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Intervention effectiveness following gender-based violence and forced migration: A critical systematic literature review and synthesis of qualitative studies from the voice of the client

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Intervention effectiveness following gender-based violence and forced migration:

A critical systematic literature review and synthesis of qualitative studies from the voice of the client

MSW Clinical Research Project

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a single semester timeframe to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Aim. This systematic review aims to understand effective therapeutic interventions from the voice of the client; female forced migrants, post-migration who have endured and survived gender-based violence.

Background. Professionals are implementing therapeutic interventions for this population whose experiences convey both vulnerabilities and resiliencies, yet a common understanding of what effective interventions are has not yet been established in the literature.

Design. Systematic narrative review and synthesis of literature.

Data sources. Electronic database search sources included ScienceDirect, SAGE, PubMed, and Scopus. Professionals in the field, think tanks, and research organizations were also consulted to locate texts which could contribute to the review.

Review methods. A systematic narrative review and synthesis was undertaken including academic and grey literature. To begin, general search terms were used to include all relevant texts. The selection of final literature was then narrowed by defining inclusion and exclusion criteria.

Results. A total of nine texts were identified for the final synthesis of findings. The representation of women the studies focused on was narrow. However, four core themes were identified: professional preparedness and perspective, intentional progression of therapeutic themes, interprofessional collaboration and referrals, and culturally-informed therapy.

Conclusion. Four core themes describing effective interventions for female forced migrants who are victim/survivors of gender-based violence have emerged from current gray and academic literature. These themes may impact the effectiveness of implementing programs and therapeutic interventions for clients within this population in the future.

Keywords: female, forced migrant, gender-based violence, therapeutic intervention, effective

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The views of the author expressed in this article are her own and not the official position of St. Catherine University - University of St. Thomas School of Social Work.

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The need for effective therapeutic interventions for female forced-migrants has been a pressing issue for several decades. The number of displaced persons around the world has been increasing at a shocking rate, meanwhile human rights violations, such as gender-based violence (GBV) against women, are being exposed and professionals are working fervently to prevent and intervene on behalf of such defilements. In the heart of these colossal efforts, it is pertinent that mental health professionals listen to and incorporate what the female clients themselves feel have been the most operative ways forward in their resettlement and healing. Thus, the purpose of this study is to identify themes within effective therapeutic interventions, as documented by female clients who are victim/survivors of forced migration and gender-based violence. The themes will be identified using a systematic narrative review.

Background

The need for effective mental health interventions for female forced migrants who identify as victim/survivors of gender-based violence (GBV) is explained through the history of their plight and the significance of this population's size and strength. This section discusses how forced migration and gender-based violence are defined and statistics within each focus area. The salient socio-systemic and mental health concerns of forced migrants are then identified. Additionally, therapeutic interventions are briefly mentioned within this contextual section, as well as evidence supporting a need for effective therapeutic interventions, and the objectives of the systematic narrative review.

Forced Migrants

The Universal Declaration of Human Rights of 1948 guarantees the right to seek asylum as an international human right (International Justice Research Center, 2017). While many immigrants choose to relocate for economic gains, forced migrants leave their country of origin against their will due to persecution. Individuals forced to immigrate to another country and who are unable or unwilling to return to their home country because of persecution or a well-founded fear of persecution based on race, religion, nationality, political opinion, or membership in a particular social group could be granted

a legal protection called asylum in the host country (Advocates for Human Rights, 2017). The International Association for the Study of Forced Migration (IASFM) recognizes that the forced movement of populations can be due to armed conflict, fleeing war, natural phenomena, targeted persecution, famine, political unrest, inhumane violence or torture, or a major development project among other reasons why people would need to seek protection (2017). Forced migrants include refugees, asylees, asylum seekers and internally displaced persons (IDP). Refugees apply and are granted asylum before migrating to the host country. Asylum seekers apply for asylum at the host country's border or when they are already on the host country's soil. An asylum seeker becomes an asylee after being granted approved for asylum. IDPs have not left their country of origin, yet have been displaced from the life they once knew due persecution, war, natural phenomena or other circumstances.

There are over 60 million people that have been forcibly displaced worldwide and less than one-tenth percent that get the chance to resettle, reclaim their lives, and start anew (U.S. Committee for Refugees, 2017). This is approximately six million people who have had the opportunity to resettle. The United Nations High Commissioner for Refugees (UNHCR) estimates there are 65.6 million people forcibly displaced worldwide, with 815,600 living in the United States (UNHCR, 2017). This figure excludes forced migrants who have permanently resettled in another country. In 2016, the U.S. immigration court and asylum systems were backlogged with over 620,000 pending cases (American Immigration Council, 2016). During the legal process of requesting asylum or refugee status, individuals face many complexities, the cornerstone aspects of such include significant lack of access to work authorization and health insurance, limited social capital and job insecurity, poverty, a divided family and social isolation, potential detention, fear of deportation, and the ambiguous wait towards an asylum decision and resettlement (Chantler, 2012; Essex, 2013; Seck, 2015). Women and children make up the largest portion of refugees and forced migrants around the world, and have increased vulnerabilities due to violence and corruption (Sherwood & Liebling-Kalifani, 2012).

Mental Health Concerns of Forced Migrants

In addition to the confounding trauma experienced before forced migration, the course of migration can also be traumatic with added psychological, social, and physiological impacts during travel, potential detention, and the resettlement process. Many forced migrants arrive to a host country with pre-existing mental distress such as anxiety, depression, somatization, and post-traumatic stress disorder (PTSD) symptoms due to traumatic experiences that forced them to leave their home countries and the ambiguous journey (Utržan & Northwood, 2017). Additionally, the systemic challenges and social constraints in the host country have been proven to worsen their mental distress. The challenges and lack of access to social services and basic needs experienced by forced migrants create compounded mental health impacts, leading to worsened conditions of anxiety, stress, loneliness, depression, lack of control, fear, substance use disorders, suicidal ideation, and additional psychological effects (Bloch, 2014; Essex, 2013; Seck, 2015; Tol et al, 2013; Utržan & Northwood, 2017). The barriers of living without work authorization alone was proven to lead to constant anxiety and fear, which compounded into additional psychological effects, such as panic attacks, recurrent nightmares, and an inability to sleep (Bloch, 2014).

Although everyone has a unique case composed of experiences of trauma, personal obstacles, and their individual health, some people can become completely immobilized by such mental health stressors or compounded abuses and vulnerabilities even after migration. Seck (2015) identified that West African female immigrants, with and without legal status, experienced great obstacles with legal status, mental health issues, and systemic impediments to using their skill and potential in employment. Similarly, Chantler (2012) delineates how there are mental health consequences directly related to components of the government run asylum-seeking process, particularly enforced poverty without authorization to work, social isolation and limitations to housing, and regularly-practiced detention combined with legal status uncertainty and insecurity. Fear also leads to compounded disadvantages,

such as individuals refraining from seeking social and health services, and not requesting services although they are allowed and qualify (Prentice, Pebley, & Sastry, 2005; Seck, 2015). However, the asylum seekers, asylees, and refugees represented in the research were mostly those who sought or were referred to social, legal, and mental health services despite the access obstacles detailed above. Minimal studies were based on general demographic information, and very few individuals were recruited for the sole purpose of research.

Protective factors. Researchers have identified protective factors for the mental health of forced migrants. Cohesiveness with social and family support, religious beliefs and practices, and having a space where they can narrate and speak out about their experiences were proven to help migrants be more resilient during the resettlement process (Sherwood & Liebling-Kalifani, 2012). Asylum seekers provided evidence on the need for human dignity through governmental provisions and rights, especially the right to work, and how this access helps stabilize mental health (Fleay & Hartley, 2015). Employment allows residents to improve financial situations and creates a sense of belonging through socializing and community involvement. It was shown how informal social groups also formed lasting relationships of trust and inspiration, and a structure for interdependence and mentorship (Seck, 2015), all of which are components towards a positive, healthy lifestyle. Current literature also addresses direct and indirect mental health concerns of forced migrants and how such concerns were caused or exacerbated by the current system and lack of access for the population. There is a strong relationship between immigration status in the U.S. and improved mental health conditions, which was identified when individuals underwent an adjustment of legal status while living in the U.S. (Chantler, 2012; Utržan & Northwood, 2017). Of critical importance, Chantler (2012) discusses how trauma can impact physical and mental health differently for females, and how these differences complicate the already challenging task of proving validity in their asylum cases. Similarly, Sherwood & Liebling-Kalifani (2012) assert psychological effects may be exacerbated in survivors of gender-based violence. There is clearly need for

research, literature, and intervention in the adjoining areas of forced migration, gender-based violence, and mental distress.

Gender-Based Violence

Around the world, one in three women are victim/survivors of gender-based violence (Tahirih Justice Center, 2017). Presumably, the prevalence of gender-based violence would increase within more vulnerable sub-populations, such as forced migrants. To that point, a report completed by the Medical Foundation for the Victims of Torture (MF) found that 80 of the 100 female asylum-seeking clients who were featured in case studies in their 2009 research had been raped, one subset act within the term gender-based violence (Chantler, 2012). Gender-based violence is any harmful act committed against someone's will, based on socially-assigned gender differences, where males most often are privileged (Tol et al., 2013). Gender-based violence is an umbrella term used for human rights violations such as sexual violence, rape, female genital mutilation (FGM), intimate-partner violence, domestic violence, sex trafficking, and other physical, emotional, sexual, and financial abuses that are gender related. Women victim/survivors experience trauma symptoms and report intrusive thoughts, flashbacks, nightmares, and poor concentration (Tol et al., 2013). While the journey of seeking legal protection is arduous, stressful, and challenging, the added reality of gender-based violence indicates additional obstacles and psychological and social challenges for female forced migrants.

Need for Effective Therapeutic Supports

Research and documentation remains scarce on therapeutic interventions that have proven effective for female forced migrants who have survived gender-based violence. Although the literature is growing, there are challenges to synthesizing studies, interventions, and effectiveness to draw conclusions. The academic literature on the subject is diverse in therapeutic interventions, time of intervention after the gender-based violence and migration, location and frequency of intervention, individual or group focused therapy, additional concurring interventions, and perspective of the

intervention and effectiveness coming from the service provider or the client. It is beyond the scope of this narrative review to systematically assess all current knowledge on physical, emotional, social, and psychological obstacles and mental health practices for female forced migrants due to the diversity of research and literature. However, as shown through the articles reviewed, there is international interest and an expansion in evidence on the effectiveness of specific therapeutic practices, perspectives, and supporting services.

To address the issue of psychological needs for female forced-migrants who have endured and survived gender-based violence, there are innumerable initiatives underway by health, development, mental health, case management, relief, and other professional workers. There are prevention and intervention efforts in countries of origin, relief efforts for internally-displaced persons (IDPs) commonly in refugee camps, or refugee camps in host countries, and for those residing in a host country outside of a refugee camp, there are many out-patient and outreach efforts. Therapies vary greatly, and effectiveness has been documented through an extensive list of techniques; narrative therapy (NT), exposure therapy, narrative exposure therapy (NET), cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), art therapy and other experiential therapies, ambiguous loss theory, therapeutic group work using NT or CBT and many others.

Across the world, mental health and social workers are building on the clients' resilience. Many service providers document the effectiveness of therapeutic support groups for women using a holistic model (Sherwood & Liebling-Kalifani, 2012). Another tactic is underway with mental health professionals in Minnesota who documented a successful case of couple's therapy with asylum-seekers through a lens of ambiguous loss theory, one that has not been used for this population frequently (Utržan & Northwood, 2017). Furthermore, mental health professionals are enhancing the quality of care by collaborating with other supportive services through interprofessional partnerships. Interprofessional collaboration is occurring with the clients' legal team, case management, physiological

health services, and preventative, advocacy work within the community. Additionally, a systematic review suggests there is agreement that cultural sensitivity and collaboration with traditional healers was highly important for mental health and social support interventions working with sexual and gender-based violence in areas of armed conflict (Tol et al., 2013).

Providers and professionals have reported cultural stigma, language barriers, social and economic exclusion, and access to services as obstacles to providing mental health services to female forced migrants (Chantler, 2012; Fleay & Hartley, 2015; Sherwood & Liebling-Kalifani, 2012; Utržan & Northwood, 2017). Due to the nature of the study, the vulnerability of the population, and the social barriers and access obstacles, this therapeutic work undoubtedly necessitates a social justice lens. As any social services, mental health, or social work provider, the contextual literature informs the practice that social structures, or lack thereof, can significantly hinder healing and add psycho-social stress. For these reasons, and potentially others, it can be difficult for women to fully participate in mental health services or talk about traumatic experiences. The literature states there is a need to achieve a baseline sense of safety and having basic needs met as a foundation of therapeutic change. In the realm of research and literature, this creates challenges for studies to document interventions and effectiveness, especially from the perspective of the female forced-migrant.

In sum, the psychological impact of forced migration and gender-based violence is being explored in the mental health field. Social workers and other mental health and social service professionals have been challenged to incorporate creative, effective solutions in the aftermath of gender-based violence and displacement. Effective therapeutic provisions for this population is critical, particularly for the social workers' values of *dignity and worth of the person* (NASW, 2017). Due to this value, we are motivated to support clients' self-capacity and their opportunities to advance and self-actualize. Studies show that specialists across the world are identifying priority needs, and conducting the necessary research to demonstrate the systemic shortcomings and programmatic successes to lay

the groundwork for a positive path forward for female forced migrants who have endured and survived gender-based violence. However, further research and synthesis needs to be done.

Review Objectives

This paper reports on a systematic narrative review and synthesis of emerging literature on effective therapeutic interventions from the voice of resettled female forced migrants who have endured and survived gender-based violence. My objective is to identify if there are common elements in effective therapeutic techniques, according to the client, and if so what they are. Through this review, I question if the female clients identify factors that are universally successful and if there are first-hand suggestions on how to work with identified systemic, cultural, and access concerns. The motivation for undertaking this review is to encourage practitioners to assess the effectiveness of services informed by the perception of clients and disseminate findings to mental health practitioners and the broader community working in collaboration with female forced migrants after they begin resettlement.

Methodology of the Review

Aim

The aim of the systematic narrative review was to understand effective therapeutic interventions from the voice of the client; female forced migrants post-migration who are victim/survivors of gender-based violence.

Design

I completed a systematic narrative review and synthesis of literature to better understand effective therapeutic interventions from the perception of female forced migrants who have endured and survived gender-based violence. The subject at hand remained rather broad considering the types of forced migration (refugees, asylees, asylum seekers) and the variability of acts within the definition of gender-based violence (rape, domestic violence, sex trafficking, etc.). However, due to the scant amount of literature, especially published material, I decided to proceed without limiting the population and

their experiences any further, such as country of origin, country or resettlement, act of violence perpetrated against them, time of the gender-based violence (pre-, during, or post-migration). Furthermore, I wanted to identify if there were similarities or differences in the viewpoints of the women on how they measured effectiveness and what they felt needed to be achieved through a therapeutic relationship. This study followed the methodology of a systematic narrative review because there was not enough of a commonality in the current literature to synthesize outcomes of a specific intervention from a particular segment of this population, from the perspective of the client(s). Consequently, the theoretical question I confronted was if I considered different literature around effective therapeutic interventions for individuals or subgroups within this population as unique and separate discourses, or if they had enough similarities to be different variations of a common narrative. The systematic narrative review findings are qualitative in nature.

Search Method

I carried out a systematic narrative review identifying significant texts, research papers, textbooks, academic articles, case studies, and other grey literature that documented the effectiveness of these therapeutic interventions. An inclusion criterion for the review was that the literature provides original evidence in reference to the effectiveness of interventions, regardless of the strength of evidence. Literature included in the review is from the perspective of the women or reports on their first-hand perspective from the service provider. Therefore, the review has considered the possibility of personal, subjective bias in the literature of such reported perception. Due to the nominal quantity of texts identified that fit criteria, I did not limit the years of literature reviewed, although more recent literature that built on previous findings was taken into consideration.

Search Outcome

Texts were located by using search terms ‘women’, ‘posttraumatic stress disorder’, ‘ptsd’, ‘trauma’, ‘rape’, ‘sexual violence’, ‘refugee’, ‘migrant’, ‘treatment’, and ‘therapy’. Additional keywords

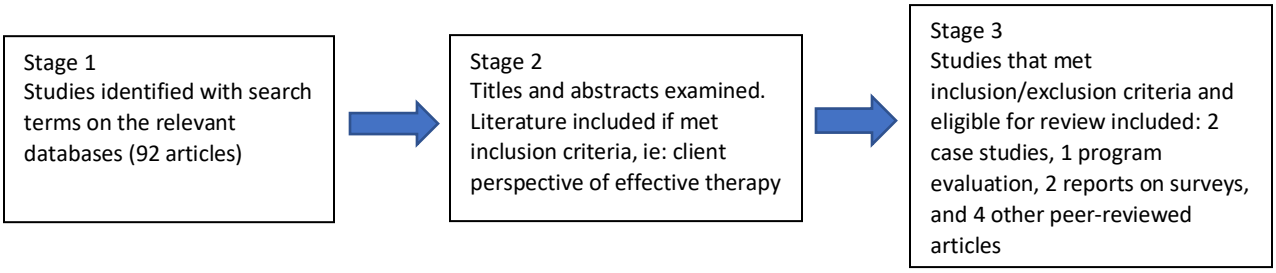
for gender-based violence were attempted and did not render the sought literature for the purpose of the study. The review covered electronic databases (ScienceDirect, SAGE, PubMed, Scopus). I also consulted with colleagues in the field and explored think tanks and research organizations involved with therapeutic interventions at the intersection of gender-based violence and forced migration to locate texts which could contribute to the systematic narrative review. Searches were limited to English language articles, platforms, and sites.

Once the search was conducted, studies that met inclusion criteria were those working with resettled female forced migrants, post-migration, who were receiving therapeutic support due to the traumas of forced migration and gender-based violence. I recognize there are other individuals along the gender continuum who have been traumatized due to the intersectionality of forced migration and gender-based violence, however those studies fell outside of the inclusion criteria for this narrative review due to exclusive and distinct obstacles those populations may face. Studies included clients who identified as asylum seekers, asylees, and refugees, or a mix of these distinct legal statuses who had been resettled in a permanent host country. Additionally, I included literature from clients of any cultural and ethnic background, since many interventions are not exclusive or designated only for forced migrants from specific countries of origin. Studies were included regardless of how the persons found themselves in relation to their resettlement process as well as type and timing of gender-based violence. However, the data abstraction process considered these differences.

I excluded literature on interventions outside of therapeutic, such as pharmaceuticals, strict case management, and physical health services. Studies on interventions that were carried out pre-migration or during migration (ie: in refugee camps or for internally displaced persons) were also excluded due to the focus of this study being on post-migration and resettlement efforts. Additionally, while of critical importance, studies that documented the effectiveness of gender-based violence prevention efforts were excluded from this narrative review. There were no exclusion criteria on the age

of the client nor the year of intervention, mostly due to the scarcity of literature identified at the intersection of therapeutic interventions, female forced migrants, and gender-based violence.

Figure 1: Flow chart of systematic review with inclusion and exclusion criteria.



Data Abstraction

The search for academic and grey literature based off the search criteria and after preliminary exclusion yielded over 100 texts. Literature was included in the final data abstraction process if they (i) discussed specific interventions for working with female forced migrants who are victim/survivors of gender-based violence; (ii) the intervention was carried out after the females were in their final stage of resettlement (rather than temporarily in a refugee camp or secondary host country); and (iii) captured the voice of the female victim/survivors or the therapist or service provider working directly with them. The researcher was particularly interested in hearing the client's voice as closely as possible. Due to the specifics of the literature search, the researcher proceeded with carefully reading and abstracting findings from nine representative texts (see Table 1).

Table 1: Data abstraction form

Reference		
Country of origin		
Country of resettlement		
Legal Status		
Location and Setting		
Timing and description of GBV		
Client characteristics		
Voice (client or therapist)		
Intervention: Therapy or Psychosocial Support		
Best practices across intervention stages: engagement, assessment, intervention, evaluation		
Characteristics that were effective		
Client's expression of effective services		
Psychoeducation Presence or not? Description		
Spirituality or Traditional Healers Presence or not? Description		
Intrepreter/Cultural Broker		
Somatic practices		
Systemic Barriers to Access		
Implications & Discussion		

Findings

Representation in the Literature

Country of origin. The representation of the women's country of origin and the country of resettlement was narrow. All the researchers and authors worked with women from Africa, the Balkan Peninsula, or Southeast Asia. However, two articles did not define a country of origin for the population with whom they were working (IRC, 2015; Jackson, 2017). There were three texts that reported on interventions with women from Africa, two of which did not define specific African countries (Akinsulure-Smith, 2014; Glover & Leibling, 2017) and one that reported on women from Ethiopia, Somalia, and Sub-Saharan Africa (Kira, et. al, 2012). A large representation of literature documented interventions carried out with women from Southeastern Europe's Balkan Peninsula. One article reported on findings with women from Albania (Akinsulure-Smith, 2012) while another focused-on interventions with Albanian Women from Kosovo (Koch & Weidinger-von der Recke, 2009). A third involved a case study with a female victim/survivor from Bosnia (Schulz, Marovic-Johnson, & Huber, 2006). Lastly, there was one article that discussed interventions with women from Southeast Asia, specifically Cambodia (Nicholson & Kay, 1999).

Country of resettlement. Narrow representation was also identified in the literature regarding the country of resettlement. The majority of articles were written on interventions carried out in the United States (Akinsulure-Smith, 2014; Akinsulure-Smith, 2012; IRC, 2015; Kira, et. al, 2012; Nicholson & Kay, 1999; Schulz, Marovic-Johnson & Huber, 2006). Two articles came from the United Kingdom (Glover & Leibling, 2017; Jackson, 2017) and one article was from Germany (Koch & Weidinger-von der Recke, 2009).

Table 2: Representation in the literature

Reference	Country of origin	Country of resettlement	Legal Status	Location and Setting	Timing and description of GBV
Akinsulure-Smith, A.M. (2012).	25 y/o married, female Albanian woman from small town with two young children	NYC, U.S.	Asylum-seeker	Program for Survivors of Torture (PSOT) Partnership with Bellevue Hospital and NY University School of Medicine	sexual violence (threats, harassment, 3 very traumatic events including beatings, gang-rape) in country of origin from members of opposing political party pre-migration
Akinsulure-Smith, A.M. (2014).	African female forced migrants Country undefined	NYC, U.S.	undefined	Program for Survivors of Torture (PSOT) and Nah We Yone community-based organization	undefined pre-migration
Glover, J. & Leibling, H. (2017).	Africa undefined	U.K.	U.K. residents from African countries.	Where the client determined	FGM; undefined perpetrator pre-migration
IRC. (2015).	Female refugees within first 8 months of arrival to U.S. Varied. Not mentioned	U.S.	Refugee status	Seattle, Dallas, Baltimore, U.S.A. Resettlement Agency	Domestic Violence or Sexual Assault ongoing. Various times of when GBV began.
Jackson, C. (2017).	undefined	U.K.	undefined	Surveys	female genital mutilation (FGM); undefined perpetrator pre-migration
Kira, I.A., et al (2012).	Somali, Ethiopian and other Sub-Saharan women	U.S. Decatur, Georgia	Refugees and torture survivors	Center of Torture and Trauma Survivor (CTTS) "Bashal Group" Group Therapy Model.	trauma and torture, female genital circumcision (FGC) in country of origin. Perpetrator undefined. pre-migration
Koch, S.C., Weidinger-von der Recke, B. (2009)	Albania- Kosovo 9 Albanian women from Kosovo	Munich, Germany	Legal status undefined < one-yr in group therapy	REFUGIO Centre for Treatment and Counselling of Refugees and Survivors of Torture	maltreatment/Rape carried out by Serbian military and paramilitary personnel premigration. 6 years ago.
Nicholson, B.L., Kay, D.M. (1999)	Cambodia	U.S.	Refugees	Outpatient, group-therapy	All had endured multiple traumatic events during 14-year reign of Pol Pot and lost family and kinship. Pre-migration

Reference	Country of origin	Country of resettlement	Legal Status	Location and Setting	Timing and description of GBV
Schulz, P.M., Marovic-Johnson, D., Huber, D.C. (2006).	64 y/o Bosnian Muslim from former Yugoslavia. Self-taught functional literacy in Serbo-Croatia. Fixed income, subsidized housing for the elderly. Continued use of depression medication.	U.S. St. Louis, MO	Refugee	In-home sessions	Repeated sexual and physical assaults by acquaintance (trusted family friend) during war in former Yugoslavia, witness of war atrocities, and sudden death of husband, numerous losses resulting from flight and resettlement as refugee. "Became a target of a particular individual's rage" Pre-migration

Location and setting. Six of the nine articles documented the full therapeutic process with clients in an outpatient setting, and discussed the intervention from engagement through evaluation phases (Akinsulure-Smith, 2012; Akinsulure-Smith, 2014; Kira, et al, 2012; Koch & Weidinger-von der Recke, 2009; Nicholson & Kay, 1999; Schulz, Marovic-Johnson & Huber, 2006). Two articles that met inclusion criteria, and had thorough findings relevant to the research question, focused primarily on the referral and engagement phase of therapeutic intervention (Glover & Leibling, 2017; IRC, 2015). These two articles were written through a case manager and social work researcher's perspective, respectively. This emphasized focus on the engagement phase and allowed additional depth of findings for that stage of therapy. The remaining article had a unique approach to identifying the information, which was through research composed of open-ended questions with therapists who have worked with survivors of female genital mutilation (Jackson, 2017). This last article reported on the voice of therapists who have worked with victim/survivors, and spoke about effective and ineffective practices through anonymity, which is considered further in the findings.

Legal status. Although the rigorous methodology for this literature review allowed for a variety of legal statuses within the forced migrant population, there was limited representation in the texts identified. Four of the articles focused on refugees resettled within the three host countries (IRC, 2015;

Kira, et al, 2012; Nicholson & Kay, 1999; Schulz, et al, 2006). One article discussed therapeutic work with an asylum seeker (Akinsulure-Smith, 2012). The remaining four authors left the legal status of their clients unknown (Akinsulure-Smith, 2014; Glover & Leibling, 2017; Jackson, 2017; Koch & Weidinger-von der Recke, 2009). There was no direct identification of informal or undocumented asylum-seekers.

Type and timing of gender-based violence in literature. Within the nine articles, there were professionals working with women who have endured female genital mutilation (FGM) (Glover & Leibling, 2017; Jackson, 2017; Kira, et al, 2012); sexual violence and gang-rape (Akinsulure-Smith, 2012; Koch & Weidinger-von der Recke, 2009); sexual assault and domestic violence (IRC, 2015); rape by acquaintances and strangers, threats, and physical violence (Schulz, et al, 2006); and other undefined gender-based violent acts (Akinsulure-Smith, 2014; Nicholson & Kay, 1999). Within these texts, females involved in sex trafficking were not represented.

It is known that there are trauma threats for this population that commonly occur at various stages of their migration and resettlement, including pre-migration, during the migration process (crossing borders or temporary placements in refugee camps), or post-migration, during the transitions of resettlement (Akinsulure-Smith, 2014; Schulz, et al, 2006). However, all the articles except one discussed violence that occurred premigration in the clients' country of origin. (Akinsulure-Smith, 2012; Akinsulure-Smith, 2014; Glover & Leibling, 2017; Jackson, 2017; Kira, et al, 2012; Koch & Weidinger-von der Recke, 2009; Nicholson & Kay, 1999; Schulz, et al, 2006). The violence committed against these women were primary reasons why they left home, and why they became forced migrants living outside of their country of origin. The article that did not discuss GBV premigration, per se, reported on engagement interventions for women who experienced sexual assault and domestic violence throughout the entire migration process including after resettlement in the U.S. (IRC, 2015).

Interventions and voice in the literature. As previously established, all nine articles reviewed interventions that were implemented after migration, during and after resettlement in a host country.

The duration and specific type of intervention varied greatly amidst the nine articles, which are documented below (see figure 3).

Table 3: Type of therapeutic intervention and perspective of the article

Author	Type of Therapeutic Intervention	Voice and Perspective of Literature
Akinsulure-Smith, A.M. (2012).	Brief Recovery Program (BRP) includes four, 2-hour psychotherapy group sessions with use of psychodynamic, cognitive, behavioral, client-centered, and supportive therapies. Participant was also in individual psychotherapy, social/case management, and had legal support.	African-American therapist voice through a clinical case study.
Akinsulure-Smith, A.M. (2014).	Group and individual therapies and psychosocial supports.	African-American therapist. Client voices come through in writings from clients, their actions, attendance to sessions, and requests.
Glover, J. & Leibling, H. (2017).	Engagement, referral, and assessment intervention through 20 interviews with survivors of FGM which were recorded, transcribed verbatim and analyzed. Obtained feedback from women regarding the results and analysis of data.	Trainee clinical psychologist researcher and 20 clients. Researcher developed a theoretical model.
IRC. (2015).	Engagement and referral intervention that screened for and respond to domestic violence and sexual assault.	IRC humanitarian field staff doing screening and case management, and quotes from female clients.
Jackson, C. (2017).	Variety of theoretical modalities. 75% of counselling professionals had been trained in and used a humanistic, person-centered approach.	Voice captured was that of 154 therapists who have worked with FGM survivors, through open-ended survey questions.
Kira, I.A., Ahmed, A.,Wasim, F., Mahmoud, V., Colrain, J., Rai D. (2012).	Group therapy that emphasizes social advocacy and community healing. Homogenous, mono-ethnic groups, open format with flexible themes. Primarily using CB approaches with psychoeducation.	Somali-American case manager/ community liaison and consulting therapist who does not identify as Somali.
Koch, S.C., Weidinger-von der Recke, B. (2009)	Verbal trauma therapy methods with additional elements of dance/movement therapy (DMT). Treatment follows stages of stabilization, confrontation, and integration.	Therapist via detailed case study.
Nicholson, B.L., Kay, D.M. (1999).	Weekly 2.5 hour group sessions for 2 years. Participants first engaged in individual therapy. Strengths perspective coupled with theoretical constructs from social constructivism and narrative sharing. Group focused on direct skills learning (public transit, phones, shopping), health, and self-expression.	Therapist. Caucasian, American social worker and bilingual social worker who identifies as Cambodian. Unsure of legal status of the social worker from Cambodia.

Author	Type of Therapeutic Intervention	Voice and Perspective of Literature
Schulz, P.M., Marovic-Johnson, D., Huber, D.C. (2006).	25, two-hour, in-home sessions over course of 9 months. Cognitive-behavioral approach, cognitive processing therapy for rape victims.	Therapist and their supervisor. Therapist was native of former Yugoslavia fluent in English and Serbo-Croatian. Unsure of citizenship.

Themes of Effective Therapeutic Interventions in the Literature

This section synthesizes findings from the literature on what therapists and clients identified as effective characteristics of interventions. From the synthesis, 12 sub-themes emerged and were then organized into four salient themes:

1) Professional preparedness and perspective;
2) Intentional progression of therapeutic themes;
3) Interprofessional collaboration and referrals; and
4) Culturally-informed therapy.

Professional preparedness and perspective. Effective therapies captured and discussed in this section include the therapists' professional development, their ability to understand clients through a theory-driven practice, and their own personal demeanor and perspective of the women's' situations.

Professional development. Within the professional social work field, it is recognized that the workers carry strength in the tools of their presence and their ability for critical thinking, based on gained knowledge. Especially with this population, it is critically important for the clinician to have a deep-rooted sense of self and understand how her own demographics such as race, culture, and gender influence the clinical work with female victim/survivors (Akinsulure-Smith, 2012; Akinsulure-Smith, 2014; Glover & Leibling, 2017; Nicholson & Kay, 1999; Schulz, Marovic-Johnson & Huber, 2006). Practices that can both inform the clinician's self-awareness and sustain the positive influence in their clinical work is having regular self-care and support systems, such as consistent supervision and peer support groups (Akinsulure-Smith, 2014).

Through recognizing the enormous levels of diversities for this population, clinicians can gain important insights into unique personal experiences, strengthen the therapeutic alliance, and offer more relevant information to overcome the client's obstacles (Akinsulure-Smith, 2014). As stated by one

author, what is abnormal to the therapist or might even be a human rights violation, could be completely normal and positive from the client's perspective (Jackson, 2017). This point leads into the next effective strategy in professional development when working with this population; client and issue-specific trainings. Beyond self-awareness and cultural-awareness, the articles documented the need for more concrete trainings on specific themes when working with this population. The article written by Jackson (2017) focused solely on victim/survivors of FGM/C, and identified that survivors often present with trauma symptoms, feelings such as shame, embarrassment or guilt, physical problems, and emotional disorders. The training sessions mentioned and encouraged by Jackson (2017) tended to cover legal issues around disclosure and safeguarding.

Theory-driven. The literature from this review highlighted several theories that are pertinent to the lens professionals carry into therapeutic sessions with female forced migrants and victim/survivors of gender-based violence. Tying to the self- and cultural-awareness mentioned in the previous section, a required theory and perspective highlighted throughout the literature was that of cultural-sensitivity. In addition to knowing important components of one's culture and sub-culture, cultural-sensitivity does not assume how the client interacts within their assigned culture. Rather, it views differing cultural values with humility and without hierarchy, and allows for client self-determination within their own completely unique and personalized, individual culture. While in a group session, "typical Albanian plaintive cries are uttered while simultaneous folding of hands onto the breast and swaying of the torso is observed. Immediately, several women begin to speak but then let the oldest woman go first" (Koch & Weidinger-von der Recke, 2009, p. 292). In this example, the therapists viewed the experience through a lens of cultural-sensitivity. Koch and Weidinger-von der Recke (2009) learned from the experience, they allowed the clients to express themselves as they desired (self-determination), and were sensitive in understanding and humble in allowing the eldest woman to speak first, as was their cultural practice.

Strengths perspective and empowerment theory were discussed in the articles as cornerstone practices to providing client-centered care (Akinsulure-Smith, 2012; Akinsulure-Smith, 2014; Glover & Leibling, 2017; Kira, et al, 2012; Koch & Weidinger-von der Recke, 2009; Nicholson & Kay, 1999; Schulz, et al, 2006). Nicolson and Kay (1999) coupled strengths perspective with theoretical constructs from social constructivism to improve clients' sense of safety, security, and empowerment for adaptive functioning during the acculturation phase. The authors also emphasized client and communal strengths and linked women with ethnic community supports when the women were ready to further enhance their strengths and sense of empowerment (Nicholson & Kay, 1999). The clients of Glover and Leibling (2007) discussed how their therapist/researcher displayed a palpable sense of admiration and respect for the women. It was observed that the professionals employed strengths perspective and empowerment theory, allowing client comfort and voice to talk about such an intimate and traumatic experiences, FGM/C in this case (Glover & Leibling, 2007).

According to the literature, another social work concept that is imperative to working with this population is witnessing and tapping into their resiliency. When clients are victim/survivors of human rights violations, atrocities, or devastations, the challenge of the helping professional is to elicit the same strength and resiliency that enabled the women to survive and migrate to a safe land (Akinsulure-Smith, 2014). Ironically, according to Kira et al (2012) another way to bring forth the women's resiliency is through being empathic, supportive, and empowering the clients' emotion of anger. Therapeutic interventions should elicit their refusal to surrender, build on the group-based anger, validate it, and allow that motivation to reinforce resiliency (Kira, et al, 2012). Nicholson and Kay (1999) determined that a primary goal was to help the women make meaning of their disruptive experiences. Furthermore, the authors proposed that in helping the women make meaning of their experiences, the women's capabilities to successfully adapt to a new environment could be strengthened and they would become more resilient.

The ethical value and lens of allowing the client to determine their actions, unless it involves harm to self or others, is known as client-determination. Professionals and the women they serve voiced in the literature that effective therapy happens when a therapeutic relationship of nonjudgement, understanding empathy, and accepting gratitude is fostered. These characteristics give the client reassurance and allow them the permission to speak and act from their true selves (Jackson, 2017). Furthermore, in the research study written by Glover and Leibling (2017), clients said interventions are effective when they have voice, and are given the opportunity to honestly talk about what happened to them. When they are listened to, cared for through empathic responses, they are shown that people really can be trusting (Glover & Leibling, 2017).

Ethical values that were highlighted in the literature included awareness of transference and countertransference while in session. Glober and Leibling (2017) noted this awareness as high importance, especially when service providers are assessing effectiveness of interventions. Additionally, the professional service provider should feel a strong sense of moral and ethical duty toward the women they are working with (Glober & Leibling, 2017), a concept that circles back to the need for professional development previously described.

Intentional progression of therapeutic themes. For many of the professionals and clients whose voices were documented in the literature, the progression of therapeutic themes was critically important. For the context of female forced migrants, many identified acculturation to the new society as the presenting problem rather than the mental health symptoms (Nicholson & Kay, 1999). To carry out effective, healing therapy for this population, authors reported that the client's basic needs first had to be met, often through case management, and an empathic introduction to Western therapy had to be provided, through psychoeducation.

Pace and flexibility. Most authors emphasized that while it is important to have structured, planned sessions or follow guidelines for modalities, flexibility is critically important for this population

due to individual needs and unique realities (Akinsulure-Smith, 2012; Akinsulure-Smith, 2014; Kira, et al, 2012; Nicholson & Kay, 1999; Schulz, Marovic-Johnson, & Huber, 2006). One article found it effective to double the timeframe for cognitive processing therapy (CPT) and maintain therapeutic flexiblity by incorporating written exposure and having the woman complete a dream journal (Schulz, Marovic-Johnson, & Huber, 2006). In the case of Nicholson and Kay (1999), the client's non-verbally or indirectly voiced that the intervention was effective. The clients decided to double the frequency of the sessions, they took initiative in choosing session topics, planned activities, took public transit together instead of individual taxis to get to therapy, and built a support network to socialize outside of the organized group. It is vital to allow treatment to be inconsistent, progress in uneven stages, and to use creativity (Akinsulure-Smith, 2014).

Psychoeducation. Since therapy and social supports were new concepts to most of the women, the data emphasized the need for psychoeducation throughout the therapeutic relationship. Psychoeducation occurred before, during, and outside of the therapeutic sessions, including during screenings and research surveys. Through psychoeducation, the therapists helped clients understand symptoms, primarily of depression, anxiety, trauma, and normalized coping mechanisms and reactions (Akinsulure-Smith, 2012). It was also used to describe how therapy works and what is to be expected during therapy (Schulz, Marovic-Johnson & Huber, 2006). A client voiced that psychoeducation made it possible to deal with PTSD symptoms (Kira, et al, 2012). Likewise, clients who worked with the International Rescue Committee (2015) and their early screening tool claimed that the identification of GBV and having education and mental health service was critical to their therapeutic engagement.

The presence of psychoeducation also clarified questions, doubts, fears about confidentiality and documentation, and normalized situations so women did not feel "crazy", which was frequently due to stigma women received when referred to mental health services (Akinsulure-Smith, 2014). Psychoeducation also meant educating the attorney on the impact of trauma and how to respond to the

client's changed affect during legal cases (Akinsulure-Smith, 2012). Psychoeducation was described as a part of the "flowing transitions" of therapy (Koch, Weidinger-von der Recke, 2009, p. 292) with provision of information on symptoms, outlining steps of healing, and later interventions to help the psychic symptoms.

Theme progression. The articles addressed a similar progression of themes for this population. From what the therapists have witnessed, victim/survivors have needed themes of safety, loss (family, identity, status, culture), grief and mourning, shame and anger, and cultural adaptation (Akinsulure-Smith, 2014, p. 688). These therapeutic themes also fit into the stages of stabilization, confrontation, and integration put forth by Koch & Weidinger-von der Recke (2009). There was agreement in the literature that an initial phase of therapy, in conjunction with initial and ongoing psychoeducation, was the pressing need to overcome current-day traumas and obstacles in the host country prior to discussing past trauma. In fact, premature discussion of past trauma has been known to reactivate traumatic reactions (Kira, et al, 2012). It was observed that some traumatized clients do not talk for years or decades about the horrible experiences they've lived because they feel guilt and shame around the traumatic occurrences (Koch & Weidinger-von der Recke, 2009). Furthermore "everyday demands in exile usually require the repression of earlier devastating experiences: refugees need to maintain their defense mechanisms to manage in the new environment, care for their families, and demonstrate strength" (Koch & Weidinger-von der Recke, 2009, p. 289).

Articles that discussed group therapy (Akinsulure-Smith, 2014; Kira et al, 2012; Koch & Weidinger-von der Recke, 2009; Nicholson & Kay, 1999), established that the first step was to create a new identity and way for everyone to belong to the group. At times, this made homogeneity of group members important (ie: gender). Data reported that group therapy was a place the women could form emotional support, group cohesion, and explore important issues like politics and religion (Kira, et al, 2012). Cultural adaptation then took on a form of group case management, or direct skills learning, in

which the women would support each other, manage new social systems (health, phones, transit, shopping), and address daily concerns (Kira, et al, 2012; Nicholson & Kay, 1999).

Evaluation. The article written by a therapist researcher (Glover & Leibling, 2017) documented the voices of the client population and reported that the clients did not feel their needs were being met. The clients expressed a lack of meaningful and effective service response. More specifically, the women (Glover & Leibling, 2017) felt that their pressing needs were exacerbated by not having meaningful and effective therapeutic interventions. (Note: their recommendations for effectiveness are documented in other sections).

In the remaining articles, it was reported that female clients evaluated the interventions through verbal and physical means. After one client shared her private story of rape one year into group therapy, she said it helped her to talk about her loneliness, and she was grateful for a cohesive and understanding group (Nicholson & Kay, 1999). Another therapist witnessed her client's "disposition blossom" and a "significant reduction in her PTSD and depressive symptoms, and finding joy in her life" (Akinsulure-Smith, 2012, p. 294). The female client had a safe space to admit that although she still missed her family and friends in Albania, she anticipated her family having a good, safe future, free from persecution (Akinsulure-Smith, 2012). Data stated that through ongoing evaluation, the clients had voice and self-determination. In fact, one group had received so much motivation that they became a self-sustaining group and went on to mentor the next generation of therapy groups (Kira, et al, 2012). The women reported that the group effectiveness originated from their comfort level with one another and the visual presence of healing (Kira, et al, 2012). Nicholson and Kay (1999) carried out ongoing evaluation and witnessed a lessening of symptomology, increase in self-esteem, more expressive interactions, and adaptive functioning.

Findings from Schulz, Marovic-Johnson and Huber (2006) suggest that evaluations were an effective therapeutic intervention because it demonstrated both the client and the clinician progression

throughout the therapeutic relationship and buffered the client ‘s strength to continue healing after therapy ended. Standardized tests, such as the PSS, also demonstrated effectiveness (Schulz, Marovic-Johnson & Huber, 2006).

Interprofessional collaboration and referrals.

Referral to therapy. Since female forced-migrants and victim/survivors of GBV have many pressing, basic needs and mental health can be a foreign concept, "the referral source and the reason for referral can significantly influence the treatment process and outcome" (Akinsulure-Smith, 2014, p. 682). For example, an interdisciplinary referral could come from a client’s lawyer who informs them that mental health services could strengthen their asylum case or calm the overwhelming symptoms they are experiencing (Akinsulure-Smith, 2012). Similarly, the case managers from IRC (2015) who implemented an early scanning tool to identify domestic violence or sexual assault, provided psychoeducation to the women in situations of ongoing violence and successfully referred them to therapy. Furthermore, health care providers have been effectively introducing clients to therapy by identifying reported distress from war, providing psychoeducation, and making an interdisciplinary referral (Schulz, Marovic-Johnson & Huber, 2006). Referrals can also happen between therapists when needs are identified that primary therapists cannot meet, such as group therapy (Nicholson & Kay, 1999). Through another research project, Glover and Leibling (2017) introduced, or re-introduced, therapeutic services to females who have endured FGM/C. Through their work, women admitted that “they had not considered talking about their experiences to be beneficial in any way” (Glover & Leibling, 2017, p. 21) and that, "talking may be an answer [she] had not yet considered (p. 22).

Referrals from therapy to other services. Similar to the effect of interprofessional collaboration strengthening the effectiveness of clients understanding and entering therapy, data reported that when therapists refer clients to other services, it can buffer their own therapeutic interventions and increase effectiveness. Akinsulure-Smith (2014) states that access to multi-disciplinary services (ie: legal, medical,

food) is critical to the therapeutic relationship and effectiveness. The findings indicated that women who come from collectivistic cultures may want to be referred to or incorporate community and social networks into the therapeutic process. The literature mentioned interventions such as incorporating social outings or providing information on cultural locations, like places of worship, country- or continent-specific markets or restaurants, or hair and personal care businesses (Akinsulure-Smith, 2014).

Support outside the office. Findings show that the therapist themselves must be comfortable providing this population support outside of the office (Akinsulure-Smith, 2012; Nicholson & Kay, 1999; Schulz, Marovic-Johnson & Huber, 2006). Examples given in the literature include providing support in court to be a calming presence or to testify (Akinsulure-Smith, 2012), or "care-calling" clients one or two times between sessions to help them cope with distress or remind them of coping skills (Schulz, Marovic-Johnson & Huber, 2006). Nicholson and Kay (1999) emphasized that the very structure of therapy needs to be participatory and extremely flexible in the case of any issues arising, like teaching clients how to use public transit or other immediate, direct skills learning. Effective support from the therapist also involved understanding legal issues and entitlements for the female forced-migrant population, especially due to the new cultural systems, language, and symptoms of trauma. Clinicians take on additional roles as advocates, expert witnesses, cultural educators, community outreach liaisons, and representatives for public policy (Akinsulure-Smith, 2012).

Culturally-informed therapy.

Culturally-like therapist or interpreters. The therapeutic relationships took on different forms throughout the literature. Akinsulure-Smith (2014) was a culturally-like therapist for her clients, and defined this therapeutic relationship as "a willingness to move outside traditional Western ideas of therapy" (p. 689). She found herself serving in different capacities, such as a cultural translator, interpreter, expert witness, and impassioned advocate. Akinsulure-Smith (2014) also described this

depth of culturally-informed therapy as maintaining “clinical flexibility" (p. 687), and mentions how she needed to re-inform her learned concepts of therapy. For example, for her clients, the culturally-acceptable way to organize meetings was impromptu (Akinsulure-Smith, 2014). Akinsulure-Smith (2014) recognized that this could be due to socio-economic limitations or psychological vulnerability brining up overwhelming memories of trauma which made it unlikely to meet regularly.

The co-therapists, Nicholson and Kay (1999), restructured their leadership by assigning the older social worker the supervisory role, which was common practice in the culture with whom they were working, while the younger social worker who identified as Cambodian, took on the role of translating Khmer into English for her senior co-therapist. Organizing therapy around the respect for elders was reflected in another article reporting on group-therapy (Kira, et al, 2012) in which the presence of wise elders and a case manager from Somalia facilitated an effective therapeutic process. The intentional use of an interpreter as a primary member of the therapy group was also mentioned as operative (Koch, S.C., Weidinger-von der Recke, B., 2009). Furthermore, with the incorporation of cultural brokers or interpreters, the therapists identified the need for additional work with the interpreter, so they could develop more of a partnership or team (Akinsulure-Smith, 2012). "This required the clinician to conduct a very careful review of each of the [modality] components with the interpreter" (Akinsulure-Smith, 2012, p. 292) including outside of the session. The authors built rapport as a triad between the clinician, interpreter, and the client. Glover and Leibling (2017) limited the research and efforts due to the language limitations, and therefore the validity and quality of information. While interpreters were utilized, cultural sensitivity guided the researcher’s questions and she observed that confessing that she knew very little about a certain subject was advantageous in the interviews (Glover & Leibling, 2017). This shift enabled the women “to adopt an 'expert' position, thereby placing them in a more empowered standpoint (Glover & Leibling, 2017, p. 20). "This approach enabled women's underlying

belief systems to emerge" (Glover & Leibling, 2017, p. 21), a feat that can be challenging cross-culturally with women who feel ashamed and silenced due to crimes committed against them.

Spirituality and traditional healers. The findings showed high interaction with or discussion around spiritual communities or traditional healers as an integral part of the therapeutic process. Some noted mild incorporation through intentionally involving discussion of the importance of faith and culture in the women's survival (Kira, et al, 2012). Other women clients brought the subject of spirituality to the session, through epistemological exclamations or justifications, such as "mercy of God" (Koch, S.C., Weidinger-von der Recke, B., 2009). Yet another article reported this subject was breached when a client was processing grief and loss of her family and home country, exclaiming how challenging it was to not bury and engage in the religious traditions during the death of her husband in her home country (Schulz, Marovic-Johnson & Huber, 2006). With regards to prayer and spiritually, "elements of religion and spirituality frequently offer a means of self-soothing, meditation, and meaning making" (Akinsulure-Smith, 2014, p. 686). One therapist incorporated mourning traditions which allowed the clients to feel spiritually connected, cope with missing family members, and make peace with those losses (Akinsulure-Smith, 2014). The therapy group run by Nicholson and Kay (1999) engaged in the discussion of healing and health, reaffirming a sense of identity, and role played how to use the systems in their new country such as calling the doctor and talking about what to expect. Nicholson and Kay (1999) also reached out to the local Buddhist Temple as a group to further adjust to the drastic changes in lifestyle and find a sense of belonging.

Benefit of group practices. While the literature did not result in findings on a particular methodology for this population and the mental health obstacles they are experiencing, there were findings on the importance of distinguishing between individual or group therapeutic interventions. While both individual and group sessions were proven effective, the data testified that careful consideration of which type of intervention was critical to client's healing. Akinsulure-Smith (2014)

understood her client's perspective of effectiveness through their presence in session and personal requests. Akinsulure-Smith (2014) observed that while in group sessions, her clients benefitted from emotional and social supports, while the discussion of trauma mostly came up only in individual sessions. Nicholson and Kay (1999) reported that the communal support of group therapy enhanced feelings of safety and security, increased feelings of empowerment, allowed collaborative aid in the acculturation process, and reinforced individual and communal strengths. The therapists claimed, "the most important curative factor of support groups is the mutual aid and normalization of experience by members, whereas the most important goal is the enhancement of coping skills gained through the mutual aid and sharing" (Nicholson & Kay, 1999, p. 471).

Psychological supports were mentioned as being effective in group therapy, including validation of shared harsh realities such as discrimination and oppression (Kira, et al, 2012). Kira, et all (2012) stated, "community healing - working with the traumatized collective identities and damaged collective self-esteem of the individuals - is an essential task in these groups" (Kira, et al, 2012, p. 76). The authors identified therapeutic processes, such as emotional release and regulation and the moral processing of existential guilt [self-blame when other people had a different outcome from the traumatic event], which was processed successfully in group settings (Kira, et al, 2012). Although some authors thought individual sessions were best for talk therapy around trauma (Akinsulure-Smith, 2014), one group was able to breach the subject (Koch & Weidinger-von der Recke, 2009). After one year of treatment together in Germany, an Albanian client decided to share her story of rape with the other members, displaying that she had gained inner strength and stability resulting from effective group therapy. The client voiced "it [the process of sharing in a group] was good", expressed further gratitude several times, and physically appeared to have gained control and acceptance of herself (Koch & Weidinger-von der Recke, 2009, p. 293). An Albanian asylum-seeking client of individual therapy in the U.S. made a similar

decision to share her story with others. "One day she reported that she had spontaneously decided to tell her husband" (Akinsulure-Smith, 2012, 293).

In addition to how group therapy proved effective by providing social, psychological, and emotional supports, the literature showed that client-guided, and group-established rituals were also highly effective. Near the beginning of their therapeutic relationship, the women clients who worked with Koch and Weidinger-von der Recke (2009) established the simple, yet ritualistic exercise of standing and holding hands in a circle. It symbolized connection with one another, and the closure of a theme or state of affect before a transitioning to another topic (Koch & Weidinger-von der Recke, 2009). Another therapy group shared lunch together after the session, using the extra time for socializing and for the group members to share their generosity to the group leaders (Nicholson & Kay, 1999). Nicholson and Kay (1999) also observed the client-initiated practice of sharing the cultural learning curve and embarrassing moments, which became a source of mutual support, comedic relief, and sense of cohesion.

Somatic interventions. The literature did not present preferred therapeutic methodologies for this population. However, six of the articles emphasized the importance of incorporating somatic work as a part of the therapeutic interventions. The authors that emphasized somatic intervention were mostly Koch and Weidinger-von der Recke (2009) who accounted its effectiveness to the following dynamic:

> Memory and attention deficits in persons with PTSD interfere with the ability to engage within one's present situation and current life context. For this reason, the treatment of trauma survivors must focus on body awareness and affect regulation (modulation of physiological arousal) and must offer concrete and efficient methods for self-help in order to overcome feelings of helplessness. (p. 290)

Koch and Weidinger-von der Recke (2009) elaborated further by explaining that typical talk therapies are designed to treat cognitive and emotional components of trauma, but that the trauma residing in the body is not addressed. Since most symptoms of trauma are heavily based on somatic factors, nonverbal therapies provide an important compliment to common talk therapies (Koch & Weidinger-von der Recke, 2009). Kira, et al (2012) incorporated relaxation breathing and guided visualization for pain management and relief from stress and intrusion phenomena. Furthermore, their group incorporated physical activities such as crocheting, knitting, drawing, and auto maintenance which served to calm, soothe, connect with the body and the exercises continued outside of session (Kira, et al, 2012). The group sessions that incorporated somatic interventions helped normalize the clients' situations, and diminish shame and blame in a friendly, social environment (Kira, et al, 2012).

The authors mentioned simple movements such as relaxation and healing rituals to obtain effectiveness (Koch & Weidinger-von der Recke, 2009). Glober and Leibling (2017) mention incorporating simple somatic awareness, such as tuning into the client's facial features and body movements, and Nicholson and Kay (1999) found it important to note any body language changes in group dynamics. Integrative methods for psychotherapy, such as breathing techniques and deep muscle relaxation assisted the clients in coping with symptoms and proved to be very important in the recovery process (Akinsulure-Smith, 2012; Kira, et al, 2012; Schulz, Marovic-Johnson & Huber, 2006). The 25-year-old woman from Albania, seeking asylum in the U.S., reported it beneficial having deep muscle relaxation and calm breathing techniques audio recorded in her mother tongue so she could practice them outside of the session (Akinsulure-Smith, 2012).

Discussion

Limitations and Strengths of the Review Findings

The limitation of utilizing literature only in the English language creates a bias in the review, and may explain the absence of research from Latin America and other geographic regions, as well as narrow

representation on the women's country of origin. However, due to representation of certain populations, such as female forced-migrants from Latin America residing in the U.S., it is a curious finding not having any articles reflecting their experience within this search criteria. There is also a limitation in the representation of diversity in legal status and timing of the GBV, which may be due to the vulnerability of individuals who are seeking asylum or undocumented. Since many Latin American forced migrants arrive to the U.S. as asylum seekers or without documentation, these two populations who are underrepresented in the literature are likely related. This could mean many things, including they are not accessing therapeutic services equitably or are not a priority for research funding and publications. Additionally, the specific types of gender-based violence committed against the women in the research were very limited. There are various cultural stigmas around different acts of GBV, such as sex-trafficking or spousal abuse, which may have attributed to what the women reported or felt ready to report in therapy and in the research.

Another limitation is the lack of a systematic evaluation on the quality of the literature reviewed. The quality of reporting in the literature varies considerably. However, the methodology of a systemic narrative review grants each author the same weight in this researcher's findings and recommendations. There are indications of subjective bias in the value of effectiveness within each article, especially since the intervention outcomes are mostly reported by the clinician, or author-selected quotes of client voice. The clinician and agency also selects the clients they work with and the physical spaces for the interventions. Therefore, the original story of cultural values and norms, such as those who ethically agree with FGM/C, is not a part of this measure of effectiveness. The therapeutic value within these articles are truly defined by the clinician, or author, and not dictated by people outside of the ethical understandings held in this systematic review.

Finally, this researcher was limited to information that was documented or grey literature, and was consequently unable to benefit from other epistemological means which were highly valuable to this

novice area of research (i.e., interviews, conferences, discussions). Knowledge from professionals in the field working with this population and individuals from the population still hold many salient, effective interventions not yet documented in academic or grey literature. The researcher identified such professionals, women from the population, several literary works still unavailable to the public, and references from a conference that were highly relevant, yet fell outside of the inclusion criteria for this methodology.

The primary strength of this review is that it seeks the client voice to understand effective therapeutic interventions for an identified vulnerable, yet very resilient and influential population. Most other reviews of this literature do not focus on the client voice or the female experience. The findings conclude that there are significant central themes to consider when implementing therapeutic interventions with female forced migrants, and victim/survivors of GBV. However, as is discussed in the next section, different authors and clients conceptualize effectiveness and interventions differently, which is an aspect of research and practice that requires further exploration.

Bias from Western, Majority Voice

As was the case with all the literature reviewed, the perspective of mental health and, therefore, therapeutic interventions, was that of the western mentality. There is a recognition that the research and review itself is western, including the use of mental health diagnoses and symptoms from the western developed Diagnostic and Statistical Manual of Mental Disorders (DSM-V). These western concepts and the understanding of mental health impacts the voice of effectiveness, since it is the lens of focus and majority voice used to teach psychoeducation and report on developments of such interventions.

The majority voice of the therapists as authors also creates subjective bias on the measurement of effectiveness. Some literature begged the question how to analyze or evaluate validity of the literature when a dominant voice reports the findings and effectiveness of their own intervention.

Moreover, how can practitioners of the dominant culture serve as a conduit to give the clients voice in the literature, or are such attempts further dominating and silencing the clients' unique cultural thoughts and voice. For example, one article reported, "the American social worker was responsible for supervising her bicultural coworker in group process. This co-sharing of responsibility while using each of our strengths worked well for both of us" (Nicholson & Kay, 1999, p. 473). In this case, the article was evidently written by the majority culture with Western bias. The same article brought to light an additional impediment to obtaining the pure voice of the female forced-migrant perspective. Nicholson and Kay (1999) discussed how open discussions were unfamiliar for women from subtle or more indirect cultural communication styles. The authors observed how cultural politeness interfered with individuals sharing their opinion, especially if different from others (Nicholson & Kay, 1999). Each culture and sub-culture has a unique expression of self, including the critique of effectiveness.

The article from Jackson (2017) reported a detailed reflection on subjective bias coming from therapists and researchers working directly with this population. Jackson (2017) hypothesized that due to the simple, anonymous survey that they administered to therapists, that the professional respondents perhaps responded from a depth of honesty regarding effectiveness or ineffectiveness. The author (Jackson, 2017) insinuated that anonymous surveys likely had more validity since the respondents were not influenced by the public knowing who reported such statements, as is the case with many academic articles and literature. This is an important finding to consider in future research and literature reviews as professionals try to find effective interventions for this population.

Barriers to Research on this Population

As discussed in the literature on women who are forced migrants and victim/survivors of gender based violence, the women have multiple points of contact with service providers who are carrying out various interventions. The background and contextual information on this population, makes it undeniably clear that ongoing support is needed throughout the migration process. However, focusing

on therapeutic interventions post-migration means working with mental health symptoms that previously may not have been apparent.

> Many of these women developed serious psychosocial and psychological problems, often manifested in physical complaints. However, symptoms frequently did not appear until after initial resettlement tasks were accomplished. Only then did the awareness of the depth of losses become apparent and grief and sadness settle in. (Nicholson & Kay, 1999, p. 470)

Taking this into consideration, as well as the quality of life for asylum seekers and the undocumented population who are still caught in the process of resettlement, asylum seekers and individuals without legal documentation are needing to prioritize daily survival and the initial case management phase mentioned in the findings. Due to the necessity of establishing a foundation of safety prior to doing intensive trauma work in therapy-like initiatives, asylum seekers face a great therapeutic barrier. This preliminary requirement of safety, which is ambiguous for most asylum-seekers, makes the therapeutic process and forward movement more challenging, longer, and necessitates flexibility from the service providers.

The research, documentation, and literature on effective interventions for this population post-migration is recently starting to blossom, but certainly not without ongoing barriers to the research process. Researchers Glover and Leibling (2017) reported being met with resistance, distrust, or even was ignored when approaching nongovernmental organizations working with FGM survivors in England. The authors went on to assert that in doing so, the service providers are exercising power over the clients, in terms of restricting the victim/survivors informed choice to participate in the research (Glover & Leibling (201). "The dominance of the gatekeeper has been observed in other sensitive research within the sexual and gender-based violence literature... some gatekeepers overpowered and drowned the voices of others" (Glover & Leibling, 2017). This action places the client in a disempowered position

and does not allow them the opportunity of self-determination (Glover & Leibling, 2017). Given that there is a lack of evidence-based research, and some service providers are suspicious and uncooperative when approached by researchers, it could be a slow and uncomfortable process to finding evidence-based material and improving interventions.

Implications

Social Work Practice. Based off the need for grounded self-awareness when working cross-culturally, it is imperative that therapeutic providers recognize the vast diversity and sub-cultures within more-broadly named populations, such as African cultures. Due to the heterogeneity among cultures commonly referred to, the need to educate oneself on the geopolitical histories of client's narratives is also essential to providing effective therapeutic interventions. These research findings have implications when service providers group women together from an entire continent without considering the intricacies of their sub-culture and individual diversities. Thus, there must be a cultural sensitivity and respect, knowledge, and understanding for clients down to an individual level, as is the case for all client and social worker encounters, and cannot be overlooked with these clients either.

Additionally, it's ethical and essential for therapeutic professionals to be educated on the presenting issues identified in the population whom they are serving. There are trainings for specific types of GBV, such as female genital mutilation or cutting (FGM/C), human trafficking, or ongoing domestic violence (DV). Therapists working with this population need to have strong professional development in these areas. Thankfully, these trainings are becoming more common, as the service providers anticipate and respond to what issues arise within the female forced-migrant population.

Again, while resiliency and strengths are important perspectives when working with any population, the literature emphasized viewing therapy through these lenses more acutely when working with female forced migrants and victim/survivors of gender based violence. These perspectives further allow social workers to support their client in recognizing their strengths, embracing anger, and creating

meaning in their adversities; all of which strengthen resiliency. The resilient person will identify meaning and purpose in the adverse event and use it to drive change for themselves and others, as was the case with the female therapy group that decided to become mentors for the next group therapy members.

Research and literature is highlighting interprofessional collaboration as a salient way forward for effective therapeutic interventions at all levels, including referral to and from therapy itself. Particularly for female forced migrants and victim/survivors of GBV, interdisciplinary treatment teams can include therapists, psychiatrists, medical providers, legal teams, immigration representatives, social services, social networks, cultural organizations, spiritual communities, and interpreters. Access to information shared between these multifaceted services increases chances of comprehensive care for the women clients from a bio-psycho-social-spiritual perspective. The theme of support outside of the office as an effective intervention circles back to the social work ethical values of *dignity* and *social and political action* (NASW, 2017) and transcends beyond this population, although it is highlighted in the literature as crucial for female forced migrants and victim/survivors of GBV.

In seeking the client voice to measure effectiveness, data showed that ongoing evaluation throughout therapeutic services is important. Some clients expressed in the literature, that their pressing needs were exacerbated by not having meaningful and effective therapeutic interventions (Glover & Leibling, 2017); meaning without ongoing evaluation and knowledge of effective services; the interventions themselves could be causing further stress and distress; or due to the many complex issues explored in the literature review and systematic review findings.

In sum, the findings of this review suggest implementing therapeutic interventions that have been developed based on and fully-informed by the women and their unique experiences. Professionals should allow their interventions to be greatly informed by the culture of the population being served. Very few of the articles mentioned specific therapeutic methodologies that were used. Rather than testing how efficacious pre-existing interventions were with this client population, the professional

service providers prioritized client-driven therapy with flexibility to re-inform their therapeutic plan as the relationship evolved. Most authors and therapists from the review allowed the client's culture to inform the way they proceeded with therapy. Specifically, this meant incorporation of ongoing culturally-sensitive psychoeducation, welcoming spirituality concepts and cultural brokers or interpreters as a part of the therapeutic alliance, and choosing the appropriate therapy, whether it be individual, group, or both. Furthermore, the technique of combining verbal and nonverbal/somatic modalities supported victim/survivors of GBV to strengthen the relationship with their body and fully experience life with an empowered voice and sense of self.

Future research. The preliminary literature review of this current study details the depth of literature on the context and statistics for this population, including all stages of their journey (i.e., pre-, during, and post-migration). The quantity and quality of these reviews provide a solid background for further research on effective therapeutic interventions for the population being served. However, there is a critical need for evidence-based research on effective post-migration interventions from the voice of the client. This need for research includes the documentation of unique experiences of the female forced-migrants culture, sub-cultures, and historical contexts. In efforts to achieve the least-subjective and biased perspective of effectiveness, it's essential for service providers and researchers to build trust with one another. There is currently an apparent distrust towards researchers which complicates their ability to carry out important research and disseminate information. The research itself can be greatly empowering for the researchers, female clients, clinical therapists, and literary audience, alike.

Summary

The findings conclude that there are significant central themes to consider when implementing therapeutic interventions with female forced migrants, and victim/survivors of GBV. These salient therapeutic components include culturally-sensitive considerations, perspectives and theories, and processes that are essential for the practice of clinical social work and other professions providing

therapeutic services for this population. Provision of therapeutic interventions to this population is complex and requires a very deep understanding of the self- and the client's cultural and historical dynamics. However, the common themes identified were successfully arranged into four groupings of considerations for professionals in the field: professional preparedness and perspective, intentional progression of therapeutic themes, interprofessional collaboration and referrals, and development of culturally-informed therapy. While it is a complicated task to approach the position of the forced-migrant female voice in therapeutic intervention to improve symptoms and obstacles of gender based violence and migration, it is critically important to our profession and systemic well-being. There is a great opportunity to understand the limits of the research, improve provider trust in the research process, and further the knowledge base of effective therapeutic interventions in working with this highly resilient and influential population of females.

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