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Gwladys Demazure[1], Céline Baeyens[1] & Nicolas Pinsault[2,3]

[1]*Univ. Grenoble Alpes, Univ. Savoie Mont Blanc, LIP/PC2S, Grenoble,*
[2]*Univ. Grenoble-Alpes/CNRS/TIMC-IMAG UMR 5525, Grenoble,*
[3]*Univ. Grenoble-Alpes/Critical Thinking Federation FED 4270, Grenoble, France*

Background: Unaccompanied refugee minors (URMs) are a population at risk of mental health problems and a population with whom the therapeutic alliance can be difficult to set up. The therapeutic alliance's quality can impact the result and effectiveness of psychotherapeutic interventions. The aim of the present study was to gather URMs' points of view about mental health services and mental health professionals (MHP) in the host country. A summary of interviews conducted with URMs will allow a better understanding of their perception and expectations. **Methods:** Seven databases were searched with English and French keywords. In the end, nine studies were selected. **Results:** The review of the interviews shows that URMs do not have a clear perception of MHP – it seems difficult for them to trust MHP, but also to understand the value of sharing past painful experiences to reduce current symptoms. They can have a negative perception of mental health and consider that this is not a priority. URMs prefer to focus on day-to-day problems, do activity-based interventions and do group sessions to value social interactions. **Conclusions:** Clinical and methodological implications are discussed. The development of an instrument to evaluate therapeutic care for URMs could be interesting for future research and for clinicians.

Key Practitioner Message

- Unaccompanied refugee minors (URMs) are at risk for developing mental health problems.
- They need adapted mental health care, but therapeutic alliance can be difficult to build with them.
- URMs have a biased perception of mental health and mental health professionals (MHP), and MHP seem to not fulfil URMs' expectations.
- MHP could improve therapeutic alliance with URMs by getting interested in their day-to-day problems in the first place rather than past painful experiences and do activity-based interventions.
- Developing an instrument allowing a quantitative assessment of therapeutic care would provide a more precise view of the situation and could have clinical implications.

Keywords: Systematic review; unaccompanied refugee minors; semistructured interviews; therapeutic interventions; mental health professionals

Introduction

The United Nations General Assembly (UNGA) defines unaccompanied refugee minors (URMs, also known as unaccompanied asylum-seeking minors or unaccompanied separated children) as 'girls and boys under 18 years of age who are separated from both parents and are not being cared for by an adult who – by law or by custom – is responsible for doing so' (UNGA, 2005). They are considered 'unaccompanied' if they were separated from their parents or primary caregiver(s) before leaving their country of origin or during the journey to a host country. In mid-2020, the United Nations estimates there are around 26 million refugees with four million are asylum seekers (UNHCR, 2020b). Between 2010 and 2019, around 400,000 URMs applied for asylum in 117 countries or territories (UNHCR, 2020a).

Unaccompanied refugee minors may have experienced one or more stressful life events before or during the escape from their country of origin, such as physical violence, loss of close family members or life-threatening events (Höhne, van der Meer, Kamp-Becker, & Christiansen, 2020). They might also encounter ongoing post-migration stressors such as concern about family overseas, financial difficulties, housing security, stigma, perceived discrimination, asylum process and immigration policies (Li, Liddell, & Nickerson, 2016; Purgato, Tol, & Bass, 2017).

This population is known to be at risk for developing mental health problems, with 41.9% of them meeting the DSM-IV criteria for a mental disorder (Höhne et al., 2020), such as depression and anxiety – and more particularly post-traumatic stress disorder (PTSD) (Derluyn, Mels, & Broekaert, 2009; Hodes, Jagdev, Chandra,

& Cunniff, 2008; Huemer et al., 2009; Jensen et al., 2019; Lustig et al., 2004; Sanchez-Cao, Kramer, & Hodes, 2013; Vervliet, Lammertyn, Lammertyn, Broekaert, & Derluyn, 2014; Vervliet, Meyer DeMott, et al., 2014).

Several factors are known to influence mental health of URMs. A literature review identified that female gender and low support accommodations are considered risk factors of psychological distress. Yet social support, high support living arrangements, contact with family members and cultural competences are considered protective factors. On another hand, age, origin, residential status, time spent in host country and educational background cannot be considered reliable predictors of mental health problems in URMs (Höhne et al., 2020). Despite the conclusion that URMs seem to need an adapted mental health care, half of them reported that this need is unmet (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006; Sanchez-Cao et al., 2013). URMs also made less use of psychiatric care than born peers (Björkenstam et al., 2020). Instead, URMs sought medical care from non-MHP (physicians, nurses, etc.) for somatic complaints and health problems, often associated with emotional and behavioural problems. However, youths with PTSD did not look more for mental health care than those without PTSD (Geltman et al., 2005). Some URMs may consider PTSD symptoms to be inevitable due to their traumatic experiences and may be reluctant to discuss it, especially if they are focused on the uncertainty of their legal status and the instability of their accommodation unit placements (Sanchez-Cao et al., 2013). Björkenstam et al. (2020) concluded that the barriers to care encountered by refugee youth (including URMs) can be detrimental to their mental health (Björkenstam et al., 2020). Moreover, URMs might be reluctant to seek or accept assistance from adults, including mental health professionals (MHP) due to language barriers, culture (e.g. difficulties in acknowledging psychological symptoms), coping strategies (e.g. avoidance) and help-seeking behaviours (Sanchez-Cao et al., 2013).

According to the National Institute for Health and Care Excellence (NICE) guidelines, trauma-focused cognitive behavioural therapy (TF-CBT) interventions are effective in improving PTSD symptoms and other important mental health outcomes among refugee children and youths and that improvement is long-lasting (Jensen, Holt, & Ormhaug, 2017; National Institute for Health & Care Excellence, 2018). TF-CBT with culturally sensitive techniques incorporated into the standard protocol could also be suitable and effective for traumatized refugees (Slobodin & De Jong, 2015). In a previous review, we found that psychotherapeutic interventions offered to URMs were heterogeneous, with interventions based on cognitive behavioural approaches, systemic approaches, transcultural approaches or multimodal approaches. Almost 60% of the studies cited in the review reported a decrease in their patients' symptoms (PTSD, depression and anxiety symptoms) (Demazure, Gaultier, & Pinsault, 2017). However, most reviews on mental health with refugees and asylum seekers are mainly focused on the treatment of PTSD or trauma-related symptoms (Uphoff et al., 2020), when mental health is not limited to the presence or absence of psychopathological symptoms. There is a need to take into consideration psychopathological symptoms but also social and individual factors, pre-migration and post-migration factors, psychological and social functioning and resilience (Purgato et al., 2017). When 30% of an English sample of URMs (compared to 31% for accompanied RMs) received a trauma-focused intervention, results showed that URMs had a higher rate of missed appointments at the clinic and attended fewer total sessions than accompanied refugee minors (Michelson & Sclare, 2009). This high rate could be partly due to young people not understanding what mental health services can offer, as well as being concerned about the stigma attached to mental health (Street, Stapelkamp, Taylor, Malek, & Kurtz, 2005). Knowing this, URMs seem to be a population with whom the therapeutic alliance can be difficult to build up, thus impacting the effectiveness of the psychotherapeutic intervention. So far, studies with URMs have mainly been focused on the effectiveness of the therapeutic intervention on specific symptoms. As the effectiveness of a therapeutic intervention is intrinsically related to the therapeutic alliance and the patients' expectations, both towards the therapist and towards the therapeutic intervention, it seems surprising that no studies have looked at issues concerning the therapeutic alliance or the psychotherapeutic relationship between URMs and their therapist.

Therapeutic alliance and therapy effectiveness

Bordin (1979) defines the therapeutic alliance, or working alliance, as 'one of the keys, if not *the* key' in the process of change that occurs between the patient, the person who seeks change, and the therapist, the one who offers to be a change agent. He describes three major components of the working alliance: the mutuality of agreement on goals of therapy, the agreement regarding the tasks and responsibilities of each therapy partner and the personal bond between client and therapist (Bordin, 1979). These components seem essential in any kind of therapeutic programme, with any kind of patient. A meta-analysis showed that the more positive the therapeutic relationship is, the higher the efficacy of therapy is (Del Re, Flückiger, Horvath, Symonds, & Wampold, 2012; Karver, Handelsman, Fields, & Bickman, 2006; Martin, Garske, & Davis, 2000). The strength of the therapeutic alliance is considered a predictor of therapeutic outcomes (Martin et al., 2000; Szymańska, Dobrenko, & Grzesiuk, 2017). According to Szymańska et al., and's (2017) model, patients who rate their therapist as effective believe that the therapist is involved, interprets, informs and focuses on the relationship. It seems important for patients to feel that the therapist is interested in their problems and that a form of partnership has been created. According to patients, qualities such as respect and a nonjudgemental attitude are considered to be the most important qualities for a therapist (Bachelor, 1995).

However, some factors can affect the therapeutic alliance and lead to dropout of therapy. We know that cultural differences between health professionals and their minority patients lead to differences in the respective theories of mental health and illness. These differences, coupled with language difficulties and other ethnic variables, reduce the likelihood of therapeutic alliance and satisfaction with treatment (Foulks, Persons, & Merkel, 1986). A meta-analysis showed that dropouts were

associated with racial minority status, low level of education and low socioeconomic status (effect size ranging from .23 to .37) (Sharf, Primavera, & Diener, 2010). Most URMs display these characteristics.

No study has so far looked at synthesizing the perceptions and expectations of URMs regarding their therapeutic care, MHP and mental health services. It is an important topic considering that many of the countries refugees come from having few mental health facilities and that mental health might be stigmatized, leading to distrust regarding the health organization (Fazel & Betancourt, 2018). However, a systematic review was recently conducted regarding the psychosocial needs of refugee children and youth, identifying social support, security, culture and education as important for them (Nakeyar, Esses, & Reid, 2017). This type of review is essential given that results of scientific studies should normally influence the practice of professionals and that their practice should also be influenced by patients' expectations and objectives. It would be unfortunate not to consider the expectations and perceptions of URMs if we wish to improve practices of MHP working with this population.

That is why the aim of the present study was to gather URMs' points of view about mental health services and MHP in the host country, in order to have a better understanding of their perceptions and expectations and to better adapt the practice of MHP.

Methods

The protocol was registered on PROSPERO (CRD42018085365) on 12 March 2018.

Search strategy

Seven databases (MEDLINE, PsycINFO, PsycARTICLES, Psychology and Behavioral Sciences Collection, Library Information Science & Technology Abstracts, SAGE, Cairn) were searched in February 2020, using both English and French search terms. The English search terms were "unaccompanied" and "minor" or "youth" or "adolescent" or "refugee" and "interview". The French search terms were "mineurs non accompagnés" or "mineurs isolés étrangers" et "entretien" ou "témoignage".

For the sake of completeness, a complementary search was conducted to search for documents that are not considered as scientific articles or book chapters, but which contain URMs' interviews. 517 records have been identified through database searching, and 7 additional records have been identified through complementary search (see Figure 1, PRISMA diagram).

Inclusion and exclusion criteria

No limitation was used regarding publication date or geographical location. All studies which included URMs interviews about psychotherapeutic intervention, mental health services or MHP were included. Studies which did not report interviews with URMs (using questionnaires for example) or which contained URMs' testimonies not concerning therapeutic care, mental health services or MHP were excluded. Only testimonies of URMs were considered, and their caregivers' were not. Quantitative studies were excluded from this review in order to keep a methodological coherence. In fact, only one study was available (Geltman et al., 2005) at the time of the search. The population had to be unaccompanied refugees and less than 18 years of age. We also included refugees that were older than 18 years old at the time of the study but who arrived in the host country as URMs. A list of all excluded studies is available in Appendix S1.

Quality of included studies was peer-reviewed and assessed using the 21-item checklist of the Standards for Reporting Qualitative Research (SRQR). The SRQR is composed 21 items that seem essential for complete and transparent reporting of qualitative research. Criteria include the article's title and abstract (items 1 and 2); problem formulation and research question (items 3 and 4); research design and methods of data collection and analysis (items 5 through 15); results, interpretation, discussion and integration (items 16 through 19); and other information (items 20 and 21). These items were intentionally defined by reviewers to not favour one methodological approach over others (O'Brien, Harris, Beckman, Reed, & Cook, 2014). First, both authors independently conducted quality assessments of all 9 manuscripts included in the systematic review and disagreements between raters were resolved through discussion (see Table S1 for detailed SRQR scores).

Results

After screening titles and full-text articles, 30 records were assessed for eligibility. Results included documents in English, French and Spanish. Nineteen studies were excluded because URMs did not talk about therapeutic care, mental health services or MHP (n = 14), the study did not conduct any interviews and only used questionnaires (n = 1), and the sample did not contain URMs (n = 2) or because published manuscripts duplicated data already included in a PhD thesis which was already included in the review (n = 2; Majumder, 2014) (see Figure 1). In the end, 9 studies, published between 2005 and 2018, were included – 4 were scientific articles, 2 were PhD theses, 2 were reports and 1 was included in a book chapter.

The authors did not always specify whether URMs are mentioning psychologists, counsellors, psychiatrists, nurses or therapists. The term "mental health professionals" (MHP) will be used when it was not specified in the studies.

Studies characteristics

Whereas our inclusion criteria are URMs' opinions on their experiences of mental health services and professionals, only two studies focused on exploring the experience of URMs in mental health services (Jarlby, Goosen, Derluyn, Vitus, & Jervelund, 2018; Majumder, 2014). One study was not specifically centred on that question but explored well-being and psychological processes in the face of difficulties (Groark, Sclare, & Raval, 2011). Among the other documents, URMs addressed the subject in their testimonies but it was not the main objective of the studies. Three studies described their experience in the host country (Groark et al., 2011; Luster, Qin, Bates, Rana, & Lee, 2010; Thommessen, Corcoran, & Todd, 2015). One study sought to understand their definition of success once in the host country (Lee, 2013). One study described an art-based therapeutic group project (Clacherty, 2015). And finally, two documents related URMs' testimonies with no specific objective (Jamet & Keravel, 2017; Lamb, 2005). Table 1 reports a summary of included studies with their objectives, results and limits.

The nine manuscripts had SRQR scores ranging from 0 to 19 out of a maximum of 21 (M = 11.33, SD = 7.55) (*Total Score SRQR* in Table 1). Some studies obtained low scores because interviews and methodology did not follow strict guidelines.

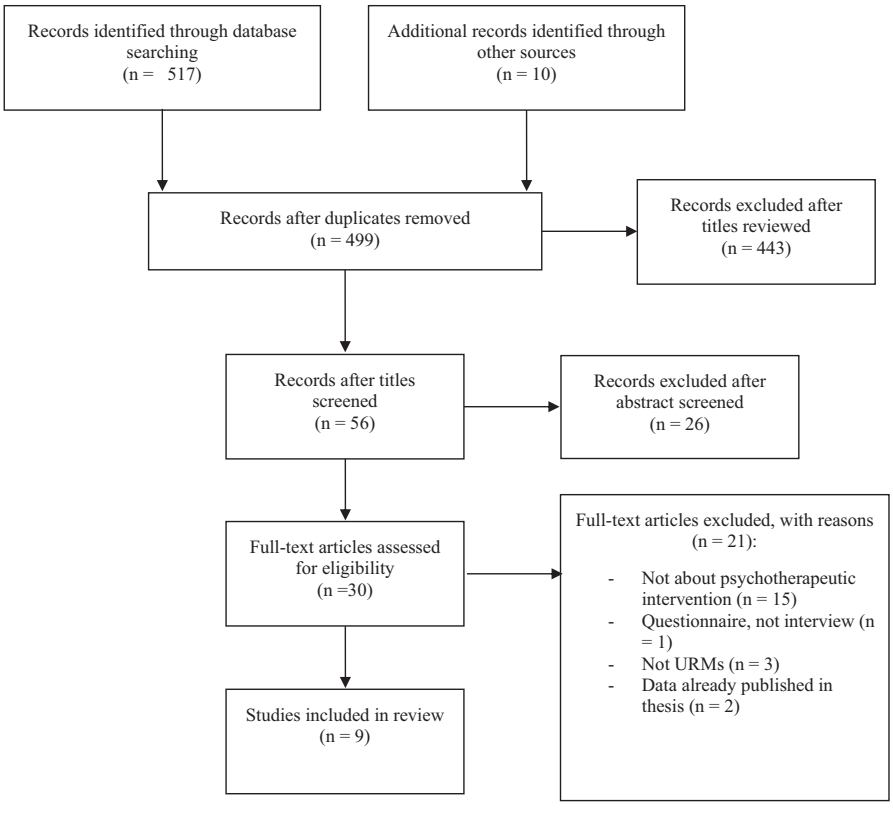

Figure 1. PRISMA diagram – flow chart of study selection

After an analysis of the studies included in this review, major themes emerge from the experience of URMs with therapeutic care, mental health services or MHP. These themes, mentioned in the PROSPERO protocol, were identified post hoc. The results are categorized into three themes: negative perceptions, barriers to the therapeutic process and positive view of the psychologist. Negative perceptions were composed of five sub-themes (i.e. distrust towards MHP and mental health interventions, activity-based interventions rather than talking, rejection of medication, asymmetrical relationship between patients and professional, negative perception of mental health); barriers of four sub-themes (when mental health is not a priority, when language slows down the therapeutic process, no possibility to talk to a MHP, perception of the venue of mental health services); and a positive view of the psychologist had no sub-theme.

Negative perceptions

Distrust towards mental health professionals and mental health interventions. The results show that URMs experience a form of distrust towards MHP and therapeutic care in Western countries. In Clacherty's study, out of twenty testimonies, most report suspicions about the traditional counselling approach after their first encounters with psychologists. Clacherty quotes the words of URMs who talked about their meeting with a psychologist, indicating that they felt significant pressure to talk from MHP, with the feeling that asking questions was a way to make them talk about things they do not want to talk about (Clacherty, 2015). The perceived pressure to talk about the past and questioning 'like the police do' is also found in Jarlby's interviews. According to the URMs, conversational therapy seems meaningless and inadequate in enhancing their mental health (Jarlby et al., 2018). This feeling is also shared by URMs interviewed in Majumder's study that indicates that MHP sometimes ask too many questions. These questions are sometimes asked several times because of the administrative process in which they are involved in to obtain the legal status required to stay in the host country. This can create a sense of being interrogated and indirectly prevent the building of a necessary therapeutic alliance.

The question of trust towards MHP seems to predominate among youths interviewed by Majumder. In fact, most young people reported that they do not trust professionals, having the feeling that they did not receive appropriated help, or even that they were hurt when they trusted them. URMs' main concern was that some information may be disclosed to authorities and that they would subsequently be deported or imprisoned. In addition, it seems difficult for the youth to share personal information with people they do not know such as MHP. This underscores the importance of establishing a good therapeutic alliance in order to minimize the risk of discontinuing therapy (Majumder, 2014).

Some young people feel that not all these questions are necessary, mixed with the feeling that professionals do not respond to their daily concerns. Some youth reported that the MHP appear as more focused on taking notes and completing reports than solving their problems. Some may have the feeling that the professional is imposing his vision of what could be good for them (Majumder, 2014). Many URMs do not recognize the benefit of talking to a therapist as a treatment, sometimes with the feeling that these sessions can even

Table 1. Overview of studies included (n = 9)

Authors, year, country, type	Total score SRQR[1]	Method	Participants	Objective	URMs' vision of mental health and professionals	Themes and sub-themes related in review	Limits
Thommessen, Corcoran, & Todd 2015 United Kingdom Scientific article	19 (90%)	Semistructured interviews	6 URMs (Sweden)[2] 18 to 19 years old	URMs' experience arriving to the Swedish host society Description of what is helpful and what is challenging after their arrival	Need for psychological support	A positive view of the psychologist	Sample majority from the same country Only male sample Risk of selection bias: well-adapted URMs Risk of social desirability bias due to interview recording Interview schedule not provided
Lee 2012 USA Thesis	18 (86%)	Semistructured interviews	15 URMs >18 years old	Definition of success according to URMs Their changing perspectives of success over time URMs' most effective strategies for success	Counselling or therapy is not considered as a useful resource for URMs	Barriers to the therapeutic process: -No possibility to talk to a mental health professional	Risk of selection bias Sample majority from the same country Sample majority male Risk of social desirability bias due to interview recording No interpreter available
Jarlby, et al. 2018 Denmark Scientific article	17 (81%)	Participant observation, semistructured individual interviews and focus group interview	6 URMs 17 to 18 years old	Explore how URMs perceive mental health and the mental health care they are provided with, and which services they believe would benefit them	Professionals may know about cultural differences Shared activities between therapists and youth help Striving for an 'ordinary' everyday life and avoiding talking about past traumatizing events	Negative perceptions: -Distrust towards mental health professionals and mental health interventions -Activity-based interventions rather than talking -Biased perception of mental health	Small sample size Only male sample Interview schedule not provided

(continued)

Table 1. (continued)

Authors, year, country, type	Total score SRQR[1]	Method	Participants	Objective	URMs' vision of mental health and professionals	Themes and sub-themes related in review	Limits
Majumder 2014 United Kingdom Thesis	16 (76%)	Semistructured interviews	15 URMs and their caregivers 15 to 18 years old	Explore the experience of URMs in mental health services Explore their perspective on improving mental health services	Limited knowledge of URMs in mental health services Lack of trust and fear of stigma Preference not to talk about the past and focus on present problems Activity-based treatments are preferred over narrative therapies	Negative perceptions: -Distrust towards mental health professionals and mental health interventions -Activity-based interventions rather than talking -Asymmetrical relationship between patient and professional -Biased perception of mental health Barriers to the therapeutic process: -When mental health is not a priority -Perception of the venue of mental health services -When language slows down the therapeutic process A positive view of the psychologist	No double coding Sample majority from the same country Sample majority male Risk of selection bias Risk of social desirability bias due to interview recording
Groark, Sclare, & Raval 2011 United Kingdom Scientific article	15 (71%)	Semistructured interviews	6 URMs 16 to 18 years old	Have a better understanding of the experience of being a URM in the UK Have a better understanding of how past and present experiences impact their well-being Explore URMs psychological processes to manage difficulties	Mixed response regarding mental health assistance Forget rather than talk about problems Focus on everyday problems rather than the past	Negative perceptions: -Distrust towards mental health professionals and mental health interventions	Small sample size Sample majority male Risk of social desirability bias due to interview recording

(continued)

Table 1. (continued)

Authors, year, country, type	Total score SRQR[1]	Method	Participants	Objective	URMs' vision of mental health and professionals	Themes and sub-themes related in review	Limits
Luster et al. 2010 USA Scientific article	12 (57%)	Semistructured interviews	19 URMs 18 to 26 years old	Description of their experiences in the United States and in foster care (goals, challenges, general adjustment, accomplishments, help, adjustment)	Only two URMs viewed mental health services to be a supportive factor that helped to succeed	Negative perceptions: -Biased perception of mental health Barriers to the therapeutic process: -No possibility to talk to a mental health professional	Sample majority male Sample majority from the same country Risk of selection bias: well-adapted URMs Risk of social desirability bias due to interview recording No interpreter available Interview schedule not provided
Clacherty 2015 South Africa Book chapter	3 (14%)	Testimonies	20 URMs 9 to 20 years old	Description of an art-based therapeutic group project to help URMs manage difficulties of their new life	Distrust about counselling Feeling pressure to talk	Negative perceptions: -Distrust towards mental health professionals and mental health interventions	Risk of selection bias No description of the sample No interview methodology No methodology for analysis of testimonies Scattered and nonspecific testimonies Interview schedule not provided
Lamb 2005 Spain Report	2 (10%)	Semistructured interviews	60 URMs 12 to 20 years old	Presenting what URMs have to say	Need to talk to someone about their journey, difficulties, etc.	Barriers to the therapeutic process: -No possibility to talk to a mental health professional	No detailed description of the sample No description of methodology used No description of the interview analysis method Risk of social desirability bias due to interview recording Interview schedule not provided
Jamet & Keravel 2017 France Report	0 (0%)	Testimonies	2 URMs 16 to 17 years old	Testimonies of their experience in the host country	Declining to accept medication from the psychiatrist	Negative perceptions: -Rejection of medication	No interview methodology No interview analysis methodology Scattered and nonspecific testimonies Small sample size Interview schedule not provided

[1]The Standards for Reporting Qualitative research (SRQR) was used to assess the quality of the studies included (n = 9). The score is calculated with 1 = requirement met; 0 = note met or unable to determine. The scores can range from 0 to 21.
[2]Authors of the study are from United Kingdom, but participants are from Afghanistan and arrived in Sweden as URMs.

become unpleasant (having headaches because of talking too much). These sessions with psychologists can be considered ineffective, with the feeling that they are not making progress. They may also feel that talking treatment is not fast enough or may even make their condition worse by reminding them of traumatic memories they would rather forget. It does not allow them to focus on how best to solve present and future problems (such as immigration, education and sleep difficulties). Therapy is then perceived as a process that is the opposite of what they would have wished for. However, this is not shared by all URMs because some feel that talking has been beneficial to them (Majumder, 2014). Groark et al. (2011) conducted semistructured interviews with URMs to gain a better understanding of their experience in the UK, the impact of past and present experiences on their well-being and the coping strategies they use daily. Three out of six URMs interviewed indicated that they would have preferred some form of counselling in which someone helped them to solve their problems, rather than sharing their emotional difficulties. Two said they refused to talk about their problems, indicating that it makes them angry when they think or talk about it. The authors hypothesize that having experienced periods of instability in their lives and the difficulties they encounter in trusting someone again are factors that prevent them from feeling safe enough to explore their emotions and thoughts (Groark et al., 2011).

Activity-based interventions rather than talking. Unaccompanied refugee minors seem to appreciate activity-based interventions, allowing them to share similar interests, interact with other youths and develop long-term relationships. This type of intervention is much more widely accepted than speech-based interventions because it is perceived to be active, entertaining, facilitating interaction and integration and improving clinical engagement (Majumder, 2014). Social, physical and artistic activities helped URMs feel better (be calm, feel happy, sleep better) whereas conversational therapy seemed meaningless and inadequate because it actively evoked feelings and memories they were unable to cope with (Jarlby et al., 2018).

Rejection of medication. One URM interviewed met a psychiatrist for anxiety, sadness and anger management difficulties. He did not want to comply with the psychiatrist's prescription because he did not want any medication and this did not meet his expectations (Jamet & Keravel, 2017).

Asymmetrical relationship between patient and professional. For the most part, the minors interviewed considered their relationship with MHP as asymmetrical, with professionals being positioned as authority figures in charge of directing and guiding the intervention process. Many seemed to be following the doctor's instruction without questioning or clarifying any aspect of the treatment or intervention (Majumder, 2014).

Biased perception of mental health. According to URMs in Jarlby's study, poor mental health is caused by interlinked problems in life (e.g. illness, loneliness, poverty or war) or by supernatural explanations (e.g. ghosts). One of their strategies for healing could be through prayers and/or herbal medicine (Jarlby et al., 2018). Fourteen out of the fifteen youths interviewed by Majumder have a negative perception of mental illness and mental health services, often associated with the terms 'crazy', 'mental' or 'mad'. Some of them explicitly told to psychologists that they are not crazy. Many of them deny having a mental illness and avoid talking about it, despite having access to mental health services. This perception of mental health services is also mentioned in Luster et al.'s study (Luster et al., 2010). Majumder hypothesizes that young people's vision is influenced by their own sociocultural conception of mental health. This leads to a stigmatized vision of mental health problems, which is reflected in URMs' interviews. Mental illness is automatically associated with severe mental pathologies that could lead to isolation, rejection by the family and friends, and eventually to a downward drift of social life (Majumder, 2014).

Barriers to the therapeutic process

When mental health is not a priority. Young persons interviewed by Majumder do not prioritize mental health, which comes after basic needs such as education and material possessions. The author hypothesizes that since the concept of mental health is not clearly formed in URMs' minds, they do not place it among their priorities. Instead, having experienced material deprivation during their childhood could influence their perception of priorities with a greater willingness to possess material goods (such as clothes and electronic devices) in the first place (Majumder, 2014).

Perception of the venue of mental health services. Some young people report that they would have preferred therapeutic work to be done in a more comfortable, familiar and nonintimidating place than the formal, institutionalized, impersonal environment of a clinic. According to the Majumder, this type of environment does not help to establish trust with the professional (Majumder, 2014). However, the author only asked young people who had received therapeutic care in medical facilities (Majumder, 2014) while URMs can also be met by independent MHP or directly in the institutions that care for them (schools, foster homes, etc.). We do not have any data that allow to draw any comparison between URMs that were met in medical facilities and those who were met in other types of context.

When language slows down the therapeutic process. Some URMs indicate that language barriers can be a drag on engagement and completion with MHP. Having sufficient language capacity is an important factor for URMs but also for MHP working with them. This perception is also confirmed by URMs' caregivers. In some cases, an interpreter can be present to help the young person; however, most of the young people interviewed indicated that they were dissatisfied with the presence of the interpreter, having difficulties understanding each other (Majumder, 2014).

No possibility to talk to a mental health professional. Lamb cites two URMs indicating that they would have liked to talk about their journey, being lucid about the fact that they may still feel threatened and not 'psychologically healed'. However, out of the 60 young

people surveyed by Lamb, only two testimonies emerged concerning a need to talk to professionals about their mental health difficulties (Lamb, 2005). Out of the nineteen youths interviewed in Luster et al.'s study, only two mentioned mental health services as a supportive factor that helped them to succeed (Luster et al., 2010). This can be understood by the fact that URMs often come from cultures where verbal communication is not valued, where the most commonly used coping strategy is 'forgetting', meaning avoiding thinking about past or current stressful experiences (Goodman, 2004; Lee, 2013; Majumder, 2014; Summerfield, 1997). Thus, this does not encourage engagement into the western therapeutic approach that uses talking as the main therapeutic tool. URMs will find more social support from peers, family, social workers, foster families, teachers or in religion (Lee, 2013). It can also be explained by a lack of knowledge of the psychologist's profession, with the feeling that it will not be useful or that psychologists only help crazy people (Baily, 2017; Bræin & Christie, 2011; Majumder, 2014).

A positive view of the psychologist

On the other hand, some URMs were able to express their satisfaction with the fact that they were able to ask questions about different aspects of treatments or care and to receive answers and encouragement from professionals. Some report the kindness of professionals, indicating that they were good listeners and accessible (Majumder, 2014). According to one URM out of six, psychological support is being considered as the second most important element after obtaining asylum-seeker status (Thommessen et al., 2015). However, in the study of Thommessen et al., exploring what is helpful and what is challenging in Swedish host society for URMs, psychological difficulties only appeared once in all interviews.

Discussion

The present review summarized URMs' points of view about mental health services and MHP in the host country gathered from qualitative studies in order to better understand their perceptions, expectations, biases and to better adapt the practice of MHP. Out of the nine studies finally included, only two are specifically centred on URM perceptions of mental health services (Jarlby et al., 2018; Majumder, 2014) and only one is about the description of their well-being and psychological processes (Groark et al., 2011). In the other studies, URMs mention some of their experiences with MHP although is not the main theme of the study. A reason which can explain why so few studies have been conducted on this subject is that this population has very little access to care, meaning that only a few URMs can testify to their experience (Baily, 2017; Bean et al., 2006; Bræin & Christie, 2011; Majumder, 2014). Indeed, only about 11% of URMs have access to mental health services for their psychological or behavioural difficulties (Baily, 2017; Bean et al., 2006), while they are a population at risk of presenting or developing psychopathologies such as depression, anxiety or post-traumatic stress (Derluyn et al., 2009; Hodes et al., 2008; Huemer et al., 2009; Lustig et al., 2004; Vervliet, Lammertyn, et al., 2014; Vervliet, Meyer DeMott, et al., 2014). Considering the number of URMs worldwide and the fact that their mental health does not seem to improve with time spent in the host country (Jensen, Skårdalsmo, Fjermestad, Skardalsmo, & Fjermestad, 2014; Vervliet, Lammertyn, et al., 2014), this should be considered a public health issue.

The literature shows that URMs do not have a clear vision of MHP that it is difficult for them to trust MHP (Clacherty, 2015; Majumder, 2014), but also to understand the value of sharing past painful experiences to reduce current symptoms (Clacherty, 2015; Groark et al., 2011; Majumder, 2014), and to accept the fact that the results cannot be as fast as they would have hoped for (Majumder, 2014). In fact, URMs could be reluctant to share personal details with MHP if they fear that it can be used against them (Byrne, 2008). However, in one study URMs had a deep suspicion of the traditional counselling approach. But the author does not specify what he means by this (Clacherty, 2015), so it makes it hard to know what URMs are really suspicious about. The term 'counselling' has been democratized by Carl Rogers (Vincent & Hamad, 2001). Counselling practice varies, and, depending on the country, it can be practiced by psychologists, but also by social workers, nurses or educators (Brison, Van Broeck, & Zech, 2015). Counselling is designed to help mobilize the individual's resources and problem-solving skills, to help him or her to better cope with everyday life and difficult situations (Brison et al., 2015; Schneider-Harris, 2007; Vincent & Hamad, 2001). Some authors consider counselling as a form of psychotherapy (Schneider-Harris, 2007; Vincent & Hamad, 2001), while others claim that it is a 'therapeutic relationship approach' (Schneider-Harris, 2007), or conversely that it cannot be considered as a therapy (Vincent & Hamad, 2001).

Instead of talking in therapy, they would rather do activity-based interventions and value the creation of social connections (Jarlby et al., 2018; Majumder, 2014). They can have a negative perception of mental health (Luster et al., 2010; Majumder, 2014) and consider that it is not a priority for them (Majumder, 2014). In fact, mental health is also not a priority for adult refugees (Fazel & Betancourt, 2018). Indeed, if basic needs are not met, such as a sense of security, if socioeconomic and legal (e.g. asylum process and visa obtention) difficulties are not overcome, it seems difficult to give importance to other issues, such as mental health. Yet, these are factors that can impact mental health of refugees (Li et al., 2016). Fazel and Betancourt (2018) recommend that services offer both practical support and psychological support to refugees (Fazel & Betancourt, 2018).

However, this perception of MHP and mental health might not be specific to URMs although little is known on the perception of mental health and MHP among non-refugee minors. However, studies indicated that, in Australia, adults seemed uninformed about the role and skills of psychologists. Indicators suggested a very unfavourable public perception of psychologists, with less than a quarter of respondents willing to consult one for a personal problem (Hartwig & Delin, 2003). This proportion is also found among students (Ebert et al., 2019) for whom attitudinal barriers seemed the most important barriers. Students could feel embarrassed to talk to a therapist and preferred to handle problems on their own (Andrade et al., 2014; Ebert et al., 2019; Mojtabai et al., 2011) and/or talk to friends or relatives instead (Ebert et al., 2019). Psychologists are seen as the least

necessary profession compared with others such as nurses, general practitioners, teachers, lawyers and psychiatrists. However, individuals who have ever seen a psychologist (only 16.3% of participants) are more willing to see one in the future than those who have never seen one (Hartwig & Delin, 2003).

They also seem to consider the relationship with the MHP as asymmetrical (Majumder, 2014) and can feel that MHP do not answer their questions, their needs and ask too many questions that do not seem related to their main concerns (Clacherty, 2015; Groark et al., 2011; Majumder, 2014). Language difficulties can slow down the therapeutic process, and having an interpreter does not seem to help them (Majumder, 2014). Sometimes, they do not even have the possibility to talk to a MHP at all (Lamb, 2005). This is worrying given that in medicine, just as in mental health, the patient's informed consent is essential and is supposed to be obtained from each patient. According to the American Psychology Association, 'when psychologists conduct research or provide assessment, therapy, counselling, or consulting services in person or via electronic transmission or other forms of communication, they obtain the informed consent of the individual or individuals using language that is reasonably understandable to that person or persons' (p. 7) and 'psychologists inform clients/patients as early as is feasible in the therapeutic relationship about the nature and anticipated course of therapy, fees, involvement of third parties, and limits of confidentiality and provide sufficient opportunity for the client/patient to ask questions and receive answers' (p. 14) (American Psychological Association, 2002). This means that, in the case of URMs too, they should be informed about the nature of therapy (or medication in the case of an appointment with a psychiatrist), about limits of confidentiality and should have the opportunity to ask questions and receive answers. They need to be informed in a way that is most understandable to them, for example with the help of an interpreter. However, with URMs, this does not always seem to be the case, as indicated in the studies selected in the review.

Conclusions based on this review are consistent with a larger literature, indicating that cultural differences, coupled with language difficulties and other ethnic variables, reduce likelihood of therapeutic alliance and satisfaction with treatment (Björkenstam et al., 2020; Foulks et al., 1986).

Implications

It seems essential that MHP adapt their practice to URMs' needs. In the first place, in order to build a better therapeutic alliance, it seems important that MHP get interested in their day-to-day problems rather than focusing on past experiences. Especially when we know that ongoing post-migration stressors are also important factors of the mental health of refugees (Li et al., 2016; Purgato et al., 2017), working on pre-migration difficulties could be intended in a second place, when the therapeutic alliance is built and the URM is able to trust MHP more, and if this seems appropriate depending each individual URM's situation.

Mental health professionals should be very clear about the goals of therapy with URMs and find mutual agreement with them on what is important to work on in order to build working alliance (Bordin, 1979). If MHP follow the three components of the working alliance according to Bordin (agreement on mutual goals, agreements on tasks and responsibilities and personal bond) (Bordin, 1979), this could help URMs to not consider the relationship as asymmetrical. MHP could also use activity-based treatment in order to increase therapeutic alliance and adherence to the treatment because this seems to be more appealing to them than talking.

One can hypothesize that having MHP in URMs residential care homes and schools might help build trust and decrease biased perception of MHP. By being present in their everyday life environment, MHP could change URM perception of MHP as authority figures and help to overcome their perception of clinics' impersonal environment and thus adapt to the needs of URMs in terms of finding a place that is comfortable, familiar and nonintimidating. Indeed, schools can encourage a sense of belonging and play an important role in preventing mental illness (Fazel & Betancourt, 2018).

Because URMs value the creation of social interactions, MHP could consider working in group sessions rather than individual sessions. Both have benefits and limitations, and it is the MHP's decision to choose which is the most suitable depending on the participants and the goal of the intervention. Group interventions help developing new relationships, communication abilities and social skills. Individual interventions allow to address more personal issues that would not be discussed in group settings (for a review of the pros and cons of individual vs group interventions with URMs, see Demazure et al., 2017). According to Björkenstam et al. (2020), to decrease the gap in healthcare utilization of refugee youth mental health, care staff should have access to health literacy programmes and education in transcultural medicine and deliver culturally adapted mental health interventions (Björkenstam et al., 2020).

For future studies

Our review provides an overview of the points to be considered about the perceptions and expectations of URMs regarding mental health services and MHP in the host country. We suggest developing a questionnaire, based on the points raised in this review and on Geltman et al. questionnaire (Geltman et al., 2005). Gathering more systematic data based on this type of instrument would initially provide a more epidemiological view of the situation, thus avoiding the biases that may be involved in the study of isolated cases. Secondly, this instrument could be used to determine the extent to which these factors can be associated with the effectiveness of interventions. Finally, this questionnaire could have clinical implications by being used directly by clinicians working with URMs (e.g. individualized diagnosis of barriers to care).

To explore the healthcare needs and utilizations among URMs, a study protocol of a qualitative study has been published. This 3-year study will follow the Consolidated Criteria for Reporting Qualitative research (COREQ) guidelines and could be a model for future research. The future results of this study will help complete the results of this review (Ulrich et al., 2020).

Considering the fact that even native adults are uninformed about psychologists, it would be interesting to

study and compare the perception of MHP and mental health, and barriers to mental health treatment among URMs, with and without symptoms of psychopathology, and native adolescents, with and without symptoms of psychopathology in order to shed light on what is specific of URMs.

Limitations

There are some limitations to the current review because some studies relied on small sample sizes and/or present heterogeneous methodological compared with quality standards as stated by the SRQR (see Table 1 and Table S1).

Another limitation concerns the extent of the phenomena evoked by the interviewees. Indeed, the authors do not provide access to the interviews and we also found that the authors can remain imprecise about the number of young people interviewed concerned by a situation (using terms such as 'most of the young'). Quantitative data obtained by questionnaires could complete and overcome this type of limitation.

Conclusion

To conclude, it seems important to conduct future research to be able to give greater importance to URMs' point of view in their therapeutic care. Thus, the development of an instrument to evaluate therapeutic care for URMs seems essential in order to place them in a place of collaboration with MHP and to adapt interventions to their needs, expectations and perceptions.

We can conclude that there is a need for MHP to promote to URMs their role, skills and how they might help. MHP could try to be more focused on URMs' day-to-day problems, use activity-based interventions and do group sessions to value social interactions. We also suggest that MHP provide interventions directly in URM residential care homes or schools. All this could help MHP in building a better therapeutic alliance with URMs and reduce barriers to treatment.

Acknowledgements

No funding sources were provided for this study. The authors have declared that they have no competing or potential conflicts of interest.

Ethical information

No ethical approval was required for this review.

Correspondence

Nicolas Pinsault, Univ. Grenoble-Alpes/CNRS/TIMC-IMAG UMR 5525, Grenoble, France; Email: NPinsault@chu-grenoble.fr

Supporting information

Additional Supporting Information may be found in the online version of this article:

Table S1. Assessment of qualitative studies ($n = 9$) using the SRQR.

Appendix S1. List of excluded studies.

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Accepted for publication: 14 May 2021