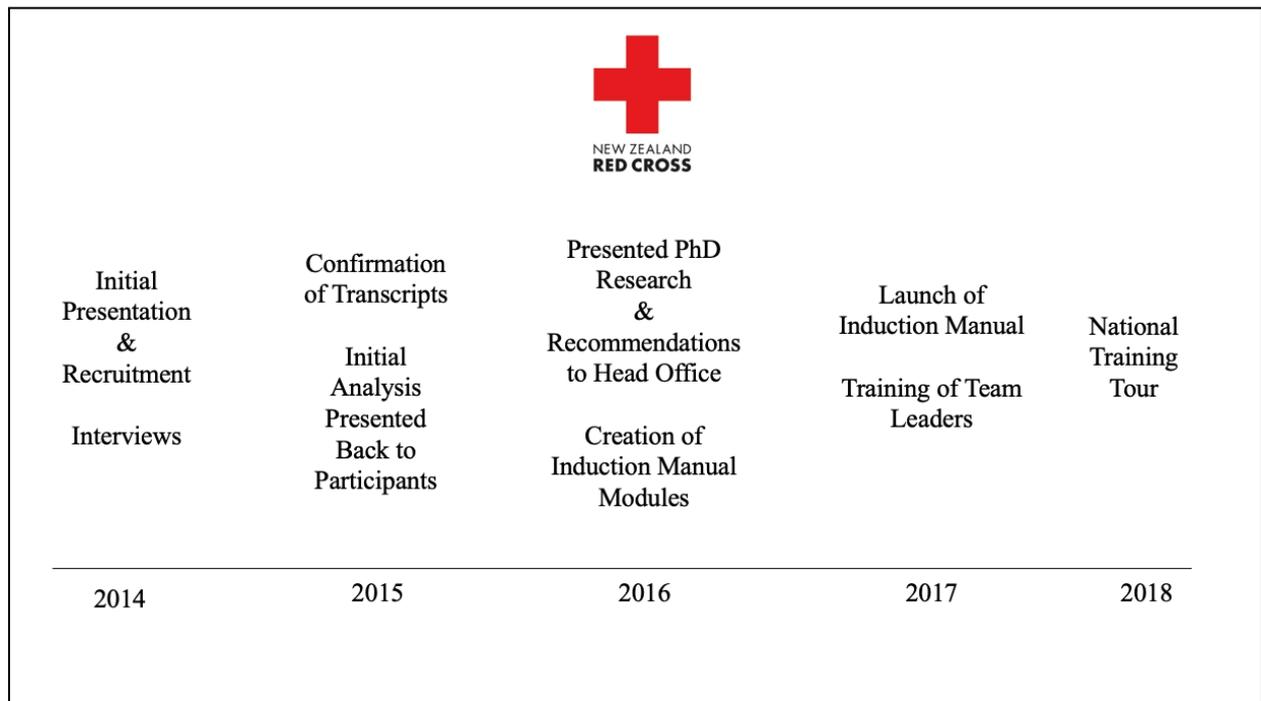
At the end of the training tour for the New Zealand Red Cross I felt I had successfully stimulated critical reflexivity in the resettlement sector in New Zealand and raised awareness of the problematic psychopathological representations practitioners tend to rely on. Practitioners responded positively, acknowledging that the research resonated with them and that they appreciated the opportunity to critically reflect with their colleagues. The responses from practitioners also validated the constructive thematic analysis I had conducted and concern of a crisis of representation I had conceptualised from interviews with practitioners in Wellington.

It is however important to acknowledge that while I didn't receive any critical feedback during the regional training tour, I mustn't assume that my PhD research and recommendations resonated with all practitioners who participated. The reflections in this chapter are restricted to my own observations and the comments and email correspondence I received. In the following section I reflect on my interactions with a number of practitioners

that did take exception to my research and attempts to stimulate critical reflexivity in the resettlement sector.

Figure 9.

Timeline of engagement with New Zealand Red Cross.



Critical incident with practitioners from a specialist psychological service

While the majority of practitioners responded positively to my attempts to share my PhD research and stimulate critical reflexivity in the resettlement sector, there was one incident that included negative responses. This incident occurred within a group of practitioners responsible for providing specialist psychological support to resettling individuals. As such, it provided a powerful opportunity for reflection and refinement of my concern of a crisis of representation in the resettlement sector. Incorporating this critical incident was also an attempt to be transparent within the transformational paradigm (Mertens, 1999) and intended to enhance the rigour of this PhD research (Crowe et al., 2011).

After completing the New Zealand Red Cross regional training tour, I was invited to provide similar training to a number of additional agencies supporting resettling communities. After accepting this opportunity, I emailed a senior staff member of the psychological service offering them and their staff a separate session. As a specialist mental health service, I was aware that they, of all the agencies with whom I had shared my research, could potentially feel criticised by the reflections and recommendations for critical reflexivity.

I received a response from that senior staff member acknowledging our previous interactions at national and international conferences and the “pertinence” of my PhD research. They said the team would welcome the opportunity to reflect on their work and suggested I liaise with a separate specific staff member. I immediately contacted this individual, acknowledging the invitation from Immigration New Zealand and introducing myself and my research. This practitioner responded saying that they were looking forward to reflecting with me but wanted to reassure me that they “approach trauma from a less Westernised paradigm”. They also suggested that I contact another colleague in their organisation as I needed to “understand my audience” and “how they approach their work”. I interpreted this response to mean that they felt they and their colleagues were not responsible for the issues of representation I was intending to raise with them.

The practitioner they suggested I contact had recently developed and delivered “trauma-informed” training across the country and I was looking forward to learning about how they had approached this training. In the process of connecting with this practitioner, they sent me the PowerPoint presentation of the trauma-informed training they had delivered. It focused exclusively on the negative effects of trauma and trauma work with no reference to the resilience of resettling communities or opportunities for vicarious resilience on any of the slides.

From what I could read, the initial part of the training took care to contextualise the refugee experience and acknowledge the significance of post-displacement stress. The perspective of a refugee background client had also been chosen to assist the audience to “understand trauma”, however quotes from them reinforced their pre-displacement trauma, resulting psychopathology and reliance on psychological support.

The training then proceeded to provide a detailed account of the physiological impact of trauma, before priming the audience to “anticipate” and “address signs of vicarious traumatisation”. Despite the reassurance from practitioners at this agency that they approach their work differently, it appeared to me that the information on the slides was reproducing some of the representational practices of which I was critical and about which I wanted to raise awareness.

I was able to connect with the practitioner who developed and delivered the training over the phone a few weeks later and they proceeded to tell me about the agency and their approach in a manner that seemed to assume that I had no prior knowledge of the resettlement sector or specialist mental health services. I was surprised by their approach because I had circulated an abstract (Appendix O) in which I identified myself and specified that my research was informed by interviews with psychiatrists and psychologists working in a service such as theirs.

On the day of the training my flight was rescheduled so I arrived late to the morning session with the psychological service. The senior staff member I made contact with initially wasn't able to attend and the anticipated 2.5 hour session was reduced to approximately 1 hour. The session felt rushed and there was little time to discuss the reflexivity prompts. In the afternoon session I presented to the other agencies and got to work through the reflexivity prompts with the audience, incorporate more clinical references and respond to questions.

I noticed a significant number of practitioners from the psychological service in attendance again in the afternoon session and felt relieved that they got to experience the session as I had intended. The concepts and conversations around critical reflexivity seemed to resonate with the attendees as several practitioners, including some from the psychological service, remained behind after the presentation to share their own observations of the sector with me.

A few days after the workshop I received an email from one of the practitioners from the psychological service telling me how much they appreciated my research and attempts to stimulate critical reflexivity:

“I think you are very brave presenting your work [...] I think we can become quite fixed with our ideas around what is therapy and what is therapeutic. There are many things that can lead to healing [...] I fully support what you are doing [...] You will meet defensiveness in the services when they are being critiqued [...] I encourage you to keep at your work. We need people like you questioning how we do this work.”

(Practitioner from specialist psychological service, 11.02.18)

This practitioner also warned me that I would be receiving an email soon that did not reflect the perspective of everyone at the service. I received the email a few days later from one of the practitioners with whom I had been in touch in the lead up to the training session. I have chosen not to seek consent to include the content of this email as I did not want to antagonise the agency, but it outlined concern that my research was undermining the significance of specialist psychological intervention for resettling individuals and that I was in no position to criticise how they approach their work.

This response indicated that some of the practitioners at the psychological service may have misinterpreted the research findings in my presentation and subsequent recommendations for reflexivity. While I had shared with them an abstract entitled “The Crisis of Representation in the Resettlement Sector” before the presentation (Appendix O), stated that the session aimed to “sensitise audiences to the issues of representation in the resettlement sector”, and named the workshop slides “Reconsidering how you represent your work and clients”, it seemed some practitioners did not understand that I was asking them to critically reflect on issues of representation in the resettlement sector, rather than on their clinical practice.

I had not encountered this kind of response before, so I contacted the director of one of the other agencies who had attended the afternoon session with their team and asked if they were able to provide their reflections on the session. Their response reflected on the intended content of the presentation. In addition to their awareness of the research I was citing:

“My recall was that the bulk of your presentation focused on avoiding pathologising language and PTSD determinations for refugees, and only a smaller section on the effects of counselling for former refugees. It did occur to me at the time that maybe the [NAME OF PSYCHOLOGICAL SERVICE] staff didn’t like some of the messages - it must be hard to hear that the therapy you have been trained to provide is not very effective for this population, but I know there is an increasing number of academics who are championing exactly the same messages [...]I thought you were rather careful not to dismiss counselling therapy.”

They also acknowledged the precedent of the psychological service reproducing the representational practices of which I had been attempting to raise awareness of. They went on to say:

“The mental health team on this site have traditionally focussed on mental health ‘screening’ and ‘talk therapy’. In the early days, the management office wall was covered in charts indicating high levels of PTSD (about 90%) for every single intake.”

I spent some time reflecting on the situation and sent a detailed response to the practitioner from the psychological service a day later addressing their concerns, clarifying the miscommunication and maintaining my critical perspective. I took responsibility for the miscommunication that occurred and acknowledged the significance of their service:

“Thank you for taking the time to carefully consolidate the team’s concerns. My initial thought is that at the beginning of my presentation I acknowledged that I was being ambitious with the amount of content I was intending to cover and ran the risk of oversimplifying complex concepts. I’m afraid this is what has happened. I will try my best to address your concerns [...] The presentation was about encouraging you all to critically reflect on the ways in which the sector represents its work with clients [...] As far as I’m concerned [NAME OF PSYCHOLOGICAL SERVICE] provides a significant service for the resettling community. I do however believe that it is important to acknowledge that not all resettling refugees will require or desire support from [NAME OF PSYCHOLOGICAL SERVICE] and the reproduction of representations that do not acknowledge this are problematic.”

I also challenged their critique of my methodology by referring to the consistency with recent clinical research and resonance of my research with their colleagues across the country:

“I would also like to reiterate that the critical reflections shared by the practitioners I interviewed correspond with clinical research conducted since [...] The reflections also resonated with a wide range of practitioners during the regional training I conducted for the Red Cross this year. I think it’s important that the team is aware that their colleagues across the country have similar concerns right now, regardless of when or where the original interviews were conducted.”

I also acknowledged that I had received, and requested, feedback from other attendees who did not share their concerns:

“I acknowledge that critical reflexivity can be uncomfortable but several staff from [NAME OF PSYCHOLOGICAL SERVICE] have reached out to tell me they appreciated the opportunity to reflect. Furthermore, a number of practitioners from the other agencies in attendance have said how the research I presented resonated with them and upon request confirmed that I constantly referred to other research and was careful not to completely dismiss the role of psychological support.”

I received a short response thanking me for my response and reiterating that the team had not understood that they were asked to reflect on the way they represent their work and clients. I responded by asking for the abstract and PowerPoint presentation to be circulated again to those who were concerned and that I would welcome any reflections on the misinterpretation that occurred in light of the content of these resources. I received no further correspondence.

The following week a piece was published on Radio New Zealand: “Quota refugee increase puts pressure on mental health provider” which outlined the concerns of the senior staff member (my initial contact) of the psychological service around the government’s commitment to increase the annual refugee resettlement quota without increasing the funding of their service. In that moment, I realised that the timing of my research presentation had coincided with concern over the resourcing of their service. They were effectively caught in the very crisis of representation on which I had been asking them to reflect.

As discussed in the previous analytical chapter (Chapter 5), I suggested that there is a ‘crisis of representation’ in the resettlement sector whereby resettlement agencies continue to reproduce representations that promote assumptions of psychopathology in order to obtain recognition and resources for the services they provide. I call this a ‘crisis’ because many practitioners realise these representations fail to acknowledge the resilience of resettling communities and complexities of resettlement but may feel compelled to perpetuate them anyway.

I also suggested that practitioners providing specialist psychological support are particularly compromised. This is because alternative approaches to representing their work and clients could compromise the resourcing of their services and consequently, their ability to support the subsection of the resettling population, who both require and desire their support. The concerns expressed by that senior staff member in the NZ Radio piece were consistent with these reflections and could explain some of the resistance I experienced.

A month after my visit I contacted the senior staff member of the psychological service. My email sought feedback on how my PhD research and recommendations for critical reflexivity were received by the team. They had initially been supportive when offered a separate session and I wanted to take responsibility for resolving the situation which

had resulted. They responded straight away saying that I should liaise with the staff member they had referred me to as they were at the presentation and involved in the feedback process.

That staff member agreed to my request for feedback and we reconnected several weeks later. This practitioner asked me to reflect on what had happened first. I reiterated the purpose of my PhD research and specified that the majority of reflections I had shared in my presentation came from practitioners working in a specialist service such as theirs. I reiterated that the impetus for the research came from my own involvement in the resettlement sector in Wellington and shared my reflections on how the relationships (i.e. relational context) I had with these practitioners most likely influenced the critical reflections they choose to share. I also added my insights on the significance of the relational context for the reception of critical research and how this was something we had not had the opportunity to develop.

My perspective seemed to resonate with this practitioner. They agreed that the lack of time and trust had influenced their reaction towards me and my research, and indicated that the team had reflected on their reaction since. They acknowledged that the service they work for had historically been responsible for some of the issues I had raised in my presentation. Since implementing a psychosocial approach to supporting clients however, they felt I was accusing them of something they were already attempting to address. For instance, they had recently hired a cultural director with a refugee background, a social worker and more physiotherapists. I acknowledged the importance of these initiatives and carefully explained how adhering to a psychosocial approach in their clinical work did not necessarily address the issues of representation I was attempting to raise awareness of.

To illustrate my point, I referred to the trauma-training they had developed and delivered earlier in the year and asked for reflection on their decision to focus exclusively on the negative effects of trauma and trauma work. I explained how this could be interpreted as an instance of relying on representations that promote assumptions of psychopathology and

perpetuate the stigmatised status of resettling communities. While I acknowledged that it was important to raise awareness of the negative impact of trauma with practitioners wanting to support resettling clients, I asked why they had not incorporated any of the available research on resilience and opportunities for vicarious resilience into their training. The practitioner's response was that they had not been involved with the development of that training so they could not comment.

Towards the end of our conversation the practitioner mentioned that the clinicians in the community team had had some of the strongest reactions to my research and recommendations for critical reflexivity. The community team seemed preoccupied with their own observations of psychopathology in the sector (i.e. PTSD and VT). I was told in response to this observation the clinical manager was considering rearranging the clinical roster so the community team spent more time onsite interacting with a range of resettling individuals as opposed to working exclusively with those who struggle with significant mental health issues. They acknowledged that the clinicians in the community team seemed to suffer from the clinician's bias (Chapter 5, p. 142) I had tried to raise awareness of. Those working onsite were much more comfortable acknowledging my research findings and the range of responses to trauma and trauma work. Thus, while this practitioner's reflections continued to centre around the perceived critique of how they 'approach' their work, as opposed to how they 'represent' their work, our conversation had confirmed that I had stimulated critical reflexivity within the psychological service - albeit not in the way I had anticipated.

The resistance I observed towards the findings of my research and recommendations for critical reflexivity from practitioners at the service responsible for providing psychological support to resettling communities are consistent with observations from other scholars who have documented what they have termed the "defensiveness" of resettlement

agencies and their reluctance to implement the recommendations from external research (Harrell-bond, 2002; Krause, 2017; Lokot, 2019; Szczepanikova, 2010; Walkup, 1997). Walkup (1997) conducted an analysis of the organisational cultures within humanitarian agencies such as the UNHCR and concluded that they had develop a culture of defensiveness due to the dilemmas and distress associated with their roles. The most significant dilemma Walkup identified in his analysis concerned the choices associated with acquiring recognition and resources and how this can create significant stress for practitioners and compromise agencies accountability to their clients:

“HOs [Humanitarian organisations], which focus primarily on helping others, also have the fundamental motivation of survival, which is dependent on fundraising and image. This requirement of image maintenance often threatens internal consistency of HOs when the interests of their clients (their raison d’etre) conflict with the requirements for organizational survival. These common predicaments cause great stress for individuals who must make choices based on conflicting decision rules while maintaining their faith in organizational coherence and policy validity. In short, the morale and internal consistency of HOs is much more significantly threatened than that of for-profit firms, and the collective efforts to mediate the resulting tension produce a predominantly defensive cultural dynamic in HOs [...] HOs often fail to cooperate with researchers.”

(Walkup, 1997, p. 51).

In addition to acknowledging the resistance of agencies towards external research, Walkup (1997) recommended professional development that introduces practitioners to interdisciplinary research and opportunities to critically reflect. He specifically mentions the

importance of “open confessions of institutional burdens” (p. 58), and indeed that is what I had attempted with practitioners responsible for providing specialist psychological support to resettling communities.

The compromised capacity of practitioners to critically reflect has also been identified more recently by Lokot (2019) who investigated the monitoring and evaluation practices of NGOs supporting Syrian refugees in Jordan. Practitioners she interviewed identified similar issues regarding the lack of reflexivity, one noting that “The culture of humanitarianism doesn’t suit itself well to thinking, reflecting, or analysing. It’s all about just doing” (p. 476). Her analysis also identified resistance to criticism with claims that “We are the experts, we know better”, (p. 473) and a tendency to dismiss qualitative research as “merely stories” (p. 473).

In light of the discrepancy between the responses of New Zealand Red Cross and the specialist psychological service I also considered Miller’s (2004) insights into the significance of the relational context for acquiring authentic accounts from refugee and resettling communities and how this could extend to the reception of critically reflexive research. In terms of my engagement with the New Zealand Red Cross and Refugee Trauma Recovery, I had an established reputation and existing relationships within these agencies. I also had the endorsement of senior staff and time to establish a relationship with those I had yet to meet. I did not have the opportunity to develop this relational context with the team at the specialist psychological service and therefore was not granted the “backstage access” (p. 217) required for critical reflexivity.

Similar experiences were recently documented by Krause (2017) who wrote a working paper for the Refugee Studies Centre at Oxford based on her experiences conducting research on sexual and gender-based violence in refugee camps in Uganda. In this paper she

acknowledged the resistance of humanitarian agencies to external research and how pre-existing relationships were a fundamental factor in the reception of research:

“In the past, I have had good experiences with open, problem-oriented discussions in the contexts of workshops [...] However, these open and critical workshops were only possible due to established contacts which I had and maintained over years” (p. 24).

My interactions with the specialist psychological service also appear to have illustrated the issues of power and interest Nimisha Patel (2019) has raised in her publication addressing the institutional responses to supporting refugee and resettling communities. As a clinical psychologist supporting resettling individuals in the UK for over two decades her argument is that ‘psy’ professions tend to privilege positivist psychological research that perpetuates the assumptions of psychopathology, which in turn promote their specialist status and silence the perspectives of resettling individuals and communities. She has often spoken out about the way the “‘psy’ professions” (i.e. psychiatry and psychology) disempower refugee and resettling populations (Patel, 2003, 2007, 2011, 2016, 2019).

More specifically, the way that some members of the specialist psychological service responded to my research may have been, at least in part, because I was not a registered clinician working for a specialist mental health service, or because I had not conducted positivist clinical research. Their responses may have indicated a belief that they were the only ones qualified to speak for resettling individuals and their recovery from trauma in New Zealand and a reluctance to explore their potential complicity within the crisis of representation I was suggesting.

Patel (2003) also discusses the role of psychological conferences in providing a platform to promote positivist psychological research that perpetuates assumptions of psychopathology, the specialist status of ‘psy’ practitioners and silences the perspectives of

the clients and communities they claim to support. During the course of my candidature I also observed this dynamic and will reflect here on The Australia and New Zealand Refugee Trauma Recovery in Resettlement Conference hosted in 2017 and 2019 in Sydney and Brisbane respectively. I had the opportunity to present at both. The first time I presented the analysis that corresponds with Chapter 5 in this thesis, I immediately noticed the preoccupation with psychopathology in the opening plenary address, in addition to the absence of presenters with refugee backgrounds. I was anxious about how my presentation would be received but numerous practitioners approached me afterwards to share how the critical reflections I raised resonated with their own observations of their respective resettlement sectors. I continued to receive this type of feedback after the conference and received the following unprompted email from an attendee who observed how aspects of my analysis arose in the conference itself:

“It was great to hear you speak at the conference on Friday. I thought you made excellent points about the representation of refugees, especially “specialists” speaking for refugees [...] It was interesting in the afternoon session I attended that people from the audience were suggesting “we don't need any more consultations” and after this session someone lamenting the lack of refugee voice at the conference which was not addressed by the panel of speakers. I think this is what sociologists mean by reification [...] I note there was also a limited and somewhat patronising response (you won't lose your job) to another person of refugee background raising the issues of Eurocentric psychiatry and how it clashed with his culture.”

(Australian resettlement practitioner, 02.04.17)

Two years later I returned to the 2nd Australia and New Zealand Refugee Trauma Recovery in Resettlement Conference in March, 2019 to share my reflections on stimulating

critical reflexivity in the resettlement sector and the resistance I experienced from specialist psychological practitioners (Chapter 6). I concluded the presentation with the following challenge to the audience:

“I really think it’s worth reflecting on this ‘crisis of representation’, and resistance towards critical reflexivity, especially at a conference such as this that brings ‘specialists’ together and aims to promote the perspectives of refugee background communities and their priorities for resettlement and recovery. So, on that note I will leave you with this final reflection from one of the clinical psychologists who participated in my PhD research: “I think working in this area we can get a bit precious, that we are the people that know, that we are the specialists. We need to watch that.”

Again, multiple practitioners from Australia, Canada, Denmark and The United Kingdom, approached me afterwards to discuss how my presentation had resonated with them. I also observed an anonymous poster asking, “Who is the expert & when?” illustrating that other practitioners were attempting to raise similar concerns about practitioners “expert” status and the “silencing” of clients in the resettlement sector:

“Torture and trauma counselling can get categorised as acute high-end specialist work with subsequent research, models, training and ways of working. The intensity of this work can place us as somewhat ‘experts’ in this field [...] With this influencing our work, can it silently ‘silence’ our clients or have their contributions less privileged in our conversations and thinking [...] I would like to explore the role that an expert positioning plays in relation to our work with survivors of torture and trauma.”

(Australian resettlement practitioner, 29.03.19)

The responses I received from resettlement practitioners at the two conferences and the concerns being raised in the poster indicated to me that practitioners were also concerned about how the sector represents resettling communities' distress and the consequences of how we respond to this distress. The concerns of local resettling communities regarding the pathologisation and specialisation of their distress, that initially inspired this PhD research, seemed to be just as prevalent in other resettlement contexts. A significant number of practitioners approached me to reflect on being 'caught' in a potential crisis of representation and acknowledged that despite the best of intentions they may inadvertently be silencing the resilience of resettling client's and their priorities for resettlement and recovery.

Conclusion

A commitment to disseminating research to decision makers is a crucial component of the transformative paradigm. My commitment to sharing my research resulted in a constructive collaboration with New Zealand Red Cross. This collaboration included conducting a regional training tour that enabled me to sensitise approximately 500 practitioners to the assumptions of psychopathology being promoted in the resettlement sector and encourage them to critically reflect on the ways in which they represent their work and resettling clients. While the research resonated with a range of practitioners across the country, a presentation to a service responsible for providing specialist psychological support to resettling individuals prompted a series of less positive interactions that provided an powerful opportunity to reflect on and refine the crisis of representation I had conceptualised in my original analysis. The concern of a crisis of representation suggests that practitioners are compelled to rely on overstated assumptions of psychopathology to attract recognition and resourcing for the services they provide. A critical incident with practitioners at the specialist psychological service also illustrated how their positioning within this crisis could be influenced by the desire to secure resources to keep supporting clients that need their

services as well as to potentially preserve their specialist status in the resettlement sector. The critical incident also confirmed the significance of the relational context in the reception of critical research and ability of practitioners to critically reflect with external researchers.

Chapter 7

Conclusion

“This kind of research is just really important for us as professionals in the sector but also for our society as a whole. Trying to change how we think and talk about refugee background communities is important on so many levels.”

(Female, NZ born, practitioner, P12)

The impetus of the research and transformative agenda

The impetus for this PhD research was the uncomfortable realisation that while resettlement agencies are powerful advocates for resettling communities, they are also accused of perpetuating the stigmatised status of resettling communities by relying on representations that promote inaccurate assumptions of psychopathology. The preoccupation with PTSD and vicarious traumatisation that characterises such representations results in resettling communities being subjected to two levels of stigmatisation within society. They are simultaneously ‘at risk’ and ‘a risk’ in their new society of settlement and their resilience and the opportunities for vicarious resilience in the sector are silenced. At the time of initiating this research there were indications that the way in which specialist agencies were promoting their work to the New Zealand public reproduced such assumptions of psychopathology and representatives of local resettling communities were concerned that such assumptions dismissed their priorities for resettlement and recovery. With these issues in mind, I set out to conduct reciprocal research that raised awareness of the responsibility that resettlement practitioners have for representing resettling communities and their potential role in perpetuating assumptions of psychopathology.

Such an agenda aligns with the transformative paradigm, which acknowledges the politics of knowledge production and maintains that the pursuit of knowledge should improve society (Mertens, 1999). The transformative paradigm doesn't prescribe a specific methodology but encourages researchers to reframe their research around a number of parameters. More specifically, conducting research that responds to historically marginalised communities' concerns, recognises the power of combining quantitative and qualitative data, and the responsibility researchers have to tie this data to socio-political transformation (Mertens, 2007).

In the context of this research it is acknowledged that positivist psychological research which reinforces assumptions of psychopathology has historically been promoted throughout the resettlement sector. The transformation anticipated from this research was to raise awareness of the range of responses to trauma and trauma work by sharing critical reflections from practitioners, obtained through socially constructed semi-structured interviews, together with recently published positivist psychiatric research, which is not widely acknowledged or accessible outside of academia. My intention was that this approach to research would corroborate the concerns of local resettling communities and challenge practitioners to reflect on how they represent resettling individuals and resettlement work.

The two aims of this research were:

1. To explore how psychopathological representations are resisted and/or reproduced by practitioners working within the resettlement sector in Wellington, New Zealand.
2. To raise awareness of the assumptions of psychopathology resettlement practitioners tend to rely on and to promote the resilience of resettling communities and realities of supporting them settle in New Zealand.

In the sections below, I review my methods to address each aim and summarise my key findings.

Reflections on the psychopathological representations of resettling individuals and resettlement work

The first aim of this transformational research was to explore how practitioners working within the resettlement sector in Wellington, New Zealand resisted and/or reproduced psychopathological representations of resettling individuals and resettlement work. I interviewed a cross section of resettlement practitioners from Refugee Trauma Recovery, New Zealand Red Cross and Interpreting New Zealand and identified that practitioners consistently resist, and resent, the psychopathological representations of resettling individuals, and resettlement work. However, few recognise their responsibility in the reproduction of such representations.

In Chapter 5 I identified the personal and professional pride practitioners took in advocating for resettling communities and isolated instances where this advocacy was associated with reproducing the assumptions of psychopathology. I identified instances where practitioners reflected on the implications of these representations for successful settlement and suggested that the sector suffers from a crisis of representation. The central conflict in this crisis is the way in which resettling communities' psychological wellbeing is represented and the assumptions made about the type of assistance they should receive. Practitioners felt compelled to continue relying on psychopathological representations of resettling communities and resettlement work, in order to obtain recognition and resources for the services they provide. Importantly, they continue to do this, knowing that these representations do not accurately reflect the resilience of resettling communities or the realities of supporting them to settle in New Zealand. In addition, practitioners acknowledged that such representations can potentially compromise successful settlement outcomes by perpetuating stigma, societal prejudice and service provision that reinforces passive styles of resettlement.

Such critical reflections corroborated the concerns of representatives of resettling communities, as well as clinical research published during the course of my PhD candidature. While clinical research consistently identifies that a significant proportion of resettling individuals may develop PTSD or other psychopathology such as depression (e.g. 1 in 5 resettling individuals see Charlson et al., 2019), it simultaneously refutes the assumptions of psychopathology that imply most resettling individuals suffer from PTSD from their pre-displacement trauma, and require, desire and respond to specialist psychological intervention. It does so by identifying that the majority of resettling individuals do not develop PTSD (Bogic et al., 2015; Charlson et al., 2019; Steel et al., 2009), the significance of post-displacement stress in predicting psychological distress (Bogic et al., 2015; Chu et al., 2013; Li et al., 2016;), and the modest improvement in evaluations of specialist psychological intervention for resettling clients (e.g. clinical improvement in 1 in 5 resettling individuals see Nose et al., 2017) (Turrini et al., 2019; Nose et al., 2017; Patel et al., 2016).

In light of this crisis of representation and recent clinical research, the recommendation from this analysis was to stimulate critical reflexivity in the resettlement sector. My intention was that by disseminating the critical reflections shared by practitioners in the interviews, alongside corresponding clinical research, practitioners would have an opportunity to reflect on any assumptions of psychopathology they may hold, their investment in these assumptions, and the implications of these assumptions for resettling communities, thus prompting them to reconsider how they represent their work and resettling clients.

Reflections on stimulating critical reflexivity in the resettlement sector

The second aim of this transformational research was to conduct reciprocal research that raised awareness of the problematic psychopathological representations often perpetuated by practitioners within the resettlement sector in New Zealand. Inspired by the Mountz

collective (2015) who encouraged researchers to reconsider what counts in personally and politically meaningful research and to attempt to be accountable to a transformational approach to research, I documented my approach to disseminating my research and how practitioners in the sector responded in a critically reflexive case study in Chapter 6.

The strategies I implemented included being transparent about the impetus of the research, implicating myself in my critique, and triangulating my critique with audio-recorded reflections from resettlement practitioners I had interviewed alongside corresponding clinical research. This approach was received well and resulted in a constructive collaboration with New Zealand Red Cross. This collaboration included conducting a regional training tour that enabled me to sensitise approximately 500 practitioners to the assumptions of psychopathology being promoted in the resettlement sector and encourage them to critically reflect on the ways in which they represent their work and resettling clients.

After each training session practitioners shared how the critical reflections captured in my PhD research resonated with their own observations of the sector. Practitioners admitted that they were unaware of the clinical research I shared in the presentation and acknowledged an increased awareness of the implications of representing resettling clients a certain way. A number of practitioners expressed relief that my research reinforced the significance of practical settlement support and the suggestion that they didn't have to be 'specialists' (i.e. psychiatrists or psychologists) to effectively support resettling individuals.

Whilst this suggestion provided relief to many practitioners, it also prompted a contrasting critical incident with an agency responsible for providing specialist psychological support to resettling individuals. This critical incident provided an opportunity for reflection on the crisis of representation I had conceptualised in my analysis whereby practitioners felt

compelled to rely on particular representations of psychopathology to attract recognition and resourcing for the services they provide. Deconstructing such assumptions prompted a ‘defensive’ response from a number of practitioners illustrating the compromised ability of some ‘specialists’ to critically reflect and consider alternative representations of resettling communities and resettlement work. The critical incident also seemed to illustrate how their positioning within this crisis may have been influenced by the desire to preserve their specialist status in the resettlement sector so that they are adequately resourced for the resettling clients who do desire their support. Such observations are consistent with published concerns regarding the increasing ‘specialisation’ of practitioners providing psychological support to resettling individuals (Miller et al., 2006; Patel, 2003; Summerfield, 1999) and pragmatism required in response to the pervasiveness of assumptions of psychopathology in service provision and society (Colic-Peisker & Tilbury, 2003; Walk-up, 1997; Watters, 2001). The critical incident also provided insights into the significance of the relational context in the reception of critical research in the resettlement sector (Krause, 2017; Marlowe, 2010; Miller, 2004).

Consistency with clinical research in the general population

The observation that resettlement practitioners are potentially caught in a crisis of representation and require ongoing opportunities for critical reflexivity is also consistent with a recently published study of psychosocially-oriented clinical psychologists working in the UK (Cooke et al., 2019). Cooke and colleagues (2019) interviewed 19 clinical psychologists and identified that while psychosocially-oriented psychologists reject the psychopathological assumptions associated with the biomedical model of mental health, they often strategically “step into” (p. 205) or unintentionally “slip into” (p. 206) this model in order to mobilise support for clients. In their discussion, Cooke and colleagues reflected on their participants’

consistent adherence to the biomedical model and concluded that the assumptions underlying such an approach provide “(false) safe certainty” (p. 203) that enables practitioners to not only mobilise support for their clients but manage the stress associated with their work and maintain their specialist status. In other words, they suggest it is ‘safer’ to reduce mental illness to an “illness like any other” (p. 199) and prescribe specialist interventions for individuals than acknowledge the limitations of one’s clinical practice and confront systemic issues within society.

In addition to recently published reflections from psychosocially oriented clinical psychologists, a recent review of PTSD by Richard Bryant (2019) also corroborated the critical reflections and clinical research on resettling populations reviewed in this thesis. The review acknowledged that the majority of the population exposed to trauma do not develop PTSD and cited epidemiological studies of representative samples of the general US population that report relatively low lifetime prevalence rates of PTSD. The review also confirmed that after torture, cumulative exposure to PTE’s (potentially traumatic events) best predict the development and/or maintenance of PTSD. The review also acknowledged that most people who develop PTSD do not seek treatment and that while trauma focused CBT is the recommended treatment, one third will likely not respond. Thus, the assumptions of psychopathology applied to resettling individuals and challenged in this thesis have also been challenged by recent clinical research conducted in western populations (Bryant, 2019). Whilst this may surprise some people given the popularity of assumptions of psychopathology in the resettlement sector, many of the practitioners who participated in my PhD research foreshadowed this finding. For instance, one participant with the lived experience of being a refugee shared the following reflection with me at the end of his interview:

“I think the real message here will be refugees are not different from any other person. We’re all human. We’re functioning the same way; we feel the same way and we think mostly the same way.”

(Male, refugee background practitioner, P14).

Evaluating the rigour of this PhD research

Whilst this PhD research was designed to respond to local resettling communities’ concerns and published criticism regarding the perceived relevance and practical application of positivist psychological resettlement research, this thesis has been conducted within the discipline of Psychological Medicine, a discipline still dominated by positivist approaches to research. In the following section I reiterate the differences between positivist and social constructivist approaches to resettlement research (initially discussed in Chapter 3, p. 52). I acknowledge the perceived limitations of this PhD research from a positivist perspective, and discuss the criteria for evaluating the rigour of this PhD research from a social constructivist perspective.

Often referred to as the “scientific paradigm” (Miller et al., 2006, p. 410), the underlying assumption behind positivist approaches to research is that systematic observation of the world will reveal an objective reality (Burr, 2015). The prescribed stance of the researcher is one of objectivity and it is assumed that researchers are able to quantify observable phenomena to produce an unbiased account of reality that can be generalised to other contexts (Johnson & Rasuloova, 2017). Social constructivist approaches to research on the other hand assume that there is no objective reality and that observation of phenomena will always be a subjective interpretation of the researcher. Social constructivist research has the capacity to acknowledge the co-existence of multiple perceived realities and maintains that such accounts are invariably influenced by the relationship between the researcher,

researched and research context. Social constructivist research consequently cannot be generalised (Johnson & Rasulova, 2017).

This thesis acknowledges that both positivist and social constructivist approaches to research make crucial contributions to the resettlement sector and can be complementary (Johnson & Rasulova, 2017; Moglia et al., 2011). Indeed, this was the case with positivist psychological research published during the course of my PhD candidature corroborating the practitioners' reflections captured in this research. In spite of this, this PhD was originally designed to respond to local resettling communities' concerns and published criticism regarding the perceived relevance and practical application of positivist psychological resettlement research. The concern was that positivist psychological resettlement research that focuses on identifying the prevalence and predictors of psychopathology in resettling individuals and resettlement practitioners perpetuates a preoccupation with psychopathology. Such research can be interpreted as constructing resettling individuals as simultaneously 'at risk' and 'a risk' in their new society of settlement. Social constructivist psychological resettlement research has the capacity to address these concerns by allowing researchers to conduct research that contests such constructions of 'risk' and is able to acknowledge the complex, co-existing, often contrasting and/or uncomfortable reflections on the realities of resettlement, range of responses to trauma and representation of resettling communities and resettlement work.

From a positivist perspective, such research is problematic as it is informed by subjective socio-political concerns and critique, has a socio-political agenda, and is subject to subjective interpretation. In other words, there is no objectivity and the research cannot be generalised to other contexts. Concerns of researcher bias are particularly pronounced as the researcher influences all aspects of the research process and the results and recommendations resulting from this process may not be replicated by another researcher. In the context of this

PhD research it is important to acknowledge that I constantly influenced the research process in terms of the concerns I responded to, literature I reviewed, aims of the research, methodological and analytical approach, relationships I developed and maintained with participants and practitioners and the sense of responsibility I felt to respond to unanticipated opportunities for dissemination and subsequent iterative design of this PhD research. Other researchers may have made different decisions and conducted themselves differently, thus producing different results and recommendations to those in this thesis.

Concerns of lack of internal validity, objectivity, reliability, and generalisation (external validity) will raise flags for positivist researchers; however, it is important to evaluate research by criteria that correspond with the epistemological position from which the research was conducted (Willig, 2001). Validity is often defined as “*the extent to which the researcher’s findings accurately reflect the purpose of the study and represent reality*” (Holloway, 1997, p. 159). The concept of validity is however a contested concept within social constructivist research. Some researchers maintain that research should conform to the same criteria whilst others argue that the concept of validity is a construction in and of itself (Cook & Campbell, 1979; Holloway, 1997; Lincoln & Guba, 2000). For the purposes of this discussion, I reflect on Johnson and Rasulova’s (2017) discussion of corresponding criteria in constructivist research, more specifically credibility, confirmability, dependability, and transferability adapted from Guba and Lincoln (1989).

Credibility corresponds with the concept of internal validity in positivist research and asks, “How can we be confident about the ‘truth’ of the findings?” (Johnson & Rasulova, 2017, p. 266) whilst confirmability corresponds with the concept of objectivity and asks, “How can we be certain that the findings have been determined by the subjects and contexts of the inquiry, rather than the biases, motivations and perspectives of the investigator?” (Johnson & Rasulova, 2017, p. 266). Both criteria can be addressed by transparency around

the research process, participant checking and providing sufficient evidence of participants perspectives.

Dependability corresponds with the quantitative concept of reliability and asks, “Would the findings be repeated if the inquiry were replicated with the same (or similar) subjects in the same or similar context?” (Johnson & Rasulovala, 2017, p. 266) whilst transferability corresponds with the concept of generalisation (A.K.A. external validity) and asks, “Can we apply these findings to other contexts or with other groups of people?” (Johnson & Rasulovala, 2017, p. 266). In addition to the requirements of establishing credibility and confirmability above, dependability and transferability can be established by comparing the research to research conducted in similar contexts and the resonance of the research and recommendations with practitioners who did not participate in the research.

Ultimately, I attempted to address all the criteria throughout this thesis. First with transparency regarding the impetus of the research and illustration of the issue in Chapter 1, methodological decisions described in Chapter 4, such as purposeful sampling and participant checking of transcripts and analysis. In Chapter 5, I attempted to incorporate an appropriate ratio of participants reflections, including contradictory reflections, and corroborated these with clinical and resettlement research conducted elsewhere by other researchers and other analytical approaches. In Chapter 6, I attempted to document my approach to disseminating the research and resonance of the research and recommendations with practitioners who did not participate in the research. Such an approach has allowed me to argue that I have successfully conducted transformational research that has raised awareness of the problematic psychopathological representations of resettling communities and resettlement work often perpetuated in the resettlement sector in New Zealand. In spite of this, there are still a number of limitations that are important to acknowledge and which have inspired suggestions for future research.

Limitations and associated suggestions for future research

Not interviewing resettlement practitioners from different regions of resettlement

I initially set out to interview practitioners from the agency responsible for relying on representational practices that promote assumptions of psychopathology and while I decided to expand this criterion to other resettlement practitioners in the Wellington region, it would have been interesting to explore the critical reflections of a range practitioners assisting resettling individuals in other regions of resettlement. At the time of initiating my PhD research there were seven additional regions from which I could have recruited participants (Auckland, Hamilton, Palmerston North, Nelson, Christchurch, Dunedin, and Invercargill). Doing so may have offered alternative insights into the problematic intersection of assumptions of psychopathology, necessity of advocacy and representational practices of practitioners. While I received feedback that my research resonated with a range of practitioners across the country on my regional training tour with New Zealand Red Cross, given my reflections on the significance of the relational context in resettlement research, interviewing a range of practitioners from different regions would also have allowed me to evaluate the extent to which the relational context influenced the insights practitioners chose to share with me, in addition to their ability to critically review my interpretation of their insights.

The relational context refers to the relationship that develops between the researchers and participants and is considered crucial in accessing authentic accounts that accurately reflect the perspectives of participants (Miller, 2004). Researchers are encouraged to invest in the relational context of their research, and this often involves transparency around the intentions of the research and investing time and resources to earn the trust of potential participants. Scholars such as Miller (2004), Marlowe (2010), and Krause (2017) argue that

such approaches contribute to the rigour of resettlement research and confidence in the conclusions drawn from it.

In the context of this PhD research, the relational context I developed throughout the course of my PhD candidature was considered an asset that allowed me to access resettlement agencies that were reluctant to participate in postgraduate research. It also meant I knew the majority of the practitioners that participated in an interview with me and this familiarity facilitated the critical reflections captured in this research. In spite of this, it is important to acknowledge that my previous relationships and reputation in the Wellington resettlement sector, in addition to my transparency around the impetus and agenda of my PhD research may have meant that participants refrained from reflecting on the negative aspects of trauma and trauma work to the extent they may have with someone else. Indeed, the instances of reproduction captured in this study came from participants who did not know me. In saying this, it is still important to acknowledge that the practitioners who did know me did reflect on the significance of distress, resilience in the presence of PTSD, importance of psychosocial support, and experiences of vicarious trauma which I included in my analysis. I attempted to acknowledge the representations and realities of 'risk' in the sector whilst also creating space to acknowledge the resilience, vicarious resilience, and significance of resettlement stress for both resettling individuals and resettlement practitioners. It is also important to reiterate that the critical reflections from practitioners responsible for providing specialist psychology were unprompted.

Similar concerns regarding the relational context could also be applied to the dissemination of the research. While I attempted to document my approach to disseminating my research and recommendations for critical reflexivity in a reflexive case study and reflected on the range of responses I received, it is important to acknowledge that I can't assume that the absence of critical feedback meant that the research resonated with all

practitioners that attended my workshops. It is quite possible that practitioners may not have felt comfortable raising their concerns with me publicly or privately due to the lack of relational context. Further studies designed to attend to the significance of the relational context on conducting and disseminating resettlement research could be an important avenue for future research.

Not involving resettling communities

As discussed previously, at the time of initiating my PhD research I was cognisant of the reluctance of local resettling communities to participate in psychological research (see Chapter 3). I was also aware of the published criticism regarding the perceived appropriateness and practical application of psychological resettlement research. Therefore, I made the decision to conduct reciprocal research that did not rely on the perspectives of resettling individuals. While I recognised the need for psychological research that acknowledges resettling communities' responses to trauma and priorities for recovery, obtaining a PhD from this process felt inappropriate. I therefore chose to raise awareness of the responsibility resettlement practitioners have for representing resettling communities and their role in perpetuating assumptions of psychopathology.

This decision could however be perceived as paternalistic and psychiatric researchers such as Rousseau and Kirmayer (2010) have criticized researchers who prioritize the perspectives of advocates, stating that this is “a paternalistic misuse of power” (p. 65). In their paper “From complicity to advocacy: The necessity of refugee research” they discuss the importance of obtaining all perspectives and acknowledge that researchers must accept that there is no “pure position” (p. 66) in refugee research. Instead they encourage researchers to commit to “critical self-examination” (p. 66) and “partnerships” (p. 67) with asylum seeking and resettling communities in order to address their complicity.

I reflected on the concept of a “pure position” throughout the course of my candidature and reluctance to use resettling individuals’ reflections on their traumatic experiences to further my own professional development. I did however seek solace in the fact that my research was designed to respond to local resettling communities’ concerns and that I would be interviewing a number of practitioners with refugee backgrounds. I do however have every intention of pursuing participatory action research with local resettling communities in future post-doctoral research.

Participatory action research is characterised by partnerships between researchers and members of communities (co-researchers) to conduct research that facilitates positive social change. Community members participate in all stages of the research, including the initial stages when the agenda and desired outcomes are determined, and this is what distinguishes participatory action research from any other type of research (Kendon, 2016). It is also the preferred approach for researchers attempting transformative research (Mertens, 2007).

In the context of the recommendations from this PhD research, participatory action research, in partnership with local resettling communities, has the potential to inform the development and evaluation of alternative psychosocial support provided in the resettlement sector. It would also allow me to respond to the “new collaboration” resettling communities in New Zealand are calling for when it comes to responding to their mental health:

“Positive mental health for refugees can only be achieved through genuine collaboration [...] it is impossible for the government and NGOs to address those issues without us [...] we are calling for a new collaboration that recognises the contribution of refugee communities so we can talk about and research our different understanding of mental health.”

(Awad, 2011, p. 47)

Not acknowledging indigenous approaches to restoring wellbeing in New Zealand

Another limitation of this PhD research is the lack of acknowledgement of Tangata Whenua⁵, the indigenous people of New Zealand, and substantial work of Maori scholars, psychiatrists, psychologists, and tohunga⁶ who endorse indigenous research methodologies and approaches to wellbeing (Durie, 2011; Kopua et al., 2020; Pitama et al., 2007; Tuhiwai Smith, 1999).

New Zealand is a post-colonial society and the acknowledgement of Maori and Maori approaches to research and wellbeing is relevant to resettlement research as many Maori consider themselves to have their own “refugee whakapapa” (Ngata, 2015), their ancestors displaced by the British Crown’s acquisition of their land during the 1800s (Beaglehole, 2013). A number of Maori academics have also acknowledged that Maori and resettling individuals share a similar marginalised status in New Zealand society and are likely to be subjected to similar assumptions of psychopathology and stigmatisation (Durie, 1999; Kukutai & Rata, 2017; Maniapoto, 2015; Ngata, 2015; Russell, 2018). Indeed, when I sought Maori consultation for my PhD research, the Ngai Tahu Research Consultation Committee considered the research to be of importance to Maori health and suggested the findings be disseminated to Maori health organisations. However, none of the participants I interviewed made any references to Maori or indigenous approaches to wellbeing in their interviews, so I decided it was beyond the scope of my PhD.

In saying that, a significant number of healthcare practitioners with whom I shared my PhD research at the School of Medicine and Health Sciences, acknowledged that the

⁵ Tangata Whenua translates to “*people of the land*” and refers to Maori, the indigenous people of Aotearoa/New Zealand (Te Ara: Encyclopaedia of New Zealand, 2020).

⁶ Tohunga refers to an expert practitioner in Te Reo. This includes priests, healers, navigators, carvers, builders, teachers and advisors (Te Aka Online Maori Dictionary, 2020).

critique and concepts I was raising in my research could be applied to other marginalised groups in New Zealand and specifically Maori. Furthermore, Patrick Bracken, one of the critical psychiatrists who inspired my PhD research, recently co-authored a paper in *Transcultural Psychiatry* (2020) with Maori psychiatrist Diana Kopua and her husband Mark Kopua, who developed Mahi a Atua⁷: A Māori approach to mental health. In their paper they reflect on the issues associated with the individualisation of distress and imposition of interventions that ignore the socio-political context and cultural identity of indigenous patients. They describe two successful case studies informed by Mahi a Atua and conclude that indigenous approaches to mental health should be prioritised as an alternative, not adjunct, to mainstream psychological intervention (Kopua, Kopua, & Bracken, 2020).

The adaptation of such indigenous approaches to wellbeing to the resettlement and recovery of resettling individuals and communities seems to be a crucial direction for future research in New Zealand and would likely also rely on the participatory approaches discussed above. Such a collaboration between indigenous scholars, practitioners, and communities with the resettlement sector and resettling communities would honour the principles of Te Tiriti o Waitangi⁸ and have the potential to shape more culturally responsive services for Maori and resettling communities in New Zealand.

⁷ Mahi a Atua translates to “*work of the Gods*” in Te Reo and refers to the use of Maori creation stories to assist the therapeutic process (Kopua et al., 2020).

⁸ Te Tiriti o Waitangi refers to The Treaty of Waitangi in Te Reo. Te Tiriti o Waitangi is considered New Zealand’s founding document and was an agreement made between the British Crown and over 500 Māori rangatira (chiefs) in 1840. The three principles associated with Te Tiriti o Waitangi are partnership, participation and protection (Te Ara: Encyclopaedia of New Zealand, 2020).

Clinical implications of the research

In spite of the critical reflections on psychological intervention captured in this study, it is important to acknowledge that there is growing recognition of, and attempts to respond to, issues of ethnocentrism within the discipline of Psychological Medicine.

For instance, the DSM-5 acknowledges the importance of clinicians understanding the cultural context of clients' distress in order to conduct accurate diagnoses and interventions. The DSM-5 encourages practitioners to conduct cultural formulation interviews with culturally diverse clients. Such interviews aim to identify a client's cultural interpretations of their distress in addition to identifying specific cultural and/or contextual risk and protective factors (American Psychological Association, 2013). In spite of this recognition, there is an indication that practitioners are not necessarily prioritising these processes in their clinical practice. For instance, Aggarwal and colleagues (2020) have identified that a significant number of clinicians do not conduct cultural formulation interviews as they consider it irrelevant, time consuming or haven't received sufficient training.

Cognitive behavioural therapy, the recommended approach to assisting resettling individuals with PTSD, also encourages practitioners to adapt their interventions in collaboration with clients and adopt a problem-oriented approach which should allow practitioners to respond to clients' priorities for recovery (Westbrook et al., 2011). There is also growing recognition of the role of critical reflection in cognitive behavioural therapy (Bennett-Levy et al., 2009). A recently published case study of clinical psychologists reflecting on their approach to conducting cognitive behavioural therapy with an "idiosyncratic patient" (p. 241) illustrated how practitioners must interrogate their assumptions of psychopathology when working with refugee-background clients and adapt their treatments to prioritise clients' preferences and contextual factors (Faber & Lee, 2020).

In this specific case study, Jesse Faber and Eunjung Lee (2020) reflected on a course of cognitive behavioural therapy they customised for a female refugee background client presenting with depression, anxiety and suspected PTSD. They acknowledged a number of significant clinical decisions they made which meant that they pursued a short-term course of non-trauma-focused cognitive behavioural therapy that focused on addressing the client's current concerns, such as financial hardship, isolation, and shame. Such an approach resulted in significant improvements in depression, life satisfaction, and suicidal ideation, in addition to, the client's own perceptions of improvement.

In their case study Faber and Lee (2020) reflected on the complexity that must be accounted for when assisting resettling clients and acknowledged that clinicians can often become overwhelmed when making clinical decisions. They reflected on the efficacy of cognitive behavioural therapy that does not focus on previous trauma and reiterated the importance of responding to clients' immediate concerns.

In order for practitioners to make such clinical decisions, an awareness of the resettlement context is crucial. Scholars such as Elzbieta Gozdzia (2004) have however identified that practitioners often do not receive any specific training on working with resettling clients. Gozdzia conducted a national survey in the USA of professional schools such as psychology, public health, medicine and social work and found only 30% had an aspect of their curriculum dedicated to working with displaced people. Furthermore, none of the programmes provided opportunities for internships working with resettling clients or communities. The conclusion of her study was that professional schools must integrate interdisciplinary research that exposes practitioners to the complexities of resettlement, so they are able to make more culturally-responsive clinical decisions. Similar observations regarding the necessity of professional development in healthcare settings have also been

published in New Zealand (Crezee et al., 2011; DeSouza, 2006; Lawrence et al., 2005; Mortensen, 2011).

During the course of my PhD candidature I canvassed clinical psychology programmes around the country and discovered none of them have a dedicated aspect of their curriculum towards working with refugee-background clients. Many of the clinical directors of these programmes acknowledged the shortcoming of this oversight (see Appendix P). Others referred to the Code of Ethics and Core Competencies required for registration in New Zealand.

The Code of Ethics for psychologists working in New Zealand encourages respect for the dignity of people and persons, responsible caring, integrity in relationships, and social justice (The New Zealand Psychological Society, 2012). Furthermore, reflective practice, cultural diversity and collaboration with local communities are considered core competencies for psychologists practising in New Zealand (New Zealand Psychologists Board, 2018). However, how are such standards achievable if practitioners do not receive adequate training and ongoing professional development on the resettlement context in New Zealand and research informed by local resettling communities? Identical concerns apply to psychiatrists who must adhere to a similar Code of Ethics and requirements for critical reflexivity and cultural responsiveness in their clinical practice (The Royal Australian & New Zealand College of Psychiatrists, 2018).

Addressing the potential discrepancy between aspirational codes of ethics, core competencies, and the adaptation of culturally oriented clinical assessment against perceptions of actual clinical practice and the availability of initial and ongoing professional development in working with resettling clients is another important area for development within the discipline of Psychological Medicine.

Original contribution of this PhD research

The first contribution of this research has been to identify and illustrate the implications of the crisis of representation within the New Zealand resettlement context. The concept of a crisis of representation originated in anthropology, with Marcus and Fischer (1986) raising concern over the inability of academics to accurately interpret the realities of others. In the context of refugee resettlement the crisis of representation has been referenced by Dona (2007, p. 221) who suggested the field of Refugee Studies was subject to such a crisis in light of the observation that, despite the best of intentions, the interests of those responsible for representing resettling communities can conflict with the interests of resettling individuals and/or communities (Dona, 2007; Harrell-Bond, 2002; Pupavac, 2002; Summerfield, 1999; Watters, 2001). I have responded to published concerns regarding the way in which resettling communities' psychological wellbeing is represented and the assumptions made about the type of assistance they should receive. I have identified that practitioners in the New Zealand resettlement sector can feel compelled to reproduce particular representations of their work and resettling clients in order to obtain recognition and resources. Representations that rely on assumptions of psychopathology that most practitioners acknowledge are inaccurate and do not align with the latest clinical research.

The second contribution of this research has been to go beyond identifying a crisis of representation and recommending initiatives to increase critical reflexivity. I actively sought to raise awareness of the responsibility resettlement practitioners have for representing resettling communities and their potential role in perpetuating assumptions of psychopathology. I pursued opportunities to disseminate my research and recommendations for critical reflexivity to decision makers which resulted in a collaboration with the New Zealand Red Cross and development of an induction manual and regional training tour. This

collaboration also influenced the development of a new website for the local specialist mental health service that inspired this PhD research.

The third contribution of this research has been to conduct reciprocal research informed by the transformational paradigm – a first in the Department of Psychological Medicine at the University of Otago, Wellington. The transformational paradigm has primarily been utilised in evaluation research (Mertens, 1999) and I have yet to see it referenced in psychiatry. While there is a precedent of participatory action research in psychiatry, such an approach is underutilised and subject to significant scepticism and tokenism (Brett et al., 2012; Friesen et al., 2019; Patterson et al., 2014). Mertens (2007) has also been quick to point out that while the principles of participatory action research align well with the transformational paradigm, participation does not necessarily guarantee transformation. Indeed, scholars such as Friesen and colleagues (2019) have raised concerns about the potential detrimental effects for service users participating in psychiatric participatory action research and similar concerns from local resettling communities informed my decision not to conduct participatory action research with refugee background service users for this PhD.

Instead, in response to criticism that psychological research has frequently reproduced assumptions of psychopathology, this PhD research, informed by the transformational paradigm, inspired me to combine recent clinical research with critical reflections from resettlement practitioners to challenge the perception that psychological resettlement research isn't relevant to resettling communities or the agencies supporting them. This PhD research has also responded to ChangeMakers Refugee Forum's challenge to produce resettlement research that strengthens perceptions of resettling communities in New Zealand (ChangeMakers Refugee Forum, 2009, p. 4) by raising awareness of their resilience and opportunities for vicarious resilience in the resettlement sector.

Conclusion

In the context of unprecedented levels of conflict and published concerns from clinicians and representatives of refugee and resettling communities, this thesis sought to critique the psychopathological response to the refugee crisis and subsequent ‘crisis of representation’ in the refugee resettlement sector in New Zealand. Semi-structured interviews with a selection of resettlement practitioners based in Wellington suggested that they were caught in a crisis of representation, often reproducing inaccurate assumptions of psychopathology in their attempts to advocate for resettling clients. Participants reflected on the detrimental implications of these assumptions however few recognised their responsibility for perpetuating such assumptions. By utilising my unique position as a privileged cross-cultural psychology graduate, former resettlement practitioner and PhD candidate in Psychological Medicine, I was able to disseminate the critical reflections captured in the interviews I conducted, alongside corresponding clinical research on the range of responses to trauma and trauma work, to challenge the issues of representation in the resettlement sector in New Zealand.

This thesis paves the way for post-doctoral research within the School of Medicine and Health Sciences to be conducted in collaboration with resettling communities and resettlement agencies. Such a collaboration could create opportunities for considering alternative psychological interventions that acknowledge the resilience, resources and priorities of resettling communities and the practitioners committed to supporting them.

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Appendices

Appendix A: DSM-5 Criteria for PTSD

(American Psychiatric Association, 2013)

Symptoms of Posttraumatic Stress Disorder (PTSD)

The following are the formal diagnostic criteria needed to be met in order to be diagnosed with PTSD.

Criterion A: Traumatic event

Trauma survivors must have been exposed to actual or threatened:

- death
- serious injury
- sexual violence

The exposure can be:

- direct
- witnessed
- indirect, by hearing of a relative or close friend who has experienced the event—
indirectly experienced death must be accidental or violent
- repeated or extreme indirect exposure to qualifying events, usually by professionals—
non-professional exposure by media does not count

Many professionals who work in trauma differentiate between “big T-traumas,” the ones listed above, and “little-t traumas.” Little-t traumas can include complicated grief, divorce, non-professional media exposure to trauma, or childhood emotional abuse, and clinicians recognize that these can result in post-traumatic stress, even if they don’t qualify for the PTSD diagnosis.

There is no longer a requirement that someone had to have an intense emotional response at the time of the event. This requirement excluded many veterans and sexual assault survivors in the past.

Criterion B: Intrusion or Re-experiencing

These symptoms envelope ways that someone re-experiences the event. This could look like:

- Intrusive thoughts or memories
- Nightmares related to the traumatic event
- Flashbacks, feeling like the event is happening again
- Psychological and physical reactivity to reminders of the traumatic event, such as an anniversary

Criterion C: Avoidant symptoms

Avoidant symptoms describe ways that someone may try to avoid any memory of the event, and must include one of the following:

- Avoiding thoughts or feelings connected to the traumatic event
- Avoiding people or situations connected to the traumatic event

Criterion D: Negative alterations in mood or cognitions

This criterion is new, but captures many symptoms that have long been observed by PTSD sufferers and clinicians. Basically, there is a decline in someone's mood or thought patterns, which can include:

- Memory problems that are exclusive to the event
- Negative thoughts or beliefs about one's self or the world
- Distorted sense of blame for one's self or others, related to the event
- Being stuck in severe emotions related to the trauma (e.g. horror, shame, sadness)
- Severely reduced interest in pre-trauma activities
- Feeling detached, isolated or disconnected from other people

Criterion E: Increased arousal symptoms

Increased arousal symptoms are used to describe the ways that the brain remains "on edge," wary and watchful of further threats. Symptoms include the following:

- Difficulty concentrating
- Irritability, increased temper or anger
- Difficulty falling or staying asleep
- Hypervigilance

- Being easily startled

Criteria F, G and H

These criteria all describe the severity of the symptoms listed above. Basically, they have to have lasted at least a month, seriously affect one's ability to function and can't be due to substance use, medical illness or anything except the event itself.

Subtype: Dissociation

Dissociation has now been set apart from the symptom clusters, and now its presence can be specified. While there are several types of dissociation, only two are included in the DSM:

- Depersonalization, or feeling disconnected from oneself
- Derealization, a sense that one's surroundings aren't real

Appendix B: Copyright Permission Log

Page number in thesis	Details of in-copyright material	Date permission requested	Permission granted for print thesis (Y / N and date)	Permission granted for digital thesis (Y / N and date)	Conditions
Ch 1, p. 19	Screenshot of Refugee Trauma Recovery website in 2014	24/04/2021	28/04/2021	28/04/2021	Acknowledge in the thesis that it has since changed significantly.
Ch 5, p. 126, Appendix K, p. 258	STUFF article “Fears underfunding of Wellington health services will ‘re-traumatise’ Syrian refugees”	24/04/2021	24/04/2021	24/04/2021	No conditions
Ch 6, p. 158, Appendix L, p. 260	New Zealand Red Cross induction manual	24/04/2021	28/04/2021	28/04/2021	Permission to reproduce the title page and example of layout. In addition to discussing the

					aims and reflexivity prompts
Ch 6, p.160, Appendix M, p. 263	Reflection from National Migration Programmes Manager	27/11/2017	11/12/2017	11/12/2017	No conditions
Ch 6, p. 162	Screenshots of Refugee Trauma Recovery website in 2018	24/04/2021	28/04/2021	28/04/2021	No conditions
Ch 6, p. 164, Appendix N, p. 264	Email from National Migration Programmes Manager	23/08/2018	23/08/2018	23/08/2018	No conditions
Ch 6, p. 163	Email from practitioner in response to National Migration Programmes Manager	23/08/2018	23/08/2018	23/08/2018	Anonymity
Ch 6, p. 167	Email from New Zealand Red Cross practitioner	23/08/2018	23/08/2018	23/08/2018	Anonymity

	in response to my workshop				
Ch 6, p. 172	Email from practitioner from psychologic al service in response to me workshop	4/11/2018	5/11/2018	5/11/2018	Anonymity
Ch 6, p. 173	Reflection from the director of another agency who attended my workshop	10/11/2018	10/11/2018	10/11/2018	Anonymity

Appendix C: Semi-Structured Interview Schedule

I am interested in your experiences working in a refugee resettlement NGO in New Zealand...

Tell me about your role and the organization you work for?

What led you to working as a (POSITION) at (NGO)?

What has your experience been like working as a (POSITION) at (NGO)?

Tell me about the challenging aspects of your role?

Tell me about the positive aspects of your role?

How do others react when you tell them about the work that you do?

If you could let everyone know one thing about refugees and/or resettlement work what would it be?

Is there anything that we haven't spoken about that you feel is important?

Would you like the opportunity to review the transcript of this interview?

Would you like to receive a report of the findings?

Demographic Information: Sex, Age, Ethnicity, Religion, Country of origin, Year arrived to NZ (if applicable), Citizenship status (if applicable), Professional position & years' experience

Appendix D: Ethical Approval



14/109

Academic Services
Manager, Academic Committees, Mr Gary Witte

22 July 2014

Dr J Macdonald
Department of Psychological Medicine
Dunedin School of Medicine

Dear Dr Macdonald,

I am again writing to you concerning your proposal entitled "**Examining how individuals engaged in refugee resettlement talk about their work**", Ethics Committee reference number **14/109**.

Thank you for your letter of response and revised documentation which was received at the end of last week.

Thank you for outlining Professor Ellis' role in the supervisory team, and for providing a copy of the semi-structured interview schedule.

You have confirmed that you will use the Census wording to capture ethnicity data, as recommended by Ngai Tahu Research Consultation Committee (NTRCC). You note, however, that the Middle Eastern, Latin American and African category is too broad therefore specific ethnicities and county of origin will be recorded. The Committee supports this approach, which is consistent with the intent of the NTRCC's letter that participants be able to 'self-identify'.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

A handwritten signature in cursive that reads 'Gary Witte'.

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Professor P W Glue Head Department of Psychological Medicine

Appendix E: Information Sheet



EXPLORING HOW INDIVIDUALS ENGAGED IN REFUGEE RESETTLEMENT TALK ABOUT THEIR WORK

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the aim of the project?

The psychological literature on refugee resettlement has a tendency to focus on trauma and the risks of trauma work, pathologising not only refugees but those who work with them. This preoccupation with trauma does not allow for alternative discourses of survival and resilience and disregards the opportunities for personal and professional growth documented in this context.

The proposed research project involves interviewing a cross section of individuals engaged in refugee resettlement in New Zealand with the purpose of establishing whether there are alternative ways of conceptualising refugees and working in resettlement.

The proposed research project is being undertaken by Marieke Jasperse as part of a PhD in Psychological Medicine at the University of Otago.

What type of participants are being sought?

Individuals currently engaged in refugee resettlement in a professional and/or voluntary capacity are being sought. The participation of a cross section of psychiatrists, psychologists, counselors, social workers, caseworkers, cross cultural workers and volunteers is anticipated. Participants will be provided with a \$30 grocery voucher to acknowledge their participation.

What will participants be asked to do?

Should you agree to take part in this project, you will be asked to participate in one semi-structured interview, approximately one hour in length. The interviews will be conducted in a location specified by you at a mutually agreeable time.

You can withdraw from the study at any time without consequences and if you feel distressed after the interview several options for support will be available.

The Clinical Manager, [NAME], will be available for debriefing up to a week after the interview. You will be encouraged to discuss participation in this research initiative with your external supervisor and if further support is required you will be able to approach your manager [NAME] to access your organisations Employee Assistance Programme.

What data or information will be collected and what use will be made of it?

If you agree to participate in this interview you will be asked questions about your experiences working in refugee resettlement in New Zealand. The interviews will be audio recorded, transcribed verbatim by Marieke and analysed in keeping with discourse analysis, the methodological approach informing this study. Participation in this study is entirely confidential. All transcripts of interviews will be made anonymous, and will be identified by a number. The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for at least 10 years in secure storage. Any personal information will be destroyed at the completion of the research. At the conclusion of the study you will have the option to receive a report of the findings. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand).

Can participants change their mind and withdraw from the project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

What if participants have any questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:

Marieke Jasperse, Department of Psychological Medicine, [CONTACT NUMBER]
[CONTACT EMAIL]

[ORIGINAL SUPERVISOR'S NAME], Department of Psychological Medicine,
[CONTACT NUMBER] [CONTACT EMAIL]

This study has been approved by the University of Otago Human Ethics Committee (Reference Number 14/109). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator ([CONTACT NUMBER] or [CONTACT EMAIL]). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

Appendix F: Recruitment Email for Volunteer Coordinator of New Zealand Red Cross

My name is Marieke Jasperse, I'm a cross cultural psychologist, and I'm currently pursuing a PhD from the Department of Psychological Medicine at the University of Otago, Wellington.

I'm really interested in the way the psychological literature on refugee resettlement has a tendency to focus on trauma and the risks of trauma work, pathologising not only refugees but those who work with them. I'm concerned that this preoccupation with trauma and burden does not allow for alternative discourses of survival and resilience and disregards the opportunities for personal and professional growth that have been documented in this context.

In my PhD research I am interviewing a cross section of individuals engaged in refugee resettlement in Wellington to explore their experiences working in resettlement and provide an opportunity for them to challenge some of the stereotypes concerning refugees and resettlement.

If this sounds like something you would be interested in participating in, I would be looking for you to participate in an interview with me (up to 1 hour). The interviews will be confidential and no identifying characteristics will be published in my research. I've attached an official information sheet if you'd like further information and please do not hesitate to contact me with any questions.

If you are interested in participating in my research please email me at [CONTACT EMAIL] or call or text me on [CONTACT NUMBER].

I look forward to hearing from you.

Kind regards

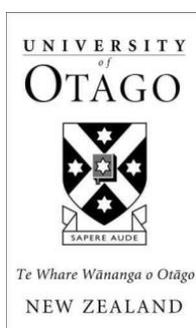
Marieke Jasperse

PhD Candidate

Department of Psychological Medicine

University of Otago, Wellington

Appendix G: Consent Form



EXPLORING HOW INDIVIDUALS ENGAGED IN REFUGEE RESETTLEMENT TALK ABOUT THEIR WORK

CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

1. My participation in the project is entirely voluntary,
2. I am free to withdraw from the project at any time without any disadvantage,
3. Personal identifying information on audio recordings will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least ten years,
4. I will receive a \$30 grocery voucher to acknowledge my participation,

5. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.....

(Signature of participant)

.....

(Date)

.....

(Printed Name)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator ([CONTACT NUMBER] or email [CONTACT EMAIL]). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

Appendix H: Simplified Transcription Scheme

Parker (1992, p.124)

1. When there are doubts about the accuracy of material, put it in round brackets (like this).
2. When material has been omitted from the transcript, signal it by putting a pair of empty brackets, thus [].
3. When you need to clarify something, put the explanation in square brackets, like so [to help the reader].

Appendix I: 15-Point Checklist for Thematic Analysis

Braun and Clarke (2006, p. 96)

Transcription:

1. The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for ‘accuracy’

Coding:

2. Each data item has been given equal attention in the coding process

3. Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive

4. All relevant extracts for all each theme have been collated

5. Themes have been checked against each other and back to the original data set

6. Themes are internally coherent, consistent, and distinctive

Analysis:

7. Data have been analysed – interpreted, made sense of - rather than just paraphrased or described

8. Analysis and data match each other – the extracts illustrate the analytic claims

9. Analysis tells a convincing and well-organised story about the data and topic

10. A good balance between analytic narrative and illustrative extracts is provided

Overall:

11. Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly

Written report:

12. The assumptions about, and specific approach to, thematic analysis are clearly explicated

13. There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent

14. The language and concepts used in the report are consistent with the epistemological position of the analysis

15. The researcher is positioned as active in the research process; themes do not just ‘emerge’

Appendix J: Amended Ethical Approval



14/109

Academic Services
Manager, Academic Committees, Mr Gary Witte

6 October 2017

Dr E Bell
Department of Psychological Medicine
Dunedin School of Medicine
University of Otago Medical School

Dear Dr Bell,

I am again writing to you concerning your proposal entitled "**Examining how individuals engaged in refugee resettlement talk about their work**", Ethics Committee reference number **14/109**.

Thank you for your email of 5th October 2017 with request for amendment attached. The Committee notes that Marieke Jasperse, student investigator, would like to incorporate extracts of comments received from conference attendees in response to the research into her PhD Thesis. You note that consent will be sought from those who have provided comments and that anonymity will be assured.

We note that the title of the thesis is currently: "*We have only certain images about refugees*": *The crisis of representation in refugee resettlement in Aotearoa New Zealand*". The Committee's records have been updated accordingly.

We further note that you have replaced Dr Joanna MacDonald as the Principal Investigator for the project.

The Committee accepts and approves the amendment and grants re-approval for a further 3 years from the date of this letter.

Your proposal continues to be fully approved by the Human Ethics Committee. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing. I hope all goes well for you with your upcoming research.

Appendix K: STUFF Media Article

Reproduced with permission (see Appendix B)

Fears underfunding of Wellington health services will 're-traumatise' Syrian refugees

CALEB HARRIS

Last updated 20:42, February 18 2016



Adam Dudding/Fairfax NZ

Refugees learn about their new home at the Mangere Refugee Resettlement Centre in Auckland.

“Syrian refugees scarred by torture, war and the loss of loved ones may be re-traumatized because our health system is underfunded, health leaders say. Up to a third of the approximately 85 Syrians arriving in Wellington, Porirua and Hutt Valley next week are suffering severe trauma, depression and anxiety, Refugee Trauma Recovery manager Jeff Thomas said. But the specialised regional counselling service is already overstretched, so without more funding, new arrivals will likely be "re-traumatized" by having to wait months for therapy. Some were suicidal, and the wait would put them more at risk, he said. "It's not like they can go off and be 'fixed' elsewhere, they're torture victims ... we have major concerns."

The service is contracted by the Wellington and Hutt Valley district health boards and, with no funding increase for three years, its waiting list has grown with each new cohort of traumatised refugees from Colombia, Myanmar and elsewhere. But the wait would become untenable as the first group of an additional 600 Syrian refugees arrived, on top of New Zealand's normal annual refugee quota of 750. The DHBs had asked the Ministry of Health to fund another trauma counsellor and a decision was expected by the end of the month, Thomas said. Given the Government's directive this week that DHBs save \$138 million this year, he was not confident. "It's certainly going to be incredibly difficult if we don't get it."

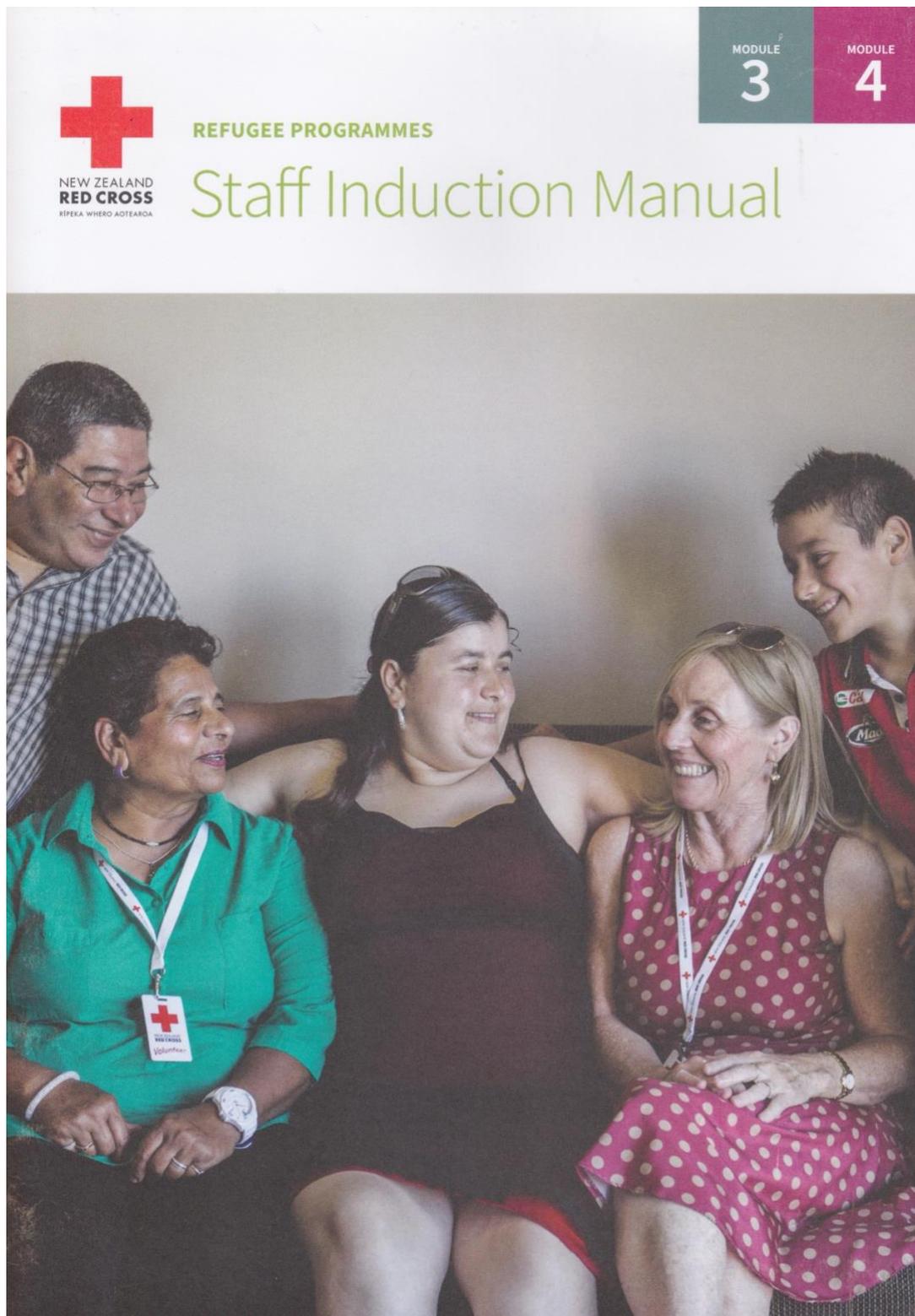
There are also concerns the 30 or more Syrians bound for the Hutt Valley may have to depend for basic health care on Hutt Hospital's emergency department, because the few medical centres that enrol refugees cannot cope with more. The manager of one of the centres, Hutt Union and Community Health Service, said unlike other DHBs, the Hutt does not have dedicated funding for refugees' GP enrolments. Hutt Valley GPs got the same funding for a refugee as for any other patient, even though refugees' complex needs meant extra costs such as interpreters, Sally Nicholl said. "We won't take any new refugees without extra funding, because the pressure it puts on us is just too much." That would leave the Syrian arrivals without a GP, a situation Jeff Thomas called unprecedented and "unbelievable". Nicholl hoped for a solution in upcoming meetings with the Hutt DHB and its primary health organisation.

The Ministry of Health's chief financial officer Mike McCarthy said it recognised additional refugees put extra pressures on health services, and was actively considering additional funding. Refugees were entitled to the same healthcare as any other high-needs patient, he said. Capital & Coast District Health Board spokeswoman Sandra Williams said it would ensure refugees had equal access to services.

The first of 600 Syrian refugees coming over the next two years arrived in Auckland in January, and have been in an orientation programme in since then."

Appendix L: Induction Manual for the New Zealand Red Cross Refugee Programme

Reproduced with permission (see Appendix B).





Perhaps this is best summed up by Giselle, who was part of our 'Get to Know Me' Campaign

"I think it's very important that people, especially young New Zealanders, understand that former refugees can contribute greatly to the New Zealand society.

Negative perceptions of refugees create a single narrative of who a refugee is and leaves no room for success stories to be heard."

<https://www.redcross.org.nz/stories/new-zealand/get-know-me-giselle/>

As employees of the New Zealand Red Cross Refugee Programme you are probably already aware of the stereotypes and stigma towards resettling refugees so it is important that we do not reinforce stereotypes in our work and organisational publications.

RESEARCH & REFLECT

Take a moment to read and reflect on what some of the resettlement workers had to say in a recent study on how people from a refugee background are discussed. The first section provides a cross section of statements made by resettlement workers that resist refugee stereotypes and stigma. The second section provides a cross section of statements that reinforce some of these stereotypes while the third section illustrates the impact on resettling refugees.

How do these quotes resonate with your experiences? What can you do to ensure you avoid reinforcing negative stereotypes?

Resisting stereotypes



"We have only certain images about refugees. When you hear "refugee" it looks like somebody is scared, it means somebody escaped and they have no options. We need to change that idea about refugees. We need to focus on the positive side of their lives. How they managed to survive. How they were able to succeed here in New Zealand."

Male, former refugee



"I find that there is not enough encouragement about what they are actually achieving here. I see it across all professionals. "Oh it was so horrible there and now you've arrived to paradise". This is not paradise."

Female, migrant



"Some of them have text book PTSD but the resilience is remarkable. They're not helpless individuals we should pity and wrap in cotton wool. They're people."

Male, migrant



"Several service providers mentioned that to me that is was difficult to work with refugees and I thought "What would you expect from a European client?"

Male, migrant

Reinforcing stereotypes



"You can't have too higher hopes. I'm getting to the stage where I don't think we can get them totally out of the PTSD. These are very damaged people"

Female, NZ born



"They come from different cultures and some are quite demanding. Some hardly say thank you"

Female, NZ born

Stereotypes and self-esteem



"If I hear somebody referring to me all the time as a "refugee", "refugee", "refugee", I feel a kind of pressure, a kind of weight on the shoulders. It means that I'm something they need to work harder with. None of us want to feel like that"

Male former refugee



"Please tell people in New Zealand that being a refugee is not identity. It is a part of life experience. If only people think about me as refugee, and they don't like refugees, then how will they give me a window or door open where I can show beyond that?"

Female Former Refugee

Organisational efforts to address stereotypes

The New Zealand Red Cross, as an organisation, has implemented a few initiatives to address these issues. Some of these have been mentioned above.

We have a glossary which sets out definitions of terms used within the refugee sector and describes the best way to refer to refugee background clients. E.g. As noted in Module One, people arriving as part of the Refugee Quota are granted permanent residence in New Zealand. At the Red Cross we refer to the people we work with "ordinary people facing extraordinary circumstances", "former refugees" or "individuals from a refugee background". https://newzealandredcross.sharepoint.com/Refugee%20Services/_layouts/15/WopiFrame.aspx?sourcedoc=%7B3C7D28B9-FEC3-4CFD-9F27-E324794C2CE0%7D&file=Glossary.docx&action=default

We have also run the "Get to know me" campaign, a series of profiles of former refugees now living in New Zealand. These profiles highlight interests of those featured and their reflections on being in New Zealand. It also describes them as 'kiwis', reminding other New Zealanders that they are also New Zealanders.



RESEARCH & REFLECT

Take some time to read through the glossary and head to the website where you can review the different profiles of the 'Get to know me' campaign <https://www.redcross.org.nz/what-we-do/in-new-zealand/refugee-programmes/refugees-new-zealand/get-know-me/>

Appendix M: National Migration Programmes Manager’s Reflection on PhD Research

“To whom it may concern,

I am the National Migration Programmes Manager for New Zealand Red Cross and it has been a privilege to engage with Marieke’s research over the past year.

We became very interested in her findings after a short presentation she gave on the importance of language and the resettlement process highlighting both the risks and opportunities. She provided us with a challenge around our role in reinforcing stereotypes simply through our use of language.

This message was timely for us and a good challenge and we subsequently engaged Marieke to develop some training resources for our staff. From this she completed two modules on stereotypes and resiliency which have now been rolled out to all 150 staff. The material is also now being integrated into our volunteer training programme which trains 600 people each year. Marieke recently provided training to our 35 key leader practitioners on these modules.

Marieke’s research has added value and made a very tangible impact to our work. Her message was quite a challenge to us and at times not an easy one to hear. It has forced us to stop and reflect on how we communicate both internally and externally which I think has led to positive changes from practitioners.

The research findings was also timely as we integrated regional mental health service into our team. We are working through a process of updating comms materials related to this service and have been able to use Marieke’s findings and recommendations as a guide.

I’m very grateful for the willingness Marieke has shared her research and findings. It has made a very real and meaningful impact in the refugee settlement sector.

Kind regards

NAME”

December 2017

Appendix N: National Migration Programmes Manager's Email to Management

“Kia ora everyone

Some of you will be familiar with Marieke who wrote our module 3 & 4 on resiliency and stereotypes, she also presented at our Team Leaders hui late last year. Since then we've had lots of requests from team leaders who have wanted her to travel to their areas and do it with the whole team. We still have some national training budget left so we've contracted Marieke to deliver regional training.

Her message is fantastic – all about taking a strengths based approach to how we talk and think about resettlement, refugees and our roles. She gives practical advice for addressing stereotypes and rethinking our language. This is something all of Red Cross would benefit from not only Migration programmes. This training can be made available to anyone in your area – staff and members.

Marieke is available over the next two months to do training in your area. All you or someone in your team needs to do is contact her with possible dates - Marieke Jasperse [CONTACT EMAIL]. I know the CSTLs were very interested after the hui about this so you may find they are happy to coordinate with Marieke.

I'd strongly encourage each area to make use of this training as the principles underlie how we want to approach our work. It is also a very practical way to engage with the two induction modules which will mean we will know all current staff have completed them.

If you want to discuss further give me a call”

April 2018

Appendix O: Abstract for the Workshop at Refugee Reception Center

“We have only certain images of refugees”:

The crisis of representation in the resettlement sector

Resettlement agencies are powerful advocates of resettling communities. However, in their attempts to acquire recognition and resources, they are also accused of perpetuating the stigmatized status of resettling communities. This workshop will share critical reflections from a cross section of practitioners (i.e. psychiatrists, psychologists, case workers and interpreters) working with resettling communities in Wellington, New Zealand, alongside the latest psychiatric research, in order to sensitize audiences to the issues of representation in the resettlement sector. The audience will then be guided through a series of exercises to critically reflect upon any assumptions of trauma they may hold and how these assumptions influence their own approach to advocacy.

Marieke Jasperse is a cross-cultural psychologist passionate about refugee resettlement in Aotearoa, New Zealand. She is currently completing her PhD in Psychological Medicine, critiquing the representation of resettling refugees in psychiatry, the resettlement sector and society, and works part-time as a psychologist and consultant.

October 2018

Appendix P: Example Responses from Directors and Administrators from Clinical Programmes in New Zealand

Hi Marieke,

Your inquiry about our clinical curriculum was forwarded to me. It's a good question and certainly a relevant one for us. It's only recently that we have had a formal presentation specifically on this for our clinical programme, so I can't say it's a regular part of our curriculum so far. We certainly discuss migration and culture, as they effect so many of the people we work with, but the issue of refugees has been less clearly on the radar. We do try to emphasize understanding the person in the broader issues of context, culture, and family, which we hope would generalize to thinking about the situation of refugees, but I am sure there is more we can do about specific needs and services. We had a guest presentation last year from a local psychologist who works with refugees, and will be considering in our upcoming curriculum planning meeting how we might incorporate this more systematically.

Director, Clinical Psychology Training Programme

Dear Marieke,

Thank you for your email.

I am not aware of any specific papers in the clinical curriculum that are dedicated towards resettling refugees.

Further information on our programme can be found here [...]

Administrator, Clinical Psychology Training Programme