***Suffering, struggles and support:* A qualitative exploration of hope and healing in men seeking asylum using photographs and I-poems.**

**Ethical Approval**

The University of East Anglia Faculty of Medicine and Health Sciences Research Ethics Subcommittee (reference no ETH2223-2297, approved 25.9.2023).

**Declaration of interest statement**

The corresponding author is funded by the NIHR [In-Practice Fellowship (NIHR302059)]. These events were funded by the NIHR Clinical Research Network. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

The authors declare no competing interests.

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**Acknowledgments (if applicable):**

The authors thank all participants of the focus groups and staff/ volunteers with The Zainab Project. We thank the professional interpreter who supported throughout. We thank the Norfolk and Waveney Integrated Care Board and NIHR Clinical Research Network for their support. The authors, alone, are responsible for errors, omissions, and the views expressed in this article. Thank you to the visual artist Chris Spalton.

Funding was provided by Norfolk and Waveney Integrated Care Board Research and Innovation team.

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**Keywords:**

Inclusion Health

Mental Health

Migration

Refugee

Culture

Inequalities

**Article Classification:** Original research

**Abstract**

***Suffering, struggles and support:* A qualitative exploration of hope and healing in men seeking asylum using photographs and I-poems**

## **Purpose**

The literature highlights that health care in the UK is not always well-adapted to meet the needs of individuals from different cultural backgrounds and within the context of the asylum system. Given this, further exploration of culturally adapted health support in the context of wider social and community support, to enable post-migration growth and ameliorate the impact of migratory grief is the focus of this paper.

**Methodology**

A community-based participatory approach was used where the research team and community organisation supporting this group collaborated as equals to foster trust and reciprocity in research. Two focus groups were run in Arabic with a professional interpreter with 14 male participants from 6 different countries, all with lived experience of the asylum process.

**Findings**

The findings are reported under three major themes: Pre-migration experiences (home, journeys and disaster), post-migration stress (suffering and meaning) and post-migration growth (hope, kinship and healing).

**Originality**

This study confirms that migratory grief as a distinct process that requires careful detection by culturally adapted conversations and language. It suggests how to adapt wellbeing interventions to support post-traumatic growth and the unique potential for group-based interventions outside of home office accommodation to reduce psychopathology due to migratory grief.

**Plain English summary**

Healthcare in the UK doesn’t always meet the needs of individuals from different cultural backgrounds and within the context of the asylum system who may have experienced losses. Health and wellbeing interventions can provide support for this loss by offering validation, hope and healing.

**Introduction**

Asylum applications in the UK have surged due to war, persecution, and political instability, with 67,337 applications made to the UK Home Office in 2023—the second highest annual rate since 2002 (House of Commons Library, 2023, 2024). Asylum seekers and refugees are a diverse group, often carrying trauma from their country of origin or from their journey (World Health Organisation, 2022). This results in poorer mental health compared to the UK general population. They are also less likely to receive adequate support (Mental Health Foundation, 2024). This includes higher levels of stress, depression, anxiety, and post-traumatic stress disorder which continues beyond the period of resettlement (Blackmore, 2020). Psychological distress, including symptoms such as fear, insomnia, and somatic symptoms, affects up to 61% of this population (Blackmore, 2020) and is not in itself a mental illness although it can persist without intervention (Royal College of Psychiatrists, 2023).

Our collaboration with a local community organisation highlighted sources of loss and psychological distress among asylum seekers and refugees, as well as supportive factors. Previous UK government’s hostile migration policies, including asylum seekers being prohibited to work, lengthy asylum processes and unstable living conditions have a harmful effect on the lives of people seeking asylum (Kings College London, 2022). A systematic review by Gleeson et al. (2020) identified key drivers of poor mental health in this population as legal liminality, language barriers, poverty and social exclusion. These stressors can overshadow the original traumatic events and are essential to address in health interventions to lower distress in this group (Hou et al., 2020).

Parallels of the experience of becoming a refugee were made with the grief process in a scoping review by Renner et al. in 2024. This review concludedthat “migratory losses” or “migratory grief” and their relationship with psychopathology receives little attention in research but should be considered in the treatment of refugees and migrants with distress given they can result in depression and mental health disorders (Renner, 2024).

Academic literature often pathologises refugee experiences, focusing on migration's negative effects (Wenning, 2021). Although high rates of trauma and stress affect many, displaced people often adapt well (Kronick, 2018). Research is less clear on factors enabling this resilience. Some studies highlight work, education, and religion as key supports (Wenning, 2021), while others suggest service, identity awareness, and spiritual growth are crucial (Taylor, 2020). Social capital, through group participation and trusting relationships, also plays a vital role in improving mental health (Van Sint Fiet et al., 2022).

Despite this evidence on what supports people to thrive, Kienzler (2024) suggested that the UK asylum system makes it extraordinarily difficult for asylum seekers and refugees to access these supportive factors. Reviews of resettlement literature highlight the importance of contextual nuance of social support connecting social interventions to health and wellbeing interventions (Wachter, 2022). The National Health Service (NHS), as an institution within immigration and government systems is unable to respond adequately and doesn’t often connect to the wider contextual factors (Hartonen, 2022). For example, this population includes diverse countries of origins, and culture plays a critical role in shaping expressions of distress, fear and stigma around mental health and may limit engagement with standard mental health interventions (Taylor, 2022; Pollard and Howard, 2021). Many cultures believe that talking about past trauma does not help or avoid it for fear of stigma and shame (Shannon, 2015). This can lead to feelings of being “lost” within the NHS health system (Palmer, 2007; Mental Health Foundation, 2024).

Current literature highlights that health care in the UK is not always well-adapted to meet the needs of individuals from different cultural backgrounds and within the context of the asylum system. Given this, further exploration of culturally adapted health support in the context of wider social and community support, to enable post-migration growth and ameliorate the impact of migratory grief is the focus of this paper.

**Methods**

The study is reported as per the COREQ guidelines (Tong, 2007). Institutional ethical approval (reference number: ETH2223-2297) was gained on 25.9.2023.

A qualitative design was used to better understand lived experiences and how and why individuals view and perceive the world around them (Green and Thorogood, 2014). The purpose of the study was to make the world of displaced people ‘visible’, which fits with a qualitative approach (Denzin Lincoln, 2003). A social constructionist approach was used to gain an understanding of how individuals relate to changing worlds. It seeks to explain how their world view (and the awareness of their world view by the professionals interacting with them) is socially constructed (Burr, 2015). Social constructionism is useful for questioning internalised concepts, knowledge and language (Green and Thorogood, 2014).

A community-based participatory approach reduced power imbalances by fostering mutual trust and respect between researchers and the community (Duke, 2020). The community organisation this research partnered with is run by a woman with experience of seeking asylum and provides community support and training in transferable skills for employment to refugees and asylum seekers. This provided cultural insight and the community then led the agenda by shaping the study's focus on men’s mental health. The organisation advised on culturally appropriate methods, such as using photo elicitation for focus groups. Two wider community engagement workshops in February 2023 built trust, inclusivity, and understanding of the research process (Clark, 2024).

Photo elicitation was utilised to prompt discussion as images evoke deeper elements of human consciousness, memory and feeling than words alone (Harper, 2002). Use of photo elicitation in qualitative methods can also connect “core definitions of the self” to society and culture to facilitate social constructionism (Harper, 2002). It also enables individuals for whom participating in research is an unfamiliar concept to relax and have an “icebreaker” at the start of discussions.

*Setting*

Two focus groups were conducted in Norwich, a city of 144,000 population in the UK with a mixed socioeconomic demographic (Norfolk County Council Public Health, 2023). It has hosted people seeking asylum for over 15 years and hosts over 600 people seeking asylum (in both contingency hotel and dispersal home office accommodation), and many homes for settled individuals with refugee status from diverse ethnic backgrounds (Norfolk County Council Public Health, 2023). Most asylum seekers in Norfolk are young single men (Norfolk County Council Public Health, 2023).

*Recruitment and sampling*

Data were gathered from a diverse group of Arabic-speaking men over 18 years old, including those seeking asylum or with refugee status (see Appendix 1). Convenience sampling initially recruited participants engaged with the community organisation activities. Snowball sampling then recruited additional men outside the organisation, invited by friends. This method supports recruitment of marginalised populations (Sulaiman-Hill & Thompson, 2011)

Exclusion criteria were inability to provide written consent and severe psychological distress (as judged by the community organisation at recruitment).

The study flyer, participation leaflet, consent statement and debrief information were translated into Arabic. A face-to-face interpreter was present at the focus groups with a signed confidentiality agreement in place. Participant information included reassurance on confidentiality, that participation would not affect their relationship with the NHS or the community organisation and would have no impact on their asylum claim.

*Data collection*

Focus groups capitalise on dialogue between research participants and so were chosen as the method to enable rich discussions to take place in a group setting (Kitzinger, 1995). Our experience with two previous engagement workshops showed that participants preferred group settings due to prior familiarity with each other. Each focus group lasted one hour and was held at a room hired by the community organisation.

Participants and researchers joined two optional “warm-up” workshops led by the community organisation. These sessions included a shared meal, discussions on health literacy, and nutrition, helping build trust and ease. The study team also introduced health research concepts, distributed translated information sheets, and addressed questions.

The authors include two general practitioners, a public health consultant, and two qualitative researchers experienced in community-based research with underserved groups. A semi-structured focus group guide developed with the community organisation, was informed by prior engagement activities. A week before the focus group, participants were invited to take mobile phone photos representing a “good” and a “bad” day (without identifiable people or triggers). Exploratory and open-ended questions encouraged discussion, such as “what feelings does this photo bring up?” and “what helps you each day?” Further questions addressed mental health experiences, like “how is mental health discussed in your country?”

Two qualitative researchers (EC & SH) led the focus groups. Written consent via a translated form was confirmed. Questions were asked in English by EC and interpreted via a professional interpreter with responses interpreted back from Arabic to English.

EC is a medical doctor with experience of working with asylum seekers as a practitioner and qualitative researcher. SH took notes during discussions, which were transcribed in English along with the audio-recording. A secondary interpreter reviewed the audio recording and transcript for accuracy. A distress protocol was established to guide researchers in supporting any participants showing signs of distress.

Participants were offered travel expenses, a traditional meal and a £10 shopping voucher (multi-shop) after the focus group. The amount suggested for the voucher and timing of the offer of a voucher was discussed with the community organisation. This was necessary to balance appreciation for participants time and avoid coercion to participate in this economically vulnerable group.

*Analysis*

Thematic analysis of focus group data (transcriptions, photos, and field notes) was conducted following Braun and Clarke's principles (2021). EC transcribed the recordings to immerse herself in the data, removing identifying names, and destroying the audio after transcription. I-poems, a multi-stage qualitative analysis method, were created to preserve participants' voices before applying themes (Gilligan, 2015). Quotes beginning with “I” were combined into poems to ensure anonymity. Themes and I-poems were reviewed by the community organisation. Creative methods like poetry elicited emotive responses and facilitated wider dissemination during Refugee Week Norwich, a festival which allows the voice of those in the asylum system to be heard.

**Results**

The two focus groups had a total of 14 male participants, seven in each group. Their ages ranged from 19 to 57 years, and all identified as being from an asylum seeking or refugee background living in home office dispersal, contingency or social housing. Their countries of origin were Sudan (5), Syria (4), Somalia (1), Yemen (1), Egypt (1) and Eritrea (2). They all spoke Arabic.

The findings are reported under three major themes: *Pre-migration experiences* (home, disaster and journeys), *post-migration stress* (suffering and meaning) and *post-migration growth* (hope, kinship and healing). These are described in more detail below. Example I-poems with graphic representation of the photos shown during the groups and punctuated by Arabic words are shown below.

*Pre-migration experiences*

Home

Participants spoke fondly of home, particularly of memories before the triggers which led them to flee, such as conflict. They showed photos of green pastures, familiar social venues and spoke of purpose such as work, social connectedness, community and stability, which they all held as strong values in their lives.

*Figure 1: Home. Credit: visual artist Chris Spalton*

Disaster

Participants shared disastrous experiences of triggers which led them to flee including war, political instability, and poverty. They expressed feelings of anger at the triggers which had forced them to leave their lives, such as political leaders.

*“I have struggled and lost my family, all because of him, the president of my home country. The biggest idiot in the world.”*

There was a sense of disbelief about what they had been through.

*“I didn’t think my life would be like that.”*

Journeys

Journeys had further compounded feelings of loss as some had lost their liberty as they experienced smuggling and enslavement, and journeys passing through multiple countries with long periods of instability. They described these experiences as suffering and abuse.

*“I went through a lot of countries to get here, and I felt the pressure.”*

*“I travelled through Libya; I suffered in Libya. I worked there and was abused.”*

Those with religious beliefs were thankful to God that they had survived, with one commenting that, “*I feel it is God’s will and destiny to go through this*. *I learned from the journey and people I met on the way.*”

*Post-migration stress*

Suffering

The group expressed differing levels of distress which appeared to correlate with the length of time within the asylum system. Those settled with refugee status were able to reflect peacefully upon past challenges. Those still within home office accommodation, particularly in hotels expressed significant distress at daily challenges such as difficultly connecting with family abroad, frustration at the asylum process and boredom.

*“I feel my life is miserable whilst waiting for my claim. ‘Wait wait wait’ and ‘slowly slowly slowly’.”*

“*Every day is the same. So boring. Nothing relieves it.”*

This was manifested as difficulties concentrating, poor motivation, sleep disturbances, lack of appetite, feelings of depletion, and anhedonia.

*“I cannot even eat. I cannot sleep at night when I remember what happened in Libya.”*

*“I go to college, but I am overthinking and find it difficult to concentrate. My brain is not with me.”*

Within the government (UK Home Office) provided hotel accommodation, the particular challenges were around quality of the food, significant loneliness and lack of purpose/work.

*“I know I have to eat the hotel food, but it smells stinky. All day I am on my own in the hotel with no one to speak to.”*

There was also a sense of loss of agency and power. For example, those from one hotel setting had been asked for feedback by hotel staff about food and when they gave honest negative feedback, they reported that the quality of food subsequently worsened. This led them to give only neutral or no feedback when asked again about aspects of hotel life.

Meaning

Participants were asked to describe what represented a “good” day and the sources of comfort in their lives. Initially, they struggled to identify these, but later mentioned distractions like religious practices, TV, reading, and physical activity. Social connections outside of Home Office accommodation emerged as vital survival mechanisms, along with daily planning and routine. Long-term goals such as learning English, cooking, and volunteering also provided motivation. Researchers aimed to focus discussions on present-day feelings, but participants often found it challenging, highlighting the intertwined nature of past experiences with current challenges.

*Figure 2: Meaning. Credit: visual artist Chris Spalton.*

*Post-migration growth*

Hope

Despite facing significant daily and past challenges, participants expressed a strong sense of hope for the future, centred on goals like reunification with family, expanding their own families, ensuring their loved ones' safety, and fulfilling their roles as providers. Men who were reunited with their families reported greater emotional stability and motivation, highlighting the crucial role family connections play in fostering resilience and hope.

*Figure 3: Hope. Credit: visual artist Chris Spalton.*

Kinship

Despite the different experiences, there was a shared understanding of the similarities of their situations, “*I am a stranger in a different country and not of my choice. In my country I belonged.”*

There was also a desire to find and support others in a similar position to themselves via peer support, knowledge sharing and connecting with the community, and the value of sharing a meal with the community organisation.

*“I have been through a lot, and I want other to be spared going through what I went through.”*

This led to feelings of safety and kinship.

*“I feel more positive that we can be here together and talk to each other.”*

*“I feel cared for here and safe in this group. You do not have to battle by yourself.”*

Healing

In order to “heal” from the past there was no separation of mind and body healing as many had experienced injuries on their journeys which caused physical pain. There were some suggestions of somatisation of mental distress in physical pain.

*“I need help to heal the damage to my back from what was done to me in Libya.”*

Participants found it challenging to explore the concept of mental health due to limited experiences in their countries of origin. Examples of others with mental health issues often reflected extreme and stigmatising perceptions, such as being “sent away” from the village, or as being a sign of weakness. They viewed poor mental health as a product of their situation rather than a medical issue.

*“I would say mental health doesn’t exist back home because you have your life sorted. Back home you are “crazy” if you see a therapist.”*

*“I see some people are weak and this leads to mental health problems. It can lead you to choose the wrong path like drugs.”*

There was a lack of knowledge on how mental health treatments may be accessed or which interventions could be offered. However, participants seemed open to opportunities to support recovery.

*“I need to get it out of my mind, talk it off my chest and feel comfortable.”*

Participants were clear that any intervention to support healing and growth needed to be outside of the hotel setting.

*“I would like to talk in a safe space. A group like this. Not in the hotel.”*

*“Relaxed and relieved, I can have fun here, but the hotel feels like a prison.”*

**Discussion**

The focus group discussions revealed three major themes: *pre-migration experiences* (home, journeys, disaster), *post-migration stress* (suffering, meaning), and *post-migration growth* (kinship, hope, healing). Participants described multiple losses, linking these to migratory grief and its impact on mental health (Renner et al., 2024). Their feelings mirrored the grief process, encompassing confusion, fear, shock, and anger (Kubler-Ross, 1969). The themes highlighted the cumulative nature of losses, including sense of self, liberty, home, cultural identity, and family role. This aligns with studies indicating that loss of culture and support can lead to prolonged grief disorder and post-traumatic stress disorder (Nickerson, 2014).

This exploratory study found that the asylum system contributed to feelings of emasculation, stripping participants of their identity, strength, values, and roles as providers. Those reunited with family expressed more hope and resolution of grief, aligning with findings that single males are approximately 1.34 times more likely to experience psychological distress than those with their nuclear family in Germany (Walther, 2020). Participants with refugee status reported healing, consistent with research indicating that most individuals exposed to trauma and loss naturally recover over time (Nickerson et al., 2014)

Professionals and policymakers should recognize migratory grief as a distinct process that requires tailored support. This study identified more relevant terms for practitioners to use when exploring symptoms with this group, such as ‘struggle’, ‘pressure’, ‘suffering’, and ‘abuse’, rather than clinical terms like ‘depression’ or ‘anxiety’. Some languages lack words for mental health conditions, leading to stigmatising or shameful translations (Translators Without Borders, 2023). When assessing protective factors, terms like ‘relief’ and ‘relaxation’ resonate more with this population than the term ‘wellbeing’. The I-poems developed in this research could serve as vignettes to initiate conversations about wellbeing.

Participants found it difficult to separate physical pain from mental distress, showing little understanding of mental health as distinct from physical wellness. Expressions of distress through physical symptoms, or somatisation, are common among displaced individuals and may lead to increased healthcare utilisation (Lanzara, 2019). In many non-Western countries, somatic symptoms are central to expressions of worry, while individuals of European descent tend to emphasise psychological aspects (Lewis-Fernandez, 2010). Therefore, mental health screening should consider the possibility of somatisation.

Migratory grief may require processing mechanisms similar to other forms of grief (Renner et al., 2024). Health professionals should acknowledge the human experience of these losses rather than pathologising them prematurely. Practitioners can play a supportive role by listening, validating challenges, and avoiding premature labelling of migration-related mourning as depression (Renner et al., 2024). Participants were willing to discuss their mental health but required gentle guidance and a ‘safe’ setting—preferably outside of distressing environments, like hotels, and facilitated by a supportive professional. This aligns with studies indicating that feeling heard and safe is crucial for adaptation, even amidst trauma (Sheth et al., 2023; Nickerson et al., 2014).

In this study, participants found relief in sharing personal testimonies, empathising, and connecting through their shared precarious legal status, which transcended culture, language, and identity (Salt et al., 2017; Sheth et al., 2023; Baird et al., 2023). Mental health support should reinforce existing coping strategies, resilience, and identity to help achieve personal and cultural goals. Psychoeducation, focusing on concepts of mental health and treatment options, can reduce stigma and encourage support-seeking (Baird et al., 2017).

In our study, participants valued learning, mutual support in the asylum process, and receiving accurate guidance from community organisations, highlighting the role of correct information in fostering personal agency and security (Chase and Rousseau, 2018). Social capital through group participation and trust-based relationships supports mental health and cultivates hope in this population (Van Sint Fiet et al., 2022). Our findings suggest that group interventions and peer support are beneficial and acceptable across diverse backgrounds and immigration statuses, though further research is needed to assess the effectiveness of different group-based well-being interventions across cultures.

Our study confirmed the priority of social determinants of health such as housing, food insecurity and social inclusion, which therefore require joined up approaches in policy between health, voluntary and local government sectors. For example, long waits for claims and the state of liminality can cause asylum seekers to re-live the loss of their past life and compound suffering and grief (Hartonen, 2022). At a policy level, further emphasis should be placed on creating structures to support these elements to prevent longer term impacts of migratory grief on emerging mental health conditions and enable coping with stress. (Rosenblatt, 2008; Hartonen,2022). This study confirmed the key role of meaningful activities (such as physical activity, volunteering and cooking), daily routine, culturally acceptable food, access to places of worship, purpose and activities which offer distraction and fulfilment (Sheth et al, 2023; Wood et al., 2019; Nickerson et al, 2014) in shaping grief reactions following loss (Rosenblatt, 2008). These findings fit with the NHS “5 steps to wellbeing” initiative, which highlights the role of connecting with other people, being physically active, learning new skills, giving to others and paying attention to the present (NHS, 2022).

*Strengths and Limitations*

Partnering with a community organisation enabled a culturally acceptable approach, where trust in the organisation extended to the research, fostering openness among participants. Pre-engagement workshops informed the topic guide, and photo elicitation sparked in-depth discussions. A professional interpreter facilitated detailed dialogue but posed transcription challenges. I-poems captured nuanced themes, adding creative expression and disseminating participants' voices to a wider audience. Findings may not be generalisable to all Arabic-speaking asylum seekers or refugees, as participant experiences and expressions varied by cultural background. Recruitment from one organisation with community-based activities likely influenced group dynamics, potentially excluding more isolated individuals, who may experience greater mental health challenges (McColl, 2008; Sheth et al., 2023).

To conclude, professionals and policy makers should recognise migratory grief as a distinct process that requires careful detection through culturally adapted conversations and language. Our findings highlight how to adapt wellbeing interventions to support post-traumatic growth and the unique potential for group-based interventions outside of home office accommodation to facilitate shared learning, peer support and psychoeducation to reduce longer term psychopathology due to migratory grief. This can support refugees to better understand and navigate their own situations, emotions and promote long-term recovery. However, without a UK asylum system which protects human rights, dignity and supports social justice, this population is likely to continue to suffer despite health interventions.

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Appendix 1

*Definitions*

In this work, the term displaced people is a collective label for forced migrants including asylum seekers, refugees and undocumented migrants (Refugee council, 2023).

* Asylum seekers: “A person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded.”
* Refugee: Someone whose asylum application has been successful; the Government recognises that: “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…”
* Undocumented migrant: Someone whose entry into or presence in a country contravenes immigration laws. This includes people who have been refused asylum status, have been trafficked or an EU migrant who does not have leave to remain, has stayed more than three months and therefore has no recourse to public funds. Refused asylum seekers may have a right to appeal against this decision, but when opportunities for appeal have been exhausted, the person is compelled to leave the country, either voluntarily or through involuntary forced deportation.