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Personal Reflection

Diasporic identity and transnational belonging: reflections from supporting mental health services in the Rohingya camps

Nargis Islam

DClinPsy, Department of Psychology, University of East London, UK

Abstract

Since August 2017, approximately one million Rohingya people from Myanmar have fled from genocide, gender-based violence and torture in northern Rakhine state, Myanmar to Cox's Bazar in neighbouring Bangladesh. International and local humanitarian agencies are now attempting to support the health and mental health needs of over 1.3 million people who are dependent on aid, including the host communities. This reflection paper considers diasporic and transnational belonging issues emerging from being an international consultant who is also Bangladeshi by origin, and the cross-learning processes that emerged through working with local services. Given the recognition that historically western narratives are privileged over non-western knowledge and experiences, key learning around this interface and the necessity of reflective and ethical practice competencies are outlined. Working with local services in humanitarian settings involved a congruence with a personal–professional value base, and a humility, openness, self-awareness and reflexivity. The importance of reflective and ethical practice competencies is discussed in the context of delivering effective and culturally congruent, meaningful and useful interventions. The paper outlines key learning and reflections from supporting work in the Rohingya camps in Bangladesh, and how this learning might apply to clinical practice in humanitarian and development settings.

Keywords: mental health, Rohingya, professional practice, cultural congruence, reflective practice, ethical practice

Introduction

This paper outlines my reflections and observations as an international consultant of Bangladeshi origin, emerging from experiences of working with local services and clinicians in development and humanitarian settings, with a particular focus on the work of developing and supporting mental health and psychosocial support (MHPSS) services in the Rohingya camps. I will start with a brief overview of my professional and personal context and the experiences that led me to explore the importance of reflective and ethical skills in these settings. This will be followed by a discussion of reflective and ethical theory–practice links. I also aim to illustrate some of the key points with reflections from my practice and consultancy experiences. Finally, I will consider how these experiences and theory–practice links may be applicable to humanitarian and development initiatives in low-resource settings.

Context

I am a UK trained and based clinical psychologist and have held clinical and academic positions throughout my career in adult mental health and on clinical and counselling psychology training programmes. My consultancy work began in 2014 with the BRAC Institute of Educational Development (BRAC IED), Dhaka, Bangladesh, where I began to provide clinical and supervision skills training and mental health strategy development. Being able to spend more time in my country of origin and using my skills to contribute to mental health work in the region was an important personal and professional development opportunity. In these consultancy roles I had the opportunity to collaborate with local clinical colleagues in the co-development of the current MHPSS para-counsellor model from their innovative '*shomaj shongi*' (community friend) model. When the Rohingya humanitarian crisis happened in August 2017, BRAC were one of the first responders to address the MHPSS needs of the forcibly-displaced

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Address for correspondence: Dr. Nargis Islam, Professional Doctorate in Clinical Psychology, University of East London, Water Lane, London, E15 4LZ, UK.
E-mail: N.Islam@uel.ac.uk

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Rohingya people, applying the model we had developed to positive effect. Since 2017, I have spent more time in Bangladesh and have been working closely with the clinical and management team to further develop capacity, quality assurance processes and service delivery efficiency, in addition to developing the theoretical and conceptual underpinning of the MHPSS para-counsellor model.

My experience of training and working in clinical contexts in the UK informed my understanding of mental health phenomena. As my consultancy work continued, it became clear that the interface between professional and personal identities is possibly more significant when working in development and humanitarian settings. I felt it important to recognise the influence of my personal, cultural and professional identity on the assumptions, perspectives and understandings I held about mental health phenomena, including skills, competencies, training and service provision. I found myself becoming more conscious of the core values of therapeutic professions, and endeavoured to remain grounded in an approach incorporating humility, openness, self-awareness and reflexivity. This enabled me to learn from my local colleagues and recognise ways in which I could meaningfully contribute to and support their practice, rather than simply deliver training that was based in western-orientated expertise. In the Rohingya camps, for example, a very large geographic area has to be covered daily, so training on supervision that recognised the human resourcing and skills mix structures enabled a process to be developed through which regular supervision could be maintained.

Working with local colleagues in services delivering MHPSS in humanitarian settings therefore required an ongoing exploration of my own personal–professional value base. The importance of these experiences, I believe, lay in an enquiry of what an authentically culturally congruent and respectful approach to working in non-western settings might look like.

One of the key influencers in my learning was from my experience of ‘belonging’ to both Bangladeshi and UK/western cultures and the ways in which parts of my identity had developed as a result, that is, a diasporic identity and a transnational belonging. When we consider and use the word ‘*diaspora*’, we refer to a scattered population whose origin lies in a separate geographic locale. Relatedly, ‘*diasporic identity*’ is when more than one country/culture is recognised as ‘*home*’ and can be experienced at the level of emotions, the level of appearance, and the level of allegiance/affiliation. Immigrant or expatriate communities therefore can retain certain elements of their cultural identity of origin, such as a shared history, language and culture. As such, a diasporic identity can also involve an emotional and sometimes intrinsic link to the culture of origin. In a related concept, ‘*transnational belonging*’ refers to the engagement in transnational ways of ‘*being*’ and in transnational practices. Those who have experienced and actively identify with groups and individuals in these different cultures or nations can experience their identity as an amalgamation of the different cultures that span those spaces. In my context, there was an assumption of cultural connection and cultural affiliation due to significant time spent in Bangladesh, and in terms of fluency in the Bangla language and with cultural norms. While this in part was true, as time went on, I began to see the more subtle and nuanced ways in which such assumptions could be barriers to a truly authentic and congruent connection to working with cultural context and need in my clinical and consultancy work. I began to recognise that the language of negotiating expectations were subject to cultural differences. Where previously my connections had been informal, embarking on communicating within a work context was a new experience, as all professional activity to date had been within a UK context. I noticed how I experienced Bangladeshi work culture as a complex and interlinking social process, often based in pre-existing social and professional relationships, for example, beginning work on a new project with someone and finding out they are related to or are close friends with others in one’s social and familial network was a frequent occurrence. The unexpected multiplicity of these interconnections was overwhelming initially, but importantly, as time went on, I noticed it also gave me a sense of community connection, belonging and social support that I was unused to in my UK clinical and academic practice. In one sense, I was more ‘integrated’ in my personal—professional identity, as both aspects were present in both social and professional experiences, respectively.

As a clinical psychologist, my training in a reflective scientist practitioner (RSP) model (Lavender, 2003) intuitively led me to explore the possible underlying psychological processes in these experiences in the service of developing more culturally congruent working practices.

The RSP model is a combined form of (1) the scientist–practitioner model which ‘*produces a psychologist who is uniquely educated and trained to generate and integrate scientific and professional knowledge, attitudes, and skills so as to further psychological science, the professional practice of psychology, and human welfare . . . and is capable of functioning as an investigator and as a practitioner*’ (Belar & Perry, 1992, p. 72) and (2) the reflective practitioner model which emphasises personal knowledge and interaction as being as important as command of technical skills (Schon, 1987). The reflective practitioner model embodies concepts such as self-awareness, reflection in action, knowledge in action, practice-based learning, and integration of theory and practice. I will expand on these concepts of reflective practice further on in the paper.

Culture and mental health

Current research shows us that remaining connected to the cultural context of a clinical population is crucial when working in a mental health context. Culture has been defined as ‘*a set of institutional settings, formal and informal practices, explicit and tacit rules, ways of making sense and presenting one’s experience in forms that will influence others*’ (Kirmayer, 2006, p. 133). Evidence from the Rohingya context in Bangladesh illustrates the

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challenge of providing services when there are culturally different idioms, expressions and manifestations of mental distress, and an underlying conceptualisation of mental distress that is different from the dominant (and western) paradigms of mental health understanding (Tay et al., 2018). The use of language, for example, is how internal experiences are articulated and are therefore central to any cultural understanding of human distress (Mills, 2018). As such, developing mental health interventions that are grounded in an understanding of how cultures name and understand their experiences of distress are important, as is the recognition that these might differ significantly from '*western, psychiatric language*' (Mills, 2015, p. 849). Essentially what has a meaning in one culture may have no meaning in others, and the issue is not necessarily about finding the right word in translation, but rather finding a conceptual term that adequately encapsulates cultural responses to stress and trauma (Mills, 2018). In the context of the Rohingya camp needs, Tay et al. (2018) note that '*there is often no direct correspondence between western defined diagnostic categories and the Rohingya lexicon of distress*' (p. 29) and as such, western discourses of mental health are not relatable.

Working with culture and in low-resource settings therefore poses certain risks of imposing western models of mental distress and associated treatments on non-western cultures and a potential to inadvertently engage in unsafe and unethical clinical practice. During my consultancy work I noted that the cultural elements of mental health delivery and practice functioned on at least three dimensions.

The first dimension is that of the personal and professional context, culture and language of the international consultant, humanitarian or development worker (where applicable). For example, my training and clinical experience was gained in the UK, and the international humanitarian aid clinicians and workers I met were also predominantly trained in western settings, with substantial experience in a range of cultures through their humanitarian work. I noted that such differences were rarely articulated in these emergency and crisis settings. The '*psy*' training (psychiatry, clinical and counselling psychology, psychotherapy) background of each health professional has potential epistemological differences depending on where the training is based (e.g., India, UK, USA) and which perspectives, theories and models are privileged on each course of training. Just as my training and clinical experience influenced and framed my understandings of mental health phenomena and ways of addressing mental distress, it is plausible to hypothesise that the same could be said for my humanitarian and development sector colleagues. Broadly speaking, psychiatry colleagues are predominantly trained in a bio-medical approach to mental health, while clinical psychologists take a bio-psycho-social approach focusing on formulating not only biological, but also contextual and situational factors, and personal understandings and temperament in the individual experience of mental distress. Counselling psychologists tend to adhere to Rogerian principles of person-centred care which is based on therapist skills in empathy and genuine positive understanding within the therapeutic dynamic. In reality, mental health professionals are informed, to greater or lesser extent, by all of these perspectives. However, what has been apparent in my clinical experiences in both the UK and Bangladesh is that certain professions, for example, psychiatry, have historically had more power to occupy an '*expert position*' and influence how and in what way interventions are delivered and indeed if interventions themselves are deemed acceptable. A comprehensive discussion of the impact of these differences is beyond the remit of this paper. However, what is apparent is that there is little recognition of how such differences in perspectives might impact and influence the systems and processes of an effective implementation of mental health training and service guidelines within the camps.

The second dimension is the personal and professional context, culture and language of local mental health clinicians. As in the above example, my local colleagues have a range of training culture contexts; some were trained at national universities and others had a combination of national and international training and skills development experiences. Similarly to the above, these experiences informed their understandings of mental health interventions, for example, regarding trauma perspectives. Discussions as to how these different cultures and approaches '*fit*' together were rarely considered or articulated, both in relation to the interface with international consultant input and in the development of service delivery. These guidelines are predominantly based on empirical evidence in a western context, albeit adapted to meet the needs of the needs of Bangladeshi or Rohingya culture. Of note, the concept of '*trauma*' was universally accepted in my workshops and supervision sessions. However, conversations about the professional differences in how to intervene and treat it in culturally congruent ways were rare.

The third dimension is the personal, social and community context, culture and language of the clinical population, who were either Bangladeshi nationals, or the Rohingya community in the camps, and where there are likely to be significant differences across the spectrum with regards to familiarity with and acceptance of mental health concepts. What is clear from the review by Tay et al. (2018) is that the Rohingya have a very different conceptualisation of mental distress, including holding significant stigma around the concept. Services and clinicians may be offering carefully considered interventions for the distress prevalent in the community. However if the community itself views such interventions as diametrically different from their own understanding of what is helpful, the risks in having such cultural differences lie in tokenistic and/or ineffective uptake of services. Language, idioms of distress, delivery of interventions (for example in 'rooms' as opposed to community settings, which Rohingya have responded well to) all factor in how an authentically cultural intervention is delivered.

Early on in my consultancy work, I noted that the reflective skills training workshops enabled rich discussions with the training attendees, (all clinical or counselling psychologists),

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about their current clinical work and applications of the assessment and intervention skills we had covered earlier in the training schedule. Reflective skills competencies appeared to be an addition to their current clinical competencies and the feedback from the attendees was positive in terms of how it might enhance their clinical work. I noticed that attendees valued the opportunity to use reflective skills to understand why they were doing and acting in particular ways, including in the context of managing more complex clinical presentations. Feedback I received included feeling more comfortable with managing risk and a renewed sense of drive and connection to their professional value base. Another key observation was that dilemmas that arose in the more perplexing clinical cases most often involved safeguarding and ethical components. As such, the discussions from these reflective practice skills workshops led me to enhance the ethical working competency practice element of the training. Additionally, I noted that counsellors and their psychologist supervisors were acutely aware of the risks of lone and remote working in low-resource settings when making sound clinical decisions. As such, the combination of reflective and ethical practice skills appeared to be one method of enabling outreach counsellors and supervisors to have an ongoing connection to core principles of safe clinical practice, applicable across '*psy*' disciplines, and that would potentially lead to a more effective and safe clinical decision-making process.

Reflective practice

Reflective practice is understood as the process of learning through and from experience towards gaining new insights of self and/or practice (Boud, Keogh, & Walker, 1985). Scaife (2010) defines reflective practice as an examination of our own meaning making processes (and the influences on these, such as cultural) together with a critical reflection on how we make discriminations, evaluate, judge, assess and weigh up options in a way that shapes our future actions. It is an essential component of effective mental health work, as it involves the individual practitioner developing an ongoing practice of self-awareness and critical self-evaluation of their own responses in therapeutic contexts. There is little research on the use of reflective practice in mental health work practices in humanitarian and development settings currently and examining this is an important step in ensuring the delivery of safe and competent therapeutic interventions, particularly in these settings. Teaching reflective skills requires the use of an experiential learning model (see, e.g., Kolb, 1984), as it involves meta-cognitive skills (i.e. observing how we think and act). Lavender (2003, p. 13)defines four domains of reflective practice as:

- **Reflection in action:** thinking about and noticing what we are doing as we are doing it, planning the next step.
- **Reflection on action**: thinking about what happened afterwards to gain insight and improve practice in future.
- **Reflection about our impact on others:** thinking about how our decisions and actions impact on others, and feedback can be sought through a number of mechanisms.
- **Reflection about self**: developing an understanding of our own vulnerabilities and the impact these may have on our work

In my experiences of delivering skills training and mental health strategy support I recognised an increased reliance on the above skills in my own practice and functioning. I noted this particularly in terms of finding a balance between delivering useful skills development, the desire to remain open, respectful and valuing of cultural skills and knowledge, differentiating between practices that may seem inappropriate or offensive in one culture but are acceptable in another, and most importantly, which practices are unsafe across cultures. For example, domestic violence with its high prevalence in the camps is recognised to be unacceptable in any culture and was an often discussed issue in training and supervision. Clinicians commented on the traditional and strict nature of the deeply patriarchal Rohingya community, at times wondering if the violence was part of such structures. Through a reflective process they identified that they felt overwhelmed by a culture they did not fully understand, helplessness and concern about clients, in addition to identifying internal professional conflicts about using standard therapy techniques for anxiety and low mood where there is a legitimate fear of attack. Using the reflective process outlined above, we were able to consider what elements could be realistically addressed, for example, provision of a safe and empathic relationship, grounding techniques and support to develop community connections. In particular there was a recognition that simply encouraging the development of autonomy and zero-tolerance for Rohingya women towards violence is potentially risky without infrastructural support such safe refuge spaces which is particularly challenging in a refugee camp environment. Enabling effected women to form relationships with advocacy and security systems within the camps while having therapy was one avenue discussed.

The issue of guarding against unsafe practice is at the core of any health or mental health interventions and is founded on the basic ethical principle of '*do no harm*'. In considering how to support and train mental health clinicians in low-resource settings to engage in culturally appropriate safe practice, alongside reflective practice skills, it seemed clear to me that ethical practice skills would also hold an important a function. Reflective skills are a key element of practising ethical decision making (Bhola & Chatuvedi, 2017) as we rely on past experiences to solve new ethical problems. Drawing on Lavender's (2003) domains of reflection to accomplish this also leads to a consideration of what factors can contribute to ongoing ethical decision making after thinking about past ethical dilemmas.

Ethical awareness and skills

Ethics can be defined as '*the moral principles that govern a person's behaviour or how an activity is conducted*' (Oxford English Dictionary). Understanding ethical mental health practice on non-western communities requires a reflective, exploratory and critical understanding of the relationship between ethics, culture and context (Bhola &

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Chatuvedi, 2017). Ethical frameworks are built on the recognition that every person has rights to autonomy, choice and self-determination during the process of interactions between mental health practitioners and patients (Bhola & Chaturvedi, 2017, p. 286). Common ethical principles are:

- Beneficence (promoting wellbeing and doing good) and non-maleficence (striving to prevent harm)
- Autonomy (individuals have rights to freedom of action and choice)
- Fidelity (being faithful to promises made, trust in practitioner)
- Respect for the person
- Justice (ensuring people are treated fairly and impartially)
- Fairness (equitable treatment irrespective of individual differences)
- Self-respect (fostering the practitioner's self-knowledge and care for self).

Lavender's (2003) domains of reflection can also be seen in Rest and Narváez (1994) four component model of ethical reasoning and practice:

- Ethical sensitivity: Interpreting a situation, and identifying the presence of an ethical issue
- Ethical reasoning: Formulating the ethically ideal course of action by identifying the relevant issues and using these principles to consider appropriate actions. Capacity to consciously articulate the rationale.
- Ethical motivation: Being motivated to act ethically when one has identified an ethical issue; links to values and willingness to engage in actions which could carry a personal cost.
- Ethical implementation: Putting an ethical plan into action includes developing skills of confidence, risk management and leadership.

In my consultancy practice and training, I found using a combination of Lavender's (2003) domains and Rest and Narváez's (1984) model to illustrate how clinical and ethical dilemmas could be addressed yielded interesting discussions and positive feedback of an enhanced confidence and comfortableness with a decision-making process. In the example of working with domestic violence above, reflective skills enabled clinicians to connect with and articulate their ethical concerns. Following these training sessions, feedback indicated that they felt professionally strengthened by this process of connecting with core ethical and therapeutic and human rights principles. Interestingly I also delivered this reflective and ethical practice in clinical decision-making to a different group consisting of medical and neuro-psychological assessment staff and yielded similar feedback. An interesting reflection from working with this second group was that while the ethical processes were familiar, the reflective practice skills felt more challenging to connect with. For example, the word '*reflection*' when first introduced elicited associations with a mirror and therefore a '*replication of practice*', rather than an association with a '*pause and connect with your internal process*' paradigm. Initially this group '*reported*' as one might do in medical notes, and developing reflection in and on action felt like it was a conceptual challenge. This could be in part to do with cultural differences between mental health and medical professions discussed at the start of this paper. I aim to return to meet with some of these clinicians to explore their experiences of putting these skills into practice.

Evidence from western contexts suggests that typical ethical dilemmas and decision-making occurs when there is a clash between fundamental values, that is:

- Compassion and justice
- Respect for a client's freedom of choice and taking responsibility
- Client safety or a client's privacy
- Respect for individual autonomy or the local legal and moral code
- Honesty and discretion
- Disclosure and professional loyalty
- Personal morality and legal requirement.

Such values appear to be those which are experienced across cultures. However, there is little evidence to support this. Nevertheless, when presented with these value conflicts, training attendees were able to connect to examples from their own practice, suggesting there is a cross cultural applicability to these areas of value conflict. There are particular issues of ethicality to consider from a cultural perspective; meanings of words such as '*consent*' and '*confidentiality*' may have different meanings, or be held within a nuanced but primarily western understanding of '*therapeutic context*' (Bhola & Chatuvedi, 2017). Definitions and interpretations of ethical frameworks are certainly likely to be influenced by cultural contexts; for example, semantic translation may not equate to a culturally conceptual equivalent. There is a lack of research on such processes as related to ethical practice and as such, it is difficult to say whether people involved in interventions are truly giving informed consent.

Reflections and applicability to other contexts

While my experiences are based on consulting in the particular cultures of Bangladesh and the Rohingya camps, there are many aspects that I feel can be applied to other environments. In supporting and developing existing skills sets and confidence in local workers, respecting and incorporating their unique and important understandings of the culture is a crucial element of providing expertise in low-resource settings. Differentiating between knowledge delivery and an openness to exploring and developing current practice is therefore important, as is the ability to explore with colleagues as to what constitutes unsafe practice in any culture, e.g., domestic violence within patriarchal social structures. Crucially, underpinning these processes are the reflective and ethical thinking skills that enable a connection to safe and attuned individual and team practice, and the co-development of culturally sensitive and ethical useful practices in line with professional values and practices. For example, recognising that there may be specific difficulties experienced by many in a community

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and in clinical presentations, the neurodevelopmental assessment team decided to incorporate a reflective and ethical practice discussion slot into their weekly team meetings to enable them to remain connected to the clinical benefits. Teams could therefore a) develop a process (such as a protected time slot in team meetings) through which dilemmas are recognised as being complex and the necessity of having open reflections on conflicts and struggles in the therapy sessions and b) develop clinical guidelines and professional networks with support agencies that address the prevalence of a particular trend in a given community, e.g., violence substance misuse, cyber bullying, etc.

In summary when working in different cultures, I found it important to keep in mind that cultural differences exist on at least three dimensions. Firstly, the culture of the international humanitarian worker or international consultant and their interface with local teams, secondly, the interface and possible contradictions between local clinicians' own cultures and formal training models (which are likely to be based in western paradigms of mental health) and finally, the culture of the populations they serve, where beliefs about mental health phenomena may be different from the mainstream understanding of mental health. All these factors affect how services are experienced and influence how training and consultancy are delivered in effective and culturally respectful ways.

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