Tree of Life with Older Culturally and Linguistically Diverse Muslim Women in the Community Setting: An Exploratory Study

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Although Australia is one of the fastest growing multicultural societies in the world, there is a scarcity of psychological interventions to support culturally and linguistically diverse (CALD) groups settled in the country. A qualitative case study methodology was used to explore the benefits, feasibility, and acceptability of the Tree of Life, a Narrative Therapy approach to group work when trialed in a CALD community setting. Nine older Muslim women from diverse backgrounds voluntarily participated in a manualized program over six weeks, at a non-government community center for Muslim women. A case study approach was adopted. Participants provided feedback after each session. They also participated in a focus group at the completion of the program to provide information about their experiences and perceptions of the program. Facilitators recorded their observations. Analysis highlighted the therapeutic benefits of the Tree of Life (TOL) program and found it to be feasible and acceptable for use in community settings. The findings have implications for community organizations and stakeholders who work with older Muslim women. Future research and practice would benefit from further exploration of the TOL program and Narrative Therapies with older Muslim and CALD communities.

Keywords

In Australia, the term "Acceptability and Culturally and Linguistically Diverse" (CALD) refers to people who were born overseas, or had a parent born overseas and identified with a culture and language different from that of Australia (Australia Bureau of Statistics, 1999). These CALD individuals are from a range of age groups and have ties with different parts of the world (Australia Bureau

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of Statistics, 2019). In the last 30 years there has been an influx of Muslim immigrants from Eastern Europe, the Middle East, South Asia, and Africa who entered Australia on humanitarian grounds for a better quality of life or to seek refuge from war or other atrocities (Khawaja & Khawaja, 2016). Data collected over the last decade shows that 59% of immigrants arriving in Australia are women (Australia Bureau of Statistics, 2019). Though most of the immigrants are young, Australia's aging population includes a number of immigrants over 65 years of age who migrated young and have spent substantial period of their life in the country (Australian Bureau of Statistics, 2020)

The mental health of immigrants can be compromised due to pre- and post-migration challenges (Sam & Berry, 2010). Ethno-cultural and migrant groups experience disparities in health and wellbeing and face barriers to engaging with healthcare services (Minas et al., 2013). Consequently, there is a surge in research efforts to develop and trial culturally sensitive interventions with CALD populations (Kalibatseva & Leong, 2014). Recently, strengths-based Narrative interventions have been found to be helpful with a range of CALD groups (Schweitzer et al., 2014; Vitale et al., 2019). Older women from Muslim backgrounds can be particularly vulnerable due to the interacting challenges associated with aging, being a member of a minority group, and identifying with a religion associated with social discrimination increases their susceptibility (Khawaja & Khawaja, 2016). Considering the scarcity of research on interventions tailored for CALD populations, it was important to explore a Narrative approach, Tree of Life, when offered to this population in a community setting.

Challenges of Older Culturally and Linguistically Diverse Muslim Women in Australia

There is substantial evidence that older age is associated with numerous physical, social, psychological, and cultural challenges (Jeste et al., 2010). In general, there is a decline of physical strength, cognitive functioning, and quality of life (Diehr et al., 2013; Kirova et al., 2015). Older individuals commonly experience psychological problems, such as depression and anxiety (Hawkley et al., 2010). Recent studies on older Muslims and other CALD immigrants living in the West indicates that changes in roles and responsibilities can decrease social interaction and increase isolation and intergenerational conflicts (Liu et al., 2018; Salma & Salami, 2020; Treas & Batalova, 2009). Although women are generally recognized as a more vulnerable group, Muslim women may be at particular risk because of their immigration history, ethnicity, identity, and religion (Jasperse et al., 2012; Reitmanova & Gustafson, 2008).

Immigration is perceived as a difficult process as it can disrupt one's values, culture, traditions, support, and social network (Khawaja et al., 2013). Compared to voluntary migration, the process is significantly more severe for those who are forcibly displaced and enter on a humanitarian visa (for a review, please see Bogic et al., 2015). As evidenced by Bogic and colleagues' review (2015), humanitarian entrants can experience pre-migration trauma, which they have to manage along with a myriad of post-migration stressors. As a part of their post-migration resettlement and reconstruction of their lives, all newly arrived immigrants face varying levels of acculturative stress marked by the feelings of isolation, identity crises, loss, and confusion (Greenwood et al., 2017). There are acculturative stressors of becoming familiar with the new society and its values, morals, culture, and infrastructure (Sam & Berry, 2010). There is an ongoing negotiation between one's original culture and norms and the adopted culture and norms.

Research indicates that acculturation can be particularly difficult for communities that are visibly different from the host society (Colic-Peisker, 2005). Muslim women can appear different from other women due to their religious clothing choices, which may increase the experience

of discrimination in daily life (Ghumman & Ryan, 2013). Since the 9/11 terrorist attacks in the United States, representation of Muslims in the media and community attitudes toward this group have become more negative (Poynting & Perry, 2007). However, while the wearing of hijab is associated with greater reports of discrimination, it is also linked to better mental health and wellbeing (Jasperse et al., 2012). Culture and belief systems therefore play a fundamental role in the way that CALD communities display, experience, interpret, cope, and adapt to their environments and mental health experiences.

The role of culture must be considered in professional services designed to support mental health among Muslim women. CALD communities are less likely to access mental health services in Australia (Minas et al., 2013) and cultural factors play a meaningful role in this. There are numerous barriers to accessing professional mental health services for migrant and Muslim women, such as social taboos and stigma, lack of information about the available services, inability to navigate the local systems, lack of English proficiency, inappropriateness of the services, and practical difficulties that deter these women from seeking help (Kirmayer et al., 2011; Whitley et al., 2006). Therefore, it is important to explore culturally safe and sensitive approaches when working with older Muslim women in mental health settings.

The Tree of Life Intervention

There has been a renewed interest in developing and trialing psychological interventions for CALD populations settled in Western countries (Kalibatseva & Leong, 2014). Most of the emphasis has been on addressing PTSD and other severe mental health disorders among humanitarian entrants by using interventions such as Cognitive Behavior Therapy, Narrative Exposure Therapy, and Eye Movement Desensitization Processing (Kip et al., 2020). However, there has been a growing interest in developing and trialing group-based interventions to enhance the resilience and acculturation process of immigrants (Khawaja & Ramirez, 2019), as the use of expressive and creative therapies can provide an important medium for engagement with mental health services (Dieterich-Hartwell & Koch, 2017; Kalibatseva & Leong, 2014; Rowe et al., 2017). It is essential that such programs accommodate the unique issues and cultural and linguistic needs of CALD communities (Kirmayer et al., 2011).

The Tree of Life (TOL) program is grounded in Narrative theory and practice (Lock, 2016; White & Epston, 1990) that draws upon the metaphor of a tree as a symbol of life (Ncube, 2006). The therapist takes a position as a "partner" in a therapeutic dialogue and listens, taking a 'not-knowing,' respectful, and curious approach (White, 2007). Metaphors and narrative questions are used to encourage individuals to tell stories that are empowering, highlight personal and shared strengths, values, and dreams for the future (Denborough, 2012, 2018; Lock, 2016). A creative approach is adopted as participants draw their own tree during the intervention, with parts of the tree reflecting meaningful aspects of their life stories (for details of the intervention, see Vitale et al., 2019; Schweitzer et al., 2014). Instead of the problem-saturated approach of discussing past challenges, the facilitator encourages participants to explore their personal skills, knowledge, and cultural contexts in a safe setting (Denborough, 2008; Ncube, 2006; Randle-Phillips et al., 2016). Therefore, this non-threatening and inclusive tool allows participants to visually externalize experiences and become aware of their resilience and positive attributes (Carlson, 1997). The group setting allows discussions among group members who play an active role as outside witnesses in validating each other's personal skills, knowledge, and alternative narratives (German, 2013).

A review of the literature indicates that, in the last decade, the TOL program has been used within different cultural and societal contexts (Denborough, 2018). A few of these studies have used the TOL program with CALD individuals or groups resettled in a Western country. Iliopoulou (2009) found benefit for the TOL program in a community setting with former refugee women, who were living with human immunodeficiency virus (HIV). Schweitzer and colleagues (2014) adopted a case study format to describe its implementation with adolescents who were former Liberian refugees in Australia. Vitale and colleagues (2019) also used a case study format to study the benefits of the TOL program with African women resettled in United Kingdom, who were victims of war-related sexual abuse and living with HIV. These studies used interviews to determine how the TOL program helped participants recognize their strengths and gain an appreciation of positive aspects of their life. Commonly reported benefits were breaking down language and cultural barriers and helping individuals who have lived through trauma to re-author their narratives in ways that emphasize their strength and resilience. TOL's social constructionist perspective allowed participants, who had undergone migration and resettlement in culturally distinct locations, to reconstruct their life stories to establish new social roles and responsibilities in new context (Bhugra & Becker, 2005).

Aims of the Study

There is now substantial evidence that older adults are at higher risk of experiencing psychological issues and social isolation (Treas & Batalova, 2009; Salma & Salami, 2020). Sociocultural factors can precipitate mental health concerns (Liu et al., 2018; Reitmanova & Gustafson, 2008), and these challenges have consequences for the older person's wellbeing and quality of life (Bryant et al., 2012; Westerhof et al., 2011). Despite substantial research on the pre- and post-migration issues of immigrants (e.g., Bhugra & Becker, 2005), there is a scarcity of research on older Muslim women, or those who have been in Australia for longer periods of time. There is a lack of evidence-based culturally sensitive and appropriate interventions and programs for CALD populations. Considering that CALD populations may not seek help from professionals, it was important to explore if they would be receptive to a program if delivered at the community level. Though research on the TOL program is emerging, little is known about its effectiveness with CALD older adults (Gardner & Poole, 2009). Therefore, it was important to use a qualitative methodology, without any a priori hypotheses, to explore whether a group-based narrative approach such as the TOL highlights connectedness and resilience, while supporting an individual's cultural values, beliefs, and religion, empowered life narratives, and promoted wellbeing (Harrison et al., 2017). To expand upon existing research, it was important to understand the effectiveness, feasibility, and acceptability of the TOL program with older Muslim women in a community setting that was easily accessible to them. As per Bowen and colleagues (2009), feasibility referred to the practical aspects of conducting the program, while acceptability referred to the participants' responses and reactions to the TOL program and whether they perceive it as satisfying and helpful.

Method

Design

A qualitative case study design was used to study the entire group of the participants as a "case" to understand the process of implementing the TOL program when used with older

Muslim women in a community setting. This design also assisted in exploring the benefits of this intervention when used with this these women. This flexible methodology lends itself to an exploration, where a complex issue is studied in real world settings (Harrison et al., 2017). Data collected through multiple forms enhanced triangulation and allowed researchers develop a deeper understanding of the effectiveness of the program; the design similarly explored the role of the facilitators as well as the barriers involved in the implementation of a program with an under-researched section of the population. The practical features of this methodology allowed a preliminary qualitative exploration of a program before it is formally trialed or piloted.

Setting

The study was conducted at the Islamic Women's Association of Australia (IWAA), a not-for-profit organization that provides support for Muslim women and families from diverse backgrounds. IWAA's services include aged care and disability services, settlement support for newly arrived refugees and migrants, and community development. It offers weekly "drop-in" social support and wellbeing sessions for Muslim women in Brisbane. These sessions are an opportunity for the women to socialize and attend educational seminars related to health, wellbeing, and life skills.

Participants

Nine English-speaking Muslim women aged between 59 and 80 years participated in the study and completed the program (M = 72.78, SD = 6.53). The women's countries of origin included Australia, South Africa, Zimbabwe, Afghanistan, Malaysia, Indonesia, and India. Most women had migrated from other countries (seven of the nine), were Australian citizens, and had lived in Australia for longer than 10 years (M = 27.29, SD = 11.56). All participants could speak English, with six participants describing their English-speaking skills as "fluent" and three "with some difficulty". Four participants reported being married, three widowed, one divorced, and one single. Education levels varied between the group and included tertiary-level qualifications, certificates or trade qualifications, high school certificates, or no schooling. Seven participants identified as being retired or unemployed, with two reporting being employed casually or full-time. Despite the common gender and religious faith, participants varied on countries of origin, educational levels, and occupational backgrounds.

Measures

Demographics. A demographic form was developed by the researchers that sought information about participants' gender, age, marital status, educational level, employment status, country of birth, language spoken at home, religion, time spent in Australia, country of origin, current visa status, and English proficiency.

Weekly session feedback. A brief feedback form was used to collect participant feedback on each session of the program. The form comprised four open-response items that asked participants to indicate the session number, how many sessions they had attended to date, and what aspects of the session they liked and disliked.

Facilitators' notes. A brief fidelity checklist was devised to aid the facilitators' assessment of their adherence to the TOL program Facilitators' Manual. Attendance records and process notes for each session were also taken. Participants' engagement with the intervention, conversations, interactions, and what they liked or disliked in the session were recorded in writing.

Focus group. Participants were asked what they liked about the TOL program, what was learned or taken away, what the challenges were, and whether they felt it would be helpful for others. They were also asked for feedback on format and program facilitation.

Ethics

Ethical and health and safety clearances were obtained from the affiliated university's committees. All participants provided informed consent, which explained that they could refuse or discontinue their participation at any point with no consequences for their relationship with IWAA or the affiliated university. Participants were informed that the research was not in any way linked with IWAA. The program was facilitated by a registered psychologist and a provisionally registered psychologist who were able to monitor and mitigate participant distress if it were to arise during the session. Participants were asked to contact the coordinator at IWAA in the case of being distressed by their participation in the study, who would refer them as per standard procedures to the mental health professional associated with the organization. The program was offered at no cost, in a safe and familiar location, and participants were informed that they would be allowed to retain their artwork from the program.

Procedure

IWAA staff and the research team disseminated information about the study among women who attended the drop-in session activities. The English-speaking, Muslim CALD women who expressed an interest in taking part in the study were informed about the voluntary nature of their participation, their option to withdraw at any time without penalty, expected benefits and risks, and privacy and confidentiality considerations. All participants provided written consent and completed the demographic forms in a group setting with the help of the research team. Seven weekly sessions of approximately 90-minute duration were held at IWAA's community center in Brisbane (Queensland, Australia). The manualized program (Vromans & Schweitzer, 2011) was facilitated by the first and third authors and Table 1 provides the processes and content of the TOL program used.

After each session, participants provided brief, anonymous feedback regarding what they liked, did not like, and what could be changed for future sessions. Facilitators met after each session to debrief, record process notes, and complete the fidelity checklist. At the end of the seventh session, a 30-minute focus group was held to gather overall feedback from participants about their experiences and perceptions of the program. This focus group was conducted by the second author. An additional female member of the research team was also present to take down detailed notes. This step was taken to ensure that participants had another safe space to provide feedback over and above the feedback provided at the end of the individual sessions. To address the impact of social desirability, researchers with whom participants had minimum interaction conducted this focus group. Finally, after the focus group, a ceremony in which participants were offered a gift and certificate for completing the program was organized at IWAA.

Data Analysis

Qualitative written data obtained through facilitators' notes, participants' responses to feedback forms, comments recorded on the drawings, and the focus group were studied. All authors read the data and had dicussions. The case study was built by combining the data collected from multiple sources to represent effectiveness, feasibility, and acecptability of the TOL program.

Table 1. Content and Processes of the TOL Program

Stage	Description
(1) Tree of Life	Systematic drawing of the tree and guided group discussions about the aspects of life that have positively contributed to the development of current strengths, skills and internal resources. • The *roots* represent family history, including heritage, ancestry, traditions, and lessons learned. • The *ground* represents current live and the activities and tasks that make up our day-to-day lives. • The *trunk* represents the knowledge, skills and abilities. • The *branches* represent hopes, dreams, and wishes for the future. • The *leaves* represent the present or past important people who have influenced us in our lives. • The *fruit* represent important gifts received from others. They may be material or non-material.
(2) Forest of Life	Tree drawings are brought together into a 'forest' and participants take turns to share stories relating to their trees. Group members become 'outsider witnesses' to these alternative narratives, providing affirming comments and supportive feedback.
(3) Storms of Life	Facilitators use externalizing conversation practices to discuss hazards experienced by trees and by people (i.e., discussing the 'Storms of Life'). The group speak collectively about challenges experienced in life and the strengths, coping skills and resilience used in response to 'storms'.
(4) Ritual of Celebration	Facilitators lead the group in a celebration through ceremony (e.g., singing a song, certificate presentation) to allow for witnessing, re-telling and consolidation of new, alternative stories of participants' lives.

Reflexivity

At each stage of the research process, the characteristics, experiences, and perspectives of each member of the research team were likely to have impacted the way that data were collected and interpreted. The research team comprised clinical psychologists or provisionally registered psychologists and women of various ethnicities, including CALD Muslim, Caucasian Australian, and Caucasian American backgrounds. It is worth noting that having multiple investigators from different backgrounds promoted dialogue and made for various understandings and perspectives throughout the research process.

Findings

Effectiveness of the TOL Program

Through their feedback provided at the end of the sessions and the focus group, participants indicated a number of personal psychological benefits. Some participants noted that they found the program "*soothing*," that they felt happier and more relaxed, that they were more confident

to communicate with others, that they were able to "*let out*" emotions rather than holding onto them, and that the group had "*helped me to feel secure*". The participants' comments inserted on the drawing and the facilitators' notes on the process issues and group interactions highlighted resilience, personal resourcefulness, and presence of social support. These experiences were reflected by the following parts of the TOL program.

Roots. The drawings and discussion associated with roots enabled them to think about their childhood, significant people, and the key values learned. They remembered their parents, grandparents, siblings, relatives, and even neighbors as important figures who played an important role in their lives and contributed to their learning (e.g., "*My mother was a role model*" (participant 1). They recognized childhood was a period when they acquired values and skills that guided them throughout their lives. They learned about humility and modesty ("*My father said to live like a rice paddy not like a tall grass. Rice paddy bends low, while the grass stands out. Show humility and modesty*" (participant 8)), and contentment ("*We lived in a small house and had nothing, but we were happy*" (participant 7)) in the absence of materialistic goods and advanced technologies. There was a consensus that resilience they developed in their earlier years helped them throughout their lives. Sharing information about the topography and flora and fauna of their hometowns, pleasant activities they engaged in as a child, and the journey to Australia was relaxing and brought them closer.

Ground. The drawings and discussions associated with ground helped the participants recognize the importance of keeping themselves busy throughout the day. They described their day-to-day activities consisting of daily chores such as cleaning, cooking, baking, and shopping, entertainment, and socializing. For entertainment, they spoke of watching television, gardening, caring for pets, completing puzzles, and/or visiting parks for exercise. Family and social interactions were also very important, as they visited family members, neighbors and friends, or others visited their homes. They reported visiting IWAA every Tuesday. Those who could not interact in person relied on telephone conversations with family or friends. Prayers and religious activities were also reported to be an important part of their daily activities (e.g., "*I recite the Quran and pray five times every day*" (participant 7). There was a consensus that keeping busy during the day lifts their mood, self-esteem, and self-efficacy.

Trunk. The drawings and discussion associated with trunk helped the participants recognize their personal skills and attributes. They saw themselves as skilled in domestic chores and taking care of their children and grandchildren. A few participants saw their skills in traveling abroad as an important quality. Three participants valued volunteering their time in community settings, such as unpaid teaching roles, helping at care homes for older people and for children with special needs, and several women engaged in leadership roles at IWAA. At a personal level, they identified that reflecting on and learning from past life experiences was an important skill too (e.g., "*After my divorce I helped myself, I did therapy to myself*" (participant 5). Concepts of staying positive, changing with the times, and accommodating to their older age were common among the group. Knowledge gained with age was regarded as a prominent quality (e.g., "*With age comes wisdom and understanding*" (participant 4). They also talked about their shared views on Islamic values and identity as a Muslim being a personal strength.

Branches. Participants' dreams, hopes, and aspirations were reflected by the drawings of the branches and statements written alongside them, as well as explanations provided in the session. Although there were references to traveling, the environment, and global safety, the main aspirations were linked with wellbeing for themselves and their children. They hoped for peace of mind in the future, considered it important to stay healthy, and hoped that God would give

them strength to live their life independently without becoming a burden on others (e.g., "*to keep well and happy*" (participant 3); "*like to have peace of mind till the end of my life*" (participant 8)). Several participants wished to be connected with God through their prayers and wished their children and grandchildren to live a pious life (e.g., "*grandchildren keep on path of Islam*" (participant 4).

Leaves and fruits. The participants drew leaves to represent important people in their lives and represented the importance of family members such as children, grandchildren, and siblings. Other important people noted were neighbors, friends, teachers, people from the mosque, and IWAA acquaintances. A few included religious figures and political leaders, like God, the Pope, John F. Kennedy, and current heads of state. They appreciated the role that religious leaders play to address prejudices toward Muslims. One participant said, "*Even the Pope said that not all Muslims are terrorists*" (participant 9). Fruits of the tree represent gifts a person has received in their life, and participants' family members, children and grandchildren in particular, were referred to as gifts. Religious values, beliefs, and education were also seen as important gifts provided by others.

Storms. Participants generated a list of threats trees could face, like fire, floods, drought, deforestation, wind, and lightning, drawing parallels to adverse events in peoples' lives like physical and mental illness, bereavement, family conflict, loneliness, discrimination, crime, and abuse. Participants shared their own fears and anxieties associated with being alone, ill, or debilitated. Nevertheless, the participants worked effectively with each other to recognize solutions and find ways to cope with adversities. Praying and relying on God were regarded as important steps. They believed in relying on family, friends, neighbors, and community for support and guidance. Participants agreed about the importance of educating neighbors and the larger community about Islam. One participant reported:

> *My neighbor talked badly about Muslims and I explained that not all Muslims are terrorists and that it is not about religion and all communities have good people and bad people.* (participant 3)

There was also discussion about protecting oneself from criminals by being vigilant or contacting police. Seeking professional help was considered important for addressing health issues. Personal qualities such as patience, optimism, hope, and problem-solving were noted as important strategies to address challenges (e.g., "*Remember that bad time will pass and good will come*" (participant 6). They recognized that they could use their personal strengths identified in their tree trunk to cope with future hazards. A couple of participants (2 and 8), who had earlier indicated feeling isolated and lonely reported that learning from each other has made them stronger.

Group processes. Participants supported one another in the process of telling their stories. They provided feedback to each other about their strengths. On a few occasions, some group members raised memories of distressing or traumatic past events and their struggles with mood and anxiety. In response, a few group members spontaneously demonstrated support and encouragement. Supportive group members would often intervene, affirm the distressed group members' experiences, reinforce their strengths and the positives in their lives, and made their support explicit (e.g., "*You are not alone, you have us*" (participant 5). Participants 2, 4, and 8 reported that the program "*inspired compassion for others*", "*increased appreciation of the hardships faced by others in their lives*", and "*helped them to recognize that others have different backgrounds and strengths*". They reported remembering that "*we are all interdependent*", and that helping one another makes the group stronger.

Feasibility

Setting. The center, being in the multicultural part of the city, was easily accessed by ethnic populations. The organization IWAA found it easy to include TOL on a day set aside for older women. As the program took place during social morning tea events, the women had access to food and drinks, and transportation to the center if needed. These factors made the TOL program more easily accessible for participants.

Although the organization has a large room for group programs, noise from the adjoining hall made it difficult for TOL facilitators and participants to hear one another at times. Additionally, many IWAA staff and women who attended the center viewed the TOL program as an "*art class*" and the sessions were disrupted at times by those who were unaware of the importance of privacy. Despite this, the women reported they appreciated that sessions were held in this convenient and familiar environment.

Attendance and engagement. Although 16 women expressed interest in attending the TOL program and completed pre-testing questionnaires, 14 women attended the first session, and 10 attended the second session. Overall, nine women regularly attended all sessions and engaged consistently. The duration and total number of sessions were considered appropriate. Participants were able to draw and engage in conversations. Some participants were verbose and eager to share their stories, while others needed more support and encouragement from facilitators.

The composition of the group was important to group processes, as similarities based on gender and faith enhanced the group cohesiveness. Members with good insight and nurturing natures had a positive impact on the group process as they played a key role in keeping the group process active. For example, the absence of one energetic group member during one session had a noticeable impact on group cohesion and morale. In the same session, a group member became distressed about an external issue (i.e., the illness of a family member) and needed to step out of the group setting to receive support from one of the facilitators. Having two facilitators was beneficial, particularly at times like this as it allowed one facilitator to provide one-on-one intervention, while the other continued to support the group.

Treatment fidelity. As assessed by the fidelity checklist, around 90% of the content was delivered according to the TOL manual (Vromans et al., unpublished); ten percent of points were missed or partially covered due to time constraints. The content relating to "storms" was presented in the second-to-last week, instead of the final week to ensure that facilitators could support the participants more effectively in the case of an increase in stress. The intention of the TOL methodology is to ensure that participants leave with their re-authored stories feeling composed.

Acceptability

The written feedback provided by participants at the end of each session and the information gathered through the focus group was consistently positive. Participants perceived the TOL facilitators as "*friendly, nice and kind, easy to understand, and well-prepared*". They appreciated discussions around the importance of confidentiality within the group and enjoyed sessions more as their understanding of the program increased. They liked talking about trees and the metaphor of how people are like trees. They reported that they found reflecting on their past and discussing their roots helpful (e.g., "*I liked talking about our foundations and roots and doing this now is blessing*"). Another participant commented that it was "*great*" to reflect on their life experiences when they were younger. They also liked listing their skills and thinking about their future, steps they have to take to improve their situation, and thinking about gifts they often take for granted. They reported that the discussion about storms was useful and supported the

idea of brainstorming solutions and discussing ways in which one's problems can be resolved. Participants reported that the program helped them to feel more comfortable with, closer to, and supported by one another. In general, including participants from different cultural groups was a good way to learn about other cultures, given that the different groups did not tend to mingle during their regular social events.

When asked what they liked in the sessions, most participants wrote "*everything.*" The program was described as "*beautiful*", and they reported having enjoyed talking with each other and listening to the stories of other group members. One participant said, "*everything was so interesting I learned so much*". When asked what aspects of the sessions should be changed, members wrote "*nothing*" or "*we loved it all*". Only one person shared her frustration about when participants started to talk about irrelevant matters. When asked about challenges associated with the program, participants reported that it took some time to adjust to sharing of personal information, drawing and singing songs, with these activities initially described as "*awkward*". However, participants noted that these elements became increasingly enjoyable over time as they understood the purpose of the program and their social ties strengthened.

Discussion

The current case study explored the effectiveness, feasibility, and acceptability of the group-based, manualized TOL program (Vromans et al., unpublished) with English-speaking older Muslim women from diverse backgrounds. The TOL program was positively received by the participants and perceived to be beneficial. The feasibility and acceptability of implementing the intervention with the targeted population in a community setting was supported.

In line with previous studies on the TOL program, the participants found the intervention a positive and beneficial experience (Vitale et al., 2019). Several Narrative Therapy principles appeared to enhance the therapeutic process (Schweitzer et al., 2014). The narrative questioning underpinned by Narrative Therapy (White, 2007) depicted through parts of the tree inspired the participants to reflect on their self and increased awareness of their skills, knowledge, and values (Lock, 2016). Consistent with previous studies (Denborough, 2012, 2018), the metaphor of storms assisted them to think about difficulties and the challenges in their own life associated with being an older female from a minority group (Jeste et al., 2010). In line with past research with older individuals, health issues, loneliness, and dependency on others were recognized as common problems (Diehr et al., 2013; Jasperse et al., 2012; Treas & Batalova, 2009). Consistent with literature, Islamophobia was recognized as a problem impacting intercultural relations (Khawaja & Khawaja, 2016). Nevertheless, participants were able to utilize the newly identified personal skills and strategies as a way of dealing with these present and future challenges (Denborough, 2008; Ncube, 2006; Randle-Phillips et al., 2016). Collectively, the participants identified religious and cultural beliefs as resources that could be applied to commonly experienced problems. Conversations about future hopes and wishes fostered optimism and warm feelings toward family members (Denborough, 2012, 2018). Social constructivist principles allowed them to construct new roles and responsibilities with refence to their context and histories (Bhugra & Becker, 2005).

From a Narrative Therapy perspective, conducting the program in a group format allowed for important therapeutic processes to occur. For example, it provided participants a safe place to interact with others and re-author their dominant narratives (German, 2013; van der Velden & Koops, 2005). Group members acted as the audience for each other and validated personal strengths and affirmed new narratives (Elderton et al., 2014; Randle-Phillips et al., 2016). Participants' strengthened narratives appeared to be centered around

enhancing awareness of personal identity, empathy, and interconnectedness among people from different CALD backgrounds and different lived experiences. Several participants noted that the program inspired compassion and understanding of others and emphasized personal and collective strengths. These findings are consistent with previous trials of the TOL program with community samples of CALD and vulnerable persons (Iliopoulou, 2009).

The findings indicated that it is feasible to conduct the TOL program at a community level with older Muslim women from CALD backgrounds. It integrated well within the organization's existing infrastructure. Organizational support, selecting an easily accessible venue, and scheduling the intervention on a day when women were already at the center maximized participation. The ethnic diversity of facilitators was purposeful and likely increased the feasibility of the intervention. Fidelity analyses indicated that the TOL manual was easy to follow by the facilitators. Participants were able to connect with the material and engaged well with the drawing process, shared their stories freely, listened to others, and provided support. They found the content suitable and appropriate, which supported the cultural sensitivity of the program (Denborough, 2018; Ncube, 2006).

Qualitative methods, such as the feedback forms, focus group discussion, and collecting their stories in sessions were practical, easy to implement, and provided useful information. These findings are consistent with previous studies that indicate experimental approaches are not a good fit with Narrative Therapy, as it is based on mechanisms and constructs not as easily operationalized (Etchison & Kleist, 2000; Vromans & Schweitzer, 2011). Given that the individuals' socially constructed experiences, perspectives, and stories are of interest in narrative therapies (Carr, 1998; Freedman & Combs, 1996; White & Epston, 1990), textual and ethnographic methodologies focused on individuals' narratives rather than clinical outcomes (Etchison & Kleist, 2000; Gardner & Poole, 2009).

Findings supported the acceptability of the TOL program with older Muslim women. They found the program enjoyable, interesting, promoting personal reflection on life, and reported greater social connection and cohesion within the group. It is important to note that similarities among the group members was a strength of this trial. Participants were all women, older in age, practiced Islam, largely from immigrant backgrounds, and spoke English. The shared identity, beliefs, and values helped them to develop group cohesiveness. Consistent with previous literature (Griner & Smith, 2006), homogeneity appeared to be an important factor to consider when the TOL program is implemented with a specific target group. The shared features strengthen a sense of safety and a sense of belongingness.

It is important to note that despite an overwhelming acceptability for the TOL program with older Muslim women from CALD background, the participants had a difficult time understanding what the program was about at the outset and this may be associated with the drop in numbers during the first two sessions. IWAA staff did not recognize the psychological nature of the activity and some continued to perceive it as a drawing class. Findings highlighted the importance of educating the participants and community organizations about the psychological nature of the program and the importance of confidentiality before commencing the intervention.

Implications

The study has practical and theoretical implications. At the theoretical level, the findings address the gaps in psychological intervention literature. Considering the dearth of appropriate approaches for elderly CALD populations, the TOL program appeared to be an effective

strategy to address mental health issues of older individuals (Hawkley et al., 2010; Holt-Lunstad et al., 2010) and discrimination, trauma, and acculturative stress experienced by former refugees and immigrants (Bogic et al., 2015; Ghumman & Ryan, 2013; Sam & Berry, 2010). The creative and expressive elements address cultural and linguistic barriers (Kirmayer et al., 2011). The findings also provided an insight into the coping mechanisms and resilience of these CALD women in the West (Jasperse et al., 2012). Their responses to various parts of the tree highlighted their day-to-day experiences and strategies used to cope with the challenges of aging. The findings can be further used by allied and mental health professionals to assist older Muslim women from immigrant backgrounds.

At a practical level, the study offers preliminary evidence that the TOL is feasible and acceptable for implementation with older CALD Muslim women in community settings. The sessions were adequately delivered, and there were no obvious barriers that undermined the acceptability or accessibility of the program. There were no reported concerns about the secular TOL program content clashing with Muslim principles or with other CALD perspectives held by group members. This is consistent with previous research that shows that Narrative Therapy and TOL programs are culturally sensitive and accessible to CALD persons (Denborough, 2008). Considering the acceptability of the facilitators, it is possible good communication and respect resolved any potential barriers. These strategies may assist health professionals in addressing common barriers to CALD persons' access to healthcare (e.g., Scheppers et al., 2006; Wohler & Dantas, 2017).

Limitations and Future Directions

Given that the study sample included older adults, the study did not assess cognitive functioning, physical health, English-speaking ability, or literacy of the participants. Future research would benefit from exploring the extent to which these factors might impact the feasibility or acceptability of the program when implemented with older CALD populations. The present exploratory study acts as a precursor for future trials and effectiveness studies. Considering that the present study was conducted with a non-clinical population in the community setting, future research might involve trialing the TOL program in a clinical setting (e.g., aged care). Although some change in narratives was noticed among more vocal participants, this change in narratives was not systematically measured; future studies could evaluate this narrative change in a systematic manner, potentially through interviews before and after the TOL program. Differences in thematic analysis from pre- to post-program interviews might also be informative. Instead of relying on facilitators' notes, sessions should be recorded and transcribed for more accurate data, which could be linked to the participant.

Conclusion

This exploratory qualitative study provides preliminary evidence that the manualized, group-based TOL program has positive effects and adequate acceptability and feasibility when implemented with a group of older Muslim women in a community setting. These outcomes suggest that the TOL program appears to be a culturally sensitive method of promoting personal skills and building connection within diverse communities.

References

Australian Bureau of Statistics (1999). 1298.0 - *Standards for statistics on cultural and language diversity.* https://www.abs.gov.au/ausstats/abs@.nsf/mf/1289.0

Australia Bureau of Statistics (2019). *Characteristics of recent migrants:*

Data about migrants arriving in the last 10 years including employment outcomes relating to visa type, birth country, education and language skills.

https://www.abs.gov.au/statistics/people/people-and-communities/characteristics-recent-migrants/latest-release

Australian Bureau of Statistics (2020). *Migration, Australia: Statistics on Australia's international migration, internal migration (interstate and intrastate), and the population by country of birth.* https://www.abs.gov.au/statistics/people/population/migration-australia/latest-release

Bhugra, D., & Becker, M.A. (2005). Migration, cultural bereavement and cultural identity. *World Psychiatry*, *4*(1), 18–24. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414713/

Bogic, N., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: A systematic literature review. *BMC International Health and Human Rights*, *15*(1), 29–29. https://doi.org/10.1186/s12914-015-0064-9

Bowen, D., Kreuter, M., Spring, B., Cofta-Woerpel, L., Linnan, L., Weiner, D., Bakken, S., Kaplan, C., Squiers, L., Fabrizio, C., & Fernandez, M. (2009). How we design feasibility studies. *American Journal of Preventive Medicine*, *36*(5), 452–457. https://doi.org/10.1016/j.amepre.2009.02.002

Bryant, C., Bei, B., Gilson, K., Komiti, A., Jackson, H., & Judd, F. (2012). The relationship between attitudes to aging and physical and mental health in older adults. *International Psychogeriatrics, 24*(10), 1674–1683. https://doi.org/10.1017/S1041610212000774

Carlson, T. D. (1997). Using art in narrative therapy: Enhancing therapeutic possibilities. *American Journal of Family Therapy, 25*(3), 271–283. https://doi.org/10.1080/01926189708251072

Carr, A. (1998). Michael White's narrative therapy. *Contemporary Family Therapy, 20*(4), 485–503. https://doi.org/10.1023/A:1021680116584

Colic-Peisker, V. (2005) 'At least you're the right colour': Identity and social inclusion of Bosnian refugees in Australia', *Journal of Ethnic and Migration Studies*, 31(4):615–638. https://doi.org/10.1080/13691830500109720

Denborough, D. (2008). *Collective narrative practice: Responding to individuals, groups, and communities who have experienced trauma*: Dulwich Centre Publications.

Denborough, D. (2012). A storyline of collective narrative practice: A history of ideas, social projects and partnerships. *International Journal of Narrative Therapy & Community Work* (1), 40–65.

Denborough, D. (2018). *Do you want to hear a story? Adventures in collective narrative practice*. Dulwich Centre Publications.

Diehr, T. Thielke, S.M., Newman, A.B., Hirsch, C., & Tracy, R. (2013). Decline in health for older adults: five-year change in 13 key measures of standardized health. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, *68*(9), 1059–1067. https://doi.org/10.1093/gerona/glt038

Dieterich-Hartwell, R., & Koch, S. (2017). Creative arts therapies as temporary home for refugees: Insights from literature and practice. *Behavioral Sciences, 7*(4), 69. https://doi.org/10.3390/bs7040069

Elderton, A., Clarke, S., Jones, C., & Stacey, J. (2014). Telling our story: A narrative therapy approach to helping lesbian, gay, bisexual and transgender people with a learning disability identify and strengthen positive self-identity stories. *British Journal of Learning Disabilities, 42*(4), 301–307. https://doi.org/10.1111/bld.12075

Etchison, M., & Kleist, D. M. (2000). Review of narrative therapy: Research and utility. *The Family Journal, 8*(1), 61–66. https://doi.org/10.1177/1066480700081009

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities*. Norton and Company.

Gardner, P. J., & Poole, J. M. (2009). One story at a time: Narrative therapy, older adults, and addictions. *Journal of Applied Gerontology, 28*(5), 600–620. https://doi.org/10.1177/0733464808330822

German, M. (2013). Developing our cultural strengths: Using the "Tree of Life" strengthbased, narrative therapy intervention in schools, to enhance self-esteem, cultural understanding and to challenge racism. *Educational and Child Psychology, 30*(4), 75–99.

Ghumman, R., & Ryan, A. (2013). Not welcome here: Discrimination towards women who wear the Muslim headscarf. *Human Relations, 66*(5), 671–698. https://doi.org/10.1177/0018726712469540

Greenwood, R. M., Adshead, M., & Jay, S. (2017). Immigrant women's experiences of acculturative stress: Ordinary privileges, overt discrimination, and psychological well-being. *Psychology of Women Quarterly, 41*(4), 497–512. https://doi.org/10.1177/0361684317719733

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, research, practice, training, 43*(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Harrison, H., Birks, M., Franklin, R., & Mills, J. (2017). Case study research: Foundations and methodological orientations. *Forum of Qualitative Social Research,* 18(1), 1. https://doi.org/10.17169/fqs-18.1.2655

Hawkley, L.C., Thisted, R.A., Masi, C.M., & Cacioppo, J.T. (2010). Loneliness predicts increased blood pressure: 5-year cross-lagged analyses in middle-aged and older adults. *Psychology and Aging, 25*(1), 132–141. https://doi.org/10.1037/a0017805

Holt-Lunstad, J., Smith, T.B., & Layton, J.B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS medicine, 7*(7), 1–20. https://doi.org/10.1371/journal.pmed.1000316

Iliopoulou, G. (2009). The 'Tree of Life' in a community context. *Dulwich Centre.* Retrieved from https://dulwichcentre.com.au/wp-content/uploads/2014/01/tree-of-life-community-context.pdf

Jasperse, W., Ward, C., & Jose, P. (2012). Identity, perceived religious discrimination, and psychological well-being in Muslim immigrant women. *Applied Psychology, 61*(2), 250–271. https://doi.org/10.1111/j.1464-0597.2011.00467.x

Jeste, D.V., Depp, C.A., & Vahia, I.V. (2010). Successful cognitive and emotional aging. *World Psychiatry, 9*(2), 78–84. https://doi.org/10.1002/j.2051-5545.2010.tb00277.x

Kalibatseva, Z., & Leong, F.T. (2014). A critical review of culturally sensitive treatments for depression: Recommendations for intervention and research. *Psychological Services, 11*(4), 433. https://doi.org/10.1037/a0036047

Khawaja, N. G. & Khawaja, S. (2016). Acculturative issues of Muslims in Australia. *Journal of Muslim Mental Health, 10*(2), 43–53.

Khawaja, N. G., McCarthy, R., Braddock, V. & Dunne, M. (2013). Characteristics of culturally and linguistically diverse mental health clients. *Advances in Mental Health, 11*(2), 172–187.

Khawaja, N.G. & Ramirez, E. (2019). Building resilience in transcultural adolescents: An evaluation of a group program. *Journal of Child and Family Studies, 28*(11), 2977–2987. https://doi.org/10.1007/s10826-019-01473-x

Kip, A., Priebe, S., Holling, H., & Morina, N. (2020). Psychological interventions for posttraumatic stress disorder and depression in refugees: A meta-analysis of randomized controlled trials. *Clinical Psychology and Psychotherapy*, *27*(4), 489–503. https://doi.org/10.1002/cpp.2446

Kirmayer, L.J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A.G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal, 183*(12), 959–967. https://doi.org/10.1503/cmaj.090292

Kirova, B., Bays, R.B., & Lagalwar, S. (2015). Working memory and executive function decline across normal aging, mild cognitive impairment, and Alzheimer's disease. *BioMed Research International*, *2015*, 748212–748219. https://doi.org/10.1155/2015/748212

Liu, G., Guo, M., Chi, I., & Xu, L. (2018). Intergenerational relationships and well-being of East Asian older adults in migrant families. *Journal of Ethnic & Cultural Diversity in Social Work*, *27*(4), 289–293. https://doi.org/10.1080/15313204.2018.1520171

Lock, S. (2016). The Tree of Life: A review of the collective narrative approach. *Educational Psychology Research and Practice, 2*(1), 2–20.

Minas, H., Kakuma, R., Too, L.S, Vayani, H., Orapeleng, S., Prasad-Ildes, R., Turner, G., Procter, N., & Oehm, D. (2013). Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion. *International Journal of Mental Health Systems*, *7*(1), 23–23. https://doi.org/10.1186/1752-4458-7-23

Ncube, N. (2006). The Tree of Life project. *International Journal of Narrative Therapy & Community Work, 2006* (1), 3.

Poynting, P. & Perry, B. (2007). Climates of hate: Media and state inspired victimisation of Muslims in Canada and Australia since 9/11. *Current Issues in Criminal Justice*, *19*(2), 151–171. https://doi.org/10.1080/10345329.2007.12036423

Randle-Phillips, C., Farquhar, S., & Thomas, S. (2016). Adapting and evaluating a tree of life group for women with learning disabilities. *British Journal of Learning Disabilities, 44*(4), 301–308. https://doi.org/10.1111/bld.12166

Reitmanova, S., & Gustafson, D.L. (2008). Mental health needs of visible minority immigrants in a small urban center: Recommendations for policy makers and service providers. *Journal of Immigrant Minority Health,* 11(1), 46–56. https://doi.org/10.1007/s10903-008-9122-x

Rowe, C., Watson-Ormond, R., English, L., Rubesin, H., Marshall, A., Linton, K., Amolegbe, A., Agnew-Brune, C, & Eng, E. (2017). Evaluating art therapy to heal the effects of trauma among refugee youth: The Burma art therapy program evaluation. *Health Promotion Practice*, *18*(1), 26–33. https://doi.org/10.1177/1524839915626413

Salma, J., & Salami, B. (2020). "Growing old is not for the weak of heart": Social isolation and loneliness in Muslim immigrant older adults in Canada. *Health & Social Care in the Community*, *28*(2), 615–623. https://doi.org/10.1111/hsc.12894

Sam, B. & Berry, J. (2010). Acculturation: When individuals and groups of different cultural backgrounds meet. *Perspectives on Psychological Science*, *5*(4), 472–481. https://doi.org/10.1177/1745691610373075

Scheppers, E., van Dongen, E., Dekker, J., Geertzen, J., & Dekker, J. (2006). Potential barriers to the use of health services among ethnic minorities: A review. *Family Practice*, *23*(3), 325–348. https://doi.org/10.1093/fampra/cmi113

Schweitzer, R.D., Vromans, L., Ranke, G., & Griffin, J. (2014). Narratives of healing: A case study of a young Liberian refugee settled in Australia. *The Arts in Psychotherapy, 41*(1), 98–106. https://doi.org/10.1016/j.aip.2013.10.006

Treas J., & Batalova J. (2009). Immigrants and aging. In: P. Uhlenberg (Ed.) *International Handbook of Population Aging* (pp. 365–394). Springer. https://doi.org/10.1007/978-1-4020-8356-3_16

van der Velden, I., & Koops, M. (2005). Structure in word and image: Combining narrative therapy and art therapy in groups of survivors of war. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 3*(1), 57–64.

Vitale, A., Khawaja, N.G., & Ryde, J. (2019). Exploring the effectiveness of the Tree of Life in promoting the therapeutic growth or refugee women living with HIV. *Arts in Psychotherapy*, 66, 1–10. https://doi.org/10.1016/j.aip.2019.101602

Vromans, L.P., Ranke, G., & Schweitzer, R. D. (Unpublished). *The Tree of Life: A narrative-based expressive arts program for young people from refugee backgrounds. Facilitator Manual*. Queensland University of Technology.

Vromans, L.P., & Schweitzer, R.D. (2011). Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes. *Psychotherapy Research, 21*(1), 4–15. https://doi.org/10.1080/10503301003591792

Westerhof, G.J., Whitbourne, S.K., & Freeman, G.P. (2011). The aging self in a cultural context: The relation of conceptions of aging to identity processes and self-esteem in the United States and the Netherlands. *Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 67*(1), 52–60. https://doi.org/10.1093/geronb/gbr075

White, M. (2007). *Maps of narrative practice*. Norton.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. Norton.

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Understanding immigrants' reluctance to use mental health services: a qualitative study from Montreal. *The Canadian Journal of Psychiatry, 51*(4), 205–209. https://doi.org/10.1177/070674370605100401

Wohler, Y., & Dantas, J.A. (2017). Barriers accessing mental health services among culturally and linguistically diverse (CALD) immigrant women in Australia: Policy implications. *Journal of Immigrant and Minority Health* 19**,** 697–701. https://doi.org/10.1007/s10903-016-0402-6