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COMPREHENSIVE REVIEW

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Refugees and asylum seekers who have experienced trauma: Thematic synthesis of therapeutic boundary considerations

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Abstract

Objective: Therapeutic boundaries are limits to appropriate behaviours within a therapist–client relationship (e.g. related to accepting gifts, self-disclosures, therapist neutrality and advocacy). Therapeutic boundary considerations are fundamental in the care of refugees and asylum seekers. Research on the experiences of therapists navigating such boundaries is sparse and warrants further exploration. The aim of this qualitative systematic review was to thematically synthesise literature regarding therapists' (psychologists, psychotherapists, counsellors) experiences of implementing flexible therapeutic boundaries with refugee and asylum seeker clients and determine how such applications have been helpful for therapeutic interventions.

Method: Six databases were searched. Following full-text screening, 21 papers were included in the analysis. Boundary theory underpinned the analysis.

Results: Three major themes were developed: (i) *Changes to Therapeutic Practice & Therapeutic Intervention*, (ii) *Re-Conceptualisation of Therapy as 'Clinical Political' and Re-Conceptualisation of Therapist Identity* and (iii) *Careful Monitoring of Personal Boundaries—Not becoming 'Hardened' or 'Haunted'*. Papers described how, when used in a reflective, considerate way, flexible therapeutic boundaries can strengthen the therapist–client alliance and positively impact therapeutic interventions. Many therapists acknowledged making conscious efforts to re-conceptualise therapeutic work with refugee and asylum seeker clients from advocacy standpoints. However, systemic constraints, and lack of guidance, made this difficult to navigate and contributed to therapist burn-out.

Conclusions: Boundary considerations manifested as interpersonal, structural and cultural changes to practice. These have implications for clinical practice and developing guidelines on boundary practices with refugees and asylum seekers. Future research should explore promoting therapist well-being and training needs for therapists supporting this population.

KEYWORDS
boundaries, cross-cultural, psychologists and psychotherapists, refugees and asylum seekers, therapeutic intervention, trauma

1 | INTRODUCTION

The refugee crisis is increasing worldwide. Recent figures suggest that 103 million people worldwide are presently forcibly displaced; 32.5 million people have been registered as refugees and 4.9 million as asylum seekers (United Nations High Commissioner for Refugees; UNHCR, 2022). It is anticipated that there will be additional demands on psychologists and therapists to provide psychological support to refugees and asylum seekers, many of whom will have experienced profound trauma. Most of the research has focused on the perspectives of refugees and asylum seekers Peñuela-O'Brien et al., 2022). Empirical evidence which has focused on the viewpoints of therapists has examined: the experiences of psychotherapists (Asfaw et al., 2020), barriers and facilitators to working with these populations (Duden & Martins-Borges, 2021a) and characteristics of the therapists themselves (Schlechter et al., 2021). Cultural sensitivity, adapting interventions and trust and flexibility within the therapeutic relationship have been identified as essential in meeting the mental healthcare needs of these clients (Duden et al., 2020; Kirmayer et al., 2011; Peñuela-O'Brien et al., 2022; Schlechter et al., 2021). However, it may not be appropriate to apply traditional therapeutic boundaries, such as therapist neutrality (i.e. not interfering with issues external to the therapeutic setting or sharing personal opinions), therapist abstinence (i.e. refraining from personal gratification) and client autonomy/independence. Moreover, it may not be helpful to adopt biomedical, arguably rigid, perspectives, in contrast to engaging in advocacy and addressing practical, basic needs (Carswell et al., 2011; Codrington et al., 2011; Duden & Martins-Borges, 2020; Karageorge et al., 2017; Watters, 2001).

Literature on boundary theory provides guidelines which are intended on supporting healthcare professionals, establishing public trust and reducing potential risk of harm to clients (Blatt, 2001; Cowles & Griggs, 2019; Gutheil & Gabbard, 1993, 1998). Put simply, 'boundaries' have been described as an edge or limit of appropriate behaviour within a clinician–client relationship; they encapsulate a rough consensus of norms which define the limits, obligations and parameters of professionals (Gabbard, 1999; Langs, 1982; Shors & Kroll, 2022; Spruiell, 1983). *Boundary crossings* have been conceptualised as transactions within the therapeutic encounter that may require ethical analysis to determine their appropriateness; some should be avoided as they may lead to *boundary violations*, whereas others are appropriate and may strengthen the clinician–client relationship (e.g. accepting small gifts, professional self-disclosures, extending treatment periods and not meeting exclusively within the clinical room) (Cowles & Griggs, 2019; Crowden, 2008; Gabbard & Crisp-Han, 2010; Savin & Martinez, 2006; Shors & Kroll, 2022; Smith & Fitzpatrick, 1995; Walker & Clark, 1999). Flexible boundaries in psychological practice have been considered helpful and do not necessarily create a 'slippery slope' into boundary violations (Black, 2017; Cowles & Griggs, 2019; Lazarus, 1994; Martinez, 2000).

Key Practitioner Message

- Therapeutic boundaries need to be more flexible when supporting refugee and asylum seeker clients who have experienced trauma, particularly within non-western contexts.
- Flexible boundaries can look like *interpersonal/relational changes*, *structural/practical changes* and *integrating cultural aspects*; however, they require reflexivity and monitoring.
- Clinical advocacy is relevant to therapeutically supporting refugee and asylum seeker clients and may challenge therapists' identities and expectations of the therapeutic process.
- Psychodynamic processes, such as countertransference and projective identification, are essential to consider when supporting this population; systemic constraints can exacerbate these processes.
- Therapists need to be supported to prevent vicarious trauma, compassion fatigue, burn-out and moral injury and to maximise the effectiveness of therapeutic interventions.

The importance of redefining therapeutic boundaries and the necessary implications this could have for the therapeutic care of refugees and asylum seekers is established in the literature (Bäärnhielm & Schouler-Ocak, 2022; Karageorge et al., 2017; Kroll, 2001; Martinez, 2000; Savin & Martinez, 2006; Sandhu et al., 2013; Shors & Kroll, 2022). Traditional therapeutic boundaries have been highlighted as not being appropriate nor optimal in supporting refugees and asylum seekers and may disrupt rapport-building. This was contextualised by cultural underpinnings, complex power dynamics, the varying and unpredictable demands of the post-migration refugee context and the difficulties of applying Westernised therapeutic concepts (Duden & Martins-Borges, 2021b; Hinton et al., 2012; Karageorge et al., 2017; Speight, 2012; Watters, 2001; Zur, 2004). The concept of psychological therapy may be unfamiliar, and clients may have entirely different values and concepts of mental health, illness beliefs and explanations for adversity. Cultural differences vary widely across various subgroups of refugees and asylum seekers. Within some cultures, psychotherapeutic practices may be unheard of. Certain subgroups (e.g. African) may hold intrinsic cultural beliefs about spirits, magic and voodoos, which may be inaccurately viewed as psychopathology through a strictly Western lens (Asfaw et al., 2020; Mayston et al., 2020;

Okpalaenwe & Odigwe, 2018; Patel, 1995). Although variable, other subgroups (e.g. Ukraine) may have more exposure to psychotherapeutic practices; however, stigma can exist (Quirke et al., 2021). Behaviours which are considered important clinical information in a Western context can have various cultural inferences (i.e., maintaining direct eye contact can be perceived as disrespectful in Japanese culture; Uono & Hietanen, 2015). Further, certain subgroups may have culturally intrinsic views on spirituality, parenting, gender roles and hierarchical social structures. There are also differences within geographical contexts in terms of cultural practices and faiths; within Syrian communities, Orthodox Christians and other minority groups exist in addition to Muslim communities (Hassan et al., 2015). Thus, there are nuanced layers of complexity in examining cultural differences which require re-examination of Western constructs and recognition of cultural assumptions and biases (Asfaw et al., 2020; Lau & Rodgers, 2021).

Establishing therapeutic rapport and trust, which is the cornerstone of any psychological intervention, may be considerably more difficult for clients who may have experienced profound suffering, torture, humiliation, internalised shame and stigma. Thus, therapists may be required to modify conventional roles and clinical practices, such as appropriate self-disclosure and considering cultural gift-receiving, to build trust (Kinzie, 2001; Kirmayer, 2003; Savin & Martinez, 2006; Tseng et al., 2004). Evidence-based treatments which are considered efficacious for refugees with multiple traumas, include Narrative Exposure Therapy (NET), Eye Movement Desensitisation and Reprocessing (EMDR), imagery rescripting, cognitive therapy for PTSD and prolonged exposure therapy, depending on client preferences; however, EMDR is not deemed suitable for combat-related traumas (Ehlers & Clark, 2000; Elbert et al., 2022; Neuner et al., 2018; NICE Guidelines, 2018; Steel et al., 2023). A phased-based model of psychological intervention is recommended for trauma treatment, which comprises of (1) safety and stabilisation, (2) processing of traumatic memories and (3) re-integration into family and community (Herman, 1992; Patel et al., 2018; Robertson et al., 2013). Importantly, the American Psychological Association and NICE guidelines are narrowly rooted in biomedical, manualised models which ignore the pivotal roles of the therapeutic relationship and responsiveness in trauma treatment (Norcross & Wampold, 2019). However, most practitioners use responsive, relational and personalised psychotherapy, rather than adhering to specific modalities (Barber & Solomonov, 2019; Huibers et al., 2021; Webb et al., 2022). The need for guidelines to include evidence-based relationships and adaptations has been acknowledged; hence, exploring the experiential and relational aspects of therapeutic trauma treatment is important (Norcross & Wampold, 2019).

A body of literature highlights that the mental health needs of refugees and asylum seekers have been best addressed through interdisciplinary and psychosocial work, practical interventions and advocacy; all of which lies within the remit of therapeutic boundary considerations (Karageorge et al., 2017). Reconsiderations and re-conceptualizations of psychiatric and psychological boundaries with refugees have included modifying interactions with clients; offering interventions to clients based on their own cultural traditions; appropriate self-disclosure as opposed to therapist anonymity; considering advocacy-based, dual-agency work as opposed to remaining neutral and transcending above therapeutic needs to address practical needs; and accepting small gifts and accepting clients' invitations to external events (Bäärnhielm & Schouler-Ocak, 2022; Karageorge et al., 2017; Kirmayer, 2012; Savin & Martinez, 2006; Shors & Kroll, 2022). Extensive research has shown that refugee and asylum seeker clients identify practical assistance (e.g. housing and employment) as therapy priorities (Al-Roubaiy, 2014; Karageorge et al., 2017; Reichelt & Sveaass, 1994; Schweitzer et al., 2015). This resonates with Maslow's Hierarchy of Needs (Maslow, 1943), which outlines that basic, physiological needs must be addressed prior to psychological needs being met. This also resonates with therapeutic approaches to trauma, which emphasise safety and stabilisation prior to processing traumatic experiences (Cloitre et al., 2002). However, risks can emerge in terms of professionals becoming over-identified with clients and not facilitating clients' independence (Codrington et al., 2011). Some therapists, particularly across therapeutic modalities, may understandably feel that helping with practical assistance and being expected to have flexible boundaries is not within their remit and that consistent and rigid boundaries must be maintained to provide safety (Bennett et al., 1994). Theory and application would benefit from further exploring the perspectives of therapists in relation to the concept of expanding therapeutic boundaries.

The literature clearly highlights that therapeutic boundary considerations are important when supporting refugees and asylum seekers, who are culturally diverse and who have endured significant trauma. There is minimal research on the experiences of therapists; as such, the assumptions underpinning therapeutic practice remain relatively uncharted (Schweitzer et al., 2015). As highlighted, some literature has highlighted how flexible boundaries have been implemented with refugees and asylum seekers. However, it is unclear what therapists' experiences specifically are of this, and what is meant by 'flexible boundaries', in terms of clinical and therapeutic applications. The concept of 'flexible boundaries' is widely debated and warrants further exploration (Duden et al., 2020). Limitations of previous qualitative syntheses involved not distinguishing client groups (i.e. adults and children) and the inclusion of both therapist and client perspectives, as well as a diverse range of mental health professionals; it is important to gather evidence specifically from therapists' perspectives as including a diverse range of professionals may have diluted the meanings/perspectives from specific disciplines (Duden et al., 2020; Karageorge et al., 2017; Tynewydd et al., 2020). The present review will focus exclusively on the perspectives of psychologists, psychotherapists and counsellors (collectively referred to as 'therapists'). Consistent with empirical recommendations, it is important that the literature is reviewed systematically to reflect therapeutic practice developments synonymous with the ever-expanding rates of displaced people worldwide (Peñuela-O'Brien et al., 2022). The aim of the present study is to systematically review and synthesise the published peer-reviewed qualitative research evidence and grey literature on the experiences of psychologists, psychotherapists and counsellors in their use of therapeutic boundaries with refugees and asylum

seekers who have experienced trauma. The review question is as follows: *How have psychologists, psychotherapists and counsellors adapted flexible therapeutic boundaries in terms of supporting refugees and asylum seekers?* To the best of our knowledge, no systematic review is presently available on this specific topic.

2 | METHODS

The protocol for this systematic review was prospectively registered on PROSPERO (CRD: 42022326876) and can be accessed in full (https://www.crd.york.ac.uk/prospero/). Preferred Reporting Items for Systematic Reviews & Meta-Analyses (PRISMA; Page et al., 2021) guidelines were used. ENTREQ guidelines (Tong et al., 2012) were used in preparation for the review, and CASP guidelines (CASP, 2018, Qualitative) were used to evaluate the quality of included studies.

2.1 | Search strategy

The SPIDER (i.e. Sample, Phenomenon of Interest, Design, Evaluation, Research Type; Cooke et al., 2012) framework was used to search the following databases: PubMed, CINAHL (via EBSCO), APA PsycINFO (via EBSCO), APA PsycARTICLES (via EBSCO), Embase and Web of Science. These databases were selected due to their scope of literature pertaining to health, psychology and clinical practice. Key journals were hand-searched, and footnote chasing/forward backward citation searches were implemented to access additional studies. This is due to difficulties with obtaining qualitative research, due to low concentration of qualitative studies in databases, indexing variation between databases and the use of quotations as article titles (Byrow et al., 2020; Tynewydd et al., 2020; Wu et al., 2012). Searches were conducted between April and May 2022. All databases were searched from database origin date to the date of the searches being conducted. Search terms related to the following concepts: psychologists, psychotherapists and counsellors; therapeutic experiences; refugees and asylum seekers; trauma interventions; and qualitative and mixed-methods research methods. Search terms were broadened as opposed to using narrow concepts, such as 'boundaries', to avoid any risks associated with missing literature. Individual databases were checked for subject headings and synonyms due to the broadness and interchangeability of these aforementioned concepts. Searches were updated prior to publication. The search terms used are available in the Supporting Information.

2.2 | Inclusion and exclusion criteria

Inclusion criteria were peer-reviewed studies published in academic journals; grey literature (e.g. academic dissertations); qualitative studies (e.g. semi-structured interviews, focus groups, case studies and reflective publications) with analysis methods from any qualitative approach (e.g. thematic, IPA, discourse and content); mixed methods with a qualitative component; studies published in English; and studies including qualitative experiences of psychologists/psychotherapists/counsellors (including trainee psychologists) who provided psychological interventions to refugee and asylum seeker clients. Studies which contained various professional perspectives were included if therapist responses were made explicit. The research focus of each study did not need to be specifically related to 'boundaries' or 'cultural flexibility' within therapeutic relationships; however, direct quotes relating to experiences of therapeutic boundaries needed to be present in the results. Original author interpretations were also included (Lachal et al., 2017; Thomas & Harden, 2008). Exclusion criteria were studies not focused on the experiences of psychologists/psychotherapists/counsellors; studies not related to therapeutic boundaries; studies not related to adult refugee clients; studies only containing client perspectives; studies without distinguishable therapist responses' from other professionals' responses; quantitative studies; reviews and meta-analyses; and studies not published in English. There were no restrictions on publication dates.

2.3 | Study selection and data extraction

The PRISMA Guidelines were adhered to throughout the selection process (Page et al., 2021; see Figure 1). Author ND systematically searched the aforementioned electronic databases and exported all results to Endnote, a reference manager. Subsequently, duplicate studies were manually removed. The Rayyan software for screening systematic reviews was used throughout the screening process. Titles and abstracts of studies were independently and blindly screened by Authors ND and PT against the inclusion and exclusion criteria. Agreements and collaborative discussions regarding eligibility were documented. Studies which were unclear in terms of meeting the inclusion criteria were fully screened. ND and PT independently and blindly screened the full texts. Discrepancies were resolved by discussion. The agreement rate for the initial screening was 97.2%, and for the full-texts, screening was 90% (Rayyan). Data were extracted by ND, which was reviewed by PT. Data were extracted according to the SPIDER search tool (Cooke et al., 2012; see Table 1). Data were extracted for synthesis included participant quotes and themes and narratives described by the original researchers. Data were analysed using the NVivo software (QSR International Pty Ltd. Version 12, 2018).

2.4 | Quality assessment (risk of bias)

The Critical Appraisal Skills Program checklist (CASP; Qualitative, 2018) quality assessment tool was used to critique the quality of studies; however, studies were not excluded for poorer quality (Karageorge et al., 2017). Studies were attributed a numerical value to checklist items, which equate to high, moderate and low categories of methodological quality. As there is no empirically tested approach for excluding qualitative studies from synthesis on the grounds of quality, and in line with accepted methods of systematic review of qualitative

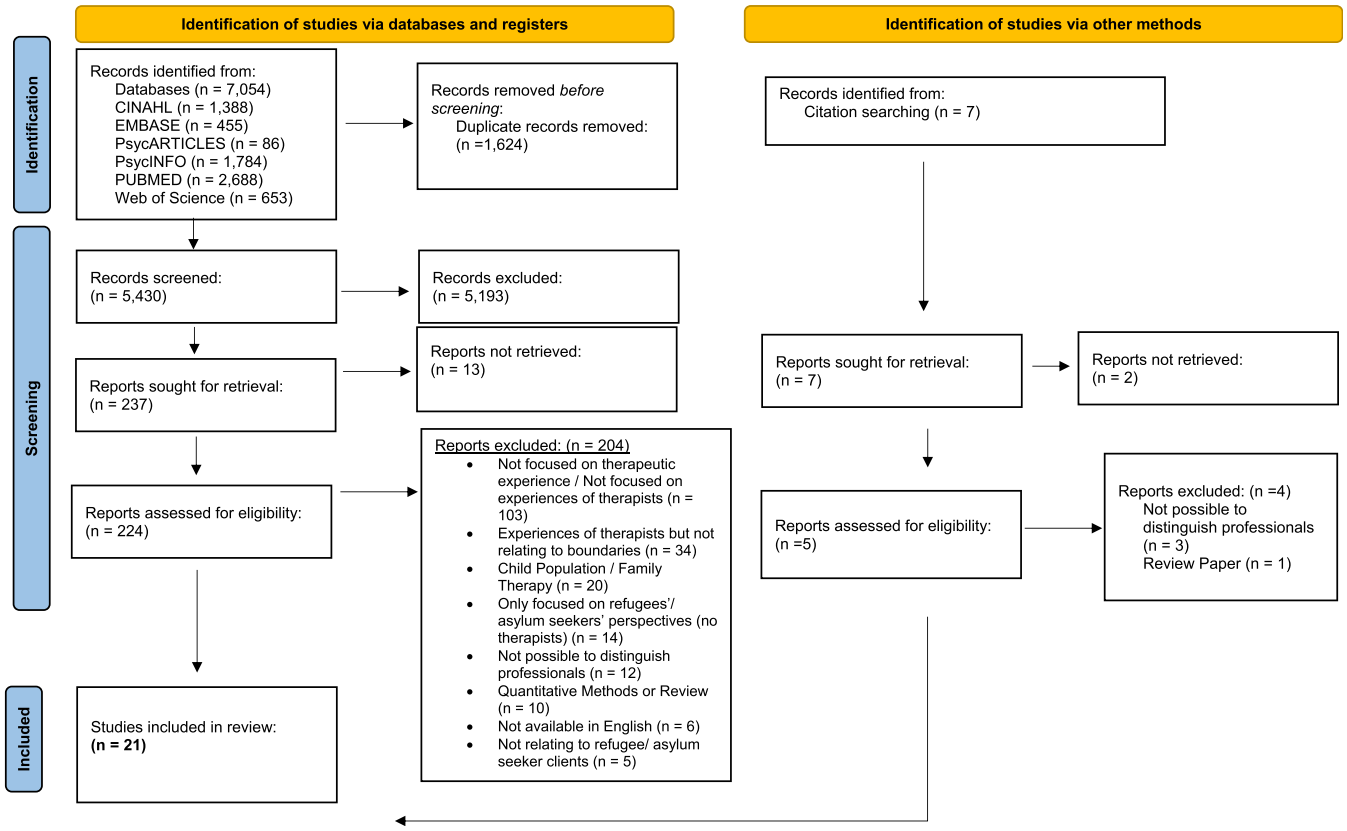

FIGURE 1 PRISMA flowchart.

research (Thomas & Harden, 2008), the CASP can be used to highlight potential bias, and higher quality studies may carry more weight in terms of the interpretation of the findings (Dixon-Woods et al., 2006; Peñuela-O'Brien et al., 2022). There is much debate on whether scoring systems should be applied to determine the quality of papers, with many authors recommending against applying scores and emphasising the collaborative discussion of outcomes and methodological limitations (Long et al., 2020; Noyes et al., 2018). A decision was made to use numerical values as a rough guide to checklist items, and emphasis was placed on collaborative discussion of the outcomes and methodological limitations. CASP Assessments were completed independently by ND, and a sample was reviewed by PT to assess reliability, which involved collaborative discussion to reach consensus. Further details on the criteria met by the studies are provided in Tables 2 and 3. Full details on CASP risk of bias scores are provided in the Supporting Information.

2.5 | Data synthesis

A thematic synthesis (Thomas & Harden, 2008) was employed to synthesise the primary qualitative data across multiple studies. Thematic synthesis was used due to its lack of restriction to a particular methodology and strong transparency and suitability in terms of adhering closely to the results of individual studies, while simultaneously facilitating the generation of new concepts and hypotheses (Barnett-Page & Thomas, 2009; Peñuela-O'Brien et al., 2022). Guidance outlined by Lachal et al. (2017) on qualitative synthesis was adhered to. Direct quotations and qualitative data from participants (first order data) in the primary studies and findings and interpretations from the respective authors' qualitative analyses (second-order data) were used. The stages of thematic synthesis involved (1) free line-by-line coding of the findings of included studies, (2) organising these codes iteratively into descriptive themes and (3) developing analytical themes. Comparisons were made within and across studies. Descriptive codes were developed and discussed in meetings with all authors. An inductive approach was implemented, in that themes were identified from the data rather than pre-specifying initial codes. Variance in the research questions within individual studies was anticipated, and the purpose of the analysis was to aggregate the textual data into themes relating to therapists' experiences of navigating boundary considerations with refugee and asylum seeker populations. The synthesis results comprise of a narrative description of the identified themes and sub-themes, further illustrated by quotes.

2.6 | Reflexivity statement

ND and PT have dual roles as both clinicians (Psychologists in Clinical Training) and researchers (PhD students). AM is an academic

TABLE 1 Characteristics of included studies.

Study #	Author(s)	Primary aim	Study design	Participants	Setting	Themes
1	Akinsulure-Smith, 2012	To highlight the therapeutic treatment and needs of female forced migrants who have experienced sexual violence (clinical case study).	Clinical Case Study (Autoethnographic Qualitative Case Illustration)	Psychologist (Autoethnographic Clinical Case Study): ($N = 1$)	USA	No discrete themes. Results highlighted the importance of promoting emotional well-being for forced migrants who have experienced sexual violence. The importance of flexible and comprehensive interdisciplinary treatment, social justice and advocacy and addressing the multi-faceted needs of this client group were acknowledged.
2	Al-Roubaiy, 2014 *Dissertation*	To explore how mental health professionals view and experience counselling and psychotherapy with Iraqi refugee men.	Focus Groups, Interpretative Phenomenological Analysis & Autoethnographic Case Illustration	Mental health professionals (psychologists, psychotherapists, counsellors; $N = 8$) & Autoethnographic perspective from (author) psychologist ($N = 1$)	Sweden	1. *Client connection to Iraq & Iraqis* (social support VS distrust; connection to Iraq) 2. *Client experiences of exile* (loss of status; integration difficulties; exile trauma not Iraqi trauma) 3. *Therapist observations on client difficulties* (Emphasising pre-migration trauma; somatisation of symptoms; using metaphor) 4. *Therapist limitations* (difficulty relating to client's worldview; therapist discomfort; limited therapist transparency) 5. *Client feedback regarding therapy* (needing practical help; it helps to talk)
3	Anastasiou et al., 2022	To explore the experiences and views of mental health and well-being service providers for Syrian refugees.	Thematic Analysis (Semi-structured interviews & Focus Groups)	Service Providers: GP, Assistant ProfessorSenior Lecturer-Practitioner in Clinical Psychology,Psychological Therapist, Consultant in Public Health, Consultant Clinical Psychologist, Psychotherapy Lead, Professional Lead ($N = 8$)	UK	1. *Positive aspects of service delivery* (Meridian GP practice; emerging refugee well-being pathway; community-based organisations) 2. *Service challenges* (discrimination and context increase distress; interpreting services; systemic and service-level gaps) 3. *Recommendations for service improvements and quality* (interpreting services; further research; policy recommendations; service provider engagement in tackling prejudice; service-level recommendations)
4	Apostolidou, 2016	To examine how notions of risk, personal meaning, personal growth and vicarious traumatisation are formulated within the context of psychotherapeutic work by specialist practitioners who support asylum seekers and refugees.	Discourse Analysis	Specialist Practitioners who conduct clinical therapeutic work with refugees; counselling psychologists, clinical psychologists and psychotherapists ($N = 8$)	UK	No discrete themes. Results highlighted the impact of clients' traumatic experiences on practitioners' perceptions of themselves and the world. Clinical work was also constructed as meaningful and rewarding. Merging clinical work with social responsibility towards refugee and asylum seeker clients counteracted the traumatising aspects for practitioners.

TABLE 1 (Continued)

Study #	Author(s)	Primary aim	Study design	Participants	Setting	Themes
5	Apostolidou & Schweitzer, 2017	To explore practitioners' perspectives on the use of clinical supervision in their therapeutic work with asylum seekers and refugees.	Thematic Analysis	7 registered psychologists (3 clinicalpsychologists & 4 general psychologists); 1 provisional psychologist & 1 community development worker ($N = 9$; 5 female, 4 male).	Australia	1. *Cross-cultural clinical work and the supervisory context* (deconstructing cultural assumptions; calibrating a cultural lens; employing culturally appropriate ways of practicing) 2. *Therapeutic work, boundaries and the supervisory context* (shifting perspective on therapeutic goals; Client's profound level of needs and boundaries) 3. *Political context and supervision* (supervision as the space for exploring the impact of the political system; supervision normalising feelings of powerlessness in relation to the political context) 4. *Supervision as a source of personal and professional empowerment* (supervision as promoting self-care and protecting practitioners from burn-out; supervision enhancing self-awareness)
6	Asfaw et al., 2020	To understand the challenges experienced by psychotherapists, and strategies used, in therapeutic practice with refugee clients.	Thematic Analysis	10 licensed Psychotherapists working exclusively on an outpatient basis. Most with a theoretical background in Cognitive Behaviour Therapy or Psychoanalysis ($N = 10$).	Germany	1. *Challenges* (expectations towards psychotherapy; cultural challenges-differences in explanatory models; communication-related issues) 2. *Strategies* (dealing with expectations-psychoeducation; dealing with culture-related challenges- 'imagining the real'; identifying counter-magic and other resources in therapy; dealing with communication-related challenges-translators as solutions)
7	Atiyeh & Gray, 2022	To identify how professional counsellors who work with refugees conceptualise multicultural competence and examine their preparedness.	Grounded Theory	8 Counsellors, 1 Facilitator, 1 Admin, 1 Manager. ($N = 12$)	USA	1. *Contexts* (work settings; reasons for doing this work; client reactions to counsellors; rewards counsellors gained from working with refugees) 2. *Challenges* (barriers-limited training, bias/assumptions, counsellor rigidity, language barriers; complexity- power dynamics, cultural intricacies, diagnosing problems, holistic and integrative care; trauma- re-traumatisation, self-care, recognising traumatic distress symptoms) 3. *Competency* (set of dispositions; skills; knowledge)

(Continues)

TABLE 1 (Continued)

Study #	Author(s)	Primary aim	Study design	Participants	Setting	Themes
						4. *Professional development* (learning from clients; being exposed and involved within communities; consulting; learning in formal courses)
8	Century et al., 2007	To explore the current practice, difficulties encountered and supports available to counsellors working with refugee and asylum seeker clients.	Thematic Analysis	Counsellors, counselling psychologists, clinical psychologists and psychotherapists (primary care settings). ($N = 13$)	UK	1. *Counselling of refugees* 2. *Limitation of resources* 3. *The use of interpreters* 4. *Culture* 5. *Practical and psychological needs* 6. *Emotional impact*
9	Cowles & Griggs, 2019	To explore how boundaries within therapeutic work with asylum seekers (i.e., clear boundaries, boundary crossings, addressing psycho-social issue, reflective-practice and supervision).	Autoethnographic (Clinical Case Study)	Clinical Psychologist (Autoethnographic Clinical Case Study ($N = 1$)	UK	No discrete themes. Results highlighted the importance of considering boundaries with refugee and asylum seeker clients. Recommends the need for clinicians to consider: Socio-political factors, sensitivity to cultural differences, supervision, reflective practice, personal impacts, critical thinking, warmth and flexibility as opposed to rigidity.
10	Duden & Martins-Borges, 2020	To explore the experiences of psychotherapists working with refugees (i.e., solutions, difficulties and valuable resources).	Consensual Qualitative Research & Thematic Analysis	18 licensed psychotherapists ($N = 18$)	Brazil	1. *Meeting contextual challenges through collective and flexible work* (support structures for therapists; networks & group therapy; structural competence; working outside the PT realm; adaptation & flexibility; feeling overwhelmed; power & helplessness; Overinvolvement; trap of assistencialism) 2. *Dealing with cultural and language differences* (cultural decentring & humility; education in cultural psychology; interpreters; non-verbal methods; having to adapt approach; ethnocentrism; feeling untrained; missing interpreters; risk of cultural camouflage) 3. *Building a trustful therapeutic relationship* (speaking patient's language; desire to attend; truly listening and being present; trust; overidentification; bonding takes longer; patients experiencing xenophobia; unfamiliarity with PT & mistrust)

TABLE 1 (Continued)

Study #	Author(s)	Primary aim	Study design	Participants	Setting	Themes
11	Duden & Martins-Borges, 2021b	To investigate the perspectives of psychologists working with refugees (i.e., working process; negative and positive aspects; necessary changes).	Thematic Analysis	14 psychologists ($N = 14$)	Brazil	1. *Experiencing the psychological care* (beyond psychology; new field in Brazil; personal closeness) 2. *Positive aspects* (resilience & transformation; new perspectives; making a difference) 3. *Facilitators* (flexibility & openness; warmth & authenticity; support structures; safe space & groups; transparency & emancipation; frustration tolerance) 4. *Negative aspects* (emergency situation; xenophobia; lack of mental healthcare; missing competencies and experiences; fatigue) 5. *Necessary changes* (state structures; Conscientization of the population; more social perspective in MHC)
12	Khalsa, 2021 *Dissertation*	To examine the experiences of mental health service providers in counselling and culturally adapting treatments for refugee clients.	Interpretative Phenomenological Analysis	11 mental health service providers (licensed counsellors, psychologists, family therapists, licensed clinical social worker) ($N = 11$)	USA	1. *Clinician cultural identities* (clinicians with refugee backgrounds; immigrant backgrounds; Caucasian American backgrounds) 2. *Academic training* (culture of academia; cultural limitations in academic training; areas of support in academic experiences; areas of personal growth) 3. *Experiential learning* (feelings of low counselling self-efficacy; re-examination of professional boundaries) 4. *Vicarious trauma* (symptoms of second-hand trauma; experiences of stress, exhaustion and professional overwhelm) 5. *Interpreter dynamics* (role of the interpreter; effect of interpreters on adaptation process) 6. *Client strengths* 7. *Supervision and consultation support* (Supervisors' understanding and knowledge of unique experiences of working with refugee clients; validation of challenges from colleagues) 8. *Cultural adaptations of counselling approaches* (changes in therapeutic conceptualization; changes in professional counselling identity)

(Continues)

TABLE 1 (Continued)

Study #	Author(s)	Primary aim	Study design	Participants	Setting	Themes
						9. *Increased counselling self-efficacy/more secure professional identity* (Recognising failure as a learning process; increased therapeutic flexibility; confidence in therapeutic abilities)
13	Kuo & Arcuri, 2014	To describe the training objectives, content, and structure of a multicultural therapy practicum for trainee clinical psychologists and provide an autoethnographic case study of an Afghan refugee client (i.e., highlight the strengths, merits, and impacts on training).	Mixed Methods: Quantitative & Qualitative (Thematic Analysis & Autoethnographic Qualitative Case Illustration)	9 clinical psychology trainees (TA) & 1 trainee clinical psychologist (autoethnographic) ($N = 10$)	Canada	1. *Active process of attuning to the differences in multicultural refugee clients and clients who do not identify as racial and ethnic minorities* (refugee clients' expectation of and expression therapy; refugee clients' understanding of therapy and its process; added importance of incorporating a cultural framework in working with refugee clients; specific skills needed to work with refugee clients) 2. *Awareness of refugee clients' cultures compared to own personal culture* (cultural divergence between refugee clients' country of origin and their own Canadian perspective; Clients' experience of working with white, Canadian therapists; relevance of acculturation and acculturative stress in conceptualising clients' issues; commonalities shared between refugee clients and therapists)
14	Kuo et al., 2020	To examine the development of multicultural competence and skills amongst trainee clinical psychologists, through providing counselling and therapy to refugees within a multicultural psychotherapy practicum.	Mixed methods: Quantitative & Qualitative (critical Incident Journal & Multi-level Model Analysis)	14 trainee clinical psychologists ($N = 14$)	Canada	No discrete themes. Results highlighted profound cognitive, affective, behavioural and interpersonal learning in terms of multicultural competence. These included: Reflexivity, cultural humility and cultural empathy, verbal and non-verbal barriers, adapting therapy conceptualisations, using strengths-focused approaches, therapist self-disclosure and critical evaluation of Western-based therapeutic assumptions.
15	Laota, 2019 *Dissertation*	To explore the learning and preparation experiences of mental health professionals who have worked with refugee clients (i.e., understand the educational/ learning experiences and developing preparedness).	Interpretative Phenomenological Analysis	7 Mental Health Professionals with Therapist qualifications: Licensed Professional Counsellor or Associate (4), Licensed Psychologist (1), Licensed Marriage & Family Therapist (1), and Licensed Clinical Social Work Associate (1). ($N = 7$)	USA	1. *Personal identity, values & worldview* 2. *Language barriers and use of interpreters* 3. *Ethics and boundaries* 4. *Barriers, access and systems* 5. *Knowledge* (cultural diversity, norms migration; political influence; family dynamics; modality; research and evidence-based practice)

TABLE 1 (Continued)

Study #	Author(s)	Primary aim	Study design	Participants	Setting	Themes
						6. *Working with trauma* 7. *Role of a counsellor* (counsellor as educator; counsellor as advocate) 8. *Developing confidence* 9. *Learning strategies* (graduate learning; self-directed learning; mentoring and supervision; professional development; immersion experiences; recommendations)
16	Munday, 2010 *Dissertation*	To explore clinical psychologists' experiences of working psychologically with refugees.	Interpretative Phenomenological Analysis	5 clinical psychologists ($N = 5$)	UK	1. *Ripple effect* (traumatic reaction; Therapist's dilemma; support; inspiring and moving) 2. *Amazement at refugee's strength and resilience* 3. *Fighting and advocating* 4. *Changing view of the world* (frustrations at the context of delivery; working with difference; broken mirror)
17	Mirdal et al., 2012	To examine how traumatised refugees, their therapists, and their interpreters perceive protective and hindering factors in psychological therapy, and to identify the mediators of change in a transcultural clinical setting.	Qualitative Phenomenological	4 senior psychologists, 16 refugees & 8 professional interpreters ($N = 4$)	Denmark	1. *Curative factors* (relationship between therapist, patient and interpreter; ordering chaos and finding meaning; Psychoeducative interventions and counselling; events external to therapeutic process and living conditions; transdisciplinary interventions and coordination) 2. *Hindering factors* (severe comorbidity and patient motivation; diverging goals and over/under-involvement of therapist and interpreter; factors external to therapy)
18	Partavian & Kyriakopoulos, 2021	To explore the impact of the UK asylum legislative framework upon the psychotherapeutic process and relationship.	Reflexive Thematic Analysis	9 psychotherapists and counsellors who worked with traumatised asylum seekers ($N = 9$)	UK	1. *Moving away from the traditional therapeutic frame* (negotiating therapeutic boundaries and frame; ethical dilemmas about professional role) 2. *Adjustments to the therapeutic process* (need for longer assessment periods; challenges with maintaining therapeutic goals; barriers for engaging in trauma processing work) 3. *Impact on the dynamics of the therapeutic relationship* (transference of power; sharing a sense of powerlessness; disclosing own thoughts and feelings about the system)

(Continues)

TABLE 1 (Continued)

Study #	Author(s)	Primary aim	Study design	Participants	Setting	Themes
19	Puvimanasinghe et al., 2019	To explore the experiences of healthcare, mental health and resettlement workers supporting refugees and asylum-seekers (i.e., reflect on experiences and identify individual, group and community intervention methods).	Inductive Thematic Analysis	28 service providers withinmental health, healthcare and resettlementservices, working with people from refugeeand asylum-seeker backgrounds. Participants included: doctors, nurses, psychologists, counsellors, agency managers, service coordinators, or case workers. **Note*: counsellors and mental health workers excluded as they included nurses & social work). ($N = 28$)	Australia	1. *Establishing safety, trust and connection* (advocating and addressing settlement problems; health assessment; skills development and information; asylum seekers context) 2. *Talking about trauma* (individual and group differences; stigma of mental illness; unfamiliarity with the counselling concept) 3. *Alternatives to 'talk therapies'* (group therapy, body work, individual therapy) 4. *Promoting resilience and growth* (using a strengths-based approach)
20	Schweitzer et al., 2015	To explore the experiences, conceptions, and guiding therapeutic practices for therapists who support refugee clients (i.e., develop understanding within a naturalistic setting).	Thematic Analysis	4 psychologists, 5 counsellors & 3 social workers (10 women, 2 men) with experience working therapeutically with clients from a refugee background. ($N = 12$)	Australia	1. *Principles of therapeutic practice* (emphasis on meaning-making; the role and characteristics of the effective therapist; the use of an integrative approach) 2. *Therapy as a relational experience* 3. *The role of context in informing therapeutic practice work with refugee clients* (resettlement context; Australian socio-political context of resettlement; Organisational context) 4. *Impact of the work on therapists* (impact of the work; self-care; role of supervision)
21	Winterson, 2019 *Dissertation*	To explore how specialist therapists understand and describe the therapeutic process in their work with traumatised survivors of torture.	Thematic Analysis	7 psychological therapists ($N = 7$)	UK	1. *Therapy versus therapeutic: Addressing complex needs* 2. *The role of the therapist: Reparenting and bearing witness* 3. *'Trauma' and the meaning of recovery* 4. *When is it safe and necessary to end?*

TABLE 2 CASP overview of included studies; numbers of studies that met each criterion for each question.

	Yes	Cannot tell	No
1. Was there a clear statement of the aims of the research?	21	0	0
2. Is a qualitative methodology appropriate?	21	0	0
3. Was the research design appropriate to address the aims of the research?	18	3	0
4. Was the recruitment strategy appropriate to the aims of the research?	16	2	3
5. Was the data collected in a way that addressed the research issue?	17	4	0
6. Has the relationship between researcher and participants been adequately considered?	11	8	2
7. Have ethical issues been taken into consideration?	14	5	2
8. Was the data analysis sufficiently rigorous?	14	4	3
9. Is there a clear statement of findings?	18	2	1
10. How valuable is the research?	20	1	0

TABLE 3 CASP categories of included studies; overview of studies within each category.

High quality	Moderate quality	Low quality
9	9	3

psychologist and integrative psychotherapist with an interest in trauma. SC is an academic psychologist and clinician, with an interest in refugees, displaced communities, culture and service provision. DGF is an academic professor and clinical psychologist with an interest in neuropsychology and trauma. Reflective journalling and supervisory team discussions helped identify potential biases. Included studies were reviewed to ensure the intending meanings were derived. Discussions explored ND's values and interests in human rights and social approaches to psychological issues and humanistic, psychodynamic therapeutic approaches. As an active researcher role is encouraged and expected in thematic analysis, ND engaged with this process and fostered her interests, while remaining aware of biases (Clarke & Braun, 2021). ND completed a bracketing exercise prior to the analysis, in which the expected outcomes were identified. This facilitated awareness of confirmatory biases and was not trying to 'fit' the results into a pre-identified framework. The anticipated themes included relational boundaries, boundaries of what therapy can offer and personal boundaries. Team discussions elicited themes of perfectionism, self-doubt and the iterative process of theme generation. Through reflective practice, this was acknowledged as being part of the thematic analysis process, which stipulates that uncertainty is integral to this approach.

3 | RESULTS

3.1 | Thematic synthesis

Three major themes were developed (Figure 2):

1. 'Changes to Therapeutic Practice & Therapeutic Intervention'. Four sub-themes coalesced under this theme: 'Interpersonal and

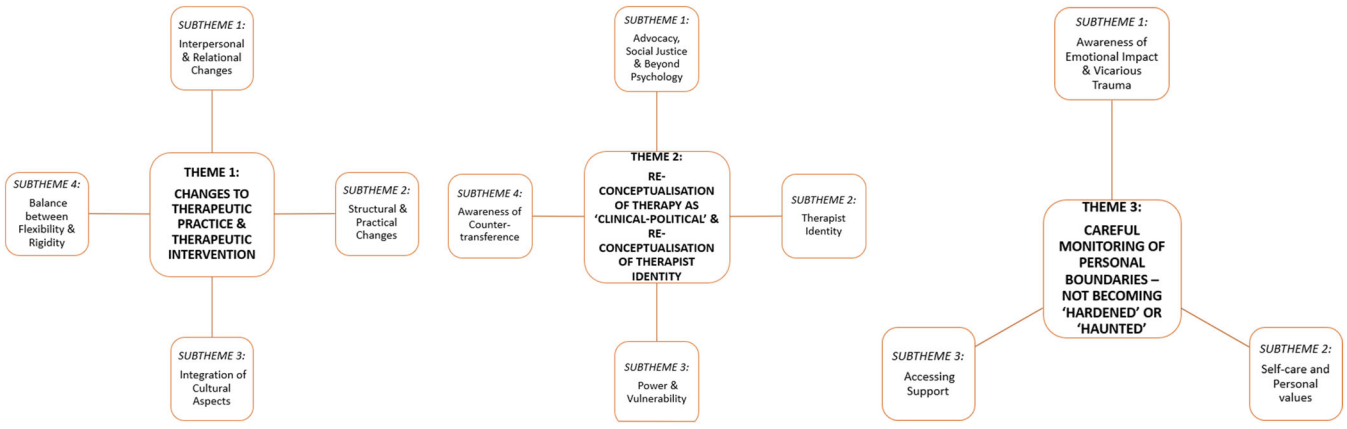

FIGURE 2 Depiction of main themes and sub-themes developed.

relational changes', 'Structural and practical changes', 'Integration of cultural aspects' and 'Balance between flexibility and rigidity'.
2. 'Re-conceptualization of Therapy as "Clinical-Political" & Re-conceptualization of Therapist Identity'. Four sub-themes coalesced under this theme: 'Advocacy, Social Justice & Beyond Psychology', 'Therapist Identity', 'Power & Vulnerability' and 'Awareness of Countertransference'.
3. 'Careful Monitoring of Personal Boundaries—Not becoming "Hardened" or "Haunted"'. Three sub-themes coalesced under this theme: 'Awareness of emotional impact and vicarious trauma', 'Self-care and personal values' and 'Accessing support'.

3.1.1 | Theme 1: Changes to Therapeutic Practice & Therapeutic Intervention

This theme captures the changes made by therapists to therapeutic practice and therapeutic interventions, including the benefits, challenges and balance between flexible and rigid boundaries.

Sub-theme 1: Interpersonal and Relational Changes

> I felt comfortable sharing with her – things I would not have shared with a Western client… it was a necessary part of the 'give and take' dynamic that had developed in our relationship. To have been vague or avoided the questions would have been rude and equivalent to rejection of the relationship. (Kuo et al., 2020)

This sub-theme was evident in 19 papers (Table 4). To connect with clients, therapists identified changes to 'typical' therapeutic practice. One therapist highlighted, 'I was willing to be more permissive with some of my boundaries as we navigated our relationship', which involved demonstrating more openness and transparency when not understanding something (Atiyeh & Gray, 2022). Therapists highlighted using self-disclosure to build connection: responding to direct questions, sharing personal opinions, providing information on therapists' beliefs; 'in my room I have pictures of my family… this is who I am, now tell me who you are' (Schweitzer et al., 2015). Therapists highlighted that changing their communication styles was necessary: using non-verbal methods, increased awareness of body language and eye contact, directly giving advice or, conversely, communicating in informal, conversational ways; 'It is important to not be dismissive of an individual's attempts to forge … connection with you. If that means disclosing a bit about yourself … If that means taking an extra 10 minutes at the start of the session for social "chit chat" to respect a client's idea of social etiquette, so be it' (Kuo et al., 2020). Reflections were made on gift-giving-and-receiving, and ethical dilemmas were experienced by therapists (e.g. receiving and giving small gifts and giving food). The importance of being attuned to intuition and reflecting on the meaning of gift-giving-and-receiving was highlighted, 'The therapist felt very uncomfortable receiving a gift from Mirella, especially in light of her financial situation. It felt important not to refuse the gift or to explore whether it was appropriate, but rather to gratefully accept the gift whilst making it clear that this was not expected' (Cowles & Griggs, 2019). Sharing emotional experiences with clients was a noticeable change to practice, while considering how appropriate and unavoidable it could be; 'if I cry, the client will also feel responsible. But acknowledging the tears, the pain, the loss, it's very important … without showing your understanding and empathy, the client will be alienated' (Winterson, 2019). Some therapists acknowledged boundary crossings, such as appropriate physical touch, contact with clients outside of therapeutic settings and attending community events, which were conceptualised as being fundamental for the therapeutic rapport. Therapists highlighted the importance of open communication to manage mismatched expectations of the therapeutic process and navigate boundaries.

Sub-theme 2: Structural and Practical Changes

> To go, 'ok … that illiterate … Burundian woman who's got seven children, well, she is not going to have time to do four records let us be real' … So, adapting mainstream therapy to suit this population is important. (Apostolidou & Schweitzer, 2017)

This sub-theme was identified in all 21 papers (Table 4). The importance of theoretical decentring, adjusting manualised treatments and being open-minded regarding the content/process of therapy was highlighted. This was primarily due to the unpredictable, contextual difficulties faced by clients, including basic unmet human needs, uncertainty and turbulent socio-political climates. Specifically, the structural and practical changes manifested as adapting interventions and adjusting the therapeutic focus depending on the clients' needs; '[A psychologist] has to be a flexible person … open/willing to change and perhaps rethink some structures. I don't think the attitude of "it has to be that way, he needs to fit into that specific frame" works' (Duden et al., 2020). Creative approaches were also highlighted: translating resources into native languages and using non-verbal methods (e.g. sand-play and art therapy). Therapists described extending recommended treatment periods and/or time limits of sessions, implementing home visits, offering telephone appointments and providing free therapeutic services. Addressing unconventional client needs was a salient and polarising concept: therapists writing letters/reports to support clients with basic needs (e.g. housing, welfare and court), as well as addressing practical, tangible maintaining factors identified through formulations (e.g. sourcing a pram for a mother). Working with interpreters was acknowledged as a significant change, which involved managing another interpersonal dynamic, extending session preparation and clearly defining each role. Therapists also highlighted the importance of working within an interdisciplinary team, which was experienced as both protective and hindering, and inter-agency working, to provide holistic care. Many therapists highlighted the need to challenge Western psychotherapy and the risk of over-pathologizing clients' difficulties with potentially reductionist labels and diagnoses; 'The idea of psychotherapy in this Western way can be pretty alien to some of them …' (Asfaw et al., 2020).

TABLE 4 Matrix of themes for included studies.

	Akinsulure-Smith, 2012	Al-Roubaiy, 2014	Anastasiou et al., 2022	Apostolidou, 2016	Apostolidou & Schweitzer, 2017	Asfaw et al., 2020	Atiyeh & Gray, 2022	Century et al., 2007	Cowles & Griggs, 2019	Duden et al., 2020
1. Changes to Therapeutic Practice & Therapeutic Intervention										
1.1 Interpersonal & Relational Changes	√	√		√	√	√	√	√	√	√
1.2 Structural & Practical Changes	√	√	√	√	√	√	√	√	√	√
1.3 Integration of Cultural Aspects		√			√	√	√	√	√	√
1.4 Balance between Flexibility and Rigidity		√		√	√		√	√	√	√
2. Re-conceptualization of Therapy as 'Clinical Political' & Re-conceptualization of Therapist Identity										
2.1 Advocacy, Social Justice & 'Beyond Psychology'	√	√	√	√			√	√	√	√
2.2 Therapist Identity	√		√	√	√	√		√	√	√
2.3 Power & Vulnerability	√		√	√	√	√	√	√		√
2.4 Awareness of Countertransference		√			√		√	√	√	√
3. Careful Monitoring of Personal Boundaries—Not becoming 'Hardened' or 'Haunted'										
3.1 Awareness of Emotional Impact & Vicarious Trauma		√		√	√		√	√		√
3.2 Self-Care and Personal Values				√	√					√
3.3 Accessing Support				√	√		√	√		√

TABLE 4 (Continued)

	Duden & Martins-Borges, 2021b	Khalsa, 2021	Kuo & Arcuri, 2014	Kuo et al., 2020	Laota, 2019	Mirdal et al., 2012	Munday, 2010	Partavian & Kyriakopoulos, 2021	Puvimanasinghe et al., 2019	Schweitzer et al., 2015	Winterson, 2019
1. Changes to Therapeutic Practice & Therapeutic Intervention											
1.1 Interpersonal & Relational Changes	√	√	√	√	√	√	√	√		√	√
1.2 Structural & Practical Changes	√	√	√	√	√	√	√	√	√	√	√
1.3 Integration of Cultural Aspects	√	√	√	√	√	√	√	√	√	√	√
1.4 Balance between Flexibility and Rigidity	√	√			√	√		√		√	√
2. Re-conceptualization of Therapy as 'Clinical Political' & Re-conceptualization of Therapist Identity											
2.1 Advocacy, Social Justice & 'Beyond Psychology'	√	√			√	√	√	√	√	√	√
2.2 Therapist Identity	√	√	√	√	√		√	√	√	√	√
2.3 Power & Vulnerability		√	√			√	√	√		√	√
2.4 Awareness of Countertransference		√			√	√	√	√		√	√
3. Careful Monitoring of Personal Boundaries—Not becoming 'Hardened' or 'Haunted'											
3.1 Awareness of Emotional Impact & Vicarious Trauma	√	√			√		√			√	√
3.2 Self-Care and Personal Values	√	√			√		√			√	
3.3 Accessing Support		√	√	√	√	√				√	√

Sub-theme 3: Integration of Cultural Aspects

This sub-theme was evident in 18 papers (Table 4). Adjusting the therapeutic focus to embrace clients' unconventional beliefs was widely acknowledged. This integration manifested as accepting clients' understandings of healing within their own context, helping clients to identify rituals/practices, distinguishing seemingly psychotic features from culturally-specific beliefs (e.g. spirits and voices), integrating cultural beliefs with clinical formulations and embracing client values (e.g. religious beliefs). Therapists acknowledged that accepting unconventional perspectives promotes client agency, a core feature of any therapeutic process; 'If someone is firmly grounded in a belief system, in my experience it does not make any sense to say, It is not magic, let me explain to you what it probably is!' (Asfaw et al., 2020). Some therapists highlighted experiencing difficulties working therapeutically with such divergent therapist-client belief systems; 'They might have a very different model … "someone used magic against me, and that is why I have this symptom"… Very difficult to work with' (Asfaw et al., 2020). Being open-minded was highlighted as a challenge for some therapists, particularly when considering 'cultural camouflage'; 'Another aspect of this externalisation and not taking personal responsibility for the situation is the belief in black magic, these traditional beliefs in external supernatural forces somehow being responsible for the client's difficulties, this I … struggle with accepting or relating to' (Al-Roubaiy, 2014). Many therapists described a significantly low-quality cross-cultural psychotherapy training and lack of preparedness for working therapeutically with refugees. For some therapists, consciously making cultural adaptations and subsequently feeling competent in their therapeutic practice stemmed from this gap in training.

Challenging cultural assumptions was highlighted as being a necessary change. This entailed awareness of ethnocentrism, awareness of cultural norms and therapist biases (e.g. viewing clients through a 'traumatised refugee' lens). Finally, demonstrating cultural humility, transparency and authenticity were acknowledged as desirable characteristics. This manifested as collaborative learning and putting clients within 'expert' roles, addressing stigma and showing curiosity. Some therapists changed the way they described their role to clients and explained it within familial terms; 'In many societies, therapy, counselling, is not known, so … I compare it to an auntie, a best friend … to confide about issues' (Winterson, 2019). Therapists also described the importance of providing psychoeducation on trauma, loss and acculturation which is fundamentally grounded in the context of historical knowledge and community dialogue.

Sub-theme 4: Balance between Flexibility and Rigidity

> [How to] be ethical and keep the boundary at the same time, but flexible. I think that that's the big challenges for those who are working for this population. (Khalsa, 2021)

This sub-theme was identified in 14 papers (Table 4). There was a consistent balancing of flexible and rigid boundaries. Many therapists expressed that due to cultural differences and external unpredictability, the rigid boundaries within a traditional psychodynamic framework could not exist, at risk of disrupting the therapeutic relationship. When therapists were aware and reflective with boundary crossings, such as expressing personal opinions, expressing emotional reactions and gift-giving/receiving, they were considered the most restorative factor in treatment and facilitating rapport. Simultaneously, therapists highlighted professional responsibility to maintain boundaries, such as professional distance, to prevent over-identification and over-involvement with clients. Some therapists acknowledged the importance of having rigid boundaries for clients to feel contained. Risks associated with being overly flexible included unnecessarily extending treatment periods, making fewer demands on clients and inadvertently creating a dynamic whereby the client may feel concern for the therapist; 'I wonder if [I had created a situation where] the patient was protecting me in hiding the most sordid details of his torture' (Mirdal et al., 2012). It is also worth noting that the discourse of therapeutic boundaries does not need to be polarised; 'A person-centred, warm and collaborative therapeutic relationship can be invaluable … although of course having firm boundaries does not necessitate that these are lacking' (Cowles & Griggs, 2019).

Continual monitoring and reflexivity of boundary considerations was highlighted as being important; 'I feel much more … confident to use this approach. At the same time, I still continue to pressure myself: where's the boundary? And where is it ethical?' (Khalsa, 2021). Openly discussing boundaries with clients and supervisors was experienced as protective. One therapist reflected on her inner-dialogue when greeting a client outside the therapeutic setting. '[I realized] that can actually be way more disrespectful not to say hi to a family that you work with so deeply… just, getting rid of some of those power dynamics … this is a different type of work that maybe you were trained to do. Maybe not totally out of the box, but you really need to think about what's best for your relationship with the clients' (Laota, 2019). Some therapists expressed feeling shame and experienced difficulties disclosing and processing boundary crossings. One therapist reflected upon their reluctance to broach the subject in supervision as being a sign that it needed exploring (Cowles & Griggs, 2019). Despite uncertainty navigating flexible boundaries, many therapists felt it was necessary to work cross-culturally.

3.1.2 | Theme 2: Re-conceptualization of Therapy as 'Clinical-Political' & Re-conceptualization of Therapist Identity

This theme captures the re-conceptualisation of the therapeutic process and therapist identity and explores advocacy, social justice and issues of power, vulnerability and counter-transference.

Sub-theme 1: Advocacy, Social Justice & 'Beyond Psychology'

> Many psychologists [believe] 'in therapy we treat emotions, affections, feelings. Everything that is outside – housing conditions, education or social

> oppression – is not clinical. All that is for politics.' We believe in the contrary: that a clinic has to be attentive to political questions to be effective. The cure does not only pass through feelings or emotions. It passes through the social conditions which form the structure for the person to build upon. (Duden et al., 2020)

This sub-theme was identified in 17 studies (Table 4). Re-conceptualising therapy involved challenging therapists' views of therapy and going 'beyond tradition', in terms of advocacy and addressing basic needs. This involved asylum applications, housing, strengthening social support networks, signposting elsewhere, providing direct advice, obtaining school placements/employment and sourcing tangible and practical resources. Some therapists understood these as therapeutic in themselves by embodying a truly person-centred approach, and others considered them part of the stabilisation stage for 'deeper' therapy. Many therapists viewed engaging in advocacy as part of their role, particularly as clients identified practical issues as their primary concerns. Generally, advocacy manifested as personal interest, research, individual work or work with others. This included addressing the basic needs of clients, as well as providing psychoeducation to stakeholders (e.g. attorneys) on the impact of trauma, engaging in community outreach, liaising with immigration officials, challenging social oppression and prejudice, community immersion activities and culturally responsive participatory action research; 'Working with this population goes beyond the walls of a counselling room' (Laota, 2019).

Embodying human rights-based approaches was highly rewarding; as described by one therapist who offered food to a pregnant client, who had not eaten in 24 hours; '[My supervisor] was like, take her to the cafeteria, like … go take a meal ticket from my desk … And that from kind of a professional stand is something you would never do, right? It's like breaking this boundary of something that you wouldn't do in counselling. In that case, like you take care of people first' (Laota, 2019). Others described that providing practical support, such as writing eligibility letters, was necessary, non-typical practice; 'It was certainly stepping outside the boundary, but it felt the right thing to do' (Century et al., 2007). Many therapists described the inner conflict of therapeutic work not 'fitting' pre-conceived schemas of what therapy should be; 'We're doing more things than what the definition of therapy is…' (Khalsa, 2021). Others expressed that they struggled to grasp this re-conceptualisation of therapy as 'clinical-political', particularly in terms of addressing practical issues; 'You may end up making phone calls and the hour is gone and we have done very little—which has probably been very therapeutic for the client, but I haven't done psychological therapy as such' (Winterson, 2019). Therapists highlighted the non-linear process of navigating how to prioritise therapeutic work with clients.

Sub-theme 2: Therapist Identity

This sub-theme was evident in 18 studies (Table 4). Therapists struggled with conceptualising their personal and professional identities, particularly given the multi-faceted needs of clients and the multiple roles they felt compelled to adapt; 'It felt uncomfortable for the therapist to deny this resource, due to questions such as "is this my role?" … it felt more appropriate to respond as a human being to someone in distress' (Munday, 2010). The multiple and competing identities described by therapists included therapist, community outreach, immigration witness, accompanying clients to asylum hearings, advocate, educator, navigating complex socio-legal systems, writing eligibility letters, liaison with GPs and other services (e.g. debt lines, hospitals and refugee support centres) and tackling prejudice. Multidimensional needs sometimes left therapists questioning their abilities; 'Oh my God where do I start, you feel powerless … "how can I help this person who has so many problems in all areas of their lives?"' (Century et al., 2007). Some therapists expressed anxiety regarding their professional identity and not wanting to be associated with a 'harmful system'; 'you feel part of the system … and … this system is seen as making all these awful things so … sometimes with our clients it's kind of trying to … regain some of that trust that they have lost in the system' (Apostolidou & Schweitzer, 2017).

Experienced therapists described becoming more comfortable with the increased and inherent need for flexible, multiple identities. Some therapists re-conceptualised their role as identifying crucial information which can help clients' asylum procedures; 'We are skilled at titrating and containing … we have a responsibility to know what to do with it so that's why it may feed into a mental health report which can tip the balance for people in terms of actually getting their status' (Partavian & Kyriakopoulos, 2021). Others expressed that while therapists should be flexible, formal therapeutic support must take priority; 'we provide a package deal and the priority is the therapy, because practical help can be found somewhere else' (Winterson, 2019). Therapists highlighted the importance of explaining to clients what they can offer; 'We try to explain to them that it is not our role, that we are independent and that we are not deciding [about residence permits]. This is something we have to do very often because the expectations are very different' (Asfaw et al., 2020). This was particularly important for therapists who felt they were overly flexible; 'just tried to do too much for the clients … I wouldn't be able to sustain that for all the clients that I was seeing' (Apostolidou & Schweitzer, 2017).

Sub-theme 3: Power & Vulnerability

> I felt very powerful, which felt very uncomfortable in terms of … what people were experiencing in this country in terms of housing and poverty, not having jobs … their asylum status. (Munday, 2010)

> Asking for help when you are in such a powerless position when there are all sorts of structural and systemic issues around power and oppression … as so many therapists in the field are white of course … there's that power dynamic. (Partavian & Kyriakopoulos, 2021)

This sub-theme was identified in 15 studies (Table 4). Many therapists expressed that therapeutic work with refugees and asylum seekers is different to 'other' client groups, largely due to the complex

interplay between power and vulnerability. The need for advocacy was seen by therapists as more of an intense experience when working with this client group. Power and vulnerability were contextualised, both in terms of clients not having power and the therapist–client power imbalance and, paradoxically, how powerless therapists feel. Risks of re-traumatization were considered by many therapists, particularly when clients must recount their narrative for resettlement purposes. Some therapists expressed fears of doing harm and reinforcing clients' powerlessness. Therapists also expressed concerns in terms of being perceived by clients as deskilled and powerless, as well as feeling powerless against legal systems; 'They will ask for everything. Everything is always denied … For us, it's not easy too, because you have to deal with the powerlessness. You say: "I can't offer everything." So, I have to reduce expectations, de-idealise …' (Duden et al., 2020). Therapists described their role in familial terms to address cultural unfamiliarity and power-vulnerability dynamics. Therapists raised awareness of how racism, prejudice and discrimination within multidisciplinary teams and systemic, cultural structures perpetuate power–vulnerability dynamics. Finally, working with interpreters sometimes exacerbated this dynamic, by clients having their power taken away from them and, paradoxically, therapists feeling powerless; 'The interpreter and the client will talk for some time and then the interpreter will say "yes" or "no"; and you think "what on earth has gone on?"' (Century et al., 2007).

Sub-theme 4: Awareness of Countertransference

> You have got to have a strong sense of self … a capacity to feel and be able to tolerate strong experiences … to have a capacity to do that while differentiating yourself from the other. (Schweitzer et al., 2015)

This sub-theme was identified in 13 studies (Table 4). Countertransference is a therapeutic process, whereby therapists react to a client's projection; 'I was furious through most of the sessions and having to contain a rage at the system she's stuck within' (Duden et al., 2020). Therapists also described experiencing client's transferences, in terms of feeling powerless. This manifested as therapists feeling de-skilled; 'You question yourself, do I do any difference for this person? Is it valuable to them what I'm doing?' (Partavian & Kyriakopoulos, 2021). Therapists noticed urges to do something practical (e.g. writing court letters) to feel helpful. Therapists recognised the importance of having a strong sense of self, distinguishing their own reactions and emotional regulation; 'I am challenged not to let me get carried away by my emotions … not let my personal side enter too much' (Duden et al., 2020). Therapists highlighted being at risk of becoming over-involved or over-identifying with clients; 'I found their level of need … personally overwhelming– if I don't help them with this, how are they going to [get help]' (Schweitzer et al., 2015). The risk of not recognising countertransference can lead therapists feeling unappreciated, resentful and disillusioned with a client's progress, which is detrimental to clients' well-being. Therapists recommended a balance between showing genuine interest and curiosity, while being aware of these processes. Distinguishing between countertransference (i.e. self-centred-reaction) and commitment (i.e. focus-on-the-other) was recommended; being able to reflect upon these reactions with clients and within supervision can address these issues and empower both parties.

3.1.3 | Theme 3: Careful Monitoring of Personal Boundaries—Not becoming 'Hardened' or 'Haunted'

This theme captures the importance of therapists monitoring personal boundaries and developing awareness of the emotional impact and vicarious trauma risks, as well as the necessity of prioritising self-care and being supported within this work.

Sub-theme 1: Awareness of Emotional Impact and Vicarious Trauma

> Having to observe certain rapes and … assaults … one can sense the suffering … And I try my best not to collapse myself upon hearing their stories … trying to sit still in my chair and allow for this space, to allow for them to express these difficult experiences. (Al-Roubaiy, 2014)

This sub-theme was identified within 12 studies (Table 4). There was a sense of unexpectedly finding it difficult to tolerate traumatic stories; 'Sometimes it's really profound, the torture details … this goes beyond anything I could imagine' (Century et al., 2007). This is further compounded by clients' multi-faceted needs and lack of support structures, which was contextualised as causing therapists to question their abilities and experience burn-out. Vicarious trauma reactions included having nightmares, feeling hopelessness/helplessness, becoming triggered/overwhelmed outside of sessions, frustration, fatigue, overwhelm and self-doubt. One therapist described experiencing vicarious trauma as inevitable when supporting refugees; 'it's almost like a midlife crisis, it's a transformative process and it isn't comfortable for people, I like the term, "alterations of self"' (Schweitzer et al., 2015). Some therapists reflected that war-related trauma and organised violence has a 'ripple effect', such that it infiltrates the minds of clients and therapists; 'You see the darker side of human nature and there is evil in ordinary human beings' (Century et al., 2007). Thus, some therapists expressed finding it hard to seek support from peers, fearing the 'ripple effect'. Some therapists coped with the emotional distress by dissociation; 'I could only take so much and I realised … I have cut off from my feelings … that quite often leads to guilty feelings and that what was something I had to work with' (Apostolidou, 2016). Acknowledging vicarious trauma reactions and processing these experiences with supervisors/peers helped therapists from becoming 'hardened' or 'haunted'. Others acknowledged that the meaning derived from this work negated the emotional impact; 'It has changed me in ways that are pretty profound. It's made me more inclusive … better understand human struggle, discrimination … it's made me very spiritual without having to have one religion … It's really helped me

sort of open my eyes … we are all so much the same, we all want to be loved … to feel validated … cared for' (Laota, 2019).

Sub-theme 2: Self-care and Personal Values

> It's a journey and I'm not going to get there right away. Offering myself forgiveness around those early mistakes and lack of knowledge. (Laota, 2019)

> … You have to like it, you have to believe in it, and you have to … dedicate yourself to it because it's often not just a nice job in the doctor's office. (Duden et al., 2020)

This sub-theme was identified within 8 studies (Table 4). Self-care strategies were fundamental to helping therapists protect their personal boundaries and emotional well-being. Many therapists highlighted difficulties with leaving traumatic stories at work; 'That's heavy, that one's coming out the building with me back home and, my last thoughts before I go to sleep' (Munday, 2010). Therapists highlighted the importance of establishing personal boundaries and work-life balance; 'If you don't have your own personal limit … you get into a fatigue … you come home very tired, you can't do anything … you can't establish a life routine. In the worst case, you end up getting lost in it for real' (Duden & Martins-Borges, 2021b). Therapists also highlighted that managing their self-talk, reframing their schemas about failure and readjusting their expectations helped establish personal boundaries; 'How can I take this person one step further? Cause if I'm trying to take them ten steps further it probably doesn't serve them very well, and doesn't serve me very well' (Laota, 2019). Self-talk encompassed recognising the limits of the therapeutic rapport; 'normalising the … experience of … powerlessness … I can do only that bit and I should accept that because I can't … take them in my own home to keep them' (Apostolidou & Schweitzer, 2017). Therapists highlighted needing to have high frustration tolerance and high levels of perseverance; 'It's fundamental, it's crucial, to like people and to have this resistance.' (Duden & Martins-Borges, 2021b). Self-awareness, knowing own limits and practical self-care, in terms of relaxation, exercise, personal therapy, writing and prioritising sufficient personal time, were described by therapists as protective coping mechanisms.

Sub-theme 3: Accessing Support

> [Supervision is] really important because … The boxer cannot box by himself, he needs a team … a doctor/coach ready to motivate him and to tell him keep going, try this … so when he comes for the second round, he is feeling more motivated … and basically ready to face those challenges. (Apostolidou & Schweitzer, 2017)

This sub-theme was identified within 12 studies (Table 4). Supervision was considered a containing space whereby therapists can acknowledge, reflect upon and process their feelings about clients and the therapeutic process. Supervision was considered a protective and normalising space which builds self-awareness, acknowledges therapist biases and prevents therapists from becoming overwhelmed and feeling deskilled. Being supported within supervision was the most prominent factor for therapists staying within this field and not becoming 'hardened' or 'haunted'. Supervision also helped therapists venture into and develop specific therapeutic techniques, such as body-based therapy, creative metaphors and rituals. Some therapists reflected that the implicit understanding and validation provided by supervisors were more valuable than tangible, practical advice; 'being held, understood, emotionally and psychologically by a professional I had a sense of trust in, and who I felt could support me to process my own responses and my clinical thinking' (Schweitzer et al., 2015). Conversely, organisational constraints meant that access to appropriate supervision was limited for some therapists. Difficulties were raised in terms of supervisors having limited experience with supporting refugee clients, or dual manager/supervisor dynamics, which compromised some therapists' abilities to fully engage within supervision. Peer support was also highlighted as being essential to helping therapists navigate personal and professional boundaries. Peer support allowed therapists to develop personally and professionally, expand learning, consider various unfamiliar therapeutic models, restore a sense of meaning and purpose, enhance solidarity and not internalise perceived failures. Peer support was considered essential as therapists highlighted that supporting refugee clients can be an isolating experience which involves stepping outside 'therapeutic norms', particularly when therapists have differing beliefs to team members. One therapist, whose language mirrors the refugee experience, expressed fears regarding not having peer support; '… it is so important for me to be part of something here, just imagine if I had been part of a private practice- what could I do then? It's only me in the wilderness!' (Winterson, 2019).

4 | DISCUSSION

To the best of our knowledge, this is the first paper to systematically review and synthesise evidence specifically regarding therapeutic boundaries with refugee and asylum seeker clients. This review examined what 'flexible boundaries' have looked like, in terms of therapeutic applications. Three themes were developed: 'Changes to therapeutic practice and therapeutic intervention' (Theme 1); 'Re-conceptualisation of therapy as 'clinical-political' and re-conceptualisation of therapist identity' (Theme 2); and 'Careful monitoring of personal boundaries—not becoming "hardened" or "haunted"' (Theme 3). This review confirms previous findings that, for clients who have endured deeply traumatising and dehumanising experiences, expanding conceptual frameworks, challenging 'professionally correct' behaviours and demonstrating compassion and human connection are required (Bala & Kramer, 2010; Mirdal et al., 2012). The present findings align with existing literature which underscores the importance of modifying Western-based systemic family therapy approaches for more practical, extended, multi-faceted and culturally sensitive therapy for marginalised populations, including refugees. Such literature emphasises prioritising trust-building,

addressing client resettlement and acculturation needs, community development, social inclusion and client empowerment (Karageorge et al., 2018). The present review expands upon these findings through exploring practical applications of a 'flexible boundaries' framework and specific considerations of therapists' well-being in doing so. As explored below, navigating therapeutic boundaries is an iterative, intuitive and subjective process (Cowles & Griggs, 2019; Duden et al., 2020).

An important finding of this review highlights that therapeutic practice changes made by therapists manifested as interpersonal and relational changes, structural and practical changes and integrating cultural considerations. For example, self-disclosures and sharing emotional experiences were described as noticeable changes for many therapists. A body of research highlights that the use of appropriate self-disclosures can strengthen therapeutic alliances and normalise clients' experiences; however, it can induce feelings of vulnerability and insecurity, particularly amongst less experienced therapists (Bottrill et al., 2010; Carballeira Carrera et al., 2022; Cleary & Armour, 2022; Gaines, 2003; Lane & Hull, 1990). Structural flexibility manifested as extending treatment periods, timing of sessions and offering appointments outside the clinical setting. Navigating the balance between upholding ethical boundaries whilst equally showing sensitivity to cultural norms can be difficult, particularly when using psychodynamic therapeutic techniques (Khalsa, 2021; Shors et al., 2022; Winterson, 2019). Consistent with previous research, traditional westernised models were largely considered inappropriate and in need of adaptation to address cultural needs (Bhui, 2022; Summerfield, 1999; Woodcock, 1995, 2001). In the absence of supportive frameworks, therapists can experience shame and uncertainty by straying from what is considered 'traditional' therapeutic approaches. This underscores the importance of having space to normalise the reality of what supporting refugee and asylum seeker clients can entail. Although flexibility, creativity, grounding and reflexivity are recommended, lack of resourcing and demands on therapists can impact service provision and opportunities to engage in these important processes.

The findings within this review highlight the importance of re-conceptualising therapy as 'clinical-political' and re-conceptualising the therapist identity. Therapists highlighted obtaining a balance between 'abstinence' 'neutral' and 'advocacy' stances. Many considered a non-neutral stance as vital for clients who require connectedness, solidarity and trust to process traumatic experiences. Others expressed struggling to maintain non-directive neutrality, as they experienced temptation to engage in advocacy and humanitarian aspects (Mirdal et al., 2012; Partavian & Kyriakopoulos, 2021; Schweitzer et al., 2015). The 'clinical-political' concept is debated within the literature. The importance of paying attention to social and structural determinants of mental health in clinical interventions and working towards systemic changes, through clinical advocacy and addressing urgent psychosocial issues, is widely acknowledged (Bäärnhielm & Schouler-Ocak, 2022; Bhui, 2022; Charlés, 2012; Due & Currie, 2022; Kirmayer et al., 2018). Some therapists expressed challenges conceptualising psycho-social supports as therapeutic, and not working on 'deeper' issues, due to chaotic environments; thus, boundary crossings (e.g. making phone-calls on behalf of clients) were deemed necessary due to shortcomings in other services. This left some therapists being dissatisfied with not putting their expertise to use and, ultimately, impacted the level of meaning derived by therapists. Other concerns related to therapists' perceptions of clients not taking responsibility for themselves, which may point towards cross-cultural empathy difficulties (Kirmayer, 2012). Importantly, being overly accommodating has been acknowledged as potentially disempowering and infantilizing clients by creating dependency and not promoting client autonomy (Century et al., 2007; Patel, 2003). The challenges faced could be under-pinned by many concepts, including compassion fatigue (Ondrejková & Halamová, 2022), burnout, helplessness or moral injury (e.g. exposure to traumatic narratives and frustration with ethical issues regarding healthcare systems). Moral injury, which is conflicted moral, self-preservation values, can arise amongst therapists who are navigating high-stakes situations with no positive outcomes (Griffin et al., 2019; Litz et al., 2009; Shay, 2014).

This review acknowledged the importance of awareness of countertransference and therapists' responses (i.e. avoidance or over-identification), power-vulnerability dynamics and therapist identity (Bäärnhielm & Sundvall, 2018; Bhui, 2022; Wilson & Thomas, 2004). Therapist reflexivity is crucial, due to the heightened emotional responses elicited within the context of social injustice and the increased pressure to incorporate therapist flexibility and intuition (Apostolidou & Schweitzer, 2017; Burck & Hughes, 2018; Duden et al., 2020). This aligns with literature, which suggests that becoming a transcultural psychotherapist involves both cultural decentring and professional decentring; the ability to distance oneself from themselves and be able to understand another person's perspectives (Carballeira Carrera et al., 2022; Duden et al., 2020; Sturm et al., 2011). Feelings of therapist helplessness and defensiveness may be heightened within the context of white privilege, systemic racism and possible internalised shame (Bartoli et al., 2015; Liggan & Kay, 1999; Weir, 2021). Therapists acknowledged expressing their anger and disappointment with socio-political and legal systems, as a way of distancing themselves from the system which perpetuates clients' distress. This desire was conceptualised as showing solidarity to clients; however, it is an interesting ethical query, in terms of whose needs are being met through such disclosures. There was a real sense of cognitive dissonance for therapists navigating the process of maintaining professional identity and simultaneously supporting clients in a meaningful way; there was often a mismatch between what clients needed and what could be offered. Lack of protective frameworks for therapists who process intense, traumatic emotional experiences with clients can render therapists feeling powerless and isolated. This also locates and internalises environment-driven problems within therapists themselves, which embodies a parallel process to the refugee experience.

Although vicarious trauma and compassion fatigue are well-established concepts, research on the well-being of therapists who support refugees and asylum seekers is scarce (Drapeau et al., 2022; Puvimanasinghe et al., 2015). To effectively monitor boundaries, it

was deemed important for therapists to be aware of the emotional impact of this therapeutic work (Drapeau et al., 2022; Hyatt, 2020; Posselt et al., 2020; Puvimanasinghe et al., 2015). Professional frameworks can become challenged, the trauma discourse can permeate the therapeutic space and therapists can be left questioning their abilities (Apostolidou, 2016). Given that many therapists have personal interests in human rights and find meaning within this field, prioritising self-care can help maintain a healthy distinction between personal and professional components. This is particularly important due to the recommendation to involve the 'authentic self' when working with refugees and asylum seekers (Apostolidou & Schweitzer, 2017; Duden et al., 2020; Khalsa, 2021; Laota, 2019; Munday, 2010). Although not always available, supervision and peer support helped provide therapists with structures for maintaining personal and professional boundaries, which allowed therapists to critically examine and extend beyond learned ethical boundaries and adapt their own approaches to meet clients' needs (Khalsa, 2021; Laota, 2019). Consistent with attachment-based frameworks, therapists who feel contained and have a 'safe base' to foster exploration and curiosity can better contain clients' distress (Bowlby, 1969, 1988; Cooper et al., 2011). Some therapists expressed finding it hard to seek support from others, at fear of the 'ripple effect' and traumatising peers; this aligns with literature which suggests that therapists can become stuck within 'caregiver' roles (McCluskey, 2010, 2011).

4.1 | Summary

In summary, it seems that the same therapeutic expectations cannot be applied for refugee and asylum seeker clients, who face chronic uncertainty, discontinuity and significant cultural barriers. Within this review, even therapists who felt that therapeutic approaches are consistently applicable across all client groups, expressed feeling heightened empathy for the refugee experience. Clinical advocacy may be the most appropriate and fitting support for clients; however, there are complexities within this concept. It may be that the basic, western therapeutic skills and concepts are applicable and that the issue is navigating this within cultural disparities, external constraints and heightened issues of power and vulnerability. Ultimately, therapists want to 'do no harm' and are doing the best they can for their clients; however, client readiness, vicarious trauma, burn-out, compassion fatigue, westernised concepts, extensive waiting lists and chronically under-resourced services could certainly prevent therapists from being able to (emotionally and physically) have the space to adapt 'typical' clinical practices. This review provides further evidence on therapeutic boundary considerations with refugee and asylum seeker clients, while considering systemic constraints and concepts such as the therapist identity, compassion fatigue, vicarious trauma and moral injury. This review sheds light on the applications of flexible therapeutic boundaries. It is hoped that therapists supporting refugee and asylum seeker clients may benefit from the examples and issues explored within this review.

5 | CONCLUSIONS

What was previously known about this topic:

1. The literature highlights that refugee and asylum seeker clients express needing more flexible boundaries, perhaps not explicitly, in terms of practical support, advocacy and culturally-appropriate, flexible psychological interventions.
2. Flexible therapeutic boundaries have been suggested as being helpful, and even required, for refugee clients. There are some examples of this; however, little research exists, and no review specifically synthesising the evidence exists.
3. Vicarious trauma and the emotional impacts are well-established concepts for therapists supporting clients who have experienced profoundly traumatic experiences.

What this study adds:

1. This review systematically synthesises evidence on how therapists have implemented 'flexible boundaries' with adult refugee and asylum seeker clients, what this has looked like in therapeutic practice and how such adaptations can be conceptualised as interpersonal/relational and structural/practical.
2. This review also highlights the importance of integrating cultural aspects and how therapists' cultural assumptions and biases, including illness attribution beliefs, need to be reflected upon.
3. The present review sheds light on the importance of therapist identity in navigating the use of flexible boundaries and how systemic constraints can impact therapists' internalised experiences.
4. This review reinforces the importance of countertransference and awareness of psychodynamic processes, particularly when supporting a client group which entails heightened distress, helplessness and empathy and which is grounded in human rights-based approaches.
5. Finally, this review reinforces the lack of preparedness and training for therapists navigating boundaries, which can result in feelings of shame or reluctance to disclose boundary dilemmas, and the importance of taking this into account for therapist cultural competence training and continual professional development (CPD).

5.1 | Limitations

A limitation of this review is that qualitative findings may not be generalisable and may be specific to a certain context. This study should be considered as an attempt at generating further evidence within this field. Steps were taken to heighten transparency and allow for repetition of the methods used (Duden et al., 2020; Thomas & Harden, 2008; Tong et al., 2012). Despite research recommendations to focus specifically on either refugee or asylum seeker clients, whose needs differ profoundly, this was not possible due to a lack of such individual empirical studies. Further, the heterogeneity of the studies included, and of the refugee experience, cannot be ignored. Given the variety

of study origins, and the diversity of services within which therapists work, their roles and responsibilities may not be directly comparable, particularly across mainstream and specialist services; this may influence how therapists conceptualise and implement 'flexible' boundaries with refugee and asylum seeker clients. A final point to highlight is that no matter what population is being examined, the consideration of therapeutic boundaries is important. Cultural differences in boundaries may be important for many groups (e.g. socio-economic differences). The complexity of working with human beings and the lack of definitive answers about what is appropriate cannot be ignored; it is largely dependent upon reflective decision-making, critical thinking and individuality. It is hoped that the present thematic synthesis provides space for such considerations.

5.2 | Implications

This evidence may inform the practice of therapists and, ultimately, may improve service delivery for refugees and asylum seekers, by providing further insights into culturally adapted and culturally competent approaches which can be integrated into therapeutic practice. An important implication of this review is that training should be developed and provided for therapists, including trainee therapists, on the importance and implementation of therapeutic boundaries with this population. Such trainings should normalise the experiences of shame and reluctance for therapists navigating boundary crossings, as well as highlighting awareness of systemic constraints and not locating problems within therapists. Supportive and skilled supervisors were widely acknowledged as important for helping therapists to navigate boundary issues. Given that not all therapists had access to appropriate supervision, it is incumbent upon services to source sufficiently skilled supervisors, from specialist services or develop supervisor competence for therapists supporting refugee and asylum seeker clients. Resolving boundary dilemmas is a largely subjective process; therefore, perhaps policies and guidance on boundaries and best practice could be developed to guide therapists within the context of supporting refugee and asylum seeker clients. Further, vicarious trauma, burn-out, compassion fatigue and moral injury processes need to be recognised to monitor therapists' well-being.

5.3 | Future research

Future research would benefit from exploring therapists' cross-cultural training needs and preparedness to support refugees therapeutically, as this review highlighted a disparity between the training therapists received and the actual therapeutic practice. It would be beneficial to explore supervisory experiences of supporting therapists to navigate boundary issues and how supervisors can be trained within this field. Future research exploring boundary considerations should distinguish between refugee and asylum seeker clients, where possible, due to the profoundly differing needs amongst these groups. Future research should also examine promoting the well-being of therapists who support this population, particularly in relation to therapists' reluctance to share traumatic stories with peers, at fear of the 'ripple effect'.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

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ETHICS APPROVAL STATEMENT

Ethical approval was not required as all data were retrieved from previously published studies.

PATIENT CONSENT STATEMENT

Consent was not required as data were retrieved from previously published studies.

REFERENCES

Akinsulure-Smith, A. M. (2012). Responding to the trauma of sexual violence in asylum seekers: A clinical case study. *Clinical Case Studies*, *11*(4), 285–298. https://doi.org/10.1177/1534650112454939

Al-Roubaiy, N. S. (2014). *Post-migration stress among adult male Iraqi refugees and its implications for counselling and psychotherapy: A qualitative study*. Doctoral dissertation.

Anastasiou, E., Liebling, H., Webster, M., & MacCallum, F. (2022). The experiences and views of service providers on the mental health and well-being services for Syrian refugees in Coventry and Warwickshire. *European Journal of Psychology Open*. https://doi.org/10.1024/2673-8627/a000017

Apostolidou, Z. (2016). Constructions of emotional impact, risk and meaning among practitioners working with asylum seekers and refugees. *Counselling and Psychotherapy Research*, *16*(4), 277–287. https://doi.org/10.1002/capr.12087

Apostolidou, Z., & Schweitzer, R. (2017). Practitioners' perspectives on the use of clinical supervision in their therapeutic engagement with asylum seekers and refugee clients. *British Journal of Guidance and Counselling*, *45*(1), 72–82. https://doi.org/10.1080/03069885.2015.1125852

Asfaw, B. B., Beiersmann, C., Keck, V., Nikendei, C., Benson-Martin, J., Schütt, I., & Lohmann, J. (2020). Experiences of psychotherapists working with refugees in Germany: A qualitative study. *BMC Psychiatry*, *20*(1), 1–8. https://doi.org/10.1186/s12888-020-02996-0

Atiyeh, S., & Gray, G. (2022). Counsellors' competency to counsel refugees: A constructivist grounded theory study. *Counselling and Psychotherapy Research*, *22*(1), 32–42. https://doi.org/10.1002/capr.12477

Bäärnhielm, S., & Schouler-Ocak, M. (2022). Training in cultural psychiatry: Translating research into improvements in mental health care for migrants. *Transcultural Psychiatry*, *59*(2), 111–115. https://doi.org/10.1177/13634615221089384

Bäärnhielm, S., & Sundvall, M. (2018). Clinical challenges in cultural psychiatry–searching for meaning, searching for methods. *Nordic Journal of Psychiatry*, *72*(Suppl 1), S9–S12. https://doi.org/10.1080/08039488.2018.1525648

Bala, J., & Kramer, S. (2010). Intercultural dimensions in the treatment of traumatized refugee families. *Traumatology*, *16*(4), 153–159. https://doi.org/10.1177/1534765610369262

Barber, J. P., & Solomonov, N. (2019). Toward a personalized approach to psychotherapy outcome and the study of therapeutic change. *World Psychiatry*, *18*(3), 291. https://doi.org/10.1002/wps.20666

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: A critical review. *BMC Medical Research Methodology*, *9*, 59. https://doi.org/10.1186/1471-2288-9-59

Bartoli, E., Bentley-Edwards, K. L., García, A. M., Michael, A., & Ervin, A. (2015). What do white counselors and psychotherapists need to know about race? White racial socialization in counseling and psychotherapy training programs. *Women & Therapy*, *38*(3–4), 246–262. https://doi.org/10.1080/02703149.2015.1059206

Bennett, B. E., Bricklin, P. M., & VandeCreek, L. (1994). Response to Lazarus's "How Certain Boundaries and Ethics Diminish Therapeutic Effectiveness". *Ethics & Behavior*, *4*(3), 263–266. https://doi.org/10.1207/s15327019eb0403_11

Bhui, K. (2022). A refugee rose of competencies and capabilities for mental healthcare of refugees. *British Journal of Psychiatry*, *8*(2), e45. https://doi.org/10.1192/bjo.2022.11

Black, S. C. (2017). To cross or not to cross: Ethical boundaries in psychological practice. *JANZSSA-Journal of the Australian and New Zealand Student Services Association*, *25*(1).

Blatt, S. J. (2001). Commentary: The therapeutic process and professional boundary guidelines. *The Journal of the American Academy of Psychiatry and the Law*, *29*(3), 290–293.

Booth, A. (2016). Searching for qualitative research for inclusion in systematic reviews: A structured methodological review. *Systematic Reviews*, *5*, 74. https://doi.org/10.1186/s13643-016-0249-x

Booth, A., Noyes, J., Flemming, K., Gerhardus, A., Wahlster, P., Van Der Wilt, G. J., Mozygemba, K., Refolo, P., Sacchini, D., Tummers, M., & Rehfuess, E. (2016). *Guidance on choosing qualitative evidence synthesis methods for use in health technology assessments of complex interventions*. Integrate-HTA.

Bottrill, S., Pistrang, N., Barker, C., & Worrell, M. (2010). The use of therapist self-disclosure: Clinical psychology trainees' experiences. *Psychotherapy Research*, *20*(2), 165–180. https://doi.org/10.1080/10503300903170947

Bowlby, J. (1969). *Attachment and loss* (Vol. 1). Basic Books.

Bowlby, J. (1988). Attachment, communication, and the therapeutic process. *A Secure Base: Parent-Child Attachment and Healthy Human Development*, 137–157.

Buber, M., & Smith, R. G. (1958). *I and thou* (Vol. Scribner, 11).

Burck, C., & Hughes, G. (2018). Challenges and impossibilities of 'standing alongside'in an intolerable context: Learning from refugees and volunteers in the Calais camp. *Clinical Child Psychology and Psychiatry*, *23*(2), 223–237. https://doi.org/10.1177/1359104517742187

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, *75*, 101812. https://doi.org/10.1016/j.cpr.2019.101812

Carballeira Carrera, L., Lévesque-Daniel, S., Moro, M. R., Mansouri, M., & Lachal, J. (2022). Becoming a transcultural psychotherapist: Qualitative study of the experience of professionals in training in a transcultural psychotherapy group. *Transcultural Psychiatry*, *59*(2), 143–153. https://doi.org/10.1177/1363461520950065

Carswell, K., Blackburn, P., & Barker, C. (2011). The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *The International Journal of Social Psychiatry*, *57*(2), 107–119. https://doi.org/10.1177/0020764009105699

Century, G., Leavey, G., & Payne, H. (2007). The experience of working with refugees: Counsellors in primary care. *British Journal of Guidance and Counselling*, *35*(1), 23–40. https://doi.org/10.1080/03069880601106765

Charlés, L. L. (2012). Producing evidence of a miracle: Exemplars of therapy conversation with a survivor of torture. *Family Process*, *51*(1), 25–42. https://doi.org/10.1111/j.1545-5300.2012.01381.x

Clarke, V., & Braun, V. (2021). Thematic analysis: A practical guide. *Thematic Analysis*, 1–100.

Cleary, R., & Armour, C. (2022). Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy. *Counselling and Psychotherapy Research*, *22*(4), 1100–1111. https://doi.org/10.1002/capr.12569

Cloitre, M., Koenen, K. C., Cohen, L. R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology*, *70*(5), 1067–1074. https://doi.org/10.1037/0022-006X.70.5.1067

Codrington, R., Iqbal, A., & Segal, J. (2011). Lost in translation? Embracing the challenges of working with families from a refugee background. *Australian and New Zealand Journal of Family Therapy*, *32*(2), 129–143. https://doi.org/10.1375/anft.32.2.129

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Cooper, G., Hoffman, K., Powell, B., & Marvin, R. (2011). The circle of security intervention. *Disorganized Attachment and Caregiving*, 318.

Cowles, M., & Griggs, M. (2019). Considering boundaries when doing therapeutic work with people who are seeking asylum: A reflective case study. *British Journal of Guidance and Counselling*, *47*(1), 50–64. https://doi.org/10.1080/03069885.2018.1507535

Critical Appraisal Skills Programme, CASP. (2018). *Qualitative checklist*. Retrieved August 12, 2022, from https://casp-uk.net/images/checklist/documents/CASP-Qualitative-Studies-Checklist/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Crowden, A. (2008). Professional boundaries and the ethics of dual and multiple overlapping relationships in psychotherapy. *Monash Bioethics Review*, *27*(4), 10–27. https://doi.org/10.1007/BF03351302

Curtin, M., Richards, H. L., & Fortune, D. G. (2022). Resilience among health care workers while working during a pandemic: A systematic review and meta synthesis of qualitative studies. *Clinical Psychology Review*, *95*, 102173. https://doi.org/10.1016/j.cpr.2022.102173

Derr, A. S. (2016). Mental health service use among immigrants in the United States: A systematic review. *Psychiatric Services*, *67*(3), 265–274. https://doi.org/10.1176/appi.ps.201500004

Dixon-Woods, M., Bonas, S., Booth, A., Jones, D. R., Miller, T., Sutton, A. J., Shaw, R. L., Smith, J. A., & Young, B. (2006). How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research*, *6*(1), 27–44. https://doi.org/10.1177/1468794106058867

Drapeau, C. E., Plante, P., & Drouin, M. S. (2022). Beyond art expression: Understanding participants' experience and outcomes of a vicarious trauma and response art workshop. *The Arts in Psychotherapy*, *79*, 101909. https://doi.org/10.1016/j.aip.2022.101909

Drožđek, B. O. R. I. S., & Wilson, J. P. (2004). Uncovering: Trauma-focused treatment techniques with asylum seekers. In *Broken spirits: the treatment of traumatized asylum seekers, refugees, war and torture victims* (pp. 243–276). Brunner-Routledge.

Self-disclosure in the therapeutic relationshipDryden, W. (1990). Self-disclosure in rational-emotive therapy. In (pp. 61–74). Springer. https://doi.org/10.1007/978-1-4899-3582-3_5

Duden, G. S., & Martins-Borges, L. (2021a). Psychotherapy with refugees—Supportive and hindering elements. *Psychotherapy Research*, *31*(3), 402–417. https://doi.org/10.1080/10503307.2020.1820596

Duden, G. S., & Martins-Borges, L. (2021b). Psychologists' perspectives on providing psychological care for refugees in Brazil. *Counselling Psychology Quarterly*, *35*(3), 605–633. https://doi.org/10.1080/09515070.2021.1933909

Duden, G. S., Martins-Borges, L., Rassmann, M., Kluge, U., Guedes Willecke, T., & Rogner, J. (2020). A qualitative evidence synthesis of refugee patients' and professionals' perspectives on mental health

support. *Community Psychology in Global Perspective*, *6*(2/1), 76–100. https://doi.org/10.1285/i24212113v6i2-1p76

Due, C., & Currie, E. (2022). Practitioner competencies for working with refugee children and young people: A scoping review. *Transcultural Psychiatry*, *59*(2), 116–129. https://doi.org/10.1177/13634615211043765

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345. https://doi.org/10.1016/s0005-7967(99)00123-0

Elbert, T., Schauer, M., & Neuner, F. (2022). Narrative exposure therapy (NET): Reorganizing memories of traumatic stress, fear, and violence. In *Evidence based treatments for trauma-related psychological disorders: A practical guide for clinicians* (pp. 255–280). Springer International Publishing. https://doi.org/10.1007/978-3-030-97802-0_12

Gabbard, G. O. (1999). Boundary violations. *Psychiatric Ethics*, 141–160.

Gabbard, G. O., & Crisp-Han, H. (2010). Teaching professional boundaries to psychiatric residents. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, *34*(5), 369–372. https://doi.org/10.1176/appi.ap.34.5.369

Gabbard, G. O., & Nadelson, C. (1995). Professional boundaries in the physician–patient relationship. *Journal of the American Medical Association*, *273*, 1445–1449. https://doi.org/10.1001/jama.1995.03520420061039

Gaines, R. (2003). Therapist self-disclosure with children, adolescents, and their parents. *Journal of Clinical Psychology*, *59*(5), 569–580. https://doi.org/10.1002/jclp.10163

Griffin, B. J., Purcell, N., Burkman, K., Litz, B. T., Bryan, C. J., Schmitz, M., Villierme, C., Walsh, J., & Maguen, S. (2019). Moral injury: An integrative review. *Journal of Traumatic Stress*, *32*(3), 350–362. https://doi.org/10.1002/jts.22362

Gutheil, T. G., & Gabbard, G. O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. *The American Journal of Psychiatry*, *150*(2), 188–196. https://doi.org/10.1176/ajp.150.2.188

Gutheil, T. G., & Gabbard, G. O. (1998). Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *The American Journal of Psychiatry*, *155*(3), 409–414. https://doi.org/10.1176/ajp.155.3.409

Hassan, G., Kirmayer, L. J., Mekki-Berrada, A., Quosh, C., El Chammay, R., Deville-Stoetzel, J. B., Youseff, A., Bahloul, H. J., Oteo, A. B., Coutts, A., Song, S. J., & Ventevogel, P. (2015). *Culture, context and the mental health and psychosocial wellbeing of Syrians: A review for mental health and psychosocial support staff working with Syrians affected by armed conflict* (p. 13). UNHCR.

Herman, J. L. (1992). *Trauma and recovery*. Basic Books.

Hinton, D. E., Rivera, E. I., Hofmann, S. G., Barlow, D. H., & Otto, M. W. (2012). Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry*, *49*(2), 340–365. https://doi.org/10.1177/1363461512441595

Holub, E. A., & Lee, S. S. (1990). Therapist's use of non-erotic physical contact: Ethical concerns. *Professional Psychology: Research and Practice*, *21*(2), 115–117. https://doi.org/10.1037/0735-7028.21.2.115

Huibers, M. J., Lorenzo-Luaces, L., Cuijpers, P., & Kazantzis, N. (2021). On the road to personalized psychotherapy: A research agenda based on cognitive behavior therapy for depression. *Frontiers in Psychiatry*, *11*, 607508. https://doi.org/10.3389/fpsyt.2020.607508

Hyatt, L. (2020). From compassion fatigue to vitality: Memoir with art response for self-care. *Art Therapy*, *37*(1), 46–50. https://doi.org/10.1080/07421656.2019.1677423

Karageorge, A., Rhodes, P., & Gray, R. (2018). Relationship and family therapy for newly resettled refugees: An interpretive description of staff experiences. *Australian and New Zealand Journal of Family Therapy*, *39*(3), 303–319. https://doi.org/10.1002/anzf.1325

Karageorge, A., Rhodes, P., Gray, R., & Papadopoulos, R. (2017). Refugee and staff experiences of psychotherapeutic services: A qualitative systematic review. *Intervention*, *15*(1), 51–69. https://doi.org/10.1097/WTF.0000000000000137

Khalsa, G. S. (2021). *The experiences of mental health service providers adapting counseling treatments for refugee clients* (Doctoral dissertation. University of Northern Colorado.

Kinzie, J. D. (2001). Psychotherapy for massively traumatized refugees: The therapist variable. *American Journal of Psychotherapy*, *55*(4), 475–490. https://doi.org/10.1176/appi.psychotherapy.2001.55.4.475

Kirmayer, L. J. (2000). Broken narratives: Clinical encounters and the poetics of illness experience. In C. Mattingly & L. Garro (Eds.), *Narrative and the cultural construction of illness and healing* (pp. 153–180). University of California Press.

Kirmayer, L. J. (2003). Asklepian dreams: The ethos of the wounded-healer in the clinical encounter. *Transcultural Psychiatry*, *40*(2), 248–277. https://doi.org/10.1177/1363461503402007

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L. J., Kronick, R., & Rousseau, C. (2018). Advocacy as key to structural competency in psychiatry. *JAMA Psychiatry*, *75*(2), 119–120. https://doi.org/10.1001/jamapsychiatry.2017.3897

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., Pottie, K., & Canadian Collaboration for Immigrant and Refugee Health (CCIRH). (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *CMAJ: Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne*, *183*(12), E959–E967. https://doi.org/10.1503/cmaj.090292

Kroll, J. (2001). Boundary violations: A culture-bound syndrome. *The Journal of the American Academy of Psychiatry and the Law*, *29*(3), 274–283.

Kuo, B. C., & Arcuri, A. (2014). Multicultural therapy practicum involving refugees: Description and illustration of a training model. *The Counseling Psychologist*, *42*(7), 1021–1052. https://doi.org/10.1177/0011000013491610

Kuo, B. C., Soucie, K., & Huang, S. (2020). Developing clinical trainees' multicultural counseling competencies through working with refugees in a multicultural psychotherapy practicum: A mixed-methods investigation. *International Journal for the Advancement of Counselling*, *42*, 249–268. https://doi.org/10.1007/s10447-019-09392-8

Lachal, J., Revah-Levy, A., Orri, M., & Moro, M. R. (2017). Metasynthesis: An original method to synthesize qualitative literature in psychiatry. *Frontiers in Psychiatry*, *8*, 269. https://doi.org/10.3389/fpsyt.2017.00269

Lane, R. C., & Hull, J. W. (1990). Self-disclosure and classical psychoanalysis. In *Self-disclosure in the therapeutic relationship* (pp. 31–46). Springer.

Langs, R. (1982). *Psychotherapy: A basic text*. Aronson.

Laota, Z. (2019). *Counseling refugees: Examining mental health professionals' learning experiences and recommendations for effective training* (doctoral dissertation). University of North Carolina at Greensboro.

Lau, L. S., & Rodgers, G. (2021). Cultural competence in refugee service settings: A scoping review. *Health Equity*, *5*(1), 124–134. https://doi.org/10.1089/heq.2020.0094

Lazarus, A. A. (1994). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics & Behavior*, *4*(3), 255–261. https://doi.org/10.1207/s15327019eb0403_10

Liggan, D. Y., & Kay, J. (1999). Race in the room: Issues in the dynamic psychotherapy of African Americans. *Transcultural Psychiatry*, *36*(2), 195–209. https://doi.org/10.1177/136346159903600203

Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, *29*(8), 695–706. https://doi.org/10.1016/j.cpr.2009.07.003

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Martinez, R. (2000). A model for boundary dilemmas: Ethical decision-making in the patient–professional relationship. *Ethical Human Sciences & Services*, *2*(1), 43–61.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370–396. https://doi.org/10.1037/h0054346

Mayston, R., Frissa, S., Tekola, B., Hanlon, C., Prince, M., & Fekadu, A. (2020). Explanatory models of depression in sub-Saharan Africa: Synthesis of qualitative evidence. *Social Science & Medicine*, (1982), 246, 112760. https://doi.org/10.1016/j.socscimed.2019.112760

McCluskey, U. (2010). Understanding the self and understanding therapy: An attachment perspective. *Context*, *107*, 29–32. Retrieved from: https://www.unamccluskey.com/wp-content/uploads/2011/03/Article-for-Context-Magazine2.pdf

McCluskey, U. (2011). The therapist as a fear free caregiver supporting change in the dynamic organisation of the self. *Association of University and College Counselling*, 12–18.

Mirdal, G. M., Ryding, E., & Essendrop Sondej, M. (2012). Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment. *Psychology and Psychotherapy: Theory, Research and Practice*, *85*(4), 436–455. https://doi.org/10.1111/j.2044-8341.2011.02036.x

Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, *6*(7), e1000097. https://doi.org/10.1371/journal.pmed.1000097

Munday, A. M. (2010). *Clinical psychologists' experiences of working with refugees* (Doctoral dissertation,).

National Institute for Health and Care Excellence (NICE) Guidelines. (2018). *Post-traumatic stress disorder*. Retrieved from: https://www.nice.org.uk/guidance/ng116

Neuner, F., Elbert, T., & Schauer, M. (2018). Narrative exposure therapy (NET) as a treatment for traumatized refugees and post-conflict populations. *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, 183–199. https://doi.org/10.1007/978-3-319-97046-2_9

Norcross, J. C., & Wampold, B. E. (2019). Relationships and responsiveness in the psychological treatment of trauma: The tragedy of the APA clinical practice guideline. *Psychotherapy*, *56*(3), 391–399. https://doi.org/10.1037/pst0000228

Noyes, J., Booth, A., Cargo, M., Flemming, K., Garside, R., Hannes, K., Harden, A., Harris, J., Lewin, S., Pantoja, T., & Thomas, J. (2018). Cochrane qualitative and implementation methods group guidance series—Paper 1: Introduction. *Journal of Clinical Epidemiology*, *97*, 35–38. https://doi.org/10.1016/j.jclinepi.2017.09.025

Okpalaenwe, E. N., & Odigwe, S. G. K. (2018). Healing technique and rituals as an approach to counseling in the African cultural contexts. *Journal of African Interdisciplinary Studies*, *2*(8), 15–26.

Ondrejková, N., & Halamová, J. (2022). Prevalence of compassion fatigue among helping professions and relationship to compassion for others, self-compassion and self-criticism. *Health & Social Care in the Community*, *30*(5), 1680–1694. https://doi.org/10.1111/hsc.13741

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Wilson, E. M., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *Systematic Reviews*, *10*, 89. https://doi.org/10.1186/s13643-021-01626-4

Partavian, A., & Kyriakopoulos, A. (2021). Therapist and counsellors' experiences of working with asylum seekers in the context of asylum-seeking processes in the UK. *Counselling and Psychotherapy Research*. https://doi.org/10.1002/capr.12501

Patel, N. (2003). Clinical psychology: Reinforcing inequalities or facilitating empowerment? *The International Journal of Human Rights*, *7*(1), 16–39. https://doi.org/10.1080/714003792

Patel, N., Tribe, R., & Yule, B. (2018). *Guidelines for psychologists working with refugees and asylum-seekers in the*. Extended version. The British Psychological Society. https://doi.org/10.13140/RG.2.2.36313.01126

Patel, V. (1995). Explanatory models of mental illness in sub-Saharan Africa. *Social Science & Medicine (1982)*, *40*(9), 1291–1298. https://doi.org/10.1016/0277-9536(94)00231-h

Peñuela-O'Brien, E., Wan, M. W., Edge, D., & Berry, K. (2022). Health professionals' experiences of and attitudes towards mental healthcare for migrants and refugees in Europe: A qualitative systematic review. *Transcultural Psychiatry*, *13634615211067360*. https://doi.org/10.1177/13634615211067360

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., and Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews*. Retrieved from: http://www.lancaster.ac.uk/shm/research/nssr/research/dissemination/publications/NS_Synthesis_Guidance_v1.pdf

Posselt, M., Baker, A., Deans, C., & Procter, N. (2020). Fostering mental health and well-being among workers who support refugees and asylum seekers in the Australian context. *Health & Social Care in the Community*, *28*(5), 1658–1670. https://doi.org/10.1111/hsc.12991

Posselt, M., McDonald, K., Procter, N., de Crespigny, C., & Galletly, C. (2017). Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: Addressing the barriers. *BMC Public Health*, *17*(1), 280. https://doi.org/10.1186/s12889-017-4186-y

Puvimanasinghe, T., Denson, L. A., Augoustinos, M., & Somasundaram, D. (2015). Vicarious resilience and vicarious traumatisation: Experiences of working with refugees and asylum seekers in South Australia. *Transcultural Psychiatry*, *52*(6), 743–765. https://doi.org/10.1177/1363461515577289

Puvimanasinghe, T., Denson, L. A., Augoustinos, M., & Somasundaram, D. (2019). Flexibility, creativity and responsiveness in trauma counselling: Working with refugees and asylum-seekers. *Australian Community Psychologist*, *30*(1).

QSR International Pty Ltd. (2018). NVivo (Version 12), https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Quirke, E., Klymchuk, V., Suvalo, O., Bakolis, I., & Thornicroft, G. (2021). Mental health stigma in Ukraine: Cross-sectional survey. *Global Mental Health (Cambridge, England)*, *8*, e11. https://doi.org/10.1017/gmh.2021.9

Reichelt, S., & Sveaass, N. (1994). Therapy with refugee families: What is a "good" conversation? *Family Process*, *33*(3), 247–262. https://doi.org/10.1111/j.1545-5300.1994.00247.x

Robertson, M. E. A., Blumberg, J. M., Gratton, J., Walsh, E. G., & Kayal, H. (2013). A group-based approach to stabilisation and symptom management in a phased treatment model for refugees and asylum seekers. *European Journal of Psychotraumatology*, 4. https://doi.org/10.3402/ejpt.v4i0.21407

Sandhu, S., Bjerre, N. V., Dauvrin, M., Dias, S., Gaddini, A., Greacen, T., Ioannidis, E., Kluge, U., Jensen, N. K., Lamkaddem, M., Puigpinós i Riera, R., Kósa, Z., Wihlman, U., Stankunas, M., Straßmayr, C., Wahlbeck, K., Welbel, M., & Priebe, S. (2013). Experiences with treating immigrants: A qualitative study in mental health services across 16 European countries. *Social Psychiatry and Psychiatric Epidemiology*, *48*(1), 105–116. https://doi.org/10.1007/s00127-012-0528-3

Savin, D., & Martinez, R. (2006). Cross-cultural boundary dilemmas: A graded-risk assessment approach. *Transcultural Psychiatry*, *43*(2), 243–258. https://doi.org/10.1177/1363461506064853

Schlechter, P., Hellmann, J. H., Wingbermühle, P., & Morina, N. (2021). Which psychological characteristics influence therapists' readiness to

work with refugees? *Clinical Psychology & Psychotherapy*, *28*(2), 334–344. https://doi.org/10.1002/cpp.2508

Schweitzer, R., Van Wyk, S., & Murray, K. (2015). Therapeutic practice with refugee clients: A qualitative study of therapist experience. *Counselling and Psychotherapy Research*, *15*(2), 109–118. https://doi.org/10.1002/capr.12018

Shay, J. (2014). Moral injury. *Psychoanalytic Psychology*, *31*(2), 182–191. https://doi.org/10.1037/a0036090

Shors, M. K., & Kroll, J. (2022). To cross or not to cross: Clinical boundary considerations with persons who are refugees. *Transcultural Psychiatry*, *59*(2), 165–174. https://doi.org/10.1177/1363461519878289

Simon, R. I. (1992). Treatment boundary violations: Clinical, ethical, and legal considerations. *The Bulletin of the American Academy of Psychiatry and the Law*, *20*(3), 269–288.

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice*, *26*(5), 499–506. https://doi.org/10.1037/0735-7028.26.5.499

Speight, S. L. (2012). An exploration of boundaries and solidarity in counseling relationships. *The Counseling Psychologist*, *40*(1), 133–157. https://doi.org/10.1177/0011000011399783

Spruiell, V. (1983). The rules and frames of the psychoanalytic situation. *The Psychoanalytic Quarterly*, *52*(1), 1–33. https://doi.org/10.1080/21674086.1983.11927019

Steel, C., Young, K., Akbar, S., Chessell, Z., Stevens, A., Vann, M., & Arntz, A. (2023). The treatment of PTSD in refugees and asylum seekers using imagery rescripting within an NHS setting. *Behavioural and Cognitive Psychotherapy*, *51*(2), 119–132. https://doi.org/10.1017/S1352465822000650

Sturm, G., Nadig, M., & Moro, M. R. (2011). Current developments in French ethnopsychoanalysis. *Transcultural Psychiatry*, *48*(3), 205–227. https://doi.org/10.1177/1363461511402868

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine (1982)*, *48*(10), 1449–1462. https://doi.org/10.1016/s0277-9536(98)00450-x

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*, 45. https://doi.org/10.1186/1471-2288-8-45

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology*, *12*(1), 1–8. https://doi.org/10.1186/1471-2288-12-181

Tseng, W. S., Matthews, D., & Elwyn, T. S. (2004). *Cultural competence in forensic mental health: A guide for psychiatrists, psychologists, and attorneys*. Routledge.

Tynewydd, I., North, S., & Rushworth, I. (2020). The experiences of mental health professionals supporting forced migrants: A qualitative systematic review. *Refuge: Canada's Journal on Refugees/Refuge: Revue Canadienne Sur les réfugiés*, *36*(1), 50–65. https://doi.org/10.25071/1920-7336.40774

UNHCR, United Nations High Commissioner for Refugees, (2022). Refugee population statistics database. Retrieved from: https://www.unhcr.org/refugee-statistics/

Uono, S., & Hietanen, J. K. (2015). Eye contact perception in the west and east: A cross-cultural study. *PLoS ONE*, *10*(2), e0118094. https://doi.org/10.1371/journal.pone.0118094

Walker, R., & Clark, J. J. (1999). Heading off boundary problems: Clinical supervision as risk management. *Psychiatric Services*, *50*(11), 1435–1439. https://doi.org/10.1176/ps.50.11.1435

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. *Social Science & Medicine (1982)*, *52*(11), 1709–1718. https://doi.org/10.1016/s0277-9536(00)00284-7

Webb, C. A., Forgeard, M., Israel, E. S., Lovell-Smith, N., Beard, C., & Björgvinsson, T. (2022). Personalized prescriptions of therapeutic skills from patient characteristics: An ecological momentary assessment approach. *Journal of Consulting and Clinical Psychology*, *90*(1), 51–60. https://doi.org/10.1037/ccp0000555

Weir, D. (2021). The white man in the room: Finding my position as a white therapist. *British Journal of Psychotherapy*, *37*(3), 390–403. https://doi.org/10.1111/bjp.12650

Wilson, J. P., & Thomas, R. B. (2004). *Empathy in the treatment of trauma and PTSD*. Routledge.

Winterson, M. (2019). *Exploring psychosocial and therapeutic needs among refugees and asylum-seekers*. Lancaster University (United Kingdom).

Woodcock, J. (2001). Threads from the labyrinth: Therapy with survivors of war and political oppression. *Journal of Family Therapy*, *23*(2), 136–154.

Woodcock, J. M. (1995). Family therapy and human rights: Working with refugees. *Mental Health Nursing*, *15*, 20–22.

Wu, Y. P., Aylward, B. S., Roberts, M. C., & Evans, S. C. (2012). Searching the scientific literature: Implications for quantitative and qualitative reviews. *Clinical Psychology Review*, *32*(6), 553–557. https://doi.org/10.1016/j.cpr.2012.06.007

Zur, O. (2004). To cross or not to cross: Do boundaries in therapy protect or harm. *Psychotherapy Bulletin*, *39*(3), 27–32. Retrieved from: https://www.zurinstitute.com/boundaries-in-therapy/

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