An Interpretative Phenomenological of Refugees' Experiences of Psychological Therapy for Trauma

Laura Jane Gilkinson

A Thesis submitted in partial fulfilment of the requirements
of the University of Hertfordshire for the degree of
Doctor of Clinical Psychology

The Programme of study was carried out in the
School of Psychology
University of Hertfordshire

July 2009

Acknowledgements

Table of Contents

1. Abstract

Background: Guidelines for the treatment of Post-Traumatic Stress Disorder recommend 8-12 session of trauma-focused CBT or EMDR, however there is an extensive body of literature criticising the PTSD paradigm and usefulness of recommended therapies in treating PTSD in the 'real world', particularly with the complex presentations of refugees . Alternative models for 'complex' PTSD have been proposed, as have transtheoretical phased stages for treatment. To date there has been no research into refugees' experience of trauma-therapy. Leaving a significant gap in understanding of how trauma therapy works.

Aims: With this gap in the research in mind, and in line with the current focus on service user involvement in research, this study aims to investigate refugees' experiences of trauma-therapy.

Methodology: Semi-structured interviews were conducted with six refugees who were coming towards the end of trauma-therapy with a specialist trauma service. The transcripts of the interviews were then analysed using Interpretative Phenomenological Analysis (IPA).

Results: Six master themes emerged from analysis: *'Therapy as a light in a dark place'*, *'Rebuilding a shattered sense of self'*, *'A changing relationship with the world and others'*, **'***Escaping the past to pursue a future'*, *'A journey from sceptic to convert'* and *'From an unknown mystery to a known mystery'*. These master themes along with the subordinate themes are expanded into a narrative account of participants' experiences.

Implications & Conclusion: Amongst numerous implications for clinical practice the need for support to engage in therapy, thorough explanation of therapy and pre-empting of possible conflicts and difficulties arising were identified. Allowing time to build a therapeutic relationship, the usefulness of the PTSD construct for individuals and the importance of the 'non-specific' factors of therapy in addition to the teaching of techniques to manage symptoms were also found to be of

importance. This study has made an important contribution to knowledge about refugees' experiences of therapy for trauma.

2. Introduction

2.1   Background

The term 'refugee', as defined by the 1951 Refugee Convention refers to those who "owing to a well-founded fear of being persecuted" are outside the country of their nationality and are unable to, or due to such fear are unwilling to avail themselves of the protection of that country (UNHCR, 2009). People become refugees for myriad reasons; persecution due to political activism, membership of a particular ethnic group, those resisting being drafted into fighting a war, political, cultural or religious affiliations or sexuality are just some of these (van de Veer, 1998). Despite these differences, van de Veer (1998) describes a commonality of refugees' experiences as suffering 'the abuse of power either by the authorities of totalitarian regimes or by armed militant groups'. Physical and psychological torture, sexual violence, bombings, living in poverty, malnourishment and dependency on humanitarian aid are just some of the traumatic experiences reported by refugees who have fled war-torn countries (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). Those displaced by persecution or torture face the additional challenge of coping with the acculturative stresses of their new environments (Ellis, Kia-Keating, Yusuf, Lincoln & Nur, 2007).

Statistics from the office of the United Nations High Commissioner for Refugees (UNHCR) indicate that there were 10.5 million refugees worldwide in 2009, not counting the 838,000 people seeking asylum or those internally displaced. Most of these will have fled one of the 30 armed conflicts in progress across the world at the time of writing. Over 57,000 people were recognised as refugees and granted asylum in the UK between 1998 and 2007 (Home Office, 2007). In the UK prior to the 1990s there were 2000 to 3000 asylum applications per year, rising to almost 50,000 in 1991 largely due to the Balkans conflict. By 2001 there were over 71,000 applications (Watters & Ingleby, 2004). This relatively sharp

rise lead to a period of increasingly negative portrayal of asylum seekers and refugees in the British Media (Watters & Ingleby, 2004).

Whilst post-traumatic stress disorder (PTSD) is not an inevitable consequence of trauma and is not, contrary to some social and professional narratives, synonymous with being a refugee, the provision of psychological therapies for refugees with trauma-related mental health problems is of relevance to many mental health services. A nationwide survey of seventeen specialist NHS psychological trauma services in the UK showed that fourteen of these worked with refugees (Jankovic-Gavrilovic, d'Ardenne, Bogic, Capuzzo & Priebe, 2005).

2.2. A Constructivist Framework

This is an exciting time for the clinical psychology profession. There are over 100 years of research, theory, practice and empirical evidence to draw upon, yet there is also a period of epistemological transformation whereby ways of working and thinking are being re-examined and deconstructed. This has commonly been referred to as the 'third wave' in psychology and reflects a move from empiricism and belief that knowledge is obtainable through an observable, external reality to postmodernist and constructivist approaches whereby the focus of knowledge is on the understanding and meaning made by the individual.

Constructivist theory is concerned with how individuals create systems for meaningfully understanding their worlds and experiences (Raskin, 2002). In contrast with the modernist ideologies of empiricism, positivism and the identification of objective truths, rather than trying to discover an objective reality, constructivism focuses on ways in which individuals and societies create constructions of reality (Raskin, 2002). Patel and Mahtani (2007) highlight the Eurocentric nature of the theories, interventions and research in psychology and the need for 'more socially responsible and relevant research'. Constructivist approaches provide a means through which to challenge and develop some of

the existing research grounded in empiricism, and it is through this lens that this research is undertaken.

2.3. Epidemiology and Treatment of Post Traumatic Stress Disorder (PTSD)

2.3.1. Epidemiology of PTSD: general population and refugees

Defined by the DSM-IV (American Psychiatric Association, 2000) as a consequence of exposure to a traumatic event that causes actual or threatened death or injury to self or others and invokes 'intense fear, helplessness or horror', PTSD and its treatment has been an area of great interest over the last 25 years; an 'explosion' of interest which Solomon & Johnson (2002) conceptualise in the context of the 'tremendous amount of trauma experienced in our society'. With terrorism and other traumatic events on the increase and affecting all areas of society, the sequelae of these events for both individuals and society have become a focus for clinicians and researchers (Zohar, Juven-Wetzler, Myers & Fostick, 2008).

Whilst there is a huge divergence in the traumatic experiences that can result in PTSD, what links each traumatized individual is the violation of their pre-existing beliefs, or schema, about themselves and the world around them (Solomon & Johnson, 2002). Trauma theory outlines three basic assumptions that are shattered by the traumatic event(s): a belief in personal invulnerability, a perception of the world as meaningful and a positive view of oneself (Janoff-Bulman, 1992). Trauma victims must negotiate the distress that comes with the violation of these beliefs, and it is this distress that can - but does not necessarily - manifest as PTSD. The psychological sequelae associated with PTSD are wide ranging, including disturbance in memory, attention, mood, cognition and beliefs (Brewin & Holmes, 2003).

Epidemiological studies have found a high prevalence rate of exposure to traumatic events in the general population, yet a comparatively low prevalence of PTSD (Keane, Marshall & Taft, 2006). Keane *et al*'s (2006) review of epidemiological literature found higher rates of PTSD reported in non-Western and less-economically developed countries, accounted for by the fact that many of these studies were undertaken in the aftermath of war and political instability.

Studies of the epidemiology of PTSD in refugee populations have yielded greatly varied results, with prevalence rates of between 4% and 86% (Hollifield, Warner, Lian, Krakow, Jenkins, Kesler, Stevenson & Westermeyer, 2008) with the variability attributed to varying rigour of study design and lack of PTSD measures validated for refugee populations. Johnson & Thompson's (2008) review of the 'methodologically sound' studies of epidemiology of PTSD in civilian adult survivors of war trauma and torture found 'relatively low' rates.

2.3.2. Epidemiology of PTSD: Critique of the existing research

A criticism of existing PTSD literature is the lack of research in populations in developing countries, particularly in light of their increased risk and the significant limitations this presents in generalising findings from developed countries to the developing world (Keane et al, 2006). Despite these limitations, Keane et al (2006) argue that the findings indicate that PTSD is not solely a Western construct and irrespective of the myriad differences which effect both prevalence and course of PTSD, there are shared biological and psychological underpinnings.

In their review of contemporary perspectives on PTSD, Zohar et al (2008) challenge the 'myth' that PSTD is a natural consequence of exposure to trauma, highlighting that 70-80% of people recover fully and arguing that PTSD can be conceptualised as a 'failure to recover to trauma'. Keane & Barlow (2002) suggest a 'triple-vulnerability model' to account for the varying aetiology of PTSD, encompassing pre-existing psychological variables, pre-existing biological

variables and exposure to trauma. A further criticism of the PTSD literature is that PTSD rarely occurs in isolation, however comorbid conditions are frequently used as exclusion criteria in efficacy research, threatening the external validity of these studies and creating an artificial homogeneity in participants which has negative implication the generalisability to 'typical' individuals presenting with PTSD in clinical practice (Spinazzola, Blaustein & van der Kolk, 2005). Research of this nature is unrepresentative of the typical presentation of those with trauma histories seeking help and support (Spinazzola *et al,* 2005), and this is particularly relevant for many refugees who will have experienced extensive and prolonged trauma in their country of origin, as well as further post-migration trauma related to living on exile. Having observed this 'research-practice gap', clinicians and researchers in the field proposed an alternative construct: complex PTSD (CPTSD) (Courtois, 2004), which is defined by seven different problem areas:

1. alterations in the regulation of affective impulses
2. alterations in attention and consciousness
3. alterations in self perception
4. alterations in perception of the perpetrator
5. alterations in relationship to others
6. somatisation and/or medical problems
7. alterations in systems of meaning

Although not yet included in the DSM-IV, other than as a feature associated with PTSD, there is increasing support for the CPTSD conceptualisation (Courtois, 2004).

2.3.3. Exploring alternative constructs: a critique of the PTSD paradigm and its application to refugees

Solomon & Johnson (2002) identify substantial flaws in PTSD interventions: inadequate research, lack of knowledge of specific treatment components or optimal duration and timing of treatment, poor understanding of the effect of

comorbidity and the need for an understanding of the effects of interventions on specific trauma populations. In addition Rosen & Lilienfeld's (2008) empirical evaluation of the core assumptions inherent in PTSD found the existing body of research showed that 'most every core assumption underlying the diagnostic construct has met with questionable support, if not falsification'. However they do acknowledge the 'substantial heuristic value' of the construct of PTSD in mobilising research into the effects of trauma.

Traumatisation is a term used to describe 'extreme, painful experiences which are so difficult to cope with that they are likely to result in psychological dysfunction both in the short and long term' (van de Veer, 1998). Van de Veer (1998) highlights that the application of this terminology when considering refugees is potentially misleading, implying that refugees have experienced one or two discrete traumatic events, whilst the reality is that traumatisation is likely to have occurred over many years, culminating in specific traumatic events and subsequent flight into exile.

The 'centrality of PTSD' in the numerous potential negative consequences of exposure to trauma is a subject of ongoing debate (Kilpatrick, 2005). As identified by Young (1995), the concept of PTSD emerged from a specific social context: the Vietnam War. Early supporters of the PTSD paradigm were part of the anti-war movement and argued that military personnel were victims, traumatised by the roles pressed upon them by the US military (Summerfield, 1999). Since then PTSD has been utilized in reference to victims of war or disaster regardless of cultural background or origin. Summerfield (1999) argues that the application of the PTSD paradigm in this way is a reflection of the 'globalisation of Western cultural trends towards the medicalisation of distress' and the rise of psychological therapies, describing PTSD as a 'pseudocondition' which serves to reframe the 'understandable suffering of war' into a problem to which short term solutions such as counselling can be applied. Summerfield (1999) claims that the assumption of traumatisation is pathologising as it moves us away from the impact of war as a social phenomena to a biomedical one, distorting our

understanding and evaluation of the human impact of war. Summerfield's critique of the PTSD paradigm highlights that many ethnomedical systems incorporate physical, supernatural and moral aspects and do not attempt the distinction of physical or mental causality inherent in Western healthcare culture. In line with this, it is argued that the PTSD framework is too narrow a lens through which to view the psychosocial impact of the trauma of war (Farwell, 2004). Summerfield (1999) argues that the label of PTSD 'pigeonholes' refugees, paying little attention to their experience of their distress and their treatment preferences. Advantages of the PTSD 'label' or diagnosis have however been identified. In a culture where human distress is quantified by psychiatric diagnosis, mobilisation of social assistance such as housing, finance and obtaining refugee status often requires such a diagnosis (Stubbs 1999).

Increasing critique of the way in which Western psychiatric categories overlook the social and political context of refugees has lead to new paradigms emerging in the mental health care of this client group (Watters, 2001). Critics argue that the focus should be on the resilience of refugees and their interpretations of, and responses to their experiences rather than viewing them as 'passive victims'' of mental health problems. This approach could be difficult to implement though as agencies involved in the care of refugees may find they have to perpetuate the bio-medical paradigm by assigning clinical categories in order to assist their client group (Watters, 2001). In the shorter term, critical analysis of the existing paradigm may compromise the mobilisation of resources and potentially jeopardise the refugee's legal position, given that being granted refugee status often requires 'evidence' of traumatisation.

Ager (1993) highlighted the need to consider existing literature on refugee mental health in the context of the 'agendas established by the social concerns of developed nations with regard to specific refugee influxes'. The contexts in which refugees in the UK exist are largely connected to government policy, with dispersal policy severing support networks and disrupting the already difficult integration process. Housing is often of poor quality and already-difficult

conditions are exacerbated by discrimination and hostile attitudes from the public (Watters & Ingleby, 2004).

2.3.3. Treatment of PTSD & CPTSD

Psychotherapeutic treatment of PTSD is well researched in western, industrialised countries such as Europe, Australia and the United States (Neuner et al, 2004). Initial development of treatments was largely driven by the return of American Vietnam war veterans and identification of the need to treat their related psychological and social difficulties (Keane et al, 2006). These early treatment models were grounded in learning theory, specifically conditioning models, and have developed to incorporate cognitive and behavioural approaches. Individually delivered trauma-focused CBT (TFCBT) and Eye-Movement Desensitization and Reprocessing (EMDR) have the most empirical support for their effectiveness to date (Bisson, Ehlers, Matthews, Pilling, Richards & Turner, 2007). Both interventions have been found to be equally efficacious, though little is understood about the way in which EMDR contributes to treatment outcome (Seidler & Wagner, 2006). Solomon & Johnson's (2002) review of the empirical evidence for the efficacy of psychosocial treatments for PTSD also found cognitive behavioural interventions to have received the most 'systematic research attention' but additionally identified psychodynamically-oriented therapy and group or family therapy as common psychological interventions offered to trauma victims. Solomon and Johnson (2002) concluded that there was insufficient systematic research to indicate that any one therapy can be pronounced effective in treatment of PTSD. Strongest support was found for treatments combining cognitive and behavioural techniques, while hypnosis, psychodynamic therapy and group therapies 'hold promise'. The limited systematic studies did indicate that no one treatment approach was likely to successfully reduce all symptoms of PTSD, however a large scale survey found that overall duration of PTSD was reduced by around two years for those seeking professional help.

Whilst cognitive-behavioural approaches have been identified as the optimum treatment for trauma, a review of the literature (Solomon & Johnson, 2002) identified various factors upon which effective intervention is dependent, the majority of which are the 'non-specific' aspects of therapy. These included establishing and maintaining trust and a good therapeutic relationship, retelling the trauma story and expectation-management. However there is limited evidence from more recent studies that TFCBT and EMDR showed greater effectiveness than supportive or non-directive treatments, suggesting that improvement is due to more than 'non-specific' factors (Bisson *et al*, 2007).

Specific treatments for CPTSD are under development (Courtois, 2004). Courtois (2004) urges caution in adopting CBT approaches without further research and highlights indications from research evidence and clinical observation that treatment for CPTSD should be 'multi-modal and transtheoretical' as necessitated by the complexity and range of problems and issues presented by clients. Courtois recommends a 'meta-model' of treatment for CPTSD incorporating a 'careful sequencing of therapeutic activities and tasks, with specific initial attention to the individual's safety and ability to regulate his or her emotional state'. A three-stage model is widely adopted (see Herman, 1997), although used as a guide rather than prescriptive series of interventions. The three stages are outlined below:

- **Stage 1**: This is likely to be the longest phase of treatment, and the most integral to treatment success and includes *pretreatment issues*, such as motivation for treatment, informed consent and education on the nature of treatment, building a therapeutic alliance, affect regulation, stabilisation, skill-building, psychoeducation and self-care. Some clients may not complete, or continue past this stage.
- **Stage 2**: This stage addresses post-traumatic impairment and is undertaken when the client has sufficient stability and affect-regulation skills. Exposure and narrative-based techniques are used

to directly address issues related to the trauma. Deconditioning, mourning, resolution and integration of the trauma are all incorporated in this stage.

- **Stage 3**: Life consolidation and restructuring is the focus of this stage, whereby the client builds on the awareness gained through stage 2 and works towards a life less affected by the sequelae of trauma, with the therapist as a secure base from which to do so.

National Institute for Clinical Excellence (NICE) guidelines suggest that 8-12 sessions of trauma-focused Cognitive Behaviour Therapy (CBT) or Eye Movement Desensitization and Reprocessing (EMDR) should be used for the treatment of individuals with 'severe' PTSD (NICE, 2005). These guidelines mostly refer to traumatic events such as assaults, road traffic accidents and childhood sexual abuse. No mention is made of war or torture as a traumatic event and little specific mention of refugees is made, other than the suggestion that practitioners consider screening refugees for PTSD. Williams (2006) suggests that 'when exposure to a catastrophic or violent event does not allow a person to resume living an undisrupted life, or if the type of trauma is both repetitive and cumulative, the result will be persistent complex manifestations that affect psychological, social, and biological systems'. Some disparity is evident between Williams' view, the CPTSD 'meta-model' and the NICE guidelines which present a more generic, 'one size fits all' approach to trauma and is more relevant to single traumatic events than the complex nature of trauma some refugees may have experienced.

The current evidence-base for psychological treatment for traumatised refugees is mixed. Some studies have shown no improvement in treatment (Carlsson, Mortensen & Kastrup, 2005). d'Ardenne, Ruaro, Cestari, Fakhoury and Priebe (2007) have found a significant improvement in refugees undergoing CBT for trauma, with a greater improvement in the refugee group who had therapy with an interpreter than without. D'Ardenne *et al* acknowledge the 'modest' therapeutic gains experienced by refugees in this study and highlighted that many clients were still within a clinical population when discharged, despite their 'significant' improvement. In their review of the efficacy of CBT in treating PTSD, Harvey,

Bryant & Tarrier (2003) identified only one randomised controlled trial (RCT) of CBT for refugees with PTSD which compared CBT and exposure therapy. Both were associated with improvements in PTSD, anxiety and depression post-treatment and at 6-month follow up, however the power of the sample was not sufficient to detect group differences. These quantitative research studies are important for reviewing the efficacy of treatment and for service development, but give us little information on why these treatments are helpful or unhelpful. Unless complementary research is undertaken with the service user, we can only guess as to why and how treatments are helpful or unhelpful and vital information that will help clinicians better understand and potentially improve their client's experience will be overlooked. There is currently no research available on refugee's experience of psychological therapy.

The need for more research with refugees has been widely recognised (Carta, Bernal, Hardoy, Haro-Abad, & the Mental Health in Europe Working Group, 2005; Ellis et al, 2007). Despite a number of studies undertaken since the 1980s, the field is only now emerging as a mainstream topic for research. Watters & Ingleby (2004) identify that while there have been an 'impressive body of critical studies' looking at provision of mental health services to black and minority ethnic groups, there have been relatively few looking at mental health provision for refugees. Research within refugee populations can elicit significant methodological and ethical challenges, as well as requiring the researcher to look beyond standard methods and practices (Ellis *et al*, 2007). These challenges may in part explain the slow progression of this area into a more mainstream research field. Johnson & Thompson (2008) identified that "the meaning that trauma and post-traumatic experiences hold among non-western survivors has not yet been investigated" and suggested that qualitative studies may be the most appropriate means through which to explore this.

2.4. Existing Research into Psychological Therapy

Outcome research shows that the majority of clients undertaking therapy make significant improvements, yet understanding of why and how therapy works is limited. Research into clients' experience of therapy has been gaining increasing importance over the last two decades (McLeod, 2001). Information from clients' accounts of their experience is vital to our understanding and yet is often overlooked in research (Paulson, Everall and Stuart, 2001). Paulson et al (2001) identify that there has been "little systematic investigation into client's experiences in therapy" despite the purpose of therapy being to effect change for the client. Quantitative research attempts to evaluate therapies, or experiences of therapy using pre-designated categories, or by comparison of pre- and post-treatment symptomatology measures, both of which leave little room for exploration of the richness of a client's individual experience. In a performance-driven society it is no surprise that psychotherapy research has fallen into the 'what treatment works quickest and cheapest' trap, and clinically, economically and ethically there is some validity to this approach. Nonetheless, valuing and researching individual experience needs to be an integral part of such research. Paley & Lawton (2001) raise concerns that in the current NHS climate the focus on evidence-based practice is moving us towards a search for 'premature implementation of certain techniques, models, or ways of working which seek to condense therapy into uniformity rather than exploring possible disparity', and that this search is leading to the "primacy of the therapeutic relationship" to be overlooked. They suggest that "there is a need for more qualitative and process research that taps into the unique experiences of therapy participants".

Review of existing literature has indicated a need to expand our understanding of treatment efficacy and the meaning of trauma and post-traumatic experiences for non-western survivors (Johnson & Thompson, 2008). Qualitative research aims to "understand and represent the experiences and actions of people as they encounter, engage, and live through situations" (Elliott, Fischer & Rennie, 1999) and therefore provides an ideal methodology through which to achieve this aim. Gaining an understanding of an individual's constructs around trauma and therapy are necessary if new paradigms of PTSD relevant to non-Western

individuals are to continue to be developed. Moodley (2001) argues that a 'research-practice gap' is created, through which the client is silenced, when clinicians maintain that research neglects the complexities and nuances of therapy, and researchers claim that clinicians fail to attend to research findings, engaging in 'an ill-informed process'. Elliot (1995) goes so far as to refer to this polarised relationship as "a troubled marriage, in which the two partners need to accept the fact that each lives in a different reality and stop trying to change the other". In undertaking qualitative research the researcher endeavours to gain understanding of the topic from the perspective of the participant, with the aim of revising and enriching existing understanding rather than verification of previous findings or existing theory (Elliott et al, 1999). This approach to research may go some way bridge the 'research-practice gap' and ensure the client remains the research focus.

Findings from a study by Simich, Maiter, Moorlag & Ochoka (2009) highlight the importance of understanding the impact of factors such as social context, social inequalities and community values on mental health and access to appropriate services, and the vital role study participants can play in generating "helpful actions and outcomes". Qualitative research which explores clients' experience will ensure this 'vital role' is included in the research literature.

2.4.1. Research into Client Experience of Therapy

A growing body of research has tried to elicit information about client perception of therapy, however much of this has been through quantitative measures utilising pre-defined categories developed by the researcher to ascertain satisfaction or change (McLeod 2001). Qualitative studies are better positioned to enable us to gain a richer understanding of client experience, in their own words. McLeod (2001) asserts that research into client's views, positive and negative, on what makes a difference to them offers an increased understanding of what contributes to effective therapy and can help us to expand existing theory. Furthermore, qualitative research is clinically useful as it can serve - as McLeod

(2001) describes - to 'de-centre' clinicians, allowing them to look at the process of therapy through the eyes of their client. Paulson et al (2001) conducted a qualitative study looking at experiences of hindering factors in counselling, with the rationale that an understanding of client perceptions of hindering experiences in therapy will improve understanding of "the relationship between client experience, therapeutic processes and positive outcome" and "the determination of aspects of treatment that are more meaningful and ultimately more effective in the therapeutic process". They identified three core aspects that clients found hindering: counsellor behaviours, external and structural barriers and client variables. Timulak and Lietaer (2001) undertook a qualitative analysis of positively experienced moments in therapy, identifying that exchanges which served to strengthen the therapeutic relationship and those that empowered the client were key to positive experience.

Qualitative case studies are a growing area of research. Currently the majority of these are psychoanalytic psychotherapist's account of the process of therapy using audio taped therapy sessions. These generally provide an analysis of the process of therapy from the perspective of the therapist, which are epistemologically and clinically useful tools, yet give us little insight into the process of therapy from the perspective of the client. A handful of these case studies have been with refugee clients (see Varvin & Stiles, 1999) and there is a small but expanding evidence base of qualitative research looking at refugees' experiences of various phenomena. Khawaja, White, Schweitzer & Greenslade (2008) conducted a study looking at the difficulties encountered by Sudanese refugees during migration and resettlement and the coping strategies used to manage these difficulties. Simich *et al* (2009) explored concepts of mental health and mental illness with Latin American, Chinese, Polish, Punjabi and Somali communities. Weine, Muzurovic, Kulauzovic, Besic, Lezic, Mujagic, Muzurovic, Spahovic, Feetham, Ware, Knafl & Pavkovic (2004) used grounded theory to investigate the family consequences of refugee trauma, constructing a model to describe "Displaced Families of War" across key areas of family life. Finally, O'Donnell, Higgins, Chauhan & Mullins (2008) explored refugees' expectations of

general practice, highlighting areas where they experienced difficulties, such as confidence in general practitioners and access to specialists. While these studies provide invaluable insights into refugees' experiences of a range of issues, there has been no research to date investigating refugees' experiences of therapy.

2.4.2. Aims of the research

The absence of literature exploring refugees' experiences of therapy forms the basis of the rationale for this research, which aims to provide an introductory study into refugees' experience of therapy. Whilst acknowledging that refugees will seek therapy for a wide range of issues, this study will focus on the experience of trauma-therapy, for which there is a great deal of research and theoretical literature, as explored in this introduction, yet an absence of research from a client's perspective.

2.4.3. Research Question

With the above aims in mind, the research question was framed as:
- How do refugees experience psychological therapy for trauma?

3. Methodology

3.1. Overview

This study aims to gain an understanding of refugees' experiences of psychological therapy for trauma. Interpretative Phenomenological Analysis (IPA) is a qualitative methodology developed by Smith (1996; 2004; Smith & Osborn 2008) and will be used to meet the research aims.

3.2. Why a Qualitative Approach?

Client experience of psychological therapy has been a relatively neglected area of research to date (Paulson et al, 2001) and the experience of therapy for people from non-Western backgrounds without English as a first language even more so. A lack of understanding of these important experiences leaves us with an 'impoverished map of psychological knowledge' (Smith, 1996). Qualitative methodologies aim to understand and represent the lived experience of individuals, based as closely on their perspective as possible (Elliott, Fischer & Rennie, 1999) and can help identify 'barriers and facilitators to change, and discover the reasons for the success or failure of interventions' (Starks & Brown Trinidad, 2007). They are particularly suited to exploratory research, therefore lending themselves to the aims of gaining an understanding of refugees' experience of trauma-therapy.

3.3. Interpretative Phenomenological Analysis

IPA was chosen as the method of analysis for this research for several reasons:

1. IPA was the methodology most consistent with the research aims of gaining an understanding of the experience of trauma therapy from the perspective of the individual. IPA's theoretical position as an inductive approach allows a detailed exploration of how participants make sense of

their lived experience (Smith, 2004). The underlying philosophy of IPA purports that there is no objective reality to be uncovered, instead aiming to capture the experience of individuals as they themselves have constructed it, whilst also acknowledging the influence of social constructions on individual meaning-making.

2. IPA is an idiographic approach with the complementary aim of understanding and giving voice to individuals experiences through the phenomenological component which necessitates an in depth analysis of aspects of the reflected personal experience (Smith, 2004). In addition IPA contextualises, or makes sense of, these experiences from a psychological perspective (Larkin, Watts & Clifton, 2006) through the interpretative aspect. The interpretative element of IPA is 'intellectually connected to hermeneutics and theories of interpretation' (Smith & Osborn, 2008) which developed in opposition of positivism and the belief that knowledge develops from interpretation and empathetic understanding (see Palmer, 1969).

3. There is a growing body of IPA research within health, clinical, counselling and social psychology (see Smith, 2004; Brocki & Wearden, 2006), demonstrating its value in psychological research, yet to date there have been no published IPA studies with refugees or regarding the experience of therapy.

4. There are detailed guidelines for undertaking IPA which facilitates its use for researchers new to this methodology (see Smith, Jarman & Osborn, 1999; Smith & Osborn, 2008).

5. The interpretative aspect of IPA positions meaning-making within an individual's personal and social context and therefore fits within my epistemological standpoint.

3.4. Why not other qualitative methodologies?

Other methodologies were considered during the developmental phase of the research, including discourse analysis, grounded theory and narrative analysis.

Starks & Brown Trinidad (2007) compare phenomenology, discourse analysis and grounded theory. They describe phenomenology as exploring how people make meaning of lived experiences; discourse analysis as attempting to understand how people use language to construct and negotiate knowledge, meaning and identities; and grounded theory as used when researchers want to build a theory or explanatory model of basic social processes. Through this comparison it appeared a phenomenological approach would be most appropriate to meet the aims of the research. Grounded theory was deemed inappropriate both due to the logistical difficulties of needing sufficient numbers of participants to reach saturation and also because, while there are similarities between grounded theory and IPA, grounded theory focuses on capturing social processes rather than individual experience, making it less suitable for this study. It has also been argued that IPA takes more of a psychological approach and grounded theory a sociological approach (Willig, 2003). In addition Narrative analysis is concerned with how people construct their own self-accounts (Burck, 2005), making and using stories to interpret the world. Whilst sharing some similarities with IPA, narrative analysis emphasises temporal narratives which may restrict the findings of the research, whereas the openness and flexibility of IPA would allow for narratives to emerge. It was therefore concluded that IPA was the optimum methodological fit for this research.

3.5. Study Development

At the planning phase of the research, numerous specialist trauma services in both the NHS and voluntary sector were approached regarding potential recruitment. However whilst many were encouraging of the research, issues such as lack of time for involvement, experience of difficulty obtaining site-specific ethical approval and anxiety about the vulnerability of the client group lead to difficulty in finding services willing to assist with recruitment.

It was therefore decided that focusing on recruiting from one service that had shown a strong interest in the research and developing the project in conjunction

with them would be the best way of ensuring recruitment. This enabled the primary researcher to develop a good relationship with clinicians and collaborate with them in the development of the project, bringing their expertise in working with client group to the research. This ensured issues such as ethics, client vulnerability and potential retraumatisation were fully considered. A further advantage of this approach was that the team got to know the primary researcher personally and professionally and that the participants' experience was at the forefront of the planning. This enabled clinicians to feel more comfortable in referring their clients for the research. The primary researcher attended the multi-disciplinary team meeting on a fortnightly basis in both development and recruitment stages of the research to remind clinicians of the research and manage any concerns or queries that arose.

3.5.1. Interview Design

Semi-structured interview is considered the 'exemplary method' for IPA, offering a focused yet flexible method of data collection (Smith & Osborn, 2008). An interview schedule was drafted by the researchers and then reviewed by the clinical team. The final schedule (see Appendix 1) aimed to elicit an understanding of the experience of the process of therapy, including referral, any aspects considered particularly helpful or unhelpful and the impact of culture and language on the experience.

3.5.2. Inclusion and Exclusion Criteria

The aim in designing this research was to be as inclusive as possible. In order to meet this aim, other than requiring participants to be refugees or asylum seekers and having therapy for trauma within the service, there were no specific exclusion criteria. Both researchers and therapists were mindful of the potential vulnerability of the client group. After consideration of various recruitment options, it was decided suitable participants should be identified through their therapists. This enabled clinicians to discuss implications of participation and consider whether

their client was stable enough to take part, alleviating some of their anxieties about potential retraumatisation.

Consideration was given as to whether or not to include participants who required an interpreter. There has been ongoing debate regarding the use of interpreters in IPA and within qualitative research generally, nevertheless it was decided that it would not be possible to meet the research aims if refugees requiring interpreters were excluded.

3.5.3. Pilot Interview

A pilot interview was conducted in order to test the interview schedule and obtain feedback from the pilot interviewee regarding the process of the interview and any suggested amendments. The only alterations identified following the pilot were the need to extend the time of the appointment from 60 to 90 minutes and reword an awkwardly phrased question. The pilot interview was included in the main study.

3.6. Ethical Issues

Ethical approval for the study was granted by Bromley Local Research Ethics Committee. Relevant documentation is provided in Appendices 2 & 3.

3.6.1. Informed Consent

Following the identification of potentially suitable participants, each were given verbal and written information about the study (see Appendix 4) by their therapist, or the information sheet was read by the interpreter where necessary. They were then asked permission to be contacted by the researcher by telephone. All but two participants spoke sufficient English for a brief telephone conversation to discuss the study and ask questions. The researcher was able to converse with one participant in his native language and the participant that could not be spoken to by telephone was keen to be involved in the research and asked the

therapist to arrange an interview with the researcher for a specific day and for a confirmation letter to be sent. During the telephone conversations, all participants were offered a copy of the information sheet in their first language. Confirmation letters were sent in the usual clinic format, with the addition of an appointment card translated into the participant's first language.

Due to concerns that some information about the study could be lost in translation and to ensure participants fully understood the nature of the research, the participants were read the information sheet again prior to interview and a discussion was had regarding what participation involved, confidentiality, anonymity procedures, the independence of the research to their therapy and the right to withdraw, as well as discussing any questions or concerns. Once these issues had been discussed, participants were offered the opportunity to withdraw or take more time to consider participating.

Interpreters were also asked to give consent regarding the recording of the interview and arrangements for transcription, which was included on the interpreter's confidentiality agreement (Appendix 5).

3.6.2. Confidentiality

Participants were made aware that any data collected would be kept confidential, no demographic information would be taken off site, audio-recordings would be password protected and subsequent transcriptions would have any potentially identifying information removed. They were also made aware that the researcher knew only their names and contact details and had no access to their records and no knowledge of their histories. Participants were informed that interpreters had signed confidentiality agreements and transcription services, if used, would also sign confidentiality agreements. Participants were made aware that research supervisors would have access to anonymised transcripts in order to help with analysis. The limits of confidentiality were also discussed and participants informed that if there were any concerns about the safety or welfare of the client, their therapist would be informed.

Some changes were made to the study design in response to client concerns. For example one client was very concerned about any personal information being obtained by members of his community or political opposition, therefore it was agreed that the researcher would transcribe the interview rather than use a transcription service and the interview would not be transcribed in the language of origin. It was also agreed not to use names during recording in order to further protect anonymity.

Interpreters were asked to sign confidentiality agreements for the research (Appendix 5) in addition to their existing NHS confidentiality agreements.

3.6.3. Affiliation of researcher

An important ethical concern to address was that on being asked by their therapist to take part in the study, participants may have felt that any further contact with their therapist or the service could be affected by their decision on participation. It was therefore highlighted by therapist, information sheet and particularly on meeting the researcher that the study and researcher were independent to the service and that participation was entirely voluntary and would have no bearing on their current or future contact with the service or the therapist.

3.6.4. Potential Distress

One of the concerns raised by the clinical team in developing this study was limiting the risk of retraumatisation which can occur when memories of past traumatic experiences are triggered off by events in the present, such as inappropriate questions or an intrusive style of relating (Van de Veer, 1998). Participants were made aware that they were not being asked to talk about their trauma which was one way of limiting this risk. In addition, as a trainee clinical psychologist the researcher had experience working with people who had experienced trauma and ensured the interviews were conducted sensitively and that the participants were put at ease as much as possible. The researcher was trained in useful relaxation and grounding techniques should any participants have become distressed during the interview and regularly checked to see if

participants were comfortable or needed a break, as well as reassuring them that they could terminate the interview at any time. Time was allocated at the end of the interview for participants to debrief. Finally, there were one of two designated members of clinical staff from the Traumatic Stress Service, the field supervisor or the head of service - both clinical psychologists - on site whenever interviews were scheduled so that the researcher could request they see the participant should any concerns arise.

Despite a small risk of participants finding the interviews distressing, on designing this study it was felt by the team of experts consulted that given the marginalised nature of this client group many potential participants would appreciate the opportunity to have their voices heard and to feel that their input could help others in their position in future. In addition the benefits of taking part in research of this nature include being given the space to reflect, make sense of their past experiences and be listened to empathically. Engaging in this process has described by some research participants as therapeutic (Birch & Miller, 2000) and clinicians in the service echoed this view.

3.7. Procedure and Data Collection

3.7.1. Service Context

The Traumatic Stress Service from which clients were recruited is a specialist trauma service in South London receiving referrals from both its catchment area and across the UK. The team are comprised of a range of clinicians including psychodynamic psychotherapists, clinical psychologists and psychiatrists. All clinicians undertake psychological therapy. Whilst the therapeutic model and techniques used vary from clinician to clinician, including attachment-based psychotherapy, cognitive analytic therapy, EMDR and trauma-focused CBT, all use the phased model of treatment (see Herman, 1992) and are strongly influenced by attachment theory. The team also run a psychoeducation group which many clients will attend prior to individual therapy.

3.7.2. Participants

It has been suggested by Smith and Osborn (2003) that five to six participants is a suitable number for a study using IPA. The aim, therefore, was to recruit a minimum of six participants for the study.

Potential participants were identified and initially approached by their therapists. The clinicians were asked to briefly explain the research to potential participants and provide them with information sheets (see Appendix 6). If the clients did not speak English, the interpreter was asked to verbally translate the information sheet and the client was asked if they would like a translation of the information sheet in their language. Therapists were asked to complete a recruitment checklist (see Appendix 7) outlining whether clients had given consent to be contacted, their preferred method of contact, whether they required an interpreter and any other issues for consideration.

Recruitment of participants was quite difficult, with therapists often struggling to find clients nearing the end of therapy or identifying potentially suitable candidates but then complications arising. However seven potential participants were identified and all but one of these agreed to take part in the study.

Many of the participants who were interviewed were very anxious about confidentiality having had experiences of political persecution, but wanted to participate in the research in the hope that it may assist treatment of people in similar situations. Out of respect for the participants who took part and in order to fulfil a promise to keep them as unidentifiable as possible, this section will deviate from the usual description of the sample and provide only a basic overview. This is particularly appropriate due to the use of one very specialist service which may render participants slightly more identifiable than in other research.

Participants will be referred to by pseudonyms for the write-up. All participants were receiving treatment at a specialist Traumatic Stress Service in South London and were at the end of, or nearing the end of, a phase of therapy with the service.

Table 1: Participant information

Gender	Two female, four male
Age	Participants ranged in age from mid twenties to late thirties
Nationality	Two Iranian, one Congolese, one Vietnamese, one Kosovan, one Ethiopian
Use of Interpreters	Three participants were interviewed using interpreters, three in English. None spoke English as a first language.
Phase of Therapy	Three had completed therapy with the service and would return only for follow-up, one had finished phase one and would return for phase two when ready, two had had a more sporadic attendance for therapy and had completed phase one and some of phase two.

3.7.3. Interviews

Interviews were conducted in the same outpatient department the participants attended for therapy in order to reduce any unnecessary anxiety for participants of travelling to unfamiliar locations. Participants were asked to allow up to 90 minutes for the interviews. The first 10 to 15 minutes of the interview was to ensure the participants were fully informed about the study and had the opportunity to raise any concerns and ask questions. At this stage participants were given the opportunity to take more time to consider whether they wanted to participate in the study. The informal and confidential nature of the interview was stressed to the participants and they were reassured that the researcher did not

know anything about their traumatic experiences and would not be asking any questions about these experiences. After they had agreed to participate and asked any questions, participants were asked to sign a consent form, translated where required (Appendix 8).

The interviews were conducted using a semi-structured schedule (Appendix 1). This was used flexibly in order to ensure an informal, conversational atmosphere that would facilitate detailed descriptions of participant's experiences of therapy and allow exploration of areas of interest. The interview schedule was reviewed after each interview and refined where necessary. Interviews lasted between 35 and 95 minutes and were recorded using a digital voice recorder.

Following each interview, a reflective diary was used to record reflections on the interview and any issues around content and process, aimed at increasing reflexivity.

3.7.4. Role of the interpreter in interviews

In their review of cross-cultural studies using interviews, Wallin & Ahlmstrom (2006) found that the methodological issues involved in using an interpreter were insufficiently addressed and suggested that researchers should attend to the interpreter's role in the research process. The importance of describing interpreter's competence, style of interpreting and seating arrangements was highlighted. As a result particular attention is paid to these issues in this section.

For interviews with the three participants without fluent English, interpreters were booked fifteen minutes before the participant was due as recommended in protocols for use of interpreters (d'Ardenne, Farmer, Ruaro and Priebe, 2007). This allowed time to brief interpreters about the nature of the interview and research. The interpreter was given the semi-structured interview schedule to read through prior to the interview so we could discuss any issues of clarity or difficulties with translation and make amendments as required.

Interpreters were asked to translate directly and verbatim as far as possible and to be transparent where they were making a cultural interpretation, in line with literature purporting that an interpreter is not just a translator of words, but a 'bi-cultural' interpreter making cultural and linguistic interpretation (Tribe, 2007). They were also asked to translate shorter sections of speech than they may normally to ensure as rich an interpretation of the participant's language as possible. This method of translating and the reason for this approach were explained to the participant prior to the interview. Interpreters were asked to use the first person as much as possible, however two interpreters struggled to do this, mostly speaking in third person.

There was no attempt to make the role of the interpreter 'invisible' during interviews. The researcher, participant and interpreter sat in a triangular formation which reflected this. The three interpreters used were professional interpreters employed by a large NHS trust as their primary occupation and therefore were all experienced in interpreting. One interpreter was of similar age and same sex as the participant, one was older and the same sex and one was older and opposite sex. Subjectively the interpreters varied in their proficiency in English, with one appearing highly skilled, one having a sufficient level of English but with some technical difficulty which may have appeared greater due to a heavy accent, and one interpreter was somewhere between the two levels of competency.

Interpreters remained to debrief after the interview and to enable reflection on the interview and any cultural or language considerations to be taken into account, as recommended in interpreting protocols (d'Ardenne et al, 2007).

3.7.5. Quality in Qualitative Research

The researchers have strived to meet guidelines for quality in qualitative research (see Spencer, Ritchie, Lewis & Dillon, 2003; Elliott *et al,* 2007) through all stages of the research and this is discussed further in the Discussion chapter.

3.8. Data Analysis

IPA was used to analyse the data from the interviews, as outlined by Smith (1996) and Smith and Osborne (2003). Guidelines for quality in qualitative research (Elliot *et al*, 1999), supervision, peer supervision and attendance of IPA work groups and seminars, and consultation with experts in the field of trauma therapy also informed the process.

3.8.1. Individual Case Analysis

An idiographic approach to analysis was followed with each interview analysed individually, allowing the researcher to detect repeating patterns whilst remaining open to new themes emerging (Smith & Osborn, 2008). Interviews were read repeatedly, with descriptions and initial ideas on interesting or significant aspects, connections, contradictions and preliminary interpretations annotated on the left hand margin. Interviews were read again, and the right hand margin used to record emerging themes.

The next stage utilised a more analytical approach, making sense of connections between emergent themes, listing them and clustering them together. Smith & Osborn (2008) use the metaphor of a magnet to describe this process, with some of the themes pulling others towards them, facilitating sense-making. The clusters of themes were given names which became the superordinate theme, aiming to capture the essence of the meaning from the text. This process involved regular checking of interpretations and themes within the text. Key quotations from the interviews were selected to represent each theme and a table of emergent themes, superordinate and subordinate themes and corresponding quotations was produced   An example of the analytic process for one interview is given in Appendix 9.

3.8.2. Cross-case analysis

Once all interviews had been analysed and tables of themes produced, a further table was produced incorporating the themes from all six interviews. A similar

process to individual analysis was followed, with the themes clustered using the 'magnet' method into superordinate and subordinate themes. Interview transcripts were reviewed to ensure accuracy of the themes, and thus a framework representing the participant's experiences of trauma-therapy was developed. These themes were then expanded into a narrative account which is the basis of the Results chapter.

3.9. Statement of Position in Research

Why position?

Self-reflexivity is of particular importance to qualitative research. Whilst qualitative researchers acknowledge that it is not possible to set aside their own beliefs and perspective, they endeavour to 'bracket' their own values and existing theory through self-reflection allowing them to more adequately 'understand and represent' the experiences of their participants than would otherwise be possible (Elliott *et al,* 1999). The remainder of this thesis requires a change in tense. Traditionally academic articles are written in third person, as has this until now. However the epistemological position of IPA, as with other qualitative methodologies, requires qualitative researchers own their own perspectives (Elliott *et al,* 2009). The use of first person allows transparency in doing so, and will be used where required throughout the remainder of the thesis.

I am a 27 year-old White British female who grew up in a largely White British, working/middle class outer London suburb and has worked in psychology for five years. My experiences through Clinical Psychology training and previous employment in conjunction with my personal values and experience have lead me to favour social constructionist, constructivist and narrative ideas in research and clinical practice.

My interest in working with people from non-Western backgrounds, in particular refugees and asylum seekers and victims of torture and trauma developed during

my two and a half years working as a Primary Care Mental Health Worker in a very multi-cultural and socially deprived area of North London. Working as a mental health worker within medical centres led me to become a mental health 'problem-solver' for GPs who did not have the time or knowledge of resources to find appropriate support for more complex cases. Many of these cases that came to my attention were refugees and asylum seekers. Until this time my knowledge of refugees and asylum seekers was extremely limited, yet as I began to learn about people's experiences, I wondered why I had not heard anything close to these stories before. I became increasingly aware of the disparity between the portrayal of this population in the media and the stories I heard from the people sat in a chair opposite. I became professionally and politically interested in working with this population, joining steering groups and special interest groups and became increasingly frustrated by the lack of both understanding of and resources to meet the needs of this population.

As well as an interest working with refugees and asylum seekers I became interested in the complexities of engaging and working with 'black and minority ethnic' communities and non-English speaking clients, and the experience of working with interpreters. The resistance and negativity to undertaking research with non-English speaking participants has been a source of frustration to me and I fought hard to get this research project off the ground. Having undertaken my training in clinical psychology in a less diverse area my interest in working with, and commitment to giving voice to, marginalised populations has remained with me, and my choice of research has enabled me to continue to cultivate this interest.

During my clinical training I have not undertaken any trauma therapy with refugees and am relatively inexperienced in working with traumatised individuals from any background. This has allowed me to stay very close to the individuals' experience without my own views or understanding of the process of trauma therapy influencing my interpretations. However in my previous work with refugees one of my roles was helping refugees to access therapy where needed.

Through this experience I witnessed firsthand that therapy can be – contrary to the views of some organisations and services – very useful for traumatised refugees even when they have unstable and/ or poor social circumstances and that support managing the trauma sequelae helped some to bear the uncertainty of possible deportation and homelessness when previously they had felt suicidal. I therefore approached this work with the belief that trauma therapy can be useful for refugees, but also open to the likelihood that therapy will not be useful to everyone. My main position was one of curiosity: if trauma therapy was helpful for the refugees in the study, why and how is it so, and if it is not helpful, why and what could help?

4. Results

This chapter presents the results of an interpretative phenomenological analysis of six refugees' experiences of psychological therapy for trauma. Six key themes emerged to form the basis for analysis:

- Therapy as a light in a dark place
- Rebuilding a shattered sense of self
- A changing relationship with the world and others
- Escaping the past to pursue a future
- A journey from sceptic to convert
- From an unknown mystery to a known mystery

These master themes and the subthemes contributing to them are summarised in Table 1 below:

Therapy as a light in a dark place	*Therapy a lifesaver*
	Needing an expert
	Therapy alone is not enough
	The problem with improving
Rebuilding a shattered sense of self	*Becoming more than the trauma: negotiating an identity*
	Ridding self of a burden
	From weak and broken to finding strength
A changing relationship with the world and others	*Reconnecting with others*
	Feeling safer in an unsafe world
	The relief of someone to 'talk it out' with
Escaping the past to pursue a future	*Trapped & powerless vs. empowered & freer*
	Therapist as navigator to future
	The freedom of finding different perspectives
A journey from sceptic to convert	*Finding a reason to engage...and stay*
	Gaining faith in therapy & therapist
	Overcoming difficulty talking
From an unknown mystery to a known mystery	*Stepping into the unknown...and staying there*
	The inexplicable nature of change
	A difficult relationship to define

Table 2.

The master themes and contributing subthemes will be expanded into a written narrative in the remainder of the chapter. This chapter offers one possible account of how refugees experience trauma therapy.

Whilst keen to avoid psychiatric and psychological jargon and remain as close to individual experience as possible, to ensure clarity for the reader I have used the term 'trauma' in the following section as shorthand to refer to the various traumatic experiences participants have been through and 'symptoms' as shorthand to refer to the fear, anxiety, flashbacks and other difficulties experienced by the participants related to their traumatic experiences.

In quotations, repeated words and utterances such as 'erm' have been omitted for ease of reading unless relevant to interpretation and anything that could potentially identify participants has been omitted, as have therapist's names. Significant pauses are indicated using dots, for example '...' would indicate a three second pause.

4.1. Therapy as a light in a dark place

All participants described feeling at rock bottom prior to therapy, feeling overwhelmed, exhausted and hopeless, unable to cope with their symptoms any longer. They found their engagement with therapy as a light in this dark place, giving them hope and, in some cases a reason to keep going. However this brought with it difficulties and frustrations; with participants investing so much hope in their therapists there was disappointment when they were unable to fix the complex array of psychological and social problems participants were facing.

4.1.1. Therapy a lifesaver
Three of the participants experienced therapy as having saved their lives:

> *(Interpreter) before I'm coming to therapy I was thinking about the [...] other world and I was thinking how can I just umm just comfort myself what can I do to something for myself it looks like that he's been thinking about as he says has been thinking about how he can suicide or something like that (Halim)*

115

Halim's experience prior to therapy was of feeling so desperate and devoid of resources that the only way he could think of to comfort himself was to commit suicide. Whilst Halim was open about this, Nasser alluded to feeling suicidal at the start of therapy:

> *with the group you come you meet same person have the same history you just feeling it's not just me who have this kind of problem and so many other people have that and they still alive (Nasser)*

Joining the group brought the realisation for Nasser that other people could live with similar problems to him, and therefore that he could too. Akil's experience of therapy as a lifesaver was slightly different:

> *if I hadn't received help probably I would end up becoming a something like serial killer [...] the possibility I get without receiving help from PTSD I would become a a criminal a negative person uh I would end up uh uh harming others myself and uh uh I would get lost (Akil)*

Akil's account tells us he attributes therapy as having saved not just his own life from suicide or criminality and prison, but potentially the lives of others. Akil's struggle for words hints that it is too unbearable for him to think about what his life could have been had he not had therapy.

4.1.2. Needing an expert

Several participants expressed their need to hand over control and responsibility to the experts, having run out of options themselves:

> *I was coming there because I want…I was think maybe that he going to that coming here going to be this other another person*

> *a second chance for me to another effort for me to avoid all*
> *those things (Nasser)*

From Nasser's previous account of feeling suicidal, his description of the therapist as holding a second chance tells us he was almost literally placing his life in the therapist's hands. For some, a need for an expert to help them transcended any other requirement:

> *(Interpreter) it doesn't matter to me actually it if it would be [own*
> *nationality] or English or whatever as long as they helping me*
> *with how can I getting on with my life and just give me some*
> *calm in the session and how to you know how to try and just*
> *getting on with my life again (Halim)*

Halim's account tells us of his sense of being passively involved in therapy, receiving help but with nothing to bring to the process. This creates a frustration for him when he feels he is not moving forward, feeling that this is his only hope and the therapist should be able to do more to help:

> *(Interpreter) he says who whatever they say about my life to me*
> *and guiding me is good but I don't have any more option that*
> *they can you know that they can which can effect on me or in*
> *my life I think it's for them to find out how is he says I think it's*
> *for them to find out how what is better for patient (Halim)*

For Halim, the 'experts' are not expert enough, but yet his need for one keeps him feeling dependent on his therapist:

> *(Interpreter) I would like to be on my two feets and not all the*
> *time just depending on the others but I try I couldn't be*
> *independent yet but I try my best (Halim)*

The need for an expert kept participants engaged in therapy, even when they doubted its usefulness:

> *Laura: so I was going to ask what was it that kept you coming back at that beginning stage when you thought that this wasn't particularly helpful*
> *Zaid: (Interpreter) I was believing that as a professional that he will have some idea about my problems and he will suggest something and I was coming*

4.1.3. Therapy alone is not enough

For three of the participants, therapy was not enough to address the severity and range of their difficulties.

> *(Interpreter) if the social issues could be part of the solution as well they are part of the problem and they should part of the solution (Zaid)*

Zaid's account shows his frustration at his isolation and the inability of therapy or therapist to change this. However despite its shortcomings, he seems to position therapy as the one thing helping him to tolerate an intolerable situation:

> *(Interpreter) I am feeling more better now since I start the therapy at worst I'm still lonely I still feel lonely and isolated at times but I can manage the feeling of loneliness and er all the therapy has helped me to cope with this loneliness (Zaid)*

Zaid's experience was of therapy being unable to touch the 'worst' of his problems, the loneliness, but he reasoned that it at least helped him feel more able to manage it.

Nasser's account indicates his frustration at learning skills to manage his temper and then returning home to a situation where doing so is futile:

> *[you] get to the hospital and was talking about how to avoid all that how to keep your temper and how to trying to forget about all those things you talk in the hospital and when you finish your talk then you are at home its an environment where you live with the person who is smoking drug the person who is violent the person who is trouble you know..then what's the point (Nasser)*

While participants described their need for social changes and support as well as therapy, their continued engagement suggests it was still worthwhile:

> *he didn't have a solution for the problem but the person was nice and the way he was working I feel comfortable to share [...] and that was what my feeling that's reason you just coming to share with someone who care about you..(Nasser)*

Nasser's relationship with his therapist, and feeling cared for was enough to keep him returning to therapy and it seemed that his experience of his therapist caring for him mediated the effect of the frustration he felt.

Akil's account of his experience of therapy was the opposite to Halim, Zaid and Nasser's. For Akil therapy was everything, and brought the other aspects of life he was missing to him:

> *when I say PTSD[1] gave me time they gave me my normal life back I have a normal life now I've started volunteer work and I'm enjoying the volunteer work and I'm beginning to feel happy again uh [laughs] (Akil)*

---

[1] Akil used the term 'PTSD' to refer to trauma therapy and his therapist as well as the diagnosis.

4.1.4. The problem with improving

For several interviewees, change and improvement was bittersweet. For two the progress they made led to some grief and regret for the time they had lost feeling a particular way:

> *Laura: and you look quite pleased with yourself that you've done it* [shared the story of her traumatic experience]*...*
> *Ana: yeah really...but now I wished I would done it before*
>
> *I was very emotional. Why? Because I had more than a decade of it suffering for a very simple thing, the way you looked at it and with a few sentences he changed the angle of looking at the situation and the relief was like I've been carrying tons of stones and uh just drop them and feeling very light and uh all you feel is left is just [laughs] a muscular pain of this uh carrying the things something like that (Akil)*

As well as regretting she had not fully engaged in therapy before, at the time of interview Ana had just finished therapy and was mourning the loss that came hand in hand with her improvement and progress:

> *...in one way I was happy cause oh I'm ending because I feel better but in one way I still feel like oh...maybe I feel better because I've got her if I don't have her maybe I...I will not feel like this but you never know you have to try and...you have to end some days...(Ana)*

Halim gave contradictory accounts about the progress he had made. Whilst some of this may be a reflection of his own internal state, I also interpreted this as reflecting an underlying anxiety that progress may lead to the withdrawal of therapy and, despite reassurances of my independence from therapy, a concern that I may have some influence:

Laura: is there anything that stands out in your mind as being particularly helpful that you've done while you've been in therapy

Halim: (Interpreter) yeah actually the particular things is that I stop to thinking about the harming myself or stop that [...] I'm going out stopping [...] in the middle of night I stop that actually

Laura: sure so that's obviously really helpful for you

Halim: (Interpreter) ok even now sometimes yeah I'm going just I'm going out and I don't I don't know that I'm going where I'm going or what I'm doing when I come back I realise that I've been out and yeah it's it's this is get a little bit less it didn't stop but it get a little less

4.2. Rebuilding a shattered sense of self

This theme aims to encapsulate the struggles of all the participants to rediscover or rebuild a sense of self they had lost through their traumatic experiences and their sequelae. Prior to therapy, participants described themselves only in terms of their trauma and the suffering they were experiencing as a result. They experienced therapy as a means through which they began to rediscover other parts of themselves, with the therapist playing an integral role in guiding them to thinking about the people they had been before the trauma, the strength and resilience they had shown in the face of the traumatic experiences and the people they could be in the future. The experience was common across all interviewees, however the extent to which they felt they had rebuilt a solid sense of self varied greatly between participants.

4.2.1. Becoming more than the trauma: negotiating an identity

This theme illustrates participants' experience of becoming, or starting to become, people made up of more than just their traumatic experiences, something they began to negotiate through therapy.

Some described this as a restorative process whereby therapy helped them to return back to their 'normal', pre-trauma self:

> *the talking therapy I have had with [therapist] has helped me to get over my past experience and to go back to normal and to er accept and also I take medication as well and all the talking therapy plus the medication has changed my life for the best (Zaid)*

> *(Interpreter) she feel it very the therapy was very good for her because now it made her like she someone like her before bad things happened to her um she feel like a normal person now (Mimi)*

At face value, Mimi and Zaid both describe a simplistic sense of returning to their pre-trauma selves through therapy. However, both seem to be alluding to there being more to the process than this, with Zaid trying to add something to his description of 'getting over' and 'going back to normal' with 'er, accept', but then swiftly moving to medication which is a far more tangible concept, and Mimi struggling to describe the process of her changing identity 'it made her like she someone um like her before'. Both give the impression of some awareness of a greater complexity to the process than their description, but a lack of language to describe it, settling on constructing their experience as returning to normal.

The key experience for Nasser in negotiating a new identity was of rediscovering the person he was before the traumatic experiences and remembering the good past:

> *just to speak about the bad thing and to speak I was talking about the..the time before all those things and I was feeling good from that feeling good talking and remember and*

remember about that time and compare about that the time I
was going through..all those things..(Nasser)

For Nasser, as for others, the trauma seems to have overwritten the past before the trauma. Remembering his pre-trauma past enabled him to think about himself in a more positive light, 'I was feeling good' and helped him to widen his construct of self to a more holistic one incorporating all his experiences, good and bad.

For all but one of the participants, the journey of establishing an identity beyond their trauma was one that was as yet incomplete:

I feel like...it was...it wasn't my fault what has been happened and
maybe other people have bad experience like me (Ana)

because of what's happening to me she didn't say that I'm...I'm
bad person or..she didn't say that it was about me why this
happened or...you know it's just...she just listen and really at the
end [of therapy] she's just saying good things about me that I was
like oh my god am I really like this or [laughs]..she just trying to
make me happy [laughs] (Ana)

While Ana has come some way to negotiating a new identity, experiencing a huge shift from her view of herself as a 'bad person', feeling ashamed and to blame for her experiences, she does not yet seem to completely believe she is a good person. That said, her pleasure at recalling what the therapist had said about her shows her desire to hold onto this different view of self. Her laughter also gave the sense of her being embarrassed to tell me what the therapist thought of her and she may have underplayed her changing sense of self. I was also struck by how important the therapist's view of Ana was to her, and it seemed that the therapist's positive view of her meant she felt it was acceptable for her to begin to consider this alternative identity.

Akil's experience of negotiating an identity was not just an internal process through therapy, but a process of having to prove to the team responsible for his care that there was more to him than the symptoms of the trauma; a negotiation in the most literal sense:

> *I was becoming a prisoner and I didn't deserve and I think there became two group one group was trying to keep me and they were the picture they had was someone been trained to kill and now having a breakdown it's not a good idea to let him walk in the street and well they had their reasons for that and they were trying to send me to this medium security place and there was another group was PTSD they believe they can help and my social worker care coordinator and they believe there is a hope we can he's not that violent he has something to say there is a problem there is a background here we have to look at and he's decided to talk so give him time and PTSD gave me that time (Akil)*

Akil was aware of being seen only in terms of the risk he presented by the team, not as a person or someone with PTSD, whereas his therapist saw beyond the risk to the individual and the possibility of the problems being caused by PTSD. Of all the participants, Akil describes the greatest struggle prior to therapy with his identity:

> *I've become a they think I'm a dangerous person and a danger to myself or the others that was what they were telling me that was the reason behind the section me going to section and uh I felt like a victim like uh someone uh a criminal being (Akil)*

Akil's account shows the difficulty he was having with his identity, moving from describing himself as a dangerous person, then a victim and then a criminal in his

attempts to define himself. 'I've become a, they think I'm a' indicates the influence of the wider system on his sense of self.

Akil was the only participant who described the experience of involvement with the trauma service contributing further to a struggle with his identity:

> *what picture are they gonna have of me you know when they*
> *well he's in contact with PTSD and he's getting help and PTSD*
> *is a place that you need help if you're affected by trauma by let's*
> *put it this way something scary and doesn't that make you like a*
> *scary cat or something [...] you don't want to produce something*
> *that position you don't want to see yourself like that (Akil)*

Akil experienced his identity as a soldier and a survivor threatened by his involvement in trauma-therapy and had difficulty considering he could have been affected by his experiences. Needing help changed the way he saw himself from a survivor to a 'scaredy cat'. I also wondered whether his misquotation of the phrase 'scary cat' further reflected his struggle to place himself as aggressor or victim. I make this interpretation tentatively as English is not his first language, however also acknowledging his subjectively exceptional level of English with few, if any other incorrect usage of words throughout the interview.

Despite having the greatest struggle negotiating his identity, Akil also gives the strongest account of a change of identity through therapy:

> *I think I'm deeply happy these days and I'm beginning to it's like*
> *being born again and what gave me that feeling is the main part*
> *of it I believe it was PTSD (Akil)*

I interpreted the powerful use of 'born again' as Akil having a strong sense of having become a whole new person through the process of therapy, in contrast with the experience of others of returning to a former self. This may reflect his traumatic experiences having begun at an early age and continuing for many

years and therefore not having a former adult self to return to, but also of his having completed all phases of therapy and experiencing this as life changing.

4.2.2. Ridding self of a burden

A key theme that emerged from interviewees' experiences of attempting to re-establish a sense of self was the importance of being able to relieve themselves of the burden of their experience through therapy. Some descriptions gave the sense of therapy functioning as a receptacle into which to deposit their burden:

> *Laura: was there anything you found unhelpful about therapy or*
> *that you would have liked to be different?*
>
> *Nasser:..I think it was sometimes the hour was too long*
>
> *Laura: the hour was too long?*
>
> *Nasser: yeah and sometimes I don't want to keep saying keep*
> *saying you know I want just to come sometimes I want just to*
> *have the session for ten minute and it was like the time for me*
> *to come and s..say something and do something else and go*
> *and do something else not to come and focus on it you know it*
> *was no point to focus on the thing you know you don't want to*
> *you want to forget*

Being able to unburden himself was such an important function of therapy for Nasser, but sometimes it was all he wanted to do, highlighting a conflict between the need to share yet avoid aspects of his trauma story. Several participants experienced feelings of lightness and relief after sharing the story of what they had been through:

> *...it's like you're taking off something you've carried for so long*
> *and you just want to get rid of that and...and then you feel like*
> *oh I'm rela...not relaxed but okay I'm taking this away so...you*
> *feel a bit...[flops back into chair] (Ana)*

Ana experienced a very strong sense of relief after sharing her story.

It seemed that whilst participants were the sole keeper of their story, this kept them stuck in the traumatic past with the shame that they felt about what happened to them. Nasser expressed this more overtly in his account:

> *I was with someone and can just say whatever I want and you know because I..and as I can be….[barely audible] I'm not ashamed (Nasser)*

Whilst none of the participants were able to explain exactly why they felt the relief at sharing their story, Nasser gives an indication that it allowed him to feel less ashamed, and I interpreted the general experience as being one of no longer having a 'shameful' secret to carry alone, allowing them more space and freedom to begin thinking about other aspects of their identity.

4.2.3. Finding strength

All participants described themselves as weak, abnormal and faulty in some way and experiencing a great number of symptoms at the start of therapy. They experienced a gradual move to finding varying degrees of strength and a reduction in their symptoms during the course of therapy.

> *I didn't want to let other people know what my life was...or you know this makes me like uh what are they gonna think about or...it just...I didn't want this (Ana)*

> *(Interpreter) she say at the beginning she always feel tired she couldn't sleep she always scared it's her feeling it like something she cried a lot she cried all day she feeling scared she couldn't do anything couldn't concentrate on anything (Mimi)*

These excerpts from Ana and Mimi show the extent to which they felt faulty in some way: Ana giving us a sense of her feeling abnormal or faulty and very

ashamed, whereas Mimi describes more a sense of feeling weakened by her range of symptoms. Both accounts tell us they experience themselves as having moved away from that earlier position.

Ana experienced aspects of therapy as further confirmation of the severity of her abnormality:

> *well I thought what was this machine [used for EMDR] I always think when some... something's new I have to use or for these kind of things and I was saying oh my god am I so bad that I have to go through this one or...this makes me feel that oh my god that I am really bad [laughs] like how I feel (Ana)*

Despite the rationale for using EMDR being explained to Ana, she interpreted the need for the use of this technique as an illustration of just how broken or faulty she was.

Akil found engaging in trauma therapy in the first place an indication of how weak he was at the point of engagement – had he not been so weak, he would not have accepted help from a therapist:

> *[the term trauma] carries over a sense of weakness uh trauma, you go through trauma and you need help [...] personally I expected that I gave up when I was on my knees I just broke down I was very tired just I didn't even know if it was day or night I just I just completely lost it it was a time I opened the door for person from PTSD to come across if I had the strength to shut the door I would shut the door* (Akil)

Participants had differing experiences of their journey towards trying to find strength. Ana found strength through being able to share the full story of her

traumatic experiences, something she had not been able to do in previous therapy:

> *Ana: All these things happened to me...I mean I didn't tell anyone...and I wasn't thinking telling the therapist everything with details and...when I didn't expect to do...from myself I...I would...I did...I don't know I didn't think I was gonna do it but then really I'm...I'm surprised that how I did it cause just one day you're saying one thing the day after one other thing and after...and when you end up you're saying oh my god I've told them everything and...[gestures]*
> *Laura: there's nothing left?*
> *Ana: yeah [laughs] e...even I don't understand how did I do it just...I don't know*
> *Laura: and you look quite pleased with yourself that you've done it...*
> *Interviewee: yeah*
> *Laura:..is...is that what it feels like*
> *Ana: yeah really uh...but now I wished I would done it before*

Ana's struggle to find the words to describe what she had achieved indicates that she recognises the strength she has gained, but experiences it as still shaky, unable to quite believe what she has achieved, reiterated by her statement *'e...even I don't understand how did I do it just...I don't know'*. The importance of the therapist's view in helping her feel stronger is illustrated in Ana's discussion of the 'ending letter' written to her by her therapist:

> *I think I will keep that letter for every...every time that I'll feel like...you know because the life is gonna be up and down you never know and I always gonna remind that letter keep it somewhere read it when I...when I need so it will give me the*

[short pause] the security or...I don't know [laughs] like to...to
believe in myself that what she's saying is really...maybe
it's...it's gonna help me in the future [laughs] (Ana)

Despite still being uncertain about her gained strength, Ana's account conveys a sense of achievement, that it is something that she has accomplished and comes from within. Halim's experience was of gaining strength through the therapist and other professionals, that the increased strength was not something he could have ownership of yet:

(Interpreter) when I'm under a lot of pressure and I'm suffering a
lot I'm thinking about how to kill myself or something like that
but when I'm remember what the doctor says this give me calm
this make me comfortable (Halim)

Mimi's experience contrasts with that of Halim, as she is able to take ownership of her new found strength, encouraging herself.

(Interpreter) she say the most important thing that she says she
had to tell herself that she have to try her best try to um forgot
all the bad things happened to her and accept it so the most
important she had to always keep telling her try her best for her
and for her daughter she had to do that (Mimi)

The following account from Nasser beautifully encapsulates not only this subtheme, but also the essence of the whole master theme:

the time that was spent here it was the time that err you know I
could stay somewhere [...] was you know I think for me it was
just I think to build something but on the um inside (Nasser)

Nasser's language in this account evokes the image of scaffolding, which in combination of his analogous use of 'building' on the inside tells us that his

experience of therapy was of having a longer term place to reinforce and rebuild a sense of himself and gradually gain stability and strength.

4.3. A Changing Relationship with the World and Others

In addition to a changing relationship with their selves, in their journey through therapy participants also experienced changing relationships with other people and the world around them. For many this was a journey from feeling isolated, disconnected from and mistrusting of others and unsafe engaging in the outside world, to reconnecting in some way and feeling safer.

4.3.1. Feeling safer in an unsafe world

Several participants reflected on how differently they had felt previously in their interactions with others or in conducting their day to day lives:

> *[therapy] changed a lot to me cause you...you always I mean before that I mean I always...even something happy was happening to me I am always...uh timid or scared that maybe something happened or...you know even the happy moments you can't enjoy them because you think something would happen and break this moment and...I don't know (Ana)*

Ana's experience had been of a general sense of unease and insecurity in the world around her. Her use of 'something' rather than 'someone' and the vagueness of her account give the sense of her anticipating an unknown threat.

For Akil the threat came from within, both from the intensity and predictability of his panic attacks which therapy helped him feel safer from:

having this information [biological explanation of panic] every week I was getting it was a big part of you know affecting my daily life because I was coping with panic attacks much better I knew it's not as scary and as bad as it looks it's just a chemical thing just stay away from the just go to your room get home as soon as you can and make yourself relax (Akil)

And also through his experience of feeling unsafe in his own ability to manage difficulties in an unpredictable world:

I used to lose my temper easily for instance just receptionist in a doctors surgery in a office housing office or was not keep me waiting for five minutes and end to have disaster and I was reporting these things [to therapist] and I remember during last two or three years I've been in contact with [therapist] each week he listens to the story of us and also he gives me some sort of tactics to deal with the daily situation (Akil)

His powerful use of the word 'disaster' gives a strong sense of the extent to which Akil felt he was unsafe in the world around him. In contrast to Akil, Nasser's experience of feeling unsafe came from others around him:

I don't want to approach no one for me everyone was you know like negative I don't know and I would just think about the experience I was going through everyone was the same and coming to the session was like the I'm not it's not going to compare every other person as the person who was responsible for my experience (Nasser)

Prior to therapy, Nasser experienced other people as unsafe, likening all others to the people responsible for his traumatic experiences. While participants felt

unsafe for differing reasons, a commonality was of their experience of the process of therapy enabling them to feel safer in the world around them.

4.3.2. The relief of someone to 'talk it out' with

All participants experienced the process of starting to talk difficult, painful and at times traumatic, something that is discussed in more detail in other themes. Despite this initial difficulty, most of the participants experienced finding someone with whom they could share their story and talk about their problems a huge relief, allowing them some respite from being alone with their pain and difficulties.

Some experienced therapy as a relief from physical isolation and its impact of being 'trapped' alone with only their minds for company:

> *I was just at home and when you're at home all the time this in*
> *your mind you know sometimes you want to do some..don't*
> *have no one to talk to and you need to you got something and*
> *you need to just need to push that thing out you know and the*
> *only thing to push that thing out is to talk (Nasser)*

In the context of other parts of his interview, I interpreted Nasser's swift move from 'you want to do some..' to 'don't have no one to talk to' as a fleeting hint of his experience of feeling suicidal and the thing he wanted to 'push out' was that feeling. It seems for Nasser the relief of talking was such that it allowed him to stay alive. For others the experience of relief was more subtle:

> *by talking by sharing the problem like you feel a bit on ease*
> *although when you go back to home you still have the problems*
> *but by coming here I was unloading all my problems it's good*
> *(Zaid)*

Zaid conveys the sense of his experience being relieving to some degree, but that this relief was limited by his stagnant social situation. For Ana, who was less socially isolated, her relief came from finding someone she could share the full story of her traumatic experiences with:

> *for me it was good talking to her and take all my feeling out share it with her and then I don't feel that I'm..I'm on my own..or I don't know now I've got someone that I can share my bad things and...and really that helped me (Ana)*

Her experience of relief seemed to be due to finding someone with whom she could share her whole self, 'bad things' included, highlighting how isolated she had felt before, despite being less physically isolated than other participants having referred to friends at various points in the interview. Having someone she felt listened but did not judge her was important:

> *she didn't say that it was about me why this happened or...you know it's just...she just listen (Ana)*

The relief for some participants came from feeling understood:

> *you have this feeling that you're you're [sighs] alone and you're alien completely alien and my therapist [...] he gave me that feeling that he understands and he was understanding not pretending not I had this belief that he understands and that gave me this ability to talk (Akil)*

His choice of the world 'alien' tells us that Akil's experience was of feeling like an outsider, misunderstood by those around him and his relief came from finding in

his therapist someone who - because of a similar background - understood him, both linguistically and culturally; someone he could identify as a fellow alien.

In contrast to the experience of other interviewees, Halim described no sense of relief at having someone to share his story with during his interview, only how traumatic he found sessions in the early phase of therapy. I interpreted this as reflecting that the relief was only possible in hindsight once participants felt more stable. Through both the analysis of his transcript and my experience of interviewing Halim, it was apparent that he was experiencing the greatest struggle in his day-to-day life and as a result of this he was not in a position to reflect on therapy from a more 'observer perspective' as others did.

4.3.3. Reconnecting with others

All interviewees experienced themselves as being disconnected from others:

> (Interpreter) I would like to actually I would like to be like other people other normal people and umm but I'm under lots of pressure and I'm suffering a lot (Halim)

> ...for the people friends or family you've got around you feel you're hiding something from them and [...] it's like your relationship with your friends or..[...]..you are always scared from...from something or...if they find out if they found out that...and what are they gonna be like maybe they don't like to be your friend anymore or...(Ana)

Halim's experience was of the pressure and suffering he felt keeping him from being like others. His use of present tense indicates he still feels disconnected from others, feeling faulty whilst others are 'normal'. Ana's experience was of feeling disconnected through the shame she felt about her experiences, and the

fear of rejection and judgement if people found out about what had happened to her.

Akil's experience was of being disconnected from the Western world, both physically and through language and cultural barriers, as well as through the inaccurate portrayal of his experiences in the Western media and the subsequent feeling that Western people would have no understanding of his experiences:

> *I was in a situation that uh well everybody was trying to avoid having contact with me (Akil)*

> *I have five years of guerrilla fighting in [country] and he's from [same country] and so he had an understanding from the situation and that was the biggest help it gave me that feeling speaking to somebody first of all he's speaking my language so he's not coming from he's not I'm not trying to be disrespectful to the western all they know about war is from TV and movies they see of Hollywood and that's something like compared to the reality we have seen it's like reading a comic book (Akil)*

Akil's account tells us that he did not find himself connected with 'the western' through therapy; I interpreted his following statement as Akil's identification of me as part of the Western world that he was still experiencing being misunderstood by:

> *you expect the person the survivor to be happy right away but you have no idea (Akil)*

However, his disconnection moved from a frustrated one to a more contented disconnection, whereby he felt that he had something more than others around him:

I believe these days I can enjoy my life more than any of these
celebrity lucky celebrities you see (Akil)

For some participants, their connection with the therapist was the catalyst for a changing relationship with others:

I don't know how her opinion is and things like that it doesn't
mean that it's very big problem for other people and...I don't
know (Ana)

Ana's relationship with her therapist and the therapist's reaction when she disclosed the details of her experiences served as a means for her to reconsider how other people may react to her, and subsequently feel more connected to those around her:

I feel like...it was...it wasn't my fault what has been happened
and maybe other people have bad experience like me maybe
not the same but I mean you never know how other people's life
(Ana)

Several participants also experienced the psychoeducation group as a means through which to reconnect with others:

with the group you come you meet same person have the same
history you just feeling it's not just me who have this kind of
problem (Nasser)

Nasser's realisation that there were other people who were having similar problems to him indicates how alone he felt with his problems prior to joining. However for Nasser and Zaid, their ability to reconnect with others was limited because of the isolation they were experiencing:

tell me as why should be comfortable that mean in community
and they just forgot about me (Nasser)

Nasser's account gives us a sense of his frustration at having been discarded and forgotten in the community by the system, with 'why should be comfortable' perhaps hinting at an underlying anger that the therapist has also 'forgotten' about his situation.

Both Zaid and Nasser found therapy had helped them acquire the greater sense of safety and stability they required to enable them to reconnect with others, but their social situation meant they remained isolated and disconnected:

you can't be with the person with the rude and violent person
yeah get to the hospital and was talking about how to avoid all
that how to keep your temper and how to trying to forget about
all those things you talk in the hospital and when you finish your
talk then you are at home it's an environment where you live
with the person who is smoking drug the person who is violent
the person who is trouble you know..then what's the point
(Nasser)

Nasser's experience was of learning to keep his temper in therapy but then returning to a situation where it was not only difficult to maintain, but also necessary to protect himself at times. I interpreted Nasser's use of 'what's the point' as indicating a feeling of therapy being futile given his poor environment, and his only option to reconnect with others in his immediate environment would be to join with those he describes as 'trouble'. Zaid's account tells us that reconnecting with others was the one thing therapy was unable to help him with:

(Interpreter) it was helping me the therapy but that problem was
not solving at all completely because I still have to go to be on
my own and feeling isolated (Zaid)

4.4. Escaping the past to pursue a future

A common experience for all participants was of feeling in some way trapped either within their traumatic past or because of it. They were engaged in a struggle to escape or avoid this past in order to move forward and find a future for themselves or their children. Finding a future, or a better future, was a key role of therapy for all participants as by the time they had arrived at therapy most felt a future was out of their reach, feeling stuck, hopeless and - for some - suicidal. Most experienced their therapists as playing a key role in helping to direct them towards a future when they were unable to find one themselves. Gaining a better understanding of, and the skills to manage, their symptoms as well as looking at their beliefs about their traumatic experiences further aided participants in moving away from the past and towards a future.

4.4.1. Trapped & powerless vs. empowered & freer

Most participants experienced feeling trapped and powerless at the start of therapy. For most the experience was of being trapped within themselves, as if they were being held hostage in their own mind by their traumatic experiences:

> *I can't do it anymore I can't just stand and thinking about what's happened to me cause this doesn't take me anywhere (Ana)*

Halim's experience was of being trapped with a mind and body he felt little control over:

> *(interpreter) at the beginning of the sessions I was for example*
> *in the middle of my I was just walking out of the my place and I*
> *didn't know where I'm going to go or what I'm doing so but now*
> *it's get better I don't have that kind of bad experience any more*
> *(Halim)*

Halim's account suggests the powerlessness he felt over himself, his aimless wandering giving the impression he was trying to find an escape. Mimi gives a further sense of being trapped and powerless, knowing why she was experiencing her difficulties but at the mercy of them, unable to find a way to escape:

> *(Interpreter) she know that [her difficulties were] because of [...]*
> *bad things happened in her past yeah but before the therapy*
> *she didn't know how to try come out of it to escape from it*
> *(Mimi)*

Some participants came to therapy actively seeking an escape from the impact of the past:

> *for me I want I just start going because need to or want to avoid*
> *that these feelings hitting so then they told me that yeah this is*
> *another way to we go and we try to avoid this these feelings for*
> *me it was fair enough (Nasser)*

In contrast to other participants who felt trapped and powerless within themselves, Akil was more literally trapped and powerless at the start of his therapy:

> *I've become a they think I'm a dangerous person and a danger*
> *to myself or the others that was what they were telling me that*
> *was the reason behind the section me going to section and I felt*
> *like a victim like someone a criminal being just being under*
> *custody (Akil)*

Akil's use of the word 'victim' emphasises how powerless he felt, particularly in contrast to the wider system's view of him as dangerous. As well as being

physically trapped and powerless, Akil was trapped by language and a lack of knowledge held – both by himself and by those responsible for his care – about the impact of his experiences on his functioning:

> *I had this problem at the time I couldn't speak and no one could understand me no one could understand the situation and I didn't speak about war or my experiences of horror in the past that's the only word I can use for it and we didn't know the problems of I was did experiencing are related to my previous experiences and I have no idea (Akil)*

Akil's language gives the impression of him being completely silenced, mute. Not being able to speak to others and not having any understanding of the link between his past experience and present difficulties kept him trapped.

Through the course of therapy, participants experienced a sense of feeling less trapped by their past and observed an improvement in their functioning:

> *I can see the difference how it is...I don't think of that anymore I mean you can think but not on the way that you...you used to it...it doesn't hurt so much anymore when you think about this...so...I mean even think then...even you think sometime it doesn't hurt you so much it doesn't...I don't know doesn't get me upset so much anymore and this is good (Ana)*

Ana's struggle to describe the change, moving from explaining she was not thinking of the trauma to thinking of it but not experiencing it as painful, gives the impression of her experience being of an intangible change observable in retrospect. As with many of the participants, it seems the past has lost its power over her in terms of the pain it can inflict and has freed her to engage more with the present. Halim also gives a vague account of the change:

(Interpreter) my past is comes to my mind again anyway it comes but I try not to engage with it totally then yeah of course I'm thinking about future mostly but yeah it takes me to the remind me to the past well of course (Halim)

Halim's experience seemed to be of feeling more distant from the past, able to attempt not to think about it and orient himself to thinking of the future. Some experienced gaining both an understanding as well as some control over their symptoms as a key part of the transition from feeling trapped and powerless:

having this information every week I was getting it was a big part of you know affecting my daily life because I was coping with uh panic attacks much better I knew it's not as scary and as bad as it looks it's just a chemical thing (Akil)

(Interpreter) she said that the most important that [the therapist] teach her that she asked her what she liked the most and she says the sea and so she say when she feeling scared to try to imagine close her eye imagine you in the sea in front of the sea and walk around the sea and what you like to do at the seaside and she say she likes swim so she say that imagine that you swimming so try to do that every time if you feeling scared or like try to imagine this make you feel happy so and a happy thing..(Mimi)

Several participants experienced accepting the past as pivotal to feeling freer and more able to move forward:

(Interpreter) she say like before when someone ask her about her what happened to her and even think about that she feeling scared and she's cry a lot and she feel depressed but after the therapy when she talked to [her therapist] and she say now she

142

has to accept it because all the thing it already happened to her and it already in the past so she need to accept it it [...]so after she accept it she feeling ok (Mimi)

(Interpreter) she say after the class and after the things [her therapist] teach her she now when she feeling scared she know how to control it how to accept it (Mimi)

For Mimi, accepting the past helped her to be more in control and less trapped and powerless over it despite being paradoxical to her early desperation to avoid the past.

I chose to use the word 'freer' rather than 'free' in the title of this theme to ensure it reflected the reality that only a couple of the participants felt freed, or close to it, through therapy. Participants experienced feeling less trapped and less powerless, but some were still very much trapped by their isolation and lack of support beyond therapy and disempowered by their social situation:

(Interpreter) the problem is when I go back when I finish the session and I feel ok and I learn a bit and this and when I think about going back home to the very isolated place where I see no one I talking to nobody even when starts my journey on the bus that's when I started then thinking about um I'm going to a dark place I'm not going to see anyone (Zaid)

For Zaid, the improvement he felt through therapy would disappear before he got home. His account is likened to going to prison:

(Interpreter) I didn't find anyone who could support me with the housing issues and any professional and it felt like I'm in on a voluntary detention this and I've been detained because you

don't meet anyone and you don't speak to your neighbours
(Zaid)

However for those that did feel freed the effect was profound, and for Akil reflecting on the time prior to therapy felt like revisiting a bad dream that he had subsequently woken from:

when I look at my daily life my feelings my emotions this these days I think...I feel much better than a few years ago uh it's like it's like waking up from a nightmare and then realising it was just a nightmare (Akil)

4.4.2. Therapist as navigator to future

During the course of therapy participants experienced their therapists as guides to the future, reminding them that their pasts were in the past and helping them to consider their future:

(Interpreter) when I'm just coming here and he talking about how can I getting on *with the life its very helpful for me..it's very helpful (Halim)*

Ana's experience seemed to be of her therapist's ongoing encouragement to look forward:

she understand my feeling and she always tried to encourage me for everything like go forwards this happened we leave this...I mean you never forget what...what your life been or...cause everybody's got a past but it's...it's a past so we...we don't have to stuck on the past and not thinking the future (Ana)

This encouragement freed Ana to accept that the past is there, but that accepting it was not incompatible with looking to the future. Nasser was the only participant to describe his therapist as guiding him in the opposite direction; to the person he was before the trauma:

I was coming because sometimes I'm coming here we need to speak about the past need to talk something who can remind you the good er the good experience you have in your life or something like this and..the longer you're by yourself you know you only think about the bad experience didn't think about the good experience (Nasser)

Nasser's description gives the sense of him being trapped with the trauma he had suffered and his need for someone to help free him from the restrictions of this. Despite his experience being the therapist guiding him to remember his pre-trauma experience, the effect seems similar – a reminder that he could be more than his traumatic past.

All participants directly refer to the role of the therapist in assisting this process of reorientation to the future, which suggests that they all feel it is something they could not have done alone.

4.4.3. Freed by finding different perspectives

Two of the participants experienced being freed through a changing view of their traumatic experiences and the beliefs they held about them. Whilst this theme is woven through many of the others, it was so powerful for these participants that it felt important to include it as a specific subtheme.

it was like some parts in me got shot and it was just a painful part of it and I was very emotional why because I had more than a decade of it suffering for a very simple thing the way you looked at it and with a few sentences he changed the angle of looking at the situation and the relief was like I've been carrying tons of stones and just drop them and feeling very light (Akil)

Akil's metaphoric use of 'shot' tells us just how powerful and sudden he found this change of perspective. He experienced 'opening the door' to looking at things another way as fundamental to the huge change he underwent through therapy:

> *Laura: and how do you think the words heal what's the process?*
> *Akil: [...] let's put it this way there are few sides to anything if you look at that any problem for instance there's my side there is your side and there is the right side uh we might never find the truth or the right side but at least the minimum thing you get from this therapy is you can look at things from other side too. When we look at one thing one problem one situation from more than one side we can have a clear picture and many times that can be that can help it can help us to open the windows open the doors to a new idea to a to learn to look at things from a different point of view and uh it's very important to be able to do that*

Ana's feeling that the trauma was her fault or something she deserved, and that she was alone in her experiences changed dramatically through therapy:

> *I mean I feel like it wasn't my fault what has been happened and maybe other people have bad experience like me maybe not the same but I mean you never know how other people's life (Ana)*

She experienced her therapist key to helping her look at things differently, though she maintained a slight suspicion that the therapist may have just been trying to please her:

at the end she's just saying good things about me that I was like
oh my god am I really like this or [laughs]...she just trying to
make me happy [laughs] (Ana)

4.5. A Journey from Sceptic to Convert

All participants were sceptical about therapy at the outset, the reason for which varied depending on the individual. Some were sceptical about the notion of a 'talking therapy', wondering how that could possibly help with their problems. Some were unsure whether the benefits of talking would outweigh the discomfort of engaging with strangers and telling their story and some had to go against their instinct and learned ways of protecting themselves or trying to cope with their problems. Participants described their need to find a reason to put themselves through the trauma of attending therapy. They highlighted the gradual process of gaining trust in their therapist and therapy as a treatment as well as overcoming their difficulty talking about their trauma. Some became great advocates of talking therapy, while for others their conversion was partial and some scepticism remained.

4.5.1. Finding a reason to engage...and stay

For all participants, the support and encouragement of someone else or a reason greater than themselves was fundamental to their engagement. For the two mothers in the group their children gave them reason to take the first steps:

when I had the first appointment to come I said oh my god I was
thinking that oh do I really have to go or maybe I just cancel the
appointment and tell them not to go that is the feeling I had I
mean every time when I think about my children and how to
help them and still I change mind and really I think I find...I

found the point where [...] when I am between what to do and then when I think about them just I decide the right thing (Ana)

Those with the support of a third party found them crucial in overcoming early difficulties with therapy:

Laura: what do you think it would have been like if you hadn't had [support worker] to start with encouraging you to go?
Mimi: (interpreter) she says she wouldn't like she didn't like she wouldn't she still feeling scared like before [...] she say if [support worker] hadn't encouraged her to go then she would not go

I was just furious [when he felt there had been a breach of confidentiality] I said [...] I just tried to just deny everything just leave completely my doctor my GP everything just leave it and keep silent and that's what I told myself you're just you're putting your life in danger again [...] when I talked to my care coordinator about this said this is what's going on and I'm worried it even before that before first session this is happening and he explained to me say no this is not breaking confidentiality that was the reason really repeatedly we ask you if we could contact one of your relatives and we couldn't and that was the only option was left for us and he hasn't done anything wrong he was we were aware of that and I was I was happy (Akil)

Some also found that previously gaining trust in, and being helped by, another professional allowed them to have faith that therapy would also be helpful:

> *Laura: 'cause it sounds like you were very brave and I'm wondering what made you take that step [to attend therapy] if you didn't know what on earth would happen to you?*

> *Mimi: (interpreter) she say before the therapy [support worker] already talk about that a lot and she say she try like she do best for her*

Mimi's account also gives a sense of her engaging through a sense of loyalty and wanting to please her support worker by doing what she had been asked.

For others, sheer exhaustion and a lack of other options lead to their engagement:

> *I came to this point to say well let's try maybe I need help maybe let's put it this way maybe I'm just tired maybe uh I'm too tired and maybe I just need some rest and PTSD is giving me this rest (Akil)*

This account from Akil shows he felt some ownership of his decision to attend therapy, although as he was under section and at risk of being sent to a medium secure unit, he really had little option but to attend.

4.5.2. Gaining faith in therapy & therapist

All participants were mistrustful of either the process of therapy or the therapist at some time. In part this was because they often had little or no understanding of the concept of therapy, and also because of their previous experiences at the hands of others.

Akil had little faith in therapy as something that could help him, conceptualising it as a frivolous luxury:

At the beginning I didn't believe in it in mental health completely I just I found it impossible I found that it's something like just decoration things just something luxury something like how can

I say something like you know some people go to a spa for things (Akil)

Having been struck by the superficiality of western media and celebrity, Akil's account of his beliefs about therapy tell us that he had associated it with this aspect of western culture. Zaid also had little faith in therapy:

(Interpreter) at first I didn't take it seriously because I was coming here and talking and it was like a joke for me and from time to time when the therapy sessions were going and I have start to noticing some change in myself then I thought this therapy thing think it's working actually so (Zaid)

Zaid began to have more faith once he noticed himself changing. Having invested a great deal of hope in therapy, Ana describes a loss of faith when she did not experience change quickly:

I don't know I mean at the beginning when you just speak little things you feel okay then it's...it's...what this therapy kind of like cause I don't feel any change but I mean because you expect something to change and you expect to happen quickly and then you think oh maybe it's not working...but then after a while then...then when you see yourself or when other people see you and you don't feel like what they're thinking anymore and what...what is kind of...and you say okay then maybe something changed...[laughs] (Ana)

Ana's account tells us the change was more gradual and less easily defined than she had thought it would be. Nasser's experience was similar:

> *at the end of the day it was helpful but for me it was its take too long and sometimes I was asking myself like..is..I..I need just to forget about all those therapy and everything and you know go do my way by myself (Nasser)*

Akil lacked faith in therapists in general and what they could offer him:

> *I thought they were far far from reality I thought that their knowledge is limited by their what they read in university and I always believe that there is no magic to learn in university because I studied philosophy in university and I never finished it [laughs] (Akil)*

Whilst Akil joked about his experience of studying philosophy, it is apparent from his comparison that he considers mental health a similar subject, one with more questions than answers. He felt it was unlikely that the extent of his traumatic experiences was covered in university and therefore that they would be unable to help him. There was a striking change in Akil's views on therapy from start to end:

> *if we can compare it to a knife the sharp edge of this help obviously has been from PTSD they've been touching the problem (Akil)*

His comparison of therapy to the sharp edge of a knife gives us a sense of how powerful a tool he now sees therapy.

The two participants who had a therapist from a similar background initially identified their therapist as a threat, someone who may belong to the same group responsible for their torture and it took time for them to be able to trust him:

> *(Interpreter) at the beginning when I came for the therapy and he was [therapist] here and I couldn't be you know comfortable to give my you know background to him everything explain everything and the [...] process of the you know after torture that I've been through I didn't want to explain all of this to him because I thought so he's [nationality] he might be belonging to that group of people that they I shouldn't say anything to them and then after while when its the time is passing I realise no he's not he's ok so that's why now I'm alright (Halim)*

For Ana, who had a therapist from a different background, she initially felt her therapist may not be able to understand what she had been through:

> *Laura: what was it like for you seeing a therapist from a sort of different cultural background to yourself*
> *Ana:..I mean it's always I got this feeling that maybe they...they will not be able to understand what I really been through or what I've...really want to tell them...[...]*
> *Laura: did that change as you went along or was there always that sense that somebody who hasn't been through it might not be able to understand it*
> *Ana: I don't know [laughs] I...I...I mean I don't know if you can understand or not but I mean the most important thing that is I'm not thinking about that anymore and then if you understand or not then I don't know but...I...I hope you will understand because I mean well some...some...the most important...I think she...she had understand because it...it...it wouldn't done this work then I don't know [laughs]*

> *Laura: so it feels like it...if she hadn't understood it wouldn't*
> *have worked*
> *Interviewee: yeah so...yeah I think she understand really (Ana)*

She still expresses an uncertainty as to whether her therapist could have understood her and I interpreted this disbelief as perhaps reflecting disbelief herself about what she has been through. However, she reasons that the fact that therapy worked for her meant her therapist must have understood.

4.5.3. Overcoming difficulty talking

All participants struggled in some way with talking to their therapist and sharing their story. Some found the notion of talking about something they wanted to forget paradoxical:

> *it was very strange how can I speak the thing you don't want to*
> *you want to forget? (Nasser)*

For two of the participants, being in an interview situation was incredibly difficult, reminding them of their traumatic experiences:

> *(Interpreter) I never been in a talking therapy before and at the*
> *beginning when I came here I was sitting on a chair and my*
> *thought went back to the past and prison and everything and*
> *the torture room and everything that I been sitting on a chair*
> *and I was waiting (Halim)*

> *In a period of in a period of seven years twenty seven different*
> *prisons I was arrested in short times but many times in*
> *interrogations and sometimes under torture extreme torture and*
> *so any uh kind of interview and speaking with especially with*
> *someone from uh system was making me alarmed (Akil)*

Mimi found the feeling of exposure from attending the group very difficult, and may have also related this in some way to her trauma:

> *(Interpreter) she say the other person they ok she think but they have a man and he keep staring it makes me feel scared (Mimi)*

From initially finding therapy traumatic to attend, Halim later found it traumatic not to attend:

> *(Interpreter) if I receive two or three days later the appointment I really under pressure and I feel more stress and nervous and it's cause me diarrhoea I'm going to toilet use the toilet a lot (Halim)*

Several participants had to overcome cultural barriers to talking. This was particularly the case for Akil who was grappling with the requirements of talking in therapy in contrast to the culture of the military and a country at war:

> *Akil: the only thing they did* [after a previous 'breakdown' whilst in the military] *they kept me I remember what thirteen days in something like cage I call it uh they just disarmed me and they kept me there until I calmed down and as soon as uh I could say my name and uh do you know what your serial number what division you were they said do you know where you are I said yes do you know which side is north I said yes as soon as I could say these things [gestures]...*
> *Laura: straight back out?*
> *Akil: straight back uh somewhere scarier because they thought I'm in a mood for it*

Akil's experience of the military was of being expected to 'get on with it' rather than receive support with his difficulties. He also describes a cultural expectation of depression in a country collectively grieving:

> *We lost a lot [of people] so in a country like that depression is uh a nation is depressed. You walk on the street with sad people. Every single street is named uh of the uh soldier killed [...] and so in a country like that to go to doctor with some depression this it's just it's well it's uh I don't think the doctor would laugh at you but uh you won't feel comfortable doing that (Akil)*

This account hints at Akil experiencing some guilt for receiving help. Zaid also experienced difficulty talking to a stranger, something very different to ways of coping in his community:

> *(Interpreter) ok in our country it's unusual to get this talking therapy thing because people go to church people go to some place that they worship and to that they believe in like some gods or special place where there is water then they can wash up and they feel better because they trust in it and they think that their illness will go away and people pray for them and these things* (Zaid)

For all participants, language difficulties were something they had to negotiate. Some found the idea of an interpreter a 'block' to their ability to communicate, preferring to do their best without:

> *I feel that okay I'm gonna speak with a therapist if someone will be there and interpreting my words maybe...I mean maybe there are some words that I don't know how to explain...but he can't interpret what I feel like...and [...] it's better when some*

words missing there and you have your feeling your expression
because someone can't interpret...can't interpret it what you're
feeling like (Ana)

Ana's account tells us she felt she would be lost in translation with an interpreter. However, others found interpreters facilitated them telling their stories:

(Interpreter) when she goes to see her solicitor it not only once
but several times so um with the same interpreter the person
know her story already so it easy to talk about the thing (Mimi)

Mimi had the same interpreter for both therapy and her solicitor, so when it came to telling the therapist about her trauma, the interpreter already knew her story which helped. Zaid felt he could rely on his interpreter to explain any necessary cultural and social differences, making talking easier for him:

Zaid: (Interpreter) ok because there was always an interpreter
present in the sessions and and the interpreter was able to
explain the all the cultural and social difference then it will be it
was easy for me to talk to the interpreter and explain what I felt

Participants' accounts tell us that the therapist played an important role in helping participants overcome difficulties talking:

well he explained about what trauma means and the first thing
he did he made it clear that what I was scared of he took that
away and feeling embarrassed (Akil)

Akil's experience was of his therapist anticipating how he may feel. For some, establishing a bond with the therapist facilitated them sharing the story of their trauma:

(Interpreter) at the beginning [her therapist] asked her if she
want to talk about her bad things happened to her and she
didn't want to say anything about that but after few sessions
when she get close to [therapist] she tell everything happened
to her so she say everything (Mimi)

Ana's therapist introduced EMDR to her to help her to share her story:

Ana: she explained me how...how this works and then I said
okay we'll try and then...yeah it...the feeling it works because I
tell...uh I'm telling what...what I want to say and my feeling
comes out you never know
Laura: okay so did it feel like that helped you...holding that
helped you to kind of say...
Ana: yeah cause you know you're thinking your hands and
you're speaking and at the end you feel you've...you've said
something that maybe you wouldn't saying before...

Ana describes a welcome loss of control over what she was saying, helping her to overcome her inhibitions in talking about her trauma.

Having overcome their difficulties talking, interviewees reflected on their surprise that talking could have had such an effect on them:

I couldn't believe for someone with my experiences word can be
a healer. I never thought with talking you can solve you know
nightmares and flashbacks [...] I saw it on the walls one day in
during I was in hospital I was reading things posters on the wall
one of these posters I remember was [...] saying the words the
words can heal and it was funny to me words that's rubbish but
to be very honest to you during this turning period [therapist]

made me believe and I strongly believe now that yes the words
can heal and uh I'm an example of that yes (Akil)

(Interpreter) at the beginning I had no idea that just by talking it
solve your problems and to have the thoughts improve though
with the feeling improve but by having sessions with [the
therapist] I have found it that it will actually help (Zaid)

4.6. From an unknown mystery to a known mystery

Although participants experienced a journey from scepticism about therapy to a degree of conversion, all found there was an air of mystery surrounding therapy that was there at the outset and in many ways remained throughout. The mystery began when most attended therapy not knowing exactly what they were attending, or why, and continued in the form of having great difficulty defining the process of change and the relationship with the therapist.

4.6.1. Stepping into the unknown

Only one of the participants seemed to feel that they knew what they were getting into when they attended therapy. For the rest they were unsure why, or what they were attending. Some were expecting a more medical intervention:

I was expecting some x-ray things perhaps (Akil)

Some, however, just had no idea what to expect, or the vague sense it should be something different to what they were receiving:

Laura: .before you started [therapy] did you have ideas about
what it would be like?
Mimi: [laughs] no

Zaid: (Interpreter) at the beginning I was thinking there is
something to come up not just the talking therapy that there
something some kind of other treatment to follow but then just
continue with the talking and uh
Laura: so you were just waiting for something more to happen
Zaid: (Interpreter) yes exactly that was what I was thinking

Nasser seemed unsure why he was taking the step into therapy in the first place – he had his GP there when he needed someone to talk, but was asked to attend therapy instead, and it seemed he may have experienced this as a rejection:

well for me he was I'd see him [the GP] every two months I
mean sometimes I was just like I need someone to talk to and
he just ask me if I can come here I say no problem it was alright
(Nasser)

Just by attending therapy when they did not know what it was, or continuing to attend when they thought something else should happen, tells us just how desperately some of these participants felt they needed help.

4.6.2. The inexplicable nature of change

All participants were aware of feeling themselves change through therapy, but found it very difficult to understand or explain how this change came about, describing it more as something that snuck up on them unexpectedly.

I understand that..that from the beginning when I start the
therapy and now when I end the therapy it is a big change but I
can't understand how this comes and...it's just...I mean I feel
like okay I just been talking to her and...I don't know really it's
[laughs]...it's just how it comes I don't know (Ana)

Participants struggled to conceptualise how the therapist was trying to help them, lending further mystery to the process of change:

> *Laura: do you have an understanding of how your therapist was*
> *trying to help you do you have an understanding of what*
> *Akil: uh no no I still uh I still don't that uh not like an expert no I*
> *can't explain it for instance if if uh if one were to help somebody*
> *else I will I won't be able no all I can do is to listen to them that's*
> *all I can do because uh I don't have the knowledge to uh I don't*
> *have that skill*

Nasser's confusion with regard to the nature of the change is clear from his opposing accounts:

> *the more I was going to the session and the more I was getting*
> *out of my room and trying to speak with therapist you know*
> *trying to push that thing inside and it was helpful (Nasser)*

> *you got something and you need to just need to push that thing*
> *out you know and the only thing to push that thing out is to talk*
> *(Nasser)*

Nasser was clearly aware of some sort of process occurring through talking but was unable to define it, as shown by his movement from pushing things in to pushing them out.

4.6.3. A difficult relationship to define

For many participants, some of the mystery of therapy was down to the unusual nature of their relationship with the therapist. For some it seemed their relationship with the therapist was too close, too important to think of them just in terms of a professional with a job to do. Akil's accounts indicated the greatest struggle to construct his relationship with the therapist:

I had this belief that he understands and that gave me this ability to talk not like you're talking to a therapist or expert or a doctor about your pain just like a friend about your experiences and he was the first one who uh he was getting somewhere it was getting worse they were trying to send me to a uh medium security place or something (Akil)

This extract indicates that he struggles to see his therapist as purely a professional doing a job, particularly in contrast to his experience of other professionals. His account of the therapist being 'kind enough' to meet with him tells us he sees the therapist as doing more than just a job:

he's been kind enough to encourage me to keep meeting me to come back to see me (Akil)

Akil compares therapy to coming in from the cold, hinting at the warmth he feels in their relationship:

you come back from cold weather for instance you've been camping you need some rest you're coming from extreme cold you need to be to spend some time by the fireplace and if your best way during this spending getting warm if you're between people for instance flatmates that they forget completely you're coming from extreme cold and they expect you to go and do the gardening it is not it doesn't help but if there is one person in the home that knows how cold it was outside and just to know that that will be helpful (Akil)

Ana describes her struggle to articulate her feelings about her therapist, giving the sense that words were insufficient to convey the importance of the relationship to her:

at the end we...we wrote a letter like to each other and-uh I
mean for how much I've tried to...to explain-uh and-uh [short
pause] to describe my gratitude about her I...I think it wasn't
enough [laughs] (Ana)

In contrast Mimi did not seem to struggle with positioning the role of the therapist and their relationship:

(Interpreter) she said after the class she learned some new
things and she come back to [therapist] and she taught her
more things about how to think and try to forget all the bad
things happen to her and try with the things she learn in the
class and with the things that [therapist] teach her they put
together make the best of it (Mimi)

Her use of language such as 'learn', 'teach' and 'class' tells us she saw the therapist as the teacher and herself as a pupil. Throughout her account of her experience of therapy she focused on the practical aspects of therapy, skirting the emotional elements. This teacher-pupil description seems to fit with her construction of therapy, with teachers being means through which to acquire knowledge but less usually an emotional connection. However at the end of the interview, when I asked what advice she would give a therapist who was working with people in a similar situation to her, she gave an indication of experiencing the therapist as more than a teacher:

(Interpreter) she tell the person that they have to talk to them
the people slowly nicely talk like you talk to your friend get close
to the person and almost like they have to feel close first so
they can talk to each other (Mimi)

5. Discussion

5.1. How refugees experience therapy for trauma

5.1.1. Experiences of referral and early attendance

This study found that participants were referred for trauma therapy once they had reached rock bottom, having attempted suicide, been detained under section or generally feeling that they could no longer carry on as things were. This is consistent with van de Veer's (1998) observation that when refugees ask for help they are often in need of immediate assistance, having hoped the problems would go away, or tried for some time to solve them alone. However this may also reflect findings that 'ethnic minority' clients are under-referred to psychotherapy (see Campling, 1989). Campling cites a reason for this being that differing cultural expressions of distress are grossly simplified and misunderstood as an inability to make use of psychotherapy. This study clearly refutes the notion that 'ethnic minority' and non-English speaking clients cannot make use of therapy. That the participants were very distressed before they were referred to therapy, despite most being in touch with other medical or mental health professionals, may nonetheless indicate that their distress was not recognised in its earlier stages.

Participants experienced differing understandings and expectations of therapy. Some were relatively well informed as to the process of therapy and reason for referral, whereas others had little or no idea, expecting medical interventions or a quicker, more obvious change. This fits with van de Veer's (1998) observation that difference in cultural background may mean that refugees have 'divergent ideas about mental problems and how they should be treated', and that the idea of learning about oneself through a series of sessions in order to reduce one's complaints may be a difficult construct of help to comprehend. The pre-therapy experience for most was of therapy being something of a mystery. The refugees attended despite this uncertainty, either because they had been asked to by another trusted professional or because they were in such great need of help

they were prepared to tolerate the uncertainty, even if that meant putting themselves into a situation that reminded them of their trauma. This may in part be due to the concept of therapy being non-existent in participants' countries of origin, however may also be a reflection of a more general ambiguity surrounding therapy - even in this country, where the notion of therapy is an everyday construct, it is still shrouded in mystery with clients attending for the first time often having little idea of what to expect. Some who were referred by trusted professionals seemed unsure as to why they were being referred on rather than continuing to be supported by the same person and may have experienced this as a rejection.

The study showed that most of the participants needed a reason to take this 'step into the unknown' and go through the anxiety of attending therapy – to do it for themselves was not enough. This finding is in keeping with van de Veer's (1998) observation that motivation for traumatised refugees is 'almost always ambivalent'. In the case of the two female participants their children were their key motivator, although one Mother also needed the encouragement and reassurance of her support worker. Others also experienced their support workers as essential in overcoming difficulties or misunderstandings during the early stages of engagement. For others, engagement occurred because they had little other option and were desperately in need of help. Those who had the least difficulty in initial engagement had previous experience of therapy. There has been little research into factors affecting engagement and attendance in therapy, however one study similarly found that clients attending group therapy had more positive expectations if they had attended therapy previously (MacNair-Semands, 2002).

5.1.2. Overcoming difficulty talking

This study found that talking to the therapist was initially difficult for all the refugees. Talking about the very things they wanted to forget seemed paradoxical

to some and the experience of others had taught them to mistrust professionals or not show weakness. Talking to a stranger about their difficulties was an unknown concept in their countries of origin, either because there was such a wealth of suffering individuals would not seek help, or because friends, family and church were the networks through which they would receive support. This study indicates that some refugees found it easier to talk when the therapist could anticipate and raise some of the concerns or reluctance they may have regarding talking about their trauma. For another, the introduction of a technique (EMDR) to help overcome inhibitions talking was helpful. Existing rationale for EMDR (see Shapiro, 1989; Wilson, Becker & Tinker, 1995) suggests that the process allows desensitization to the traumatic material and replacement of negative self-schema with positive self-schema. However, this study found the conscious experience of the client to be simpler, EMDR enabled her to talk about her trauma without inhibition and it was through the experience of having been able to share her story and the continuing positive regard of the therapist following disclosure of the material that brought change in self-schema. These findings support the use of EMDR, as recommended by NICE guidelines (2005), yet may add more to our understanding of how it helps.

In addition to the psychological barriers to talking, there were also the language difficulties to overcome; some of the refugees had no option but to use a translator as their English was not sufficient to communicate with their therapist. This study found that - despite technical difficulty and lack of fluency - some found it preferable to talk about their trauma in English, opting not to have an interpreter. On the other hand some found their interpreter helpful, either as they had built a relationship prior to therapy through other appointments, or because they could be relied upon to interpret cultural and social differences. These findings are similar to van de Veer's (1998) observations that the presence of an interpreter can make it harder for the refugee to 'express thoughts he considers as childish, shameful or evil', but that it can also be 'a great help in expressing himself'. Existing literature has suggested that using interpreters in therapy can

be disempowering (Patel, 2003). This was not confirmed by those interviewed through an interpreter, though those who chose to have therapy in English expressed their reservations about this approach. It could be suggested that those being interviewed through an interpreter may not feel comfortable to express any concerns they had regarding using interpreters. Despite these issues, this study supports d'Ardenne *et al*'s (2007) findings that while there may be difficulties inherent in interpreter-mediated therapy, it can result in positive outcome.

Once participants did manage to talk about their trauma with the therapist they found that *'ridding themselves of the burden'* of what they had been through hugely relieving and an important function of therapy, allowing them the freedom to begin to examine, rethink and reconstruct their beliefs surrounding their experiences. This could be widely linked with stage two of the three stage CPTSD model (see section 2.3.2.), and Ehler & Clark's cognitive model of PTSD outlining the importance of cognitive restructuring. Phase two of Santini's (1986) five phase psychodynamic framework 'catharsis and reduction of symptoms', links most closely with this finding. Santini defines this as a stage whereby the refugee 'talks about the terrible things he has experienced' which brings some relief, with the refugee becoming slightly less tense and experiencing his most disturbing symptom(s) as slightly less incapacitating. Santini's model gives little explanation however of *why* talking about their experiences brings refugees some relief, which may be answered in part through this study's findings that it brought some relief from the shame of their experience and allowed them to talk openly without being judged.

Once they had gone through the process of negotiating the difficulties with engaging in therapy and sharing the story of their trauma, this study found the refugees were surprised by the power of words to heal – a concept some initially found ridiculous. All the refugees in the study, even those who were still experiencing a great deal of difficulty, or felt held back from further progress through their poor social situation, found therapy a very valuable experience.

5.1.3. Changing understanding and attributions for the problem

The results showed that participants experienced relief and a sense of freedom through finding alternative perspectives and attributions of their traumatic experiences. For some this was profound, completely changing their view of self, others and attributions and beliefs surrounding their trauma. This links closely with cognitive and cognitive-behavioural models of treatment for PTSD (see Ehlers & Clark, 2000; Harvey *et al,* 2003) which emphasise cognitive restructuring, whereby an individual is encouraged to consider alternative perspectives about the trauma and its sequelae – for some extensive restructuring had taken place. This could be further explained by Peterson & Seligman's (1984) findings that when individuals explain bad experiences as internal, persistent and global, they are unable to see any way to improve their situation, which could help to explain why the changing perspectives participants found through therapy 'freed' them to be able to consider a future. However, as van de Veer (1998) acknowledges, this is not to say that the experiences of powerlessness refugees experience are not realistic; the losses experienced through trauma and subsequent exile are often global and persistent, yet learning to cope with the emotional impact of this, as well as differentiate between what is unalterable and where change may be possible, can be useful.

5.1.4. Gaining strength, control and a future

This study found that moving from feeling weak, faulty and abnormal to gaining strength and control was an important part of therapy for the refugees. However for some, just being in therapy initially served as an indication of how weak they were. Van de Veer's (1998) observations have been that some refugees experience the requirement of help from a mental health professional as humiliating. Humiliation does not seem to encompass the experience of the refugees in this study; their experience being better linked with the activation of

pre-existing schemas regarding the severity of their 'abnormality' and therapy presenting a stark contrast to previously learned ways of coping.

Participants initially gained their strength through the therapist, trying to hold onto the encouragement and positive feedback they were given, but most had begun to integrate their therapist's view into their own constructs of self. This finding is consistent with Rogers' (1961) concept of 'unconditional positive regard' whereby the therapist provides a facilitative environment for personal growth where an individual is able to experience sharing their worst feelings and still be accepted. Gaining an understanding of their feelings and experiences, and a subsequent greater sense of mastery over their symptoms as indicated by the CBT model (see Harvey *et al,* 2007) was another important means through which the refugees gained strength and allowed them to begin to focus on the future, as less of their energy was taken up trying to avoid their symptoms. This experience is similar to Courtois' (2004) model of treatment for CPTSD which includes psychoeducation and skill-building, though this research adds to Courtois' model by indicating the importance of this experience for the client in gaining faith in therapy and therapist and giving them the strength to move on to talking about their trauma.

This study shows the refugees found that trauma therapy helped them move from feeling stuck and trapped in their traumatic past and powerless in the face of its sequelae, to finding hope for a future. This finding links with Ehler & Clark's (2000) description of those with persistent PTSD being 'frozen in time' and the importance placed on helping people to reclaim their life. The participants' symptoms served as a constant reminder of the past and kept them trapped there, whereas gaining some control over their symptoms enabled them the space to orient themselves towards the future, as did the orientation to the future by the therapist. All of the refugees found that they could hold onto the therapist's words to varying extents and begin to remind themselves to think about the future, indicating a degree of cognitive restructuring had taken place for all. Accepting rather than avoiding the past was key for some in being able to move

forward which fits with cognitive and behavioural models, but may also have implications for the use of third wave therapies such as Acceptance and Commitment Therapy (see Cullen, 2008).

5.1.5. The experience of therapy and therapist

This study found that the majority of the refugees distrusted their therapist to begin with, feeling that they would fail to understand them, would not know how to help them or - for the refugees seeing a therapist from a similar background - fearing that the therapist would in some way be affiliated with those responsible for their trauma. This fits with phase one of Santini's (1986) framework for psychodynamic therapy, *'distrust of the therapist'* where, having lost confidence in others through their experiences, refugees will test the therapist's reaction to establish whether they are genuinely interested and can be trusted.

Despite reservations and mistrust, all the refugees felt that they needed an expert to assist them where they could no longer do so for themselves, with several seeming to want the therapist to take over and instruct them what they had to do to feel better. Similar phenomena have been observed by Pederson (1981) who suggested that it was a generic experience of those seeking assistance for mental health problems to want to be assisted by an expert they find trustworthy. Some refugees experienced frustration when the therapist was unable to 'fix' things for them. This may relate to Sundberg's (1981) research that therapists should be cautious when using a non-directive approach as many refugees misinterpreted this as a sign of inadequacy and lack of interest. However, this is also likely to relate to the huge hope invested in therapy and therapist, emphasised by the isolation and lack of additional support available.

Participants differed in their views about having therapists of similar versus different backgrounds: one felt strongly that it would have been very difficult to have worked with a therapist speaking their language or from a similar background, fitting with van de Veer's (1998) observation that the refugee may

believe that a professional from a differing background is more trustworthy, educated or objective and also Sundberg's (1981) findings that some clients prefer to discuss private or taboo issues in a second language. Another felt it would have been much harder, if not impossible, to work with someone from a different background as they would have lacked the ability to understand them. For the majority the quality of the relationship was most important, and as long as they were listened to and understood, background was irrelevant. Whether participants had therapists from similar or different background to themselves, all thought their therapeutic set-up worked well for them.

Despite their initial difficulty talking, this study found that refugees experienced a great deal of relief at having someone who understood them to talk to and share their problems with. This can be understood for some in terms of Maslow's (1943) hierarchy of needs; having had their physiological and safety needs relatively well met, love, affection and 'belongingness needs' will emerge. Given the very isolated situation of most of the refugees, their therapists may have become a means through which to meet these needs. In addition, as previously discussed, the unconditional positive regard (Rogers, 1961) given by their therapists alleviated the shame they felt. As previously observed by van de Veer (1998), regular appointments with the therapist also provide emotional support and brought an element of structure to the life of the more isolated refugees, meeting their social attachment needs (Lab *et al*, 2008). That said, as therapy progressed for the more isolated refugees, the initial relief gave way to awareness of the need for belonging outside of the therapeutic relationship for those who were very isolated. The experience of the refugees in this study has strong links with attachment theory (see Bowlby, 1969) in that participants' experience of the relationship with the therapist is of having a secure base. Whilst this is likely to be important across therapeutic situations, it may be particularly relevant with a refugee group in light of the severing of many of their attachment relationships, and the importance of consideration of attachment when working with PTSD has been highlighted in various literature (see Wang, 1997; de Zulueta, 2006). This study found that for many the therapist was their only attachment figure.

The research found that while evidently very important, the refugees found the therapeutic relationship difficult to define; it was too important to them to be conceptualised as just as a professional with a job to do. This may have added to some participants' difficulty ending therapy and to their frustration when the therapist could not help with their social situation, as seeing their therapist as more than a professional may have blurred the boundaries for them. One consistent conceptualisation of the therapists was of someone who was non-judgemental, able to listen and allowed participants to let go of their shame, in many cases for the first time.

This study showed that the refugees went through a gradual process of '*gaining faith in therapy and therapist'.* For some the idea of therapy was laughable; their problems, as they understood them, were not to be helped by talking about them. Their constructs regarding the usefulness of therapy began to change once they noticed an improvement in their functioning. Conversely, the participant who initially had a great deal of faith in therapy experienced a period of disillusionment once change did not occur as quickly as hoped, but began to build again once she noticed change. This research confirms the importance van de Veer (1998) places on explaining that improvement and gaining control is a gradual process that takes time, which while important for all therapy, is particularly important in this client group some of whom have no existing construct for therapy and therefore may have unrealistic expectations. However, given the hope invested in the abilities of the therapist, it may be that refugees do not attend well to those messages.

5.1.6. Renegotiating relationships with self, world and others

Through the course of therapy participants began to develop a new sense of their own identity, expanding their constructs of self, or *'becoming more than the trauma'*, considering, with the help and direction of the therapist, who they had been in the past and could be in the future. They also began to consider alternate

constructs of self, for example reconsidering their view of themselves as a 'bad person' because of what they had been through. In addition to a changing relationship with their own identity, participants embarked on a journey of change in their relationships with others and the world around them. They began to feel safer in a world they knew through their experience could be very unsafe and started to reconnect with others around them who they had previously been isolated from through their suffering, shame, mistrust or through the isolation of their uprooting and resettlement in a new country and culture.

Participants' experiences of '*rebuilding a shattered sense of self*' and *'a changing relationship with the world and others'* fit with Solomon & Johnson's (2002) theory that traumatic experiences can violate an individual's schema about themselves and the world around them. This study indicates that as well as violating pre-existing schema, the experience and the symptoms suffered as a result lead to new schema developing, or existing ones being activated such as 'I am a criminal' or 'I am a bad person'. Negotiating this distress through therapy allowed them to begin developing new constructs regarding themselves, others and their personal agency in an unsafe world. The refugees' experiences in this study confirm several of Courtois' (2004) criteria for CPTSD: 'alterations in self-perception', 'alterations in relationship to others' and 'alterations in systems of meaning'. They also fit with van de Veer's (1998) conceptualisation of a cognitive approach to understanding the psychological consequences of trauma in terms of 'changes in world-view and self-image' and the need to integrate their traumatic experiences into a new world-view and a new self-image in order to be able to 'function properly'. Further strength is given to this understanding when considering that the two participants who had completed the three stages of therapy, one of whom described being 'born again' through therapy, were the ones who had experienced the greatest improvement in their functioning.

This study enables us to confirm that the basic concepts of trauma theory and aims of trauma-therapy are in keeping with the actual lived experience of the six

clients interviewed on the receiving end of this therapy, as well as give some idea of the specific aspects of the therapy that clients potentially find useful.

5.1.7. Noticing change

This study found that the refugees were able to notice change in themselves during the course of therapy and reflect on the often huge change from beginning of therapy to the end, despite finding this change impossible to explain. Some were able to pinpoint significant turning points in therapy, but still struggled to clearly explain the whole process of change. Hayes, Hope and Hayes (2007) observed that research into therapy has gone some way to answering the *if* (it works) and *whom* (it works for) questions, but left the *why* and *how* largely unanswered. This research adds something to the *why* and *how*, but also indicates that the nature of change is so complex, multi-faceted and individual that may be difficult to fully theorise.

5.1.8. The Downside to Therapy

Although the study shows the participants valued therapy and found it effective, there were also some more negative aspects experienced by the six refugees. This mostly related to the negative impact of social circumstances on progress in therapy. The study found that for several of the refugees, therapy alone was not enough to meet their needs. For those who had problems with housing or were located the other side of London from an area where their community had settled and did not speak English, the division of social and psychological support seemed illogical and this brought frustration that their therapist could not do more to help them. Some found therapy helped them to tolerate an almost intolerable situation, which, along with the interaction of the therapist providing structure and focus for their week, went some way to helping them, but did not seem to be sustainable long term. Some refugees felt frustration at the futility of learning techniques to manage on an individual basis when the wider system and environment remained unchanged. These findings raise potential problems with the frameworks for trauma therapy discussed in this section, which are highly

individualistic and do not incorporate systemic, political and organisational factors. There is of course awareness of these issues. In his chapter on 'treatment of crises and symptoms' van de Veer (1998) suggest that there is often a need for 'interventions aimed at institutions', highlighting that refugees often have to live with considerable uncertainty about their future which generates understandable fear. He goes on to suggest therapists may want to make contact with the organisations responsible for maintaining that fear. That said, whilst these issues are discussed they are largely absent from models of therapy.

5.2. Implications for clinical practice

Some important considerations for clinical practice emerged from this study. The difficult nature of engagement for refugees prior to and in the early stages of therapy warrants consideration of how services can support clients in taking this first step. This may be particularly important for refugees and other populations who may not have the social support and encouragement to attend, and for whom misunderstandings around confidentiality or the nature of therapy may be particularly anxiety-provoking. The support and encouragement provided by other professionals - usually those referring the refugee for therapy - was key to their engagement with several participants feeling they would have disengaged early had they not had that support. This raises the possible need for a 'stable third' (a term I borrow from Arlene Vetere's family therapy research, see Vetere & Henley, 2001) to be involved with whom the refugee has a trusting relationship and who also has an understanding of the process of therapy and can discuss concerns with the refugee. This suggests a role for community mental health teams and/ or care coordinators in supporting and facilitating access to, and engagement in, therapy.

Following on from this, this study highlighted the need for careful and ongoing explanation of therapy, both prior to referral and during therapy, as well as acknowledgement and exploration of cultural differences in receiving support and

assumptions about the nature of therapy. Providing this to clients can promote engagement, as it indicates the therapist understands some of their client's difficulties, as well as reducing uncertainty. I was struck by the bravery of the refugees in attending therapy when they had no idea what to expect. However this also led me to wonder how many potential clients did not attend an initial appointment because of this uncertainty.

Further to the previous point, this study raised the importance of therapists being aware of the difficulties and conflicts that refugees may experience throughout therapy and to discuss these potential difficulties with them. The therapists in this study were able to do this, though they are all very experienced clinicians. It could be important for therapists newer to trauma work with refugees to be aware of the possible experience of their clients. The therapist's ability to anticipate the difficulties and conflicts their clients may experience appears to be critical to early engagement.

This research has highlighted the importance of teaching refugees undergoing trauma-therapy skills and techniques through which to manage their symptoms in the early stages of therapy. This allows the refugee to see the therapist as an 'expert', feel more confident in the potential use of continuing therapy and give them the strength to move onto the next stages of therapy and talk about their traumatic experiences. This has strong parallels with cognitive-behavioural models of PTSD (see Harvey *et al,* 2007) which recommend psychoeducation to legitimise the trauma reaction and anxiety management training to provide coping skills and a sense of mastery over symptoms. However the importance of these elements in assisting development of the therapeutic relationship and bridge differing cultural expectations are not included within the CBT model, and these findings may enhance existing understanding.

This study shows strong links with various frameworks for trauma therapy (see Herman, 1992; Courtois, 2004; Santini, 1986) and cognitive and cognitive-behavioural models of treatment. It also indicates where these models may be lacking, supporting Courtois' (2004) research and observation that treatment for

CPTSD should be 'multi-modal and transtheoretical'. Discussion of the findings of these six refugees' experiences of therapy and how it helped them has lead to links with a range of existing theory, including psychodynamic, cognitive and humanistic. This highlights that while current NICE guidance on treatment of 'PTSD' specifying CBT and EMDR treatments has a great deal of clinical use and validity, these models may be overly reductionist for this (and possibly other) client group. In addition, NICE guidelines do not take into account the time needed to develop a therapeutic relationship, particularly when there are cultural and language barriers and attachment difficulties, suggesting 8-12 sessions be offered. While a few participants mentioned specific techniques they found useful, the main themes regarding what helped them were centred on talking, suggesting that the so called 'non-specific' factors of therapy are of greatest importance to these individuals.

These findings raise concerns about the current climate of measuring outcome which, whilst important, often focus on questionnaire-style feedback. I was struck by the incredible transformation that some of the participants had made and the importance of therapy to those who were still experiencing significant difficulty. While improvements in symptoms and functioning can be demonstrated through questionnaires, as shown by Lab *et al* (2008), I was aware how much of the experience of the individuals in this study would have been lost this way, particularly for those who were still highly symptomatic, yet had made huge progress from the start of therapy. This highlights the importance of qualitative exploration of the experience of service users in the effective and ecologically valid assessment of outcome.

To return to the debate surrounding the usefulness of the construct of PTSD (see section 2.3.3.), while many of Summerfield's (1999) arguments about the importance of considering war as a socio-political phenomena rather than a biomedical one are extremely relevant, it can also be argued that the participants interviewed were evidently very symptomatic, struggling with depression, trauma, suicidality and other symptoms. This study opposes Summerfield's (1999)

suggestion that the PTSD label 'pigeonholes' refugees, finding that for some the introduction of services aimed at PTSD was a validating experience, allowing them to regain control of their lives and understand what they had been through. In at least one case an individual was pigeonholed in another, more negative way, as a dangerous person, before the therapist brought the conceptualisation of PTSD and an understanding of the impact of his previous experiences. This research shows that PTSD can be a useful construct for individuals and can facilitate access to support required. In addition, participants' accounts of their difficulties map into the diagnostic criteria of PTSD, lending some validity to PTSD as a construct.

Finally, this study confirms that therapy is very important for this client group, though it raises the question as to whether as clinicians we can just do therapy with this client group. As with other socially deprived service users, their needs range far beyond the traditional remit. Many clinicians have highlighted the need for therapists to assist refugee clients practically (see Summerfield 2001). Lab *et al*, 2007 highlight how crucial 'social intervention' can be in the early stages of therapy, particularly for asylum seekers. However the reality and pressures of working in the NHS, with ever increasing demands on time and resources, means that this may not always possible. For the needs of refugees to be met, local and government organisations need to be bringing more resources to this population group. As shown through this research, specialist trauma services are a lifeline to their clients, but working with the psychological aspects only limits the possibility of progress for clients and puts incredible pressure on therapists when they are the refugees' only link to the outside world. Access to social workers, support workers or advocates who can assist clients with housing claims and greater support in accessing social resources need to be more widely available if refugees are to be adequately supported. However, whilst immigration and asylum remain a political hot potato, 'policies of deterrence' are implemented (see Simove, 2004), negative media coverage dominates and parties such as the

British National Party gain voters and power, an increase of resources looks unlikely. While an inaccurate narrative maintained and exacerbated by political one-upmanship dominates, clinicians will continue to struggle to work effectively with refugees. This raises a further issue as to whether we, as professionals lucky enough to have the means through which to make our voices, heard should be more active in bringing alternative narratives to the fore?

5.3. Methodological Considerations

The methodology chosen for this study fitted with the aims of the research, resulting in a rich, complex and rigorous account of refugees' experiences of trauma therapy. IPA is an idiographic approach, and therefore this study does not purport to be generalisable to all refugees' experience of therapy, but does aim to offer a contribution to a gradually developing knowledge base (Smith & Osborn, 2008). While other refugees may have similar experiences of therapy, it should be highlighted that this study offers the salient themes from six refugees' accounts of trauma-therapy and the transferability and generalisability of the findings should be considered within that context. Throughout this study I have strived to ensure trustworthiness and provide clarity regarding the process, but the nature of this methodology is such that the results are my interpretations of the data and others may have found different themes more salient.

Selection for this study was through therapists identifying appropriate clients which will have created some bias. Despite the aims of the research being to gain an understanding of client experience of therapy, some clinicians may have had concerns that the research was an evaluation of their skills as a therapist. This may have lead to some clinicians choosing not to refer clients for the study or selecting particular clients over others. The range of clients accounts of the success of therapy and progress they had made indicates however that the therapists did not only refer their most successful cases to the study. Two participants interviewed were described by their therapist at referral as 'not my

greatest success', but the therapists were interested in why the therapy had not progressed as well as they had hoped and referred them for the study.

It is important to consider issues of power involved in this research project. Refugees in this country are often in a very disempowered position, having had negative experiences navigating the asylum system and obtaining basic resources. Several of the refugees showed some anxiety about seeming ungrateful, either towards their therapist, or more often towards the country, and my white British background may have exacerbated this anxiety and led them to underreport negative experiences. In addition, whereas in many western countries participating in research in varying forms is an everyday occurrence, for example telemarketing, feedback questionnaires, census and so on, this is not always the case in non-Western countries (Yu & Liu, 1986). Therefore refugees may not have been used to being asked to give their opinions and this may have made it more difficult for them to give an honest account of their opinions.

It is also important to acknowledge that my beliefs, assumptions and previous experience working with this population group, as well as my relationship with and understanding of the service from which participants were recruited, will inevitably have influenced my role in co-constructing the participants' experiences.

5.3.1. Using IPA in cross-language research

Inclusion or exclusion of those potential participants requiring interpreters raised significant methodological, ethical and moral issues. The growing cultural and ethnic diversity of people accessing health care services in the UK has highlighted the need for an improved understanding of peoples' perceptions of their health needs and services received (Tribe, 1997). It was felt strongly by researchers and the clinical team that non-English speakers should not be excluded from the research and that the benefits of including non-English speakers would outweigh the difficulties. The use of IPA within cross-language

research, specifically using interpreters, is an issue that has roused researchers and created significant methodological debate (Smith 2009, personal communication). In his reflections on the development of IPA, Smith (2004) highlighted that most IPA studies to date have been with adults whose first language is English and that there is 'plenty of scope to push the boundaries in terms of populations'. He acknowledged the need, in conjunction with the difficulty, of using IPA with non-English speakers and suggests that if the 'gains from speaking to this particular group sufficiently outweigh the costs from not speaking the same language' then it may be necessary to conduct research using an interpreter.

IPA is 'intellectually connected to hermeneutics' (Smith & Osborn, 2008), with research using interviews involving a 'double hermeneutic' whereby the researcher tries to make sense of how the participant makes sense of their lived experience. Bringing an interpreter into an interview involves a further hermeneutic layer, which could be described as a triple hermeneutic: the researcher trying to make sense of how the interpreter makes sense of the participant making sense of their lived experience. Whilst intellectually complex and not without methodological or epistemological complications, this approach translates to the 'real' world of therapy, where clinicians often have no alternative but to rely on the sense-making of the interpreter.

Researchers have highlighted difficulties with both translation and subsequent analysis of interview material and in undertaking interviews in a second language (Marshall & While, 1994). These issues present a challenge to both the reliability and validity of research. Undoubtedly the optimum design for research is for interviews and analysis to be undertaken in the participant's language of origin. However this reduces the likelihood of research being undertaken, excludes interested English-speaking researchers from undertaking useful research and subjugates the voices of a significant proportion of service users. Non English-speaking participants have traditionally been excluded from research due to the complications caused by the language barrier (Marshall & While, 1994), yet the

need for research giving minority groups a voice has been highlighted (Murray & Wynne, 2001) and NICE guidelines (NICE, 2005) state that 'differences of culture or language should not be an obstacle to the provision of effective trauma-focused psychological interventions'. Providing effective interventions also require effective user-focused research.

Twinn (1997) highlights difficulties with translating transcripts from interviews in that different translators will interpret what is said differently, yet found that superordinate categories generated during research using content analysis did not differ whether undertaken in Chinese or translated into English, and subordinate categories differed very little. Many researchers suggest caution regarding the use of translation in phenomenological research where the function is to understand the phenomenon under investigation from the participants' perspectives (see Twinn, 1997). Much of this research comes from within nursing and may reflect a greater anxiety about misinterpretation of meaning within this discipline. In addition, Twinn's and other studies have been conducted by an interviewer speaking the same language as the participant and subsequently translated into English for analysis by someone not involved in the initial interview, creating significant possibility of variation in translation. In undertaking this research, Temple's (2002) conceptualisation was used, acknowledging that interpreters are "active producers in research rather than neutral conveyors of messages". Temple suggests that researchers should not assume there is "one version of a text to be agreed on by focusing solely on the "correct" choice of words", which fits with my constructivist epistemology. Therefore, after consideration of various options, the decision was taken to conduct the analysis from transcription of the English translation given during interview. In addition to consideration of existing research, one participant was extremely anxious about confidentiality and did not want anyone from his country of origin to hear the recording, and this was a further factor in the decision to transcribe the English only. The benefits of this approach was that as both interviewer and researcher, and with a live interpreter in the room, I was able to clarify ambiguities with the participant, check back my understanding of their experience and ask questions

again or differently if I felt they had not been understood or answered as fully as possible. Further benefits were that I was able to offer increased confidentiality to participants. Drawbacks to this approach are that there may have been inaccurate translations made.

Use of interpreters presented some difficulties making higher level analysis, for example making interpretations of hesitations and 'umms'. Interpretations based on tenses was also difficult with most participants, as many struggled with using correct tenses. The only interviews I was comfortable making interpretations based on tense were one with a participant with excellent English, and one very proficient interpreter. At times during interviews it was necessary to give suggestions when interviewees were trying to find words in a way I may not have done with an interviewee who spoke English as a first language. This could have been avoided, but would have been at the expense of a good rapport with the interviewee. I have tried to be transparent about this in the write up, showing the quotes where this has occurred.

The interpreters used varied in their proficiency in English and competency in interpreting. During study design it was decided that interpreters who had not been involved in therapy should be used to allow openness about the experience of therapy. However, after the first two interviews using interpreters, I began to hypothesise that the most experienced interpreters were those used regularly for therapy due to the complexity. For the third interview with an interpreter, the participant's usual interpreter was used. I felt I got closer to the lived experience of the participant in this interview than the other two. If I were to repeat this study I would give participants the choice as to whether they would prefer their usual interpreter or a different one. That said, there subjectively appeared to be little difference in richness between interviews with and without interpreters. Some interviews were richer than others but this seemed to be related to individual differences and characteristics.

5.4. Future research

Given that both the experience of therapy from a client's perspective and more specifically research on therapy with refugees are neglected areas of research, there are a vast range of possibilities for future research. This study has highlighted the value of client-focused studies in these areas in enhancing our understanding of therapy and improving the service we can offer as clinicians.

Aside from the need for a great deal more research into the experience of therapy, as well as with refugees, it would be interesting to re-analyse the interviews with the interpreters following a full translation of the interviews and compare any differences. Comparative studies looking at different experiences of therapy following different stages of trauma therapy would build on hypotheses from this research that participants who had completed the first stabilisation phase may have different experiences and insights to those that have completed Stage 3. It would also be important to conduct research with clients who dropped out of therapy or did not attend initial appointments to investigate hypotheses that uncertainty and misconceptions may lead to non-attendance.

It would also be interesting to conduct research with participants who had experienced similar types of trauma, for example torture, as the participants who had been tortured seemed to have similar reasons for difficulties with engagement.

5.5. Conclusion

This study has made an important contribution to knowledge about refugees' experiences of therapy for trauma. Using IPA has allowed the development of a rich account of the experience of therapy for the refugees interviewed that is consistent with existing evidence, but adds to it by bringing the perspective of the client. Seeing how client experience 'maps' onto theory on treatment allows us to understand what aspects of therapy are useful to them and also highlight some areas where theory may be improved by further research into client experience.

The key findings that engagement and speaking about the trauma are very difficult emphasise the need for development of a strong therapeutic relationship and external support in the early stages of therapy. The study has also shown that an inordinate amount of hope can be invested in therapy when it is all the refugees have by way of support and social contact, and the importance of support with social circumstances. Helping refugees develop control over their symptoms can facilitate them in talking about their trauma which can subsequently allow the opportunity for the development of new beliefs about the self and others, and deconstruct previous beliefs surrounding the traumatic experiences.

To summarise, while this study tells us how complex and often difficult therapy can be, it also highlighted how valuable therapy can be to traumatised refugees:

> *if we can compare it to a knife the sharp edge of this help obviously has been from PTSD they've been touching the problem (Akil)*

6. References

Ager, A. (1993). *Mental Health Issues in Refugee Populations: A Review. Working Paper of the Harvard Center for the Study of Culture and Medicine*. Refugee Studies Programme, Oxford, U.K.

American Psychological Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders: DSM IV TR*. Washington: American Psychological Association.

Birch, M. & Miller, T. (2000), Inviting intimacy: the interview as therapeutic opportunity. *International Journal of Social Research Methodology*, 3 (3), 189-202.

Bisson, J. I, Ehlers, A., Matthews, R., Pilling, S. Richards, D. & Turner, S.(2007). *Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis*. British Journal of Psychiatry, 190, 977-104.

Bowlby, J. (1969). *Attachment and Loss: Attachment.* Vol. 1. New York: Basic.

Brewin, C.R. & Holmes, E. (2003). Psychological theories of posttraumatic stress disorder. *Clinical Psychology Review 23*, 339-376.

Brocki, M. J. & Wearden, J. A. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health, 21*, 87-108.

Burck, C. (2005). Comparing qualitative research methodologies for systemic research: the use of grounded theory, discourse analysis and narrative analysis. Journal of Family Therapy, 27, 237-262.

Campling, P. (1989). Race, culture and psychotherapy. *Psychiatric Bulletin, 13*, 550–551.

Carlsson, J., Mortensen, E. & Kastrup, M. (2005). A follow-up study of mental health and health-related quality of life in tortured refugees in multidisciplinary treatment. *Journal of Nervous and Mental Disease, 193,* 651-657.

Carta, M. G., Bernal, M, Hardoy, M. C. & Haro-Abad, J. M. (2005) Migration and mental health in Europe (Report on the State of the Mental Health in Europe Working group: Appendix 1). Clinical Practice and Epidemiology in Mental Health, 1 (13).

Courtois, C. A. (2004). Complex Trauma, Complex Reactions: Assessment and Treatement. *Psychotherapy: Theory, Research, Practice, Training, 41* (4), 412–425.

Cullen, C. (2008). Acceptance and commitment therapy (ACT): a third wave behaviour therapy. *Behavioural and Cognitive Psychotherapy*, 36 (6), 667-673.

d'Ardenne, P., Farmer, E., Ruaro, L. & Priebe, S. (2007). Not Lost in Translation: Protocols for Interpreting Trauma-Focused CBT. *Behavioural and Cognitive Psychotherapy*, 35, 303–316.
d'Ardenne, Ruaro, L., Cestari, L., Fakhoury, W. & Priebe, S. (2007). Does Interpreter-Mediated CBT with Traumatized Refugee People Work? A Comparison of Patient Outcomes in East London. *Behavioural and Cognitive Psychotherapy*, 35, 293–301.

de Zulueta, F. (2006b). The treatment of PTSD from an attachment perspective. *Journal of Family Therapy*, 28, 334–51.

Ehler, A. & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38, 319-345.

Ellis, H., Kia-Keating, M., Yusuf, S. A., Lincoln, A. & Nur, A. (2007). Ethical Research in Refugee Communities and the Use of Community. *Transcultural Psychiatry* 44, 459-481.

Elliott, R. (1995) Therapy process research and clinical practice: practical strategies. In Aveline M and Shapiro D (eds) Research Foundations for Psychotherapy Practice. Chichester: Wiley.

Elliott, R., Fischer, C.T. & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Farwell, N. (2004). War Rape: New Conceptualizations and Responses. *Affilia, 19,* (4), 389-403.

Harvey, A. G., Bryant, R. A. Tarrier, N. (2003). Cognitive behaviour therapy for posttraumatic stress disorder. *Clinical Psychology Review, 502* (23), 501–522.

Hayes, A., Hope, D. A. & Hayes, S. (2007). Towards an understanding of the process and mechanisms of change in cognitive behavioural therapy: Linking innovative methodology with fundamental questions. *Clinical Psychology Review 27* (6), 679-681.

Herman, J. (1997). *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror.* New York: Basic Books.

Hollifield, M., Warner, T., Lian, N., Karkow, B., Jenkins, J., Kesler, J., Stevenson, J. & Westermeyer, J. (2002). Measuring trauma and health status in refugees: A Critical Review. JAMA 288, 611–621.

Home Office (2007). Home Office Statistical Bulletin: Asylum Statistics United

Kingdom 2007. www.homeoffice.gov.uk

Jankovic-Gavrilovic, J., d'Ardenne, P., Bogic, M., Capuzzo, P. & Priebe, S. (2005). Survey of specialised UK traumatic stress services. *Psychiatric Bulletin, 29*, 416-418.

Janoff-Bulman. R. (1992). Shattered assumptions: Towards a new psychology of trauma. New York: Free Press.

Johnson, H & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review, 28*, 36–47.

Keane, T, M. & Barlow, D, H. (2002). Posttraumatic stress disorder. In D.H. Barlow (Ed.), Anxiety and its *Disorders*, 2nd edition, 418–453. New York: Guilford Press

Keane, T. M., Marshall, A. D. & Taft, C. T. (2006). Posttraumatic stress disorder: Etiology, epidemiology, and treatment outcome. *Annual Review of Clinical Psychology, 2*, 161–97.

Kilpatrick, D.G. (2005). A Special Section on Complex Trauma and a Few Thoughts About the Need for More Rigorous Research on Treatment Efficacy, Effectiveness and Safety. *Journal of Traumatic Stress, 18 (5), 379–384.*

Larkin, M., Watts, S. & Clifton, E. (2006). Giving voice and making sense in Interpretative Phenomenological Analysis. Qualitative Research in Psychology, 3 (2), 102-120.

MacNair-Semands, R., R. (2002). Predicting attendance and expectations for group therapy. *Group Dynamics* 3, 219-228.

Marshall, S. L. & While, A. E. (1994). Interviewing respondents who have English as a second language: challenges encountered and suggestions for other researchers. *Journal of Advanced Nursing*, 19 (3), 566 -571.

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review 50,* 370-396.

McLeod, J. (2001). Introduction: research into the client's experience of therapy. Counselling and Psychotherapy Research 1 (1), 41.

Moodley, R. (2001) Researching for a client in 2 different worlds: mind the research practice gap. *Counselling and Psychotherapy Research. 1* (1), 18-23.

Murray, C. D. & Wynne, J. (2001) Researching community, work and family with an interpreter. *Community, Work & Family*, 4 (2), 157-171.

Neuner, F., Schauer, M., Klaschik, C., Karunakara, U. & Elbert, T. (2004). A Comparison of Narrative Exposure Therapy, Supportive Counselling and Psychoeducation for Treating Posttraumatic Stress Disorder in an African Refugee Settlement. *Journal of Consulting and Clinical Psychology* 72 (4) 579–587.

National Institute of Clinical Excellence (2005). *Post-traumatic stress disorder (PTSD): NICE guideline.* www.nice.org.uk.

Office of the United Nations High Commissioner for Refugees (2009). *Figures at a Glance.* www.unhcr.org.

Paley, G. & Lawton, D. (2001). Evidence-based practice: accounting for the importance of the therapeutic relationship in National Health Service therapy provision. *Counselling and Psychotherapy Research 1*(1), 12-17.

Palmer, R. E. (1969). Hermeneutics: Interpretation theory in Schleiermacher, Dilthey, Heidegger, and Gadamer. Evanston: Northwestern University Press.

Patel, N. (2003). Speaking with the silent: addressing issues of disempowerment when working with refugee people. In R. Tribe and H. Raval (Eds.), *Working with Interpreters in Mental Health,* 219–237. East Sussex: Bruner Routledge.

Patel, N. & Mahtani, A. (2007). The politics of working with refugee survivors of torture. *The Psychologist 20* (3), 164-166.

Paulson, B. L., Everall, R. D., &, Stuart, J. (2001). Client perceptions of hindering experiences in counselling. *Counselling and Psychotherapy Research, 1*, 53–61.

Pederson, P.B. (1981). The cultural inclusiveness of counselling. In Pederson, P. B., Draguns, J.G., Lonner, W. J. & Trimble, J. E. (Eds), *Counselling across Cultures.* Honolulu: University Press Hawaii.

Peterson, C. & Seligman, M. E. P. (1984). Causal explanations as a risk factor for depression: theory and evidence. *Psychological Review 91(4),* 347-374.

Raskin, J. D. (2002). Constructivism in psychology: Personal construct psychology, radical constructivism, and social constructionism. In J. D. Raskin & S. K. Bridges (Eds.), *Studies in meaning: Exploring constructivist psychology* (pp. 1-25). New York: Pace University Press.

Rogers, C. (1961). On *Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable.

Rosen, G. M. & Lilienfeld, S. O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical Psychology Review 28* , 837–868.

Santini, I. (1986). Post Traumatic Stress Disorder, Traitmento corto. Amsterdam, Social Psychiatric Centre for refugees. In van de Veer, G. (1998). Counselling and Therapy with Refugees and Victims of Trauma (2nd Ed). Chichester: John Wiley & Sons.

Seidler, G. H. & Wagner, F. E. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. *Psychological Medicine*, *36*, 1515–1522.

Shapiro, F. (1989). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behaviour Therapy and Experimental Psychiatry, 20,* 211-217.

Silove, D. (2004). The Global Challenge of Asylum. In J. P. Wilson & B. Drozdek (Eds), Broken spirits: the treatment of traumatized asylum seekers, refugees, war and torture victims. New York: Routledge.

Simich, L., Maiter, S., Moorlag, E. & Ochocka, J. (2009). 'Taking Culture Seriously': Ethnolinguistic community perspectives on mental health. *Psychiatric Rehabilitation Journal* 32 (3), 208-214.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology *Psychology & Health, 11,* 261-271.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1,* 39-54.

Smith, J., Jarman, M. & Osborne, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), Qualitative Health Psychology. London: Sage.

Smith, J.A., & Osborn, M. (2008). Interpretative phenomenological analysis. In JA Smith (Ed.), *Qualitative Psychology: A Practical Guide to Methods.* London: Sage. (2nd ed)

Solomon, S. D. & Johnson, D. M. (2002). Psychosocial Treatment of Posttraumatic Stress Disorder: A Practice-Friendly Review of Outcome Research. *Psychotherapy in Practice 58* (8), 947–959.

Spencer, L., Ritchie, J., Lewis., J. & Dillon, L. (2003). Quality in qualitative evaluation: A framework for assessing research evidence. London: Government Chief Social Researcher's Office.

Spinazzola, J., Blaustein, M. & van der Kolk, B. A. (2005). Posttraumatic Stress Disorder Treatment Outcome Research: The Study of Unrepresentative Samples? *Journal of Traumatic Stress, 18 (5), 425–436.*

Starks, H. & Brown Trinidad, S. (2007). Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory. *Qualitative Health Research,* 17, 1372-1380.

Stubbs, P. (1999). Transforming local and global discourses: Reassessing the PTSD movement in Bosnia and Croatia. Paper presented at a Symposium on The Mental Health Care of Refugees, Utrecht.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine, 48,* 1449-1462.

Summerfield, D. (2001). Asylum seekers, refugees and mental health services in the UK. *Psychiatric Bulletin,25,* 161–163.

Sundberg, N. D. (1981). Research and research hypotheses about effectiveness in intercultural counselling. In Pederson, P. B., Draguns, J.G., Lonner, W. J. & Trimble, J. E. (Eds), *Counselling across Cultures.* Honolulu: University Press Hawaii.

Temple, B. (2002) Crossed Wires: Interpreters, Translators, and Bilingual Workers in Cross-Language Research. *Qualitative Health Research, 12*, 844 – 852.

Timulák, L. & Lietaer, G. (2001). Moments of empowerment: A qualitative analysis of positively experienced episodes in brief person-centred counselling. *Counselling and Psychotherapy Research 1* (1), 62-73.

Tribe, R. (2007). Working with interpreters. *The Psychologist, 20* (3), 159–161.

Twinn, S. (1997). An exploratory study examining the influence of translation on the validity and reliability of qualitative data in nursing research. *Journal of Advanced Nursing*, 26 (2), 418 - 423.

van de Veer, G. (1998). *Counselling and Therapy with Refugees and Victims of Trauma* (2nd Ed). Chichester: John Wiley & Sons.

Varvin, S. & Stiles, W. (1999). Emergence of Severe Traumatic Experiences: An Assimilation Analysis of Psychoanalytic Therapy with a Political Refugee. *Psychotherapy Research 9* (3), 381-404.

Vetere, A. & Henley, M. (2001). Integrating couples and family therapy into a community alcohol service: a pantheoretical approach. *Journal of Family Therapy* 23, 85 – 101.

Wallin, A. M. & Ahlstrom, G. (2006). Cross-cultural interview studies with interpreter: a systematic literature review. *Journal of Advanced Nursing*, 55, 723-735.

Wang, S. (1997). Traumatic Stress and Attachment. *Acta Physiologica Scandinavia*, 161, 164 -169.

Watters, C. (2001). Emerging paradigms in the mental health care of refugees. [Social Science & Medicine](#) 52 (11), 1709-1718.

Watters, C. & Ingleby, D. (2004). Locations of care: Meeting the mental health and social care needs of refuges in Europe. *International Journal of Law and Psychiatry 27*, 549–570.

Weine, S., Muzurovic, N., Kulauzovic, Y., Besic, S., Lezic, A., Mujagic, A., Muzurovic, J., Spahovic, D., Feetham, S., Ware, N., Knafl, K. & Pavkovic, I. (2004). Family Consequences of Refugee Trauma. Family Process, 43 (2), 147-160.

Willig, J. (2003). Discourse Analysis. In J. Smith (Ed.) *Qualitative psychology: A practical guide to research methods.* Sage Publishers: London.

Wilson, S. A., Becker, L. A. & Tinker, R. H. (1995). Eye Movement Desensitization and Reprocessing (EMDR) Treatment for Psychologically Traumatized Individuals. *Journal of Consulting and Clinical Psychology 63* (6), 928-937.

Young, A. (1995). *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton: Princeton University Press.

Yu, E. & Liu, W. (1986) Methodological Problems and Policy Implications in Vietnamese Refugee Research. *International Migration Review*, 20, 483-501.

Zohar, J., Juven-Wetzler, A., Myers, V. & Fostick, L. (2008). Post-traumatic stress disorder: facts and fiction. *Current Opinion in Psychiatry 21*, 74–77.

7. Appendices

Appendix 1: Semi-structured Interview Questions

Experience prior to starting therapy

- What brought you into having therapy - whose idea was it?
  Prompt - What did you think about it?

- What were your feelings about having psychological therapy before you started?
  Prompt - Positive/ negative?

- What did you think psychological therapy would involve before you started coming here?

- In your country of origin, how would people get support with similar difficulties?

- How did you understand the difficulties you were having after the bad things that happened to you?

Process of therapy

- What was it like for you seeing a therapist for help with the bad things that happened to you?

- Was therapy similar or different to what you expected?

- Was there anything you found particularly helpful about your therapy?

- Was there anything you found particularly unhelpful about your therapy?

- What is your understanding about how your therapist was trying to help you?

- What, if anything, changed through having therapy?
  Prompt – anything improve/ get worse?
  - understanding as to why?

- Is there anything you would have liked to have been different about the therapy?

- What was it like for you seeing a therapist from a different/ similar background to yourself?

- What was it like having therapy in a second language/ using an interpreter?

- Was there anything else happening for you at the time of the therapy that may have had an impact on how helpful (or otherwise) the therapy was?

Post-therapy/ reflections

- Now you're at the end of therapy, have your feelings about therapy changed?
  Prompt - How/ why do you think they have changed?

- What sense do you make of the difficulties you were having now you have had therapy?
  Prompt - Has this changed? How/ why?

- If you were to give one piece of advice to therapists working with people who had similar experiences to yourself, what would it be?

- Is there anything else that is important for me to know about to understand your experience?

- How has it been for you talking with me today?
  Prompt - Any questions or concerns?

Bromley Local Research Ethics Committee

Bromley PCT, Bassetts House,
Broadwater Gardens
Farnborough
Kent
BR6 7UA

Telephone: 01689 880592
Facsimile: 01689 855662

17 September 2008

Miss Laura J Gilkinson
Trainee Clinical Psychologist
c/o Jean Thomas, School of Psychology
University of Hertfordshire,
College Lane,
Hatfield
Hertfordshire AL10 9AB

Dear Miss Gilkinson

Full title of study:	**An Interpretative Phenomenological Analysis of Refugees' Experiences of Psychological Therapy for Trauma**
REC reference number:	**08/H0805/41**

The Research Ethics Committee reviewed the above application at the meeting held on 11 September 2008. Thank you for attending to discuss the study.

Ethical opinion

Members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the amendments to study literature stated below which were verbally agreed at the meeting.

1. The 'recruitment letter' should be amended to indicate that this study had been 'reviewed' by Bromley REC, rather than 'approved'.
2. The title 'Recruitment Letter' should be removed from the letter inviting potential participants to take part in the study.
3. The Confidentiality Statement which interpreters will be asked to sign should refer to the audio-recording of interviews.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

This Research Ethics Committee is an advisory committee to London Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

194

<u>Management permission or approval must be obtained from each host organisation prior to
the start of the study at the site concerned.</u>

Management permission at NHS sites ("R&D approval") should be obtained from the
relevant care organisation(s) in accordance with NHS research governance arrangements.
Guidance on applying for NHS permission is available in the Integrated Research
Application System or at http://www.rdforum.nhs.uk.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Application		13 August 2008
Investigator CV		14 August 2008
Protocol		13 August 2008
Covering Letter		13 August 2008
Letter from Sponsor		01 August 2008
Compensation Arrangements		13 August 2008
Interview Schedules/Topic Guides		13 August 2008
Letter of invitation to participant		13 August 2008
Participant Consent Form		13 August 2008
Statement of confidentiality		13 August 2008
CV for Dr Ines Santos		13 August 2008
CV for Barabra Mason		13 August 2008

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the
attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for
Research Ethics Committees (July 2001) and complies fully with the Standard Operating
Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research
Ethics Website > After Review

You are invited to give your view of the service that you have received from the National
Research Ethics Service and the application procedure. If you wish to make your views
known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed
guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0805/41	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Ms Carol Jones
Chair

Email: janine.peters@bromleypct.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers"

Copy to: *Dr Nick Wood, Research Tutor, University of Hertfordshire*
Ms Gill Lambert, South London and Maudsley NHS Trust

Miss Laura Gilkinson
c/o Jean Thomas, School of Psychology
University of Hertfordshire
College Lane
Hertfordshire
AL10 9AB

18th November 2008

Dear Miss Gilkinson,

Trust Approval: R&D2008/117   An interpretive phenomenological analysis of refugee's experience of therapy for trauma

I am writing to confirm approval for the above research project at South London and Maudsley NHS Foundation Trust. This approval applies work in Southwark directorate and relates only to the specific protocol and informed consent procedures described in your R&D Form. Any deviation from this document will be deemed to invalidate this approval. Your approval number has been quoted above and should be used at all times when contacting this office about this project.

Amendments, including the extension to other Trust Directorates, will require further approval from this Trust and where appropriate the relevant Research Ethics Committee. Amendments should be submitted to this R&D Office by completion of an R&D Amendment form together with any supporting documents. A copy of this is attached but is also available on the R&D Office website.
(http://admin.iop.kcl.ac.uk/randd/downloads/RD_Approval_Amendment_Form.doc)

I note that the University of Hertfordshire have confirmed that they will be taking on the role of Sponsor for this study.

Approval is provided on the basis that you agree to adhere to the Department of Health's Research Governance requirements including:

- Ethical approval must be in place prior to the commencement of this project.

- As Chief Investigator and/or Principal Investigator for this study you have familiarised yourself with, and accept the responsibilities commensurate with this position, as outlined in the Research Governance Framework (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4122427.pdf).

- Compliance with all policies and procedures of the Trust which relate to research, and with all relevant requirements of the Research Governance Framework. In particular the Trust Confidentiality Policy.

RDAL – V1 – April 2008

South London and Maudsley **NHS**
NHS Foundation Trust

(http://admin.iop.kcl.ac.uk/randd/downloads/Confidentiality_Policy_080219.pdf).

- Co-operating with the Trust R&D Office's regular monitoring and auditing of all approved research projects as required by the research governance framework, including complying with ad hoc requests for information.

- Informing the Trust's Health and Safety Coordinators and/or the Complaints Department or of any adverse events or complaints, from participants recruited from within this Trust, which occurs in relation to this study in line with Trust policies. Contact details are available from the R&D Office if required.

- Sending a copy of any reports or publications which result from this study to the Trust Departments involved in the study if requested.

- Honorary Contracts must be in place prior to patient contact for all relevant members of the research team. Advice on this will be provided by the R&D Office at the point of obtaining R&D approval and on an ongoing basis for new members of staff joining the research team.

- Sending a copy of the annual reports and end of project notification submitted to ethics.

Failure to abide by the above requirements may result in the withdrawal of the Trust's approval for this research.

If you wish to discuss any aspect of this research approval with the R&D Office, please contact Gill Lambert g.lambert@iop.kcl.ac.uk in the first instance.

I wish you every success with this study.

Yours sincerely

S Cannon.

pp

Gill Lambert
Research Governance/Clinical Trials Facilitator
SLaM/IoP R&D Office

cc. Nick Wood, University of Hertfordshire

Enc. R&D Approval Amendment Form

RDAL – V1 – April 2008

Appendix 4: Informed Consent Form

INFORMED CONSENT

Title of Project: **Understanding Refugee's Experience of Therapy for Trauma**

Researcher: **Laura Gilkinson**

Supervisor: **Dr Ines Santos**

1. Laura Gilkinson has explained the study and what it involves to me.   **Yes/ No**

2. I have had the opportunity to ask questions and discuss the study.   **Yes/ No**

3. I have received satisfactory answers to all my questions.   **Yes/ No**

4. I have received sufficient information about this study.   **Yes/ No**

5. I understand that my participation is voluntary and that I am free to leave the study at any time, without giving reason and without my healthcare or legal rights being affected.

Yes/ No

6. I agree to take part in this study.   **Yes/ No**

7. I understand that the interviews will be audio-taped and transcribed.   **Yes/ No**

NAME IN BLOCK LETTERS: _____

Signature of Participant: _____

Date: _____

Signature of Researcher: _____

LAURA GILKINSON

Date: _____

Appendix 5: Interpreter's Statement of Confidentiality

Interpreter's Statement of Confidentiality

Title of Project: **Understanding Refugee's Experience of Therapy for**

Trauma

Researcher: **Laura Gilkinson**

Supervisor: **Dr Ines Santos**

Name of Interpreter: _____

I have undertaken the assignment of interpreting for Laura Gilkinson and participants of this research project. I understand that all information obtained during the research sessions will be kept strictly confidential. I will not in any way divulge the contents of these sessions to any other individual or organisation. I understand that failure to maintain confidentiality will constitute a breach of my contract of employment for this project and may result in civil and criminal liability.

I understand that the sessions will be audio recorded and these recordings will be kept securely until the research is completed. I also understand that another interpreter, bound by the same confidentiality agreement may listen to the recording for transcription purposes.

Signature: _____

Name of Interpreter: _____

Date: _____

Appendix 6: Participant Information Sheet

Understanding Refugee's Experiences of Therapy for Trauma: Information Sheet

You are being invited to take part in a research study. Before you decide whether you would like to take part, it is important for you to understand why this research is being done and what it will involve. Please take the time to read the following information, discuss it with others if you wish and decide if you would like to take part. If you have any questions or anything is unclear, please do not hesitate to ask me.

We would like to understand more about what therapy has been like for people like yourselves who have come to this country as refugees. We know that therapy can be helpful for people who have experienced traumatic events, but we do not know much about why and how it might be helpful, or what it is like to have therapy in a second language or see a therapist from a different background. Also, some people might not find therapy helpful or might not like some aspects of it and it is important to understand why this might be. Finding out more about the experience of therapy for people like yourselves may help professionals to understand their clients more and develop improved ways of helping.

If you agree to take part in the research, I will ask you some questions about your experience of having trauma therapy. I will **not** ask you any questions about your traumatic experiences and would in fact recommend that you do not tell me about these to ensure that you do not find the interview upsetting. I would need to meet with you just once for about an hour and will arrange an interpreter if you had therapy using an interpreter. The interpreter will not be the same one you had for your therapy. **All the information you give me will be confidential**, however if the interviewer has concerns about your safety, she will alert your therapist. I will ask to record the interviews so that I can write down exactly what was said afterwards, but the recordings and the written transcription will be kept separately from your name and referred to only by number. Any information that may identify you will be taken out. You may also withdraw from the study at any point and do not have to give a reason for this. **You will be reimbursed for all travel costs.**

The final research project will be reported back to therapists at the service, however all information will be anonymous and therapists will not be able to identify their own clients.

It is possible that you may find some aspects of the interview upsetting. We can discuss in advance what we can do if this happens. One option is that I may arrange for you to speak to your therapist or another member of staff. **You do not have to take part in this study if you do not want to.** Whatever you decide, your treatment at the Traumatic Stress Service will not be affected in any way.

This research, which is supervised by Dr Ines Santos, is conducted as part of the thesis requirement for a Doctorate in Clinical Psychology and may later be published in a journal (all participants' names and any identifying information will be withheld). If you wish, I would be happy to send you a summary of our findings at the end of the study in September 2009. This research has been reviewed by Bromley Research Ethics Committee and is sponsored by the University of Hertfordshire.

If you have any questions about this study, please contact me on 07967034236 or l.j.gilkinson@herts.ac.uk

Yours Sincerely,

Laura Gilkinson

Note: **Laura Gilkinson** is training in clinical psychology at the University of Hertfordshire

Dr Ines Santos is a clinical psychologist at the Traumatic Stress Service

Appendix 7: Clinician's Checklist for Recruiting Participants

Checklist for Recruiting Participants

Project Administration:

Referring clinician……………………………………………………………………………

Client's Name……………………………………………………………..............

Is the client male or female?..

Client's preferred method of contact (post/ telephone/ email)…………….................

…………………………………………………………………………………………..............

……………………………………………………………………………………………..

……………………………………………………………………………………………..

Has the client given permission for Laura to contact them?   Yes/ No

Has a brief explanation of the study and researcher been given? Yes/ No

Has information sheet been given/ read to client by interpreter? Yes/ No

Did the client have an interpreter for therapy?   Yes/ No

- ▪ **What language does the client speak?**..
- ▪ **What was their interpreter's name?**...
- ▪ **Are there any considerations to take into account when booking interpreter? e.g. male/ female only, ensuring interpreter from same tribe etc?** ……………………………………………..................................

  ……………………………………………………………………………………

  ……………………………………………………………………………………

  ……………………………………………………………………………………

  ……………………………………………………………………………………

Background information:

Client's age:……………………………………………………………………………….

Client's Nationality……………………………………………………………………….

Approximate duration of therapy…………………………………………………………

Type of therapy* (if integrative/eclectic brief details would be helpful)…………..

…………………………………………………………………………………………...…

……………………………………………………………………………………………….

Please let me know about referral on <u>l.j.gilkinson@herts.ac.uk</u> or 07967034236 and I will arrange collection of form from administration office

*This information will not be included in the study without permission from clinicians

Appendix 8: Participant consent form

INFORMED CONSENT

Title of Project: **Understanding Refugee's Experience of Therapy for Trauma**

Researcher: **Laura Gilkinson**

Supervisor: **Dr Ines Santos**

1. Laura Gilkinson has explained the study and what it involves to me.   **Yes/ No**

2. I have had the opportunity to ask questions and discuss the study.   **Yes/ No**

3. I have received satisfactory answers to all my questions.   **Yes/ No**

4. I have received sufficient information about this study.   **Yes/ No**

5. I understand that my participation is voluntary and that I am free to leave the study
   at any time, without giving reason and without my healthcare or legal rights being
   affected.

                                                                        Yes/ No

6. I agree to take part in this study.   **Yes/ No**

7. I understand that the interviews will be audio-taped and transcribed.   **Yes/ No**

NAME IN BLOCK LETTERS: _____

Signature of Participant: _____

Date: _____

Signature of Researcher: _____

LAURA GILKINSON

Date: _____

Appendix 9a: Audit Trail - Emerging themes

Improvement bittersweet

Change noticeable but inexplicable

Temporary nature of improvement

Therapist as validator of worth

Lack of belief in ability to cope without therapist

Feeling disconnected from others

Connecting with therapist

Re-connecting with life and living

Connection with therapist blueprint for connecting with others

Feeling accepted

Hiding true self

Finding security to share true self

Maintaining a degree of mistrust

Life unsafe, unpredictable & insecure

Fearing confirmation of own view of self

Self as hopeless, incurable case

Trying to hold onto therapist's view of self

Lack of belief in self

Chasm between own view of self and therapist's view

Considering alternative views of self

Changing explanations & attributions

Connection independent of language

Therapist as expert

Mother tongue as inhibiting factor

Language a link to trauma

Self and control of story lost in translation

Control/ Relinquishing control

Need for safety, security & confidentiality to share story

Censoring self and story

Struggle to tell unedited story

Freeing self from burden of story,

Feeling exposed

Fear of being judged

Gaining control over impact of memories

Struggle to find motivation to engage in therapy

Anticipating therapy as an ordeal

Therapist vehicle of reorientation to future

Finding freedom to move forward

Getting rid of unwanted feelings

Moving towards acceptance

Appendix 9b: Audit Trail - Initial clustering of themes

Renegotiating identity and perspective
Changing explanations & attributions
Chasm between own view of self and therapist's view
Considering alternative views of self
Fearing confirmation of own view of self
Self as hopeless, incurable case
Trying to hold onto therapist's view of self
Lack of belief in self
Life unsafe, unpredictable & insecure
Therapist as validator of worth

Finding motivation to embark on a difficult journey
Struggle to find motivation to engage in therapy
Motivation - children, becoming a better mother
Anticipating therapy as an ordeal

Improvement bittersweet
Change noticeable but inexplicable
Temporary nature of improvement

Attribution of change to therapist
Lack of belief in ability to cope without therapist
Therapist vehicle of reorientation to future

A journey from isolation to connectedness
Feeling disconnected from others
Connecting with therapist
Re-connecting with life and living
Connection with therapist blueprint for connecting with others
Feeling accepted
Hiding true self
Finding security to share true self
Maintaining a degree of mistrust
Connection independent of language

Control/ Relinquishing control
Therapist as expert
Need for safety, security & confidentiality to share story
Self and control of story lost in translation
Gaining control over impact of memories

Censoring self and story
Struggle to tell unedited story
Freeing self from burden of story
Mother tongue as inhibiting factor
Feeling exposed
Fear of being judged

Finding freedom to move forward
Getting rid of unwanted feelings
Moving towards acceptance

Appendix 9c: Audit Trail – table of clustered themes, superordinate and subordinate themes and quotations

Key to table

Superordinate Theme		
Emerging theme (clustered)	Subordinate Theme	Quotation

Changing View of Self and the World		
- Chasm between own view of self and therapist's view - Trying to hold onto therapist's view of self	*Navigating the dichotomy of own view of self versus therapist's view*	-...she just listen and really at the end she's just saying good things about me that I was like oh my god am I really like this or [laughs]...she just trying to make me happy [laughs] -...I didn't expect really that she was gonna write these words for me no one...no one has wrote this kind of things or tell me these kind of things and this makes me like okay then I...I'm not so bad that I was thinking about myself and...so it's really...it's really helped me -… I think I will keep that letter for every...every time that I'll feel like-uh...you know because the life is gonna be up and down you never know and I always gonna remind that letter keep it somewhere read it when I...when I need so it will give me the [short pause] the security or...I don't know [laughs] like to...to believe in myself that-uh what she's saying is really...maybe it's...it's gonna help me in the future [laughs]
- Feeling disconnected from others - Connecting with therapist - Re-connecting with life and living - Connection with therapist blueprint for - connecting with others - Feeling accepted - Hiding true self - Finding security to share true self - Maintaining a degree of mistrust - Connection independent of language	*From isolated-self to connected-self (Maintaining a degree of mistrust)*	… for the people friends or family you've got around you you feel you're hiding something from them and-uh I mean I don't know it's like your relationship with your friends or...you always-uh...you are always scared from...from something or...if they find out if they found out that...and what are they gonna be like maybe they don't like to be your friend anymore or...it's just-uh...I didn't want to have this feeling anymore …I mean it's always...I...I was feeling I'm not like everybody because this strange...when it is something that happens only to you not to someone else...then you feel like oh I'm different then…I've got something and this makes you why I've got this … and maybe other people have bad experience like me maybe not

		the same but I mean you never know how other people's life and...
- Changing explanations & attributions - Considering alternative views of self - Fearing confirmation of own view of self	*Changing explanations and attributions for traumatic experiences and their impact*	- ...talking with the therapist and like it's-uh...when you speak with someone and it helps you what...what this like...why you've got this and…and why you've got that so I think just speaking with her and... - … I feel like-uh...it was...it wasn't my fault what has been happened and maybe other people have bad experience like me maybe
- Life unsafe, unpredictable & insecure	*Feeling safer in an unsafe world*	- before [therapy] I mean I always...even something happy was happening to me I am always-uh...uh taming or scared that maybe something happened or...you know even the happy moments you can't enjoy them because you think something would happen and break this-uh moment and...I don't know
- Lack of belief in self - Self as hopeless, incurable case - Trying to hold onto therapist's view of self	*Hopeless to hopeful*	- I was scared cause I thought oh my god am I going back where I was I've done all that work and then it still didn't work for me and I was like you know scared - well I thought what was this machine I always think-uh when some... something's new I have to use or for these kind of things and I was saying oh my god am I so bad that I have to go through this one or...this makes me feel that oh my god that I am really bad [laughs] like-uh how I feel
A complex relationship with change		
Temporary nature of improvement Improvement means ending therapy	*Improvement bittersweet*	...I mean you never know how the life is gonna go and...but at the moment I just feel like everybody is normal and they've got their own life and...yeah really-uh...I can I'm...I'm happy how that works -......I cried when she told me that it's only two or three appointments left and I said oh no I don't want this to happen but then...yeah we've tried to talk about and she explained that now I'm feeling better...in one way I was happy cause oh I'm ending because I feel better but in one way I still feel like oh...maybe I feel better because I've got her if I don't have her maybe I...I will not feel like this but you never know you have to try and...you have to end some days...so
Change noticeable but	*Change noticeable but*	-... I don't know really I can't

inexplicable	*inexplicable*	describe cause [short pause]...I just...everyday... I mean every week we've...we've been through this and it's just...I've...I...I just feel like okay today I feel...I mean you know like every day you're doing-uh progress but without notice that how...how comes...how does this comes to me and you just feel it...I don't know how it fast and [laughs]...I don't know really I don't know how to describe -… I understand that...that from the beginning when I start the therapy and now when I end the therapy it is a big change but I can't understand how this comes and-uh...it's just...I mean I feel like okay I just been talking to her and...I don't know really it's [laughs]...it's just how it comes I don't know
- Attribution of change to therapist - Lack of belief in ability to cope without therapist - Therapist vehicle of reorientation to future Can change last without therapist? - Therapist as validator of worth	*Attributing change to therapist*	-…she always tried to encourage me for everything like-uh go forwards this happened we leave this-uh...I mean you never forget what...what your life been or...cause everybody's got a past but it's...it's a past so we...we don't have to stuck on the past and not thinking the future and she always keep reminding me these things -… cause really you feel like uh how I'm gonna do it now on my own and you've got this like okay you've got someone that every time you want you speak with her and she listen to you she give you-uh like-uh [short pause] she...she's telling you what...what you could do and give you advances... Laura: a...advice? Interviewee: advice [laughs] yeah and it's always there for you…to encourage you and really it's good but then when you feel that's gonna end you say oh my god-uh what I'm gonna do now cause I don't have that person anymore...to speak with

Finding freedom to move forward		
- Moving towards acceptance - Feeling ashamed	*Moving from shame to acceptance of past*	-I was-uh...like this happens to me because of these things or that because maybe I deserved or...I don't know

		[laughs] and now I don't have this feeling anymore I feel well this happened and there's nothing I can do now -…I mean you never forget what...what your life been or...cause everybody's got a past but it's...it's a past so we...we don't have to stuck on the past and not thinking the future
- Gaining control over impact of memories	*Releasing the future from control of the past*	-… we always worked like-uh okay if I...when I had these bad memories coming out then I'd just go and hide like on my thought we...we had a special....special place so wh...when these bad memory comes I just go to that space where the memories can't get in and-uh...yeah I mean when I try...I mean at first I was trying to do this by always okay go to that space but always come back to this...it was like go come and [laughs]...but [short pause] uh after a while we start doing it uh I was more on that space than on...on the back
- Getting rid of unwanted feelings	*Ridding self of guilt, blame and fear*	-...I didn't want to have this feeling anymore and...and still like-uh other feeling that I...I blame someone for what's happened to me which maybe is not real or is not what...what is really what's happening and I didn't want to have this - ..I mean maybe it wasn't really […] fault…and this it makes me like-uh I had this feeling that...I mean if you feel something like that about a person who's been...I mean your parents or...and it...it makes me feel oh maybe I'm the...the bad girl but I...I start thinking this about my parent or.. -...I feel different now everything about...what I was feeling before the scare and these things what happened I feel different now -...it's like you're taking off something you've carried for so long and you just want to-uh get rid of that and...and then you feel like oh I'm rela...not relaxed but okay I'm taking this away so...
Confronting and avoiding the traumatic experience: issues of control		
-Gaining control by refusing translator - Need for safety, security & confidentiality to share story - Therapist as expert	*Needing control vs. handing control to the experts*	- I asked the GP [for help] and they *sent* me to - it's good because no one is forcing you to do it it's your choice and when the lady which I spoke at [name of place] recommend me here she said-uh if you don't feel you're going just call them or let them know or even if you're there...you're going there and you still don't feel talking to them just...you feel you're not ready just tell them… … I don't know really I'm not sure if I would go for therapy in my country […] no it's just like-uh...how it was there-

		uh...I don't...I feel it's not safe like it is here... -...I feel that okay I'm gonna speak with a therapist if someone will be there and interpreting my words maybe...I mean maybe there are some words that I don't know how to explain...but he can't interpret what I feel like...and-uh what...you know it's...it's better when some words missing there and you have your feeling your expression because someone can't interpret...can't interpret it what you're feeling like …...uh we've been using something like holding in the hands and...I don't know...and it's just gave you small abbreviation of...I don't know how it calls just holding some small thing it works with a battery and then they just give you a little bit like moving the hands and you concentrate I mean and you're talking without thinking what-uh...what is happening really you know - ...I feel...from the therapist I feel I got a lot of help from her because it looks like she understands me even...even it was difficult for me to explain or something then she...she understand my feeling and she always tried to encourage me for everything
- Finding motivation to embark on a difficult journey - Struggle to find motivation to engage in therapy - Motivation - children, becoming a better mother - Anticipating therapy as an ordeal - Encouraged to attend by another professional	*Finding reason to endure a difficult process*	- I...I did this [therapy] before and I was like oh-uh I was a bit scared cause I thought oh do I have to go through this again but then I though okay I'll try - ...I mean I don't have nothing to loose - ...when I am between what to do and then when I think about [my children] just I decide the right thing - every time when I think about the future and I want to help them and if something is going on in me and how I'm gonna be able to help them and I don't want them to feel like they've got a mother which something wrong with her... -...you think about what you have been through and you want...you want-uh your life going forward not just thinking about what has happened and just crying all day [laughs] so...you...you decide...they-uh...sometime when you come to that point that you can't-uh...can't do it anymore you feel tired I want to do something to change these things and...I mean...I can't do it anymore I can't just stand and thinking about what's happened to me cause this doesn't take me anywhere and like...when you see your children you want to move on
- Censoring self and story - Struggle to tell unedited story	*Protection and burden: censorship of trauma story*	- ...I know it that I have to tell like...I mean at...at the first therapy I didn't tell

- Freeing self from burden of story - Mother tongue as inhibiting factor - Feeling exposed - Fear of being judged		them everything what...what really like...till this time it was a bit more -...I know my English is not perfect but because I'm not speaking with someone that it's not my language I feel a bit more...I know I can't explain everything on the way I want to but it helps me to tell them more cause if...if you want someone in...that speaks my language...uh I don't know it...it would be even more block for me I couldn't -...at the beginning it was like-uh difficult...speaking and [short pause] but then you...you think about what you have been through and you want...you want-uh your life going forward not just thinking about what has happened and just crying all day -...when I first start coming I...I didn't think I was going to the end [laughs] […]I thought okay I'll...I'll start and I see when...when I'm gonna leave when...when that point come that I can't go anymore and then I just say I'm not coming [laughs] but then we came to the end [laughs] -...I'm surprised that how I did it cause just one day you're saying one thing the day after one other thing and after...and when you end up you're saying oh my god I've told them everything and...yeah [laughs] e...even I don't understand how did I do it just...I don't know

215