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ORIGINAL ARTICLE

Using composite case material to develop trauma-informed psychoeducation for social care workers looking after unaccompanied minors in residential care in Ireland

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Abstract

Although the provision of trauma-informed psychoeducation for carers of adolescents who have experienced traumatic events has been shown to be a fundamental aspect of the recovery process, it is not routinely made available to the social care workers who look after unaccompanied asylum-seeking adolescents living in residential care. Furthermore, the development of the content of trauma-informed psychoeducation is rarely informed by those who have experienced trauma or the professionals who support them. This paper documents the process of ensuring that these voices inform the development and delivery of trauma-informed psychoeducation for the social care workers working in this context. Four clinical reflection and three professional reflection composites were developed from the reflexive clinical journal data of the author's clinical practice as an expressive arts psychotherapist working with 28 unaccompanied minors during a 4-year period. As well as drawing on clinical reflections from therapy sessions (one to two paragraphs per session), the composite material drew on notes on informal conversations between the author and the professionals involved in the lives of unaccompanied minors (one to two paragraphs weekly). The latter was often a response to different situations which arose with the unaccompanied minors in their care, thereby demonstrating the need for a more structured and formalised delivery of psychoeducation for these professionals. The composite material was complemented with a training needs assessment in the form of a vignette and accompanying open questions conducted with 30 social care workers looking after unaccompanied minors in residential care. Reflexive thematic analysis on combined data sets identified the following themes:

- Impact of trauma on everyday lives
- Trauma-informed engagement
- Helping with difficult feelings and loss
- Reducing the stigma of therapy

The resulting training content was enhanced by the selection of tools and techniques developed by a number of clinicians–researchers with expertise in healing post-traumatic stress.

KEYWORDS
composite material, psychoeducation, residential care, social care worker, trauma-informed, unaccompanied minors

1 | INTRODUCTION

The support, understanding and active involvement of caregivers during the therapeutic process with children and adolescents has consistently been shown to increase the likelihood of a successful outcome (Dowell & Ogles, 2010; Martinez et al., 2017). Psychoeducation typically offers evidence-based, age-appropriate information to both the young person in therapy and their carer to explain the possible underlying causes of the difficulties, provide a rationale for the therapeutic approach and explore appropriate supports. The increased caregiver insight gained from psychoeducation has been shown to promote more effective responses to therapy, thereby improving the young person's chances of recovery (Nevas & Farber, 2001; Verma et al., 2019). Furthermore, when the young person has experienced trauma, defined for the purposes of this paper as 'the often debilitating symptoms that many people suffer from in the aftermath of perceived life-threatening or overwhelming experiences' (Levine, 2008; 7), the provision of trauma-informed psychoeducation to both the young person and their caregiver, has been shown to be critical to healing (Brown et al., 2011).

The identification through the author's clinical practice as an expressive arts psychotherapist, of the need for trauma-informed psychoeducation to assist Social Care Workers (SCW) to provide appropriate support to unaccompanied minor (UM) adolescents engaging in psychotherapy, was captured in a reflexive clinical journal which recorded clinical interpretations and reflections on regular discussions with SCW and other professionals involved in 39 UM lives, including teachers, youth workers, lawyers and interpreters, during a 5-year period. Composite case material comprising four clinical and three professional reflection composites was developed from the clinical journal data to ensure that the identities of this vulnerable group and the professionals supporting them were protected. The case material was complemented with a training needs assessment in the form of a vignette and accompanying open questions conducted with 30 SCW's caring for UM in residential units. Reflexive thematic analysis (Braun & Clarke, 2006, 2013), was used to analyse the data, the results of which informed the content of trauma-informed psychoeducation training developed specifically for use in this context.

This paper contributes to the existing psychoeducation literature in two distinctive ways:

1. through its focus on developing trauma-informed psychoeducation for SCW's in residential care settings
2. by using a qualitative, reflexive methodology which ensures that UM voices and supporting professionals inform the training content.

What is known about this topic?

- Unaccompanied minors face substantial psychological and social challenges during forced displacement.
- Psychoeducation for caregivers maximises the likelihood of a successful outcome for the adolescents in their care.
- A trauma-informed approach in residential care creates a safe environment which helps to build trust, encourage collaboration and empower individuals.

What the paper adds

- Innovative composite clinical material ensures the inclusion of the voices of unaccompanied minors and supporting professionals in the identification of trauma-informed psychoeducation content for social care workers supporting unaccompanied minors in residential settings.
- Identifies the content areas as the impact of trauma on unaccompanied minors everyday lives; the development of trauma-informed practices; supporting unaccompanied minors with difficult feelings and loss and addressing therapy stigma.

A brief overview of UM statistics in Europe and an exploration of their assessment and care in the Irish context is followed by a review of research that explores their lived experiences and responses to adversity as well as the ways in which a trauma-informed approach in a residential setting can create a safe, trusting, collaborative and empowering environment. Thematic analysis of the data and discussion of the ways in which the findings were used to identify and develop the content of two psychoeducation workshops for SCW working in residential settings with UM in Ireland, then follows.

2 | UM IN EUROPEAN AND IRISH CONTEXTS

In 2020, approximately 10,300 of the 16,700 children applying for international protection in member states of the European Union,

were considered to be UM; young people below the age of 18 who were not accompanied by, a responsible adult. The majority (83%) were aged 15–17 and were fleeing from regions of the Middle East, South Asia and Africa. UM began arriving in Ireland in the mid 1990s and this number steadily increased from 97 referrals to the dedicated Social Work Team in 2014 to 184 referrals in 2020, an increase consistent with international trends. Upon arrival in Ireland, a multidisciplinary social work risk and needs assessment is carried out, which includes child protection, medical, psychological, educational and language assessments. Whereas all UM under 12 years arriving in Ireland are placed in a foster care placement, those aged 12 and over are usually placed in children's residential units (6 places) which are run by 24-h SCW. This paper focuses on 15–18-year-old UM.

In Irish residential units, each UM is assigned a key worker who is responsible for their individual needs (Horgan & Ni Raghallaigh, 2019). However, for UM engaging in trauma-focused psychotherapy, for whom stability is particularly important, (Soderqvist et al., 2016), staff shift patterns inevitably result in a reduced number of opportunities to build trusting, supportive and consistent relationships and fewer possibilities for caregiver review sessions with the therapist, thereby limiting opportunities for psychoeducation. Following an assessment of education and English language skills, the UM is likely to be placed in a transition programme in preparation for mainstream education or other training options. A statutory care plan is developed and the social worker makes an application for international protection if considered appropriate, the priority is to meet the child's immediate clinical needs. Groarke and Arnold (2018), provide a comprehensive explanation of UM pathways to status in Ireland.

3 | UM LIVED EXPERIENCES AND RESPONSES TO ADVERSITY

Although sharing some of the same experiences as accompanied youth, UM can be considered a unique subpopulation that faces substantial psychological and social challenges during all stages of flight, which are likely to be compounded by the impact of prolonged family separation and dislocation from the community and social supports (Erikksson & Wimelius, 2018; NeMoyer et al., 2019). UM are exceptionally vulnerable during flight, facing many risks as they travel through different countries with no access to legal help or protection, often being forced to walk continuously with little sustenance and a high risk of physical or sexual abuse, being detained or trafficked. Many will find themselves on board dangerously overcrowded boats, travelling at night with no lights or life-saving equipment, often experiencing the trauma of capsizing and witnessing drownings. UM can feel overwhelmed by ambivalent feelings of not wanting to stay in the host country whilst being fearful of returning to their own country. They may also be caught up in layers of legality around their asylum claim (Derluyn et al., 2009; Groark et al., 2010; Papadopoulos, 2002).

Although the refugee experience is frequently associated with psychological trauma, it may be more useful to conceptualise it as a profound loss (of family, friends, home, identity, trust, and life as it was). The loss of home, in particular, has been shown to create a deep sense of disorientation and absence. These experiences can have varying impacts on mental health, depending on previous childhood traumatic experiences and sociocultural factors (Levine, 2013), with some survivors developing psychological difficulties, and others being more able to cope, adapt and thrive (Kohli, 2006). The natural pace of child development can also be disrupted (Davies & Webb, 2000), which might impact UM capacity for integration into local communities. The lack of parental support has been shown to place UM at a significantly higher risk for the development of psychological difficulties than accompanied children (Bean et al., 2007), and professionals working with UM need to understand the potential impact of these experiences.

4 | A TRAUMA-INFORMED APPROACH FOR UM IN RESIDENTIAL CARE

The last decade has seen an increasing recognition of the importance of a trauma-informed approach in various settings including healthcare (Sweeney et al., 2016); social care; education (Morgan et al., 2015; Walkley & Cox, 2013); child welfare (Kramer et al., 2013); criminal justice; military veteran services (Esaki et al., 2020) and refugee support services (Ostrander et al., 2017). This approach promotes a culture of understanding the impact of trauma, integrating this knowledge into service delivery, ensuring that those who are looking for help are not re-traumatised, and signposting trauma-specific interventions where necessary. A trauma-informed approach creates a safe environment which helps to build trust and facilitate choice, collaboration, and empowerment enabling survivors to experience healing relationships.

The principle of safety in the residential setting is exemplified by a safe and nurturing physical environment and culturally safe and respectful practices and interactions using non-stigmatising language (Barton et al., 2012). Safe relationships are characterised by consistency, predictability, respectability, non-violence, non-shaming and non-blaming. Instilling trust means that information is delivered with transparency and explained using appropriate language, with opportunities to ask questions. Honouring confidentiality and consistency in the respecting of boundaries are central aspects of a trauma-informed approach for UM together with collaboration in decision-making and empowerment through recognising and validating UM strengths and learning new coping skills (Kohli, 2007). Additionally, trauma responses typically defined as 'symptoms' should be normalised and seen as adaptations to difficult circumstances. Finally, providing choice is important in relation to going out, cooking meals, managing money, choosing school subjects and visiting friends.

5 | METHODOLOGY

5.1 | Protecting UM identity

Although most psychotherapists agree that writing about clinical work is essential for advancing therapeutic practice, there is no consensus amongst professional bodies, clinicians or academics about the reporting of client data (Sink, 2010). The preparation of clinical case material for publication therefore involves careful consideration of ethical questions and the most effective ways of safeguarding client privacy. The most widely documented options are seeking client permission, disguising case material and developing composite case material.

Requesting permission to publish clinical material may at first glance appear to be the safest way to protect UM privacy and reduce clinician–researcher risks (Sieck, 2012). However, the significant power differential between psychotherapist and client means that clients may feel obliged to comply (Aron, 2000; Goldberg, 1997). Sieck (2012) argues that seeking consent is likely to negatively impact the therapeutic relationship and psychological growth and Sperry and Pies (2010) highlight the incongruent feelings and meanings which may be generated for both client and clinician. Moreover, Duffy (2010) points out that informed consent cannot cover the different readings and interpretations of the clinical material over time. Furthermore, as gaining consent is an ongoing process, continually seeking consent in the context of therapy may result in discomfort and mistrust (Biros, 2018).

It is also important to acknowledge that this decision-making process is complex and nuanced. Although Carlson (2010) and Sperry and Pies (2010) question whether informed consent can ever be fully obtained in this context, Bridges (2010) reports clients feeling appreciated and validated when asked. Furthermore, McKinnon's (2017) sensitive collaborative account with a former refugee client of his experiences of the therapy process, driven by his desire to deliver key messages to other therapists, includes an insightful exploration of the potential impact of publishing clinical material. Careful consideration of the UM clients in close consultation with the author's clinical supervisor, led to the conclusion that given their specific vulnerabilities and linguistic challenges, obtaining informed consent would not be the optimum way of safeguarding their privacy.

The most widely used strategies of disguising clinical case material to protect client identity are either alter (by changing demographic descriptors), limit (by deleting personal and professional information) or obscure (by adding extraneous material), descriptions of specific characteristics. Sperry and Pies (2010) provide comprehensive guidelines for disguising case material. The main limitation associated with publishing lightly disguised clinical case material without client consent is the risk of client recognition in research output and its negative psychological impact, whereas more heavily disguised data may limit learning by not remaining true to the case.

Duffy (2010) argues that the construction of composite cases which blends clinical material from two or more client cases into a single case, removes the requirement to obtain consent and avoids developing a single case disguise that has too little or too much disguising detail. In addition to addressing the issues of anonymity and the impact on the therapeutic relationship of seeking consent, the decision to develop composite material for the current study was prompted by the desire to convey the richness and complexity of individual experiences within the context of a meaningful and trusting therapeutic relationship developed over time, thereby attaining a depth of relational engagement unlikely to be achieved using other methods.

Ethical approval for developing composite case material comprising four clinical and three professional reflection composites, as well as administering the vignette, was granted by the Faculty of Arts and Social Sciences Ethics Board in Trinity College, Dublin. This included approval for waiving the requirement for informed consent from the UM in the interest of safeguarding the confidentiality and maintaining and respecting the therapeutic relationship. Although informed consent was obtained from the professional participants, their comments were also formed into composites to ensure that neither themselves nor the UM could be identified from their material. As the vignette elicited responses to an imaginary character, the anonymisation of participants was deemed sufficient.

5.2 | The composite case material

Four clinical and three professional reflection composites were developed from clinical case material from 39 UM and the professionals supporting them over a 5-year period. All potentially identifying information was removed before constructing the composites, to ensure that anonymity was respected at every stage of the process. In selecting composite pseudonyms which originate from the Middle East, South Asia or Africa, but are found increasingly in Europe, the author sought to balance the tension between protecting UM identity and preserving the richness of the data. Although the composites mix clinical reflections for both genders, each composite has been assigned gender for simplicity: one female and three males, reflecting the UM gender split. Clinical reflection composites are named Zayn, Yasmin, Joshua and Elijah and professional reflection composites Naomi, Aisha and Danny, names which reflect the backgrounds and gender division of these professionals. As well as capturing common experiences each composite incorporates 'one off' individual experiences thereby ensuring multidimensionality.

5.3 | The vignette

The second data source comprised a short vignette and accompanying questions (see Table 1 below). Anchoring the questions using imaginary characters was designed to provide a supportive way for respondents to reflect on issues affecting UM. The administration was via the

TABLE 1 Vignette and accompanying questions

Vignette	
Abdul-Azim was 15 years old when he left his home in a rural area of Afghanistan to escape the Taliban. Abdul was the oldest of five children and the only boy, and his father sold everything he had to pay a smuggler to take him to Europe. Abdul-Azim did not want to leave his family, but if he stayed he would be forced to fight for the Taliban. The journey to Ireland took 5 months during which time Abdul-Azim spent 2 months in a prison where he ran out of money and was tortured before his father managed to get more money to the smugglers to pay the prison guards to release him. He then spent 6 weeks in a refugee camp. Every morning he would follow other refugees to try to get on to a lorry going to another country. Eventually he succeeded and arrived in Ireland. He did not know which country he had arrived in until an interpreter was brought to the immigration office where he claimed asylum and told him that he was in Ireland. He had no way of contacting his family to let them know he was safe and to make sure that they were safe	
Questions	
1	Describe the impact which you think that fleeing his home has had on Abdul-Azim
2	Describe the impact which you think that being separated from his family has had on him
3	What knowledge and skills training do you think would most help those caring for him in a residential context?
4	How do you think that you would be able to support him in this residential context while he was engaging in psychotherapy?

Smartsurvey platform to the 30 SCW in the residential units. This provided SCW with the opportunity to articulate their understanding of the impact of trauma on UM lives and their perceptions of knowledge gaps. In combination with the composite case material and relevant research, this data informed the development of targeted training.

6 | REFLEXIVE THEMATIC ANALYSIS

As preliminary screening identified connections between the composite case material and vignette responses, they were combined for the reflexive thematic analysis (Braun & Clarke, 2006) and a data-driven inductive approach with no pre-determined coding frame, was adopted within the Reflective Lifeworld Approach framework (Dahlberg et al., 2008). All written data were read repeatedly for familiarisation with complexity and scope and interesting features were assigned initial codes which were combined into potential themes according to similarity and prevalence and then re-checked against the data. Forty-four categories comprising 84% of the data were identified and grouped into the following four themes which informed the author's development of two psychoeducation workshops specifically for SCW caring for UM in residential care. These themes are aligned with the notion of a central organising concept and can be conceived as key characters in the story being told about the data (Braun & Clarke, 2013):

1. The impact of trauma on the everyday lives of UM
2. Engaging in a trauma-informed way with UM
3. Supporting UM with difficult feelings and loss
4. Reducing the stigma of therapy for UM

Spelling, grammatical errors and abbreviations in the vignette data extracts were only corrected to ensure legibility and omissions in shortened quotations are denoted by [...]. Reflections are labelled as clinical or professional together with the composite name. Vignette extracts are presented with the name (pseudonym), gender and age of the respondent.

6.1 | Theme 1: The impact of trauma on UM everyday lives

The need for knowledge about the different ways in which trauma impacts the everyday lives of UM is evoked in both data sets. Many clinical reflections highlight the need for psychoeducation in this area for the UM and their carers:

> Struggling with headaches, concentration lapses and nightmares. Needs help in understanding the impact of trauma. Normalised impact and identified football as a coping resource
>
> (Clinical: Zayn)

This professional highlights the tendency of a UM to 'zone out' in class and links this to other aspects of his life:

> Sometimes I ask him a question and it's like he just is not there and it's hard to know what to do. Perhaps he's thinking about his family (Professional: Naomi)

This SCW mentions one UM who found it very difficult to focus when she was explaining something to him:

> I find myself repeating, just something simple like a word he do not know - it's like he do not hear me (Vignette: Ciara, F, 28)

Another SCW described a constant nervousness whenever she left the house with a UM:

> He's always looking around and not listening to what I'm saying, really figety and nervous. (Vignette: Alannah, F, 32)

Van der Kolk (2015) explains how people who have been impacted by trauma can be unusually sensitive to the environment as their subconscious is constantly anticipating danger and their senses are on high alert, always ready to identify and respond to potential

threats. Other impacts of trauma such as persistent nightmares and flashbacks are also evoked in the reflections:

> Frequent nightmares and flashbacks. Self-soothing in chair rubbing fleece top. Gently normalised trauma response with simple psychoeducation. Introduced grounding techniques and mindfulness. (Clinical: Elijah)

In response to the boy in the vignette, an SCW suggested that he would be likely to experience nightmares, comparing him to a UM in his care:

> He would probably have nightmares. This happens a lot to Rashid. We give him yoga videos for practising before bed and lavender oil for his room but he still wakes up screaming. (Vignette: Conor, M, 30)

The difficulties experienced by UM around connecting with their feelings were also identified as a possible impact of trauma and a reason for going to therapy:

> Felt she'd been 'sent to therapy' to help express her feelings. So quiet I could hardly hear her. Head bowed - no eye contact. Acknowledged how difficult it must have been for her to come. Frozen feelings – need to facilitate gradual thawing through sensory interventions. (Clinical: Yasmin)

These excerpts suggest that although they have some understanding of the impact of trauma, those supporting UM feel that they would benefit from more knowledge and skills.

6.2 | Theme 2: Engaging in a trauma-informed way with UM

Trauma-informed engagement creates a safe environment where there is an understanding of the impact of trauma on cognitive and emotional functioning within trusting, collaborative and empowering relationships. This extract demonstrates the need for psychoeducation which explains a trauma-informed approach, recognising its potential impact:

> Firash cannot seem to grasp very simple concepts in the classroom. I'm wondering about an intellectual disability. (Professional: Danny)

Although an intellectual disability is a possibility, Schroeder (2019), highlight the diagnostic challenges, suggesting that trauma responses such as altered brain functioning, which has an impact on memory, logical thinking and problem-solving, together with interrupted education and linguistic difficulties, may present as an intellectual disability or conversely that this may be overlooked because of trauma responses, making a thorough assessment crucial.

UM experiences also demonstrate the absence of a trauma-informed response by some of the professionals involved in their daily lives:

> Teacher sent him out of the classroom for zoning out. Shamed him in front of class by sending him to the year below. (Clinical: Joshua).

However, there was also evidence of a sensitive trauma-informed approach in some cases:

> I told him that if he found the classroom overwhelming I would be happy for him to take a breather in the meditation room. (Professional: Aisha)

In relation to the vignette, one of the SCW talks about how overwhelmed Abdul-Azim is likely to feel when he first arrives in his accommodation:

> It's like our UM when they first arrive, we have to provide them with so much information and it would be good to learn different ways to help them to remember. (Vignette: Kieran, M, 32)

These excerpts illustrate that some of the professionals working with these young people are actively seeking trauma-informed information. This is also the case in relation to supporting UM with difficult feelings and emotions connected with their experiences of loss.

6.3 | Theme 3: Ways of supporting UM with difficult feelings and loss

The data clearly reflects different responses to the losses experienced by these UM as well as the expressed need for the professionals working with them to be equipped with the appropriate knowledge and skills to be able to offer support. The following clinical reflection documents Joshua's response to traumatic loss and ideas for pathways to healing:

> All feelings (good and bad) completely blocked in order to survive - now begins long process of unblocking. Used visual images of iceberg to illustrate conscious (above water) and unconscious (below water) and ice thawing. Explained that we were going to work on unblocking his senses to help him feel again. Started with dry messy play – loved sensory aspect of coloured rice, running his hands through it – will move on to making slime. (Clinical: Joshua)

In this case, the author also liaised with the SCW to look at different ways of introducing sensory elements into the care setting, to ensure continuity in supporting the young person to gradually unblock his feelings.

Anger and intense rage were also documented as a response to the trauma experience:

> He lashes out when he cannot get his own way so he smashed the TV. We know he's been through difficult times and want to help, but we also have to think of the other residents. (Professional: Danny)

The author visited the house after this incident and talked to staff about responding in an empathic yet boundaried way when he became dysregulated. The neuroscience behind the behaviour was explained using Dan Siegel's *Window of Tolerance* and *Hand Image of the Brain* (Siegel, 2013), two tools which were used with the UM and included in the final training materials. The author suggested having a corner where the UM could safely discharge his anger (using a punching bag, stamping on plastic bottles, bashing a pillow), as well as making his room a nurturing and safe space.

The sense of loss experienced by UM is also evoked in the data and the SCW are keen to know how to support them through their losses and complex feelings:

> Abdul-Azim, like our young people, would be worrying about his family's safety and feeling guilty about being here. How can we provide support? (Vignette: Farouq, M, 34)

6.4 | Theme 4: Reducing the stigma of therapy

Negative UM perceptions of therapy and their reluctance to engage due to mental health stigma were frequently documented in the data:

> I would love to know how to get UM to even consider coming to therapy. Cultural beliefs mean they think it's for 'mad people' and are scared of being locked up. (Vignette: Frank, M, 31)

The following reflection also captures these cultural beliefs, this time in relation to speaking about things which happened in the past:

> I'm encouraging Astur to come to therapy, but she has always been told to forget her past and focus on the future. She says that she just wants to get on with her life here rather than digging up the past. (Professional: Naomi)

UM perceptions of therapy were influenced by differing worldviews (Lago, 2011):

> She sees talking about her feelings as a sign of weakness and her faith punishes crying. I need to meet her where she is, be curious about her faith, and eventually explore different worldviews with her gently and non-judgementally (Clinical: Yasmin)

There was also a lack of awareness of the difference between mental health and mental illness (Majumder, 2019):

> Spent the session explaining how positive mental health was not an illness (Clinical: Joshua)

Taking account of these attitudes and perceptions and wishing to reduce the stigma of therapy, the author works closely with residential care workers to help them to recognise a moment when it might be possible to engage UM in conversations about psychological wellbeing. Rather than using the term 'therapy', the worker may talk to the UM about being supported with coping strategies and planning for their future. The author has frequently engaged in informal and collaborative familiarisation sessions, pre-therapy activities and conversations with the UM in different settings in order to de-stigmatise and demystify the process. Table 2 illustrates the sequence of identifying and attending to the need for support and engagement which was documented by the author and shared with social care workers in response to numerous queries:

As soon as there is an agreement for a first meeting, the author connects with the UM in the most comfortable setting for them:

> Our first session was a 'walk and talk' session. I knew that Joshua liked dogs so I brought a neighbour's dog, Teddy, with me. During three sessions I gently introduced the idea of meeting regularly and we continued with our walks until he suggested going inside when it got colder. We still engaged in occasional outdoor sessions which allowed Joshua to reconnect with Teddy, who had an incredibly calming effect. (Clinical: Joshua).

Other settings have included cafés, schools, the residential unit, the social work office, UM football tournaments and creative arts workshops. Although some UM may continue to engage in these

TABLE 2 Pathways to therapy

	Sequence
1	Therapeutic support is identified as being potentially useful for a UM by the social care worker or the social worker
2	A referral form is completed and submitted to myself
3	I schedule a call with the referrer and if the UM is anxious about or resistant to the idea of therapy, we look at different ways in which the referrer can frame therapy to the UM so that they do not feel stigmatised
4	The referrer works with myself and the UM to determine the most comfortable way to initiate the first meeting to discuss the possibility of therapy

settings, those who transition to the therapy room (or start there) are shown pictures of the room and the therapist for familiarisation. The author has also produced a short video and leaflet which introduce herself and describe the ways in which she can support the UM, thereby reducing stigma. The author also gradually increased the time that one UM spent with her from 15 min initially to the full 50 min session:

> He was clearly extremely uncomfortable in the room so we finished after 15 minutes. Planning to increase the time very gradually over the next number of weeks.
>
> (Clinical: Zayn)

Finally, in some cases, the author recognises that the best way to help a UM who is resistant to therapy is to provide trauma-informed training to their SCW.

7 | THE STRUCTURE, CONTENT AND DELIVERY OF THE TRAUMA-INFORMED PSYCHOEDUCATION TRAINING

Having identified the training needs from the reflexive thematic analysis, the author developed two trauma-informed psychoeducation workshops which she delivered via *Zoom*, a video conferencing service, in order to make them accessible to those working shifts in the geographically distanced residential units. The topics identified from the reflexive thematic analysis were further informed by

- clinical supervision and continuing professional development.
- scholarly literature on the impact of traumatic experiences on UM
- trauma-informed tools and techniques developed by clinicians–researchers with expertise in reconnecting mind and body after trauma, from psychology and psychotherapy (Levine, 2008; Malchiodi, 2020); neuroscience (Schore, 2019) and medicine (Mate, 2019; Siegel & Payne-Bryson, 2011; Van der Kolk, 2015).

In addition to psychoeducation about the impact of trauma, skills development included the modelling and practice of stabilisation, relaxation and grounding skills and tools to share with the SCW and used with the UM in their care (Darsa, 2020; Levine, 2008, 2013, 2015; Malchiodi, 2020; Van der Kolk, 2015). The author also made use of clinician–researcher Youtube[1] videos, which provided accessible visual explanations of these skills and tools (e.g. Levine, 2013).

The key aspects of awareness raising and skills development and practice included in the workshops are presented in Tables 3 and 4 below:

The workshops were delivered in July 2020. To support the SCW to embed, further develop and sustain the skills, participants were invited to monthly online sessions, where they could discuss their experiences and seek guidance.

TABLE 3 Workshop one: The impact of trauma on UM in Ireland

Raising awareness of the impact of trauma	Skills development and practice
Trauma: • Definition and psychosocial impacts • Causes • Reminders and cues Impact of trauma on • Brain and Memory • Communication • Behaviours UM may • be easily overwhelmed and feel frightened and out of control • find it difficult to understand, retain and process information • find it difficult to focus and concentrate • present with child-like coping strategies (e.g. shouting, crying, hitting out) • be unable to contain (regulate) their emotions • present with high levels of irritability, anxiety and agitation (be on edge) • present as completely closed down and disconnected from the world around them. Processing trauma creatively Vicarious trauma and self-care	Adopting a trauma-informed approach with: patience, kindness, consistency, honesty, understanding, active listening, empathy, being willing to bear witness to another's distress, being non-judgemental. When interacting with someone who presents as traumatised or distressed, trying to engage them by: • asking them about their immediate needs and supporting them to meet them • helping them to understand the impact of trauma on the mind and body • using this information to provide them with reassurance and support • connecting them with their social support networks (this involves working with them to identify who are good supports) • providing additional support and information to those people whom the individual has identified as being in their social support network Using accessible visual sources to explain • grounding strategies • breathing techniques • mindfulness practices • sleep hygiene See Psychology Tools (2022) for resources which include different language options and use Pinterest for clear infographics that address these strategies and can be downloaded onto a mobile device Encouraging creativity amongst UM, for example collaging, drawing, painting, journaling. Developing self-care practices. There is no single approach. Each individual needs to identify what helps them to relax and recharge. Some self-care ideas: • establishing and maintaining a routine • focusing on enjoyable activities and making an effort to implement them regularly • maintaining connections with family and friends • maintaining a healthy work–life balance • peer support • engaging in reflective practice

Note: Pinterest is a social curation website for sharing and categorising images found online.

7.1 | Reflections on the workshop construction and delivery

As this paper focused on the rationale for and development of, the content of trauma-informed psychoeducation training specifically for use with UM, it is beyond its scope to fully evaluate the resulting

TABLE 4 Workshop two: Positive mental Health through a trauma-informed lens for UM in Ireland

Knowledge	Skills development
What is trauma-informed practice?	How to develop trauma-informed practice:
The impact of grief and loss on UM Dan Siegel's *Window of Tolerance* Helping UM with depression Mental health and differing worldviews and cultures	• stabilisation after experiencing trauma to ensure emotional and physical safety • educating about the signs and symptoms of trauma • normalisation of symptoms • assessing the presence and availability of social supports • encouraging engagement with specialist support services How to support UM through their grief and loss Recognition of responses to loss: • anxiety • sleep difficulties • nightmares • sadness • longing • anger • acting out • physical complaints (see Malchiodi, 2015, for ideas about how to use creative interventions to help children who are coping with loss). Trauma-informed ways to help UM who are struggling with emotional dysregulation and their carers. (Siegel, 2013) How to support a UM who is struggling with depression Psychology Tools (2022) for resources which include different language options. Framing therapy as 'maintaining positive mental health' Exploring the benefits of therapy with UM Empathic listening with UM Developing mindfulness strategies with UM (see Table 1)

workshops. However, reflections on the training were captured in interactive real-time feedback integrated into the workshop (see Figure 1).

The comments illustrate the perceived effectiveness of explaining the theory and modelling and practising the approach, which was used to explore: the impact of trauma, trauma-informed practice, mindfulness and grounding techniques and the use of expressive and sensory ways of processing trauma. The feedback also showed that the participants wanted to learn about suicide prevention and further training in this area was therefore organised.

8 | DISCUSSION

8.1 | Reflections on the approach

The aim of this study was twofold: first to demonstrate how the voices of UM and the professionals involved in their lives could contribute to the identification of psychoeducation training content which would enable SCW to maximise their support for UM and second to highlight the use of the innovative composite clinical journal and vignette data sources in this process. The composite case approach, which removed the requirement to obtain informed consent, was developed after carefully considering the critical debate which questions whether bona fide informed consent can ever be truly obtained in the therapy context (Carlson, 2010; Sperry & Pies, 2010). The distinctiveness of this study lies in its unique capturing of UM experiences and needs and the use of this material to inform training content.

8.2 | Main findings

The main themes generated by the author from this data identified the need for:

- trauma-informed and therapeutic practice,
- knowledge and skills training on the impact of trauma on UM lives,
- supports to help UM with difficult feelings and loss,
- the stigma of therapy to be addressed.

The creation of workshop content informed by these themes aimed to develop SCW knowledge and skills in these areas. Crucially, this included the sharing of highly visual infographics from Pinterest[2] on the impact of trauma on the brain, stabilisation, relaxation and grounding techniques. Many UM will have been living in a state of hypervigilance in their home country with considerable attention being paid to non-verbal cues. Therefore, using multiple means of communicating information supports understanding and memory.

The combination of data sources used in the current study provided different ways of including key voices in the identification of the training content for SCW. The clinical journal data allowed the author to gain an in-depth multiple-perspective understanding of the knowledge and skills gaps relevant to supporting the UM engaging in psychotherapy in their everyday lives. Interestingly, SCW responses to the vignette questions, which formed part of the training needs assessment, tended to quickly shift focus from the fictional character to the UM in their care, suggesting that this was an effective means of eliciting pertinent information. The first three vignette questions on the impact of forced migration and family separation were addressed most comprehensively by the respondents, who did not respond to the fourth question by specifying ways in which they could support UM, while they were engaging in therapy, thereby suggesting the need for training in this area.

8.3 | Limitations

As this study is based on the experiences of 39 UM who were engaging in psychotherapy in Dublin, the findings are not representative of all UM in Ireland. Nevertheless, the in-depth exploration of UM

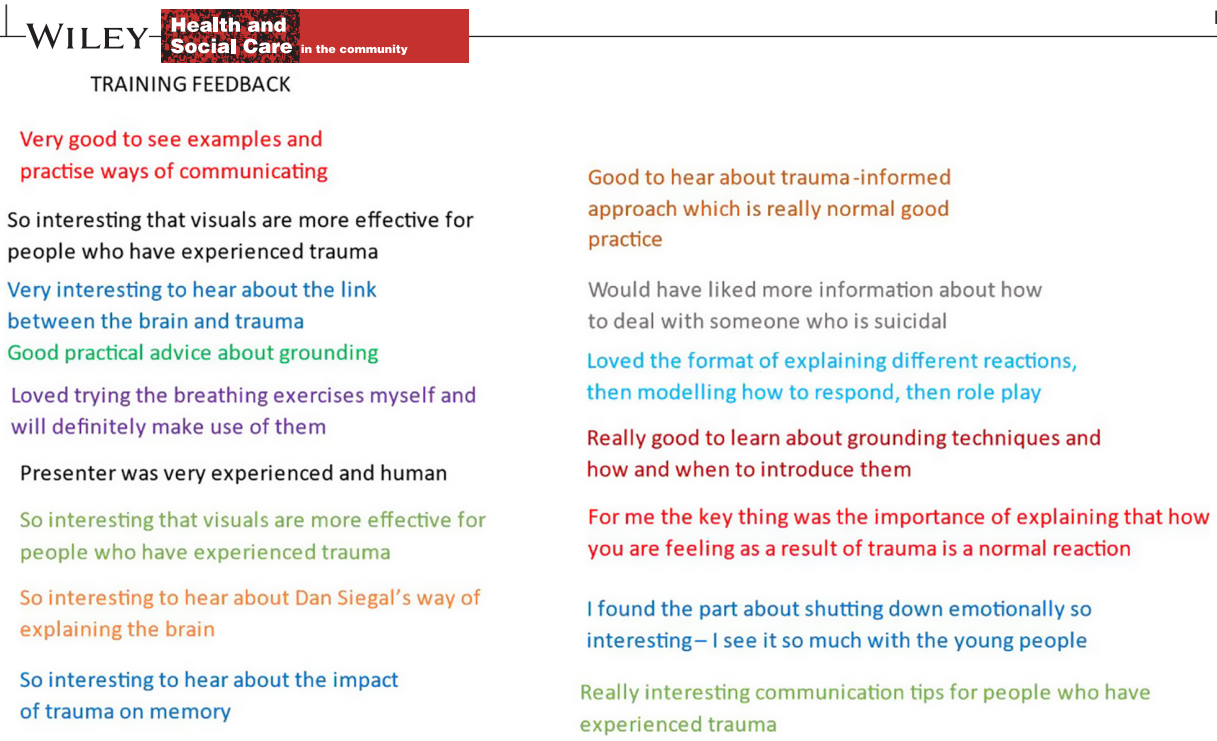

FIGURE 1 Workshop feedback

experiences of the impact of trauma on their everyday lives, the importance of engaging with them in a trauma-informed way, reducing the stigma around therapy and helping them with difficult feelings and loss, has enhanced our understanding of their support needs outside the therapy room and informed the development of training for SCW. The main limitation of the composite narrative approach is the burden of responsibility placed on the author to truly capture UM experiences in the therapy room while guaranteeing the confidentiality, although it could be argued that such judgements are a central aspect of all qualitative research. Transparency in reporting the analytical process diminishes these potential shortcomings.

8.4 | Future research and recommendations for practice

In addition to providing rich insight into the knowledge and skills gaps of professionals working with UM and using this information to develop psychoeducation training and resources for SCW to help them to support UM engaging in psychotherapy, this paper highlights the need for a more comprehensive survey of the trauma-informed training needs of all professionals working with UM irrespective of their engagement in psychotherapy. This includes social workers, educators, border agency staff, law enforcement agencies, international protection staff and immigration lawyers.

9 | CONCLUSION

The growing demand for mental health supports for UM has led to an increased need for trauma-informed training for those who support them. This paper recognises the importance of UM and supporting professional voices in informing the content and delivery of trauma-informed training for SCW, which is focused on supporting UM positive mental health. The findings have important implications for all professionals who are interested in understanding and supporting the needs of forcibly displaced young people and ultimately all looking after children and adolescents who have experienced trauma.

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CONFLICT OF INTEREST

The author has no conflict of interest to declare.

DATA AVAILABILITY STATEMENT

Data are available from the author, Dr Rachel Hoare, School of Languages, Literatures and Cultural Studies, Trinity College, Dublin, Republic of Ireland. rmhoare@tcd.ie. upon reasonable request.

ENDNOTES

[1] American online video-sharing platform

[2] Virtual discovery engine

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