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Doctoral Thesis

Exploring psychosocial and therapeutic needs among refugees and asylum-seekers

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Statement of word count

Section	Main Text	References and Appendices	Total
Thesis abstract	209	---	209
Literature review	7,877	3,017	10,894
Research paper	7,997	5, 618	13,615
Critical appraisal	3,985	502	4,481
Ethics section	4,149	2,003	6,152
Total	24,217	11,140	35,357

Abstract

Part one of this thesis explored the impact of gender on the post-migration experiences of refugees and asylum-seekers. A narrative review was conducted, which examined the findings of existing research in relation to theory and policy. The review identified key areas in which gender appears to interact with other variables that affect psychosocial wellbeing following migration: Integration, employment and social status; The changing nature of gender roles within the home; and Gender roles, culture and domestic violence. The findings demonstrate that gender is an important factor in how refugee and asylum-seeking men and women navigate changes post-migration.

Part two focuses on the therapeutic needs of refugees and asylum-seekers who have experienced torture. Specialist therapists were interviewed about their experience of working holistically with this client group. Four themes were developed from the analysis: Therapy versus therapeutic: Addressing complex needs; The role of the therapist: Reparenting and bearing witness; “Trauma” and the meaning of recovery; and When it is safe and necessary to end? The implications of the findings for clinical psychologists in statutory services are discussed.

Part three is a critical appraisal of the research process itself, focusing in particular upon the iterative nature of qualitative research and considerations regarding conducting research in collaboration with a third-sector organisation.

Declaration

This thesis consists of research undertaken as part of the Lancaster University Doctorate in Clinical Psychology between September 2014 and August 2018. The work presented here is my own, except where due reference has been given to other authors. This thesis has not been submitted for any other academic award.

Marie Winterson

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Acknowledgements

I would like to sincerely thank all of the participants who gave their time to take part, as well as both of the field supervisors who became involved with the study throughout its progress and everyone else who supported me with practical advice, ideas and inspiration. I am especially grateful to Dr Stephen Weatherhead and Professor Bill Sellwood, for their advice and support throughout this process and for guiding me through difficult periods. Finally I want to thank the family and friends who have been so unfailingly supportive throughout my training- I owe all of you a huge thanks in person!

Glossary

Asylum seeker: Someone who has formally applied for asylum in another country but whose application is still pending.

Economic Migrant: Someone who has moved to another country for reasons of work or economic and/or quality of life betterment.

Forced Migrant: Someone who has left their country under duress, for example due to war, persecution or other fear for safety.

Human rights based approach: An ethos of service provision prioritising empowerment, justice, advocacy and prevention. Often contrasted to a more neutral and pathology focused "medical model".

Illegal immigrant: Someone who has entered a country outside of official channels, under falsified circumstances or who has outstayed their leave to remain.

Refugee: Someone whose asylum application has been accepted by the government.

Torture: Is defined by the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1987, (https://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx) as *Any act by which severe pain or suffering, whether physical or mental, intentionally inflicted on a person for such purposes as obtaining from him, or a third person, information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions.*

Contents

Section One: Literature Review

An exploration of gender in the post-migration experience of refugees and asylum-seekers: A narrative review

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Abstract

The following review explores the impact of gender in the postmigration context for refugees and asylum-seekers. A narrative approach was chosen due to limited existing research that directly addresses this issue. The review finds that gender interacts with other strengths and vulnerabilities that are known to impact on mental health and functioning for refugees and asylum-seekers. Three main areas became apparent and are described in detail: Integration, employment and social status; The changing nature of gender roles within the home; and Gender roles, culture and domestic violence. Further research is called for, in addition to policy and interventions that consider the impact of gender upon other risk and resilience factors.

Keywords: Refugees; asylum-seekers; gender; narrative; postmigration

Recent years have seen an unprecedented surge in the number of individuals displaced from their homes as a result of conflict, persecution or human right violations, with the most recent figures standing at 65.6 million displaced persons (United Nations High Commissioner for Refugees [UNCHR], 2018). Gender-based statistics have only recently been routinely collected and reported by monitoring bodies such as the UNHCR or Refugee Council and estimates suggest that the overall gender breakdown of the total number of displaced persons is roughly equal for adults (15.24 million men versus 15.14 million women) and for unaccompanied children (4.5 million boys versus 4.3 million girls). Despite this parity in the numbers of men and women who are displaced from their homes, adult men have consistently made up almost two thirds of the total asylum claims in Western countries since 2001, with women and unaccompanied minors jointly comprising the remaining third (Refugee Council, 2012; Allsop, Sigona & Phillimore, 2014). This under-representation of women in the asylum seeking process in Western countries may be related to the increased likelihood of women remaining in refugee camps or in their home country in order to care for family members, in addition to males being more likely to have the internal and external resources to escape the country alone. A consistent pattern observed in migration to Western countries is that a man arrives first, as a single applicant, whereas women and children travel together at a later point for the purposes of family reunification (Mascini & Bochove, 2009; Refugee Council, 2012). It has been suggested that this dynamic has been allowed to obscure women's experiences and has contributed to a narrow and essentialist portrayal of refugee and asylum-seeking women as mothers and/or dependant family members rather than as political beings, activists or victims in their own right (O'Mahony & Donnelly, 2013; Boyd & Grieco, 2003)

Refugees and asylum seekers, once resident in a safe country, are known to have poorer mental health than the average for citizens of that country (Fazel, Wheeler & Danesh, 2005; Craig, 2010). Estimates of post-traumatic stress disorder (PTSD) in refugee populations vary greatly. The largest systematic review to date of research into serious mental health conditions among refugees however (Fazel et al., 2005), concluded that refugees resident in Western countries were around ten times more likely to suffer from PTSD than the general population of those countries. The authors stated that “worldwide, tens of thousands of refugees and former refugees resettled in western counties probably have post-traumatic stress disorder” (Fazel et al., 2005, p. 1309). The review also found that around one in twenty refugees was likely to have major depression and one in twenty-five to have a generalised anxiety disorder, with considerable co-morbidity between all conditions. Increased vulnerability to mental health difficulties resulting from forced migration can be related to: 1) the experiences people have in their countries of origin that cause them to flee, (2) further trauma engendered by the danger and stress of migration itself and 3) the impact of post-migration factors that actively continue to reduce the wellbeing of asylum seekers and refugees once resident in the host country (Bhugra, Craig and Bhui, 2010). Of these three there is evidence to indicate that post-migration factors may play a greater role in determining ongoing wellbeing and optimal functioning following resettlement than either pre-existing vulnerabilities or pre-migration factors (Gorst-Unsworth & Goldenberg, 1998; Laban, Gernaat, Komproe, Schreuders & De Jong, 2004). In particular, it has been shown that factors such as lengthy asylum processes (Silove, Sinnerbrink, Field, Manicavasagar & Steel, 1997; Ryan, Kelly & Kelly, 2009), detention (Steel & Silove, 2001; Robjant, Hassan & Katona, 2009), policies of dispersal (Silove, Steel & Watters, 2000), social isolation (Schweitzer, Melville, Steel & Lacherez, 2006) and inability to work (Allsop et al., 2014) are significantly detrimental to the health and wellbeing of asylum seekers and refugees. A recent review by Giacco, Laxham and Priebe (2018) replicated the earlier finding of higher rates of PTSD in refugees in comparison to the general population (Fazel et al, 2005).

However, Giacco et al (2018) discovered that the higher comparative rates of depressive and anxiety disorders observed were not evident in the first year following resettlement but had developed by the fifth year, a finding that they attribute to the impact of post-migration stress factors such as poor social integration and difficulties in accessing care.

Female gender has been shown to be a risk factor for poorer acclimatisation to a new country and the associated psychosocial consequences (Craig, 2010; Patel & Stein, 2007). This is not to say that being a woman on its own increases the risk of poor mental health. In all likelihood, gender interacts over time with other variables over time which impact upon successful integration and quality of life for refugees. This is supported by a recent analysis of integration outcomes based on longitudinal UK survey data, which found "significant gender differences in language, self-reported health, ability to budget for household expenses and access to formal social networks and quality housing, with women generally faring worse than men and some inequalities enduring or intensifying over time" (Cheung and Phillimore, 2017, p. 211).

Qualitative research, particularly that stemming from feminist criticisms of the invisibility of women's issues within asylum policy and practice, has sought to draw attention to the experiences of women during and subsequent to forced migration (for for critical examination of gendered issues in asylum structures see Chantler [2012]; Indra [1987]; Olivius [2016]; UNHCR [2008]). As a result there is now a growing body of academic literature that explores aspects of the displacement and migratory experience for women. However, meaningful understanding of women's circumstances and needs requires researchers to examine men's experiences also, since neither is constructed or experienced in isolation (Olivius, 2016).

Aims and rationale

Krausz and Choi (2017) state that “the refugee crisis poses one of the biggest mental health challenges for our global community” (Krauz & Choi, 2017, p. 18) and question whether health professionals have responded adequately and whether is it ethically defensible to “stay on the sidelines” (Krauz & Choi, 2017, p. 18). The wellbeing of refugees and asylum seekers is both a public health and a political issue for their new countries of residence, with little consensus over how such individuals should be managed and what support they should be entitled to (Silove et. al, 2000). Refugees and asylum seekers represent a growing area of unmet physical, mental and social need. This group has been shown to have poorer physical health in general than the existing population in Western counties, attributable to a variety of factors such as the spread of infectious and parasitic diseases in cramped and unsanitary conditions in refugee camps, injuries sustained in conflict or while travelling, and the impact of chronic diseases left untreated for long periods (Burnett & Peel, 2001; Burnett & Ndovi, 2018). In addition to the increased risk of psychological difficulties described previously (Fazel et al., 2005; Giacco, Laxham and Priebe (2018)) refugees and asylum seekers resident in a new country are often socially isolated, impoverished and may not speak the primary language of their new country, leading to problems with employment, integration and difficulty accessing support- for example legal, medical or educational entitlements (Cheung & Phillimore, 2017; Schweitzer et al., 2006; Silove et al., 1997). There is an ethical imperative for clinical psychologists (in addition to all health professionals) to explore what can be done to relieve distress and maximise wellbeing among this population. As a sudden surge in population for any reason understandably increases pressure on existing services within a country, there is also an economic rationale for statutory services to invest in exploring how best to manage the needs of a growing population, especially when such needs may differ greatly from those that clinicians are accustomed to working with (Bhugra et al, 2010).

As shown above, there is evidence that negative post-migration experiences have an impact on the psychosocial wellbeing of refugees and asylum seekers; and that gender appears to have a role in contributing to differing experiences of a host country that in turn creates differing risk and resilience factors for refugee and asylum-seeking men and women. In order to more fully understand the interaction between gender, post-migration experiences and psychological difficulties, and for mental health professional and policy specialists to address this in an effective manner, it is necessary to investigate and critically compare the experiences of male and female refugees and asylum seekers as they adjust to life in a new country.

The current study

The aim of this review is to draw together literature from a variety of disciplines in order to gain a better understanding of the impact of gender on how people adapt to life in a new country following forced migration. The initial intention was to conduct a systematic literature review and database searches were carried out using broad search terms (Gender AND refugees; Gender AND asylum seekers) in order to identify as many related studies as possible. The chief researcher reviewed the results, reading the abstracts of studies that appeared relevant and retrieving the full text where this was the case. At this stage it became clear that while there are a large volume of empirical studies available that pertain to some aspect of the refugee and asylum seeker experience, the sampled groups are so heterogeneous (in terms of such factors as culture, pre-migration experiences and current country of residence for example) and the focus and methods of the studies so diverse that it would difficult to make valid comparisons. Pope, Popay and Mays (2007) caution that while generalisability is not a requisite feature of qualitative research, attempts to systematically aggregate the findings of disparate primary literature would potentially result in overstated findings due to the lack of commonality between the subjects and methodologies of existing studies.

It also became evident that there are also relatively few empirical studies that directly explore the gendered experience of post-migration life, with much of the identified academic literature base comprising policy papers, sociological and political writing and feminist theory. A structured systematic review or metasynthesis was not an appropriate methodology to explore this and it was therefore decided that a narrative approach would be the best match between the aims of the review and the current state of evidence. This would allow for the findings of relevant empirical studies (both qualitative and quantitative) to be critically discussed in relation to theory, and a tentative description given of the overall state of knowledge in relation to the question while highlighting areas where more research is needed. This is in line with Grant and Booth (2009), who acknowledge the issues with bias and lack of replicability in narrative literature reviews but highlight their utility in "[identifying] what has been accomplished previously, allowing for consolidation, for building on previous work, for summation, for avoiding duplication and for identifying omissions or gaps" (Grant & Booth, 2009, pp 97).

The review process was an iterative one, in which the author's understanding of the topic was refined by reading a broad range of articles and policy papers in addition to empirical studies. When decisions had to be made about the scope or content of the review, supervision and a reflective journal were used by the author to maintain accountability. Priorities used to guide decisions were as follows:

1) Qualitative, first-person accounts were to be given most weight, in light of how rarely refugees and asylum-seekers own narratives appear in academic literature (Nightingale, Goodman & Parker, 2017).

2) The review would be limited to research with refugees and asylum-seekers rather than economic migrants, due to how poorly differentiated these two groups frequently are despite the likely relevance of factors such as pre-migration trauma and the impact of asylum policies to individuals experiences. While not all forced migrants seek or qualify for asylum yet may have had comparable experiences to those who do, no studies identified sampled this group and it is thus not possible to critically compare their experiences with those who identify formally as refugees or asylum seekers. It should also be noted that a further group, undocumented or “illegal” immigrants, are likely to have even greater levels of postmigration stress and deprivation. However, by definition these immigrants are not known to services and were not represented by any of the studies identified.

3) The studies needed to contain a substantial enough commentary on gender to be meaningfully included, whether this was an explicit focus of the particular piece of research or something that was more implicit within participants accounts.

Three main areas of interest were identified from empirical studies via a process of initial coding using handwritten notes, organising these codes into themes, then condensing and summarising each. The three identified themes are “Integration, employment and social status”, “Changing gender roles within the home” and “Gender roles, culture and domestic violence”. These will be explored further in relation to relevant policy and theory.

Integration, employment and social status

This area relates to the challenges of integrating into a host country post-migration, using the broad understanding of integration as involving “equal access to resources, acquisition of national languages and active participation in society” (Cheung & Phillimore, 2017, p. 212). A popular understanding of the nature of refugee and asylum seeking women's experience assumes (largely from a Western perspective) that residency in and acculturation to a more equal society may promote increased gender equality (Muftic & Bouffard, 2008). Discourse around gender in the process of integration has primarily concentrated on how the refugee experience can lead to positive changes in status for women by undermining the social dominance of men (El-Bushra, 2000). However, Neysmith and Chen (2003) highlight the fact that migration may result in increased oppression for women, pointing out that "old equalities, but also new ones…are retrenched and created through globalisation" (Neysmith & Chen, 2003, p. 245). Literature suggests that men and women face separate challenges in integrating into their new country of residence. In their recent large-scale analysis of integration in the UK, Cheung and Phillimore (2017) identify a number of key areas of interest. They found that self-reported outcomes in these areas showed "significant gender differences in access to education, training, employment, self-reported general health, difficulty budgeting, housing and language proficiency. While…integration processes do evolve over time, some gender discrepancies did not equalise across the duration of the survey" (Cheung & Phillimore, 2017, p. 225). A finding of particular note was that women were significantly more likely to report poor general health and that this worsened over time, whereas men became increasingly more likely to rate their general health as good or very good as time went on. The authors suggested that these factors were interrelated and that women's poorer health could be influenced by experiences of gender based violence (for further information on the prevalence of gender based violence during war and in refugee camps and how this impacts on the vulnerability, wellbeing and social support of women in particular see Freedman, 2016; Kellezi & Reicher, 2014; United Nations High Commissioner for Refugees [UNHCR], 2003; United Nations Population Fund, 2006; Ward & Vann, 2002), as well as poorer English language proficiency and limited access to support networks, both of which may prevent them finding out how to access help.

While they concluded that as a whole women appeared to take longer to successfully integrate, there were some areas in which men fared worse, specifically the fact that policies of dispersal meant that single men had no support network and struggled to find suitable accommodation, whereas women and children seemed to be prioritised with regards to provision of social housing.

Whereas in countries where traditional gender roles are more common men tend to participate in public life more than women and are frequently the sole formal breadwinners, arrival in a new country changes this dynamic for many people. Unable to seek employment until they have gained refugee status, men and women face increasingly lengthy periods of worklessness, social isolation and “enforced poverty” (Chantler, 2012, p. 323; Allsop at al., 2014), all known to be detrimental to wellbeing and resilience.

A group of young single men, interviewed by Fidian-Quasmiyeh and Quasmiyeh (2010) when exploring the experiences of Muslim asylum seekers and refugees in the UK, discussed the difficulties of not being allowed to work. For them, it was not just the loss of a meaningful economic role and ability to support themselves that was experienced as shameful and distressing, but the associated impact of enforced worklessness on their ability to attain other valued identities such as husband and father. Inability to work, for these men, not only impacted on their ability to integrate into the host society but also prevented them from building important social networks in the form of a family, thus increasing their isolation even further. In contrast, it has been suggested that for women who have children, their role as a mother can often provide a legitimate route into increased social interaction as a result of healthcare and education related appointments, increased access to support services and opportunities to build relationships with other mothers (Bermudez, 2013). In a study investigating the experiences of Columbian refugees and asylum seekers in the UK, Bermudez (2013) suggested that this predominantly female route into increased participation in the host society has further impact in terms of women's faster familiarisation with societal norms and ability to learn the main language of the new country due to increased exposure to it, which in turn have an impact on the eventual employability of women in comparison to men. However the author reported that this finding was not true for all participants within the study, and agreed with Aggar (1992) that having young children and little childcare support meant that refugee women sometimes found it more difficult than their husbands to make time to formally study English. In addition, where there were limited resources within a family to pursue education or training, the male partner was often prioritised (Aggar, 1992; Bermudez, 2013). Cheung and Phillimore (2017) found that women refugees had lower levels of language proficiency upon arrival in the UK than men but while this discrepancy evened out over time, women tended to access formal language classes at a later point in their residency than men.

Franz (2003) found that while Bosnian refugees in the United States found it relatively easy to acquire jobs, the majority of such jobs were entry-level, low paid and had few opportunities for advancement. This meant that it was difficult for families to survive on the man's lone wage and so women in this study often ended up also taking formal employment for the first time. In the UK the nature of jobs accessible to refugee Columbian women were often in stereotypically female occupations, such as care work, cleaning or catering industries (Bermudez, 2013). Both Bosnian and Columbian women interviewed in these studies felt that they had benefitted from their experiences of employment, highlighting areas such as increased financial independence and self-confidence as evidence of this. Somali women in the United States focused on the freedom and sense of opportunity afforded by access to education and the fact that ambitious future careers were theoretically open to them: "But when you are here [in U.S] the man and the woman are equal: you can go to school, you can take a career, she could be the president and can be police. Over there that doesn't exist" (Connor, Hunt, Finsaas, Ciesinski, Ahmed & Robinson, 2016, p. 13). On the other hand male Columbian refugees in Bermudez's (2013) study, who frequently found similarly gendered, low paid, occupations such as hotel porter or warehouse operative, felt that such roles represented a reduction in their social status. Even where the study's male participants had held similar working-class occupations in their own countries, they felt that the status associated with their unpaid yet public role as political activists was lost; something that was also evident in an older study exploring the experiences of Chilean refugees in the United States (Eastmond, 1993). The interaction between identity and integration post-migration has been explored by a number of researchers (e.g. Berry, 1997; Schwartz, Unger, Zamboanga & Szapocznik, 2010). A social identity model in particular (Kellezi, Reicher & Cassidy, 2009; Kellezi & Reicher, 2014) seems to fit the accounts of Chilean men in the studies here and may explain some gender differences in the mental health of refugees and asylum-seekers.

It is not simply the case that refugee women benefit from new employment opportunities whereas men find it harder to adjust to the loss of their previous status and associated public roles. Feminist theory promotes awareness of the concept of intersectionality, which means that individuals experience their gender at the same time as numerous other identities (class, religion, sexuality, etc), and that these dynamically interact in any given context (Crenshaw, 1994). For example studies have identified that Muslim women who wear traditional dress experience more difficulty finding employment than any other group (Cheung & Phillimore, 2013b; Connor et al., 2016). Women with children are also less likely to be employed and more likely to be reliant on benefits than single women or men (Cheung & Philimore, 2017). Additionally there is little existing research that explores the impact of pre-migration class or socio-economic status on the adjustment of refugee and asylum seeking people. A small number of Columbian women interviewed in Bermudez's

(2013) study had held higher status jobs prior to migration and stated that existing on benefits or unskilled work represented a distressing drop in their socio-economic status: “I am not here to do that sort of work, it would not be a dignified occupation for me and I would feel very bad if I had to do it” (Bermudez, 2013, p. 1168).

A study investigating the impact of employment status upon psychological distress among Somali immigrants (Warfa, Curtis, Watters, Carswell, Ingleby & Bhui, 2012) looked into the role of professional status prior to migration. Focus group participants argued that men who had held professional roles in Somalia were most affected by the relative status change:

> The Somali woman’s role is still there- to look after the children, she is studying, she is doing evening work and her roles have increased. The man had position in society, coming here, he was told you are nobody. I think that rather cracks up men. (“Professional” male participant; Warfa et al, 2012, p. 7)

However, other participants recognised that the vulnerability of “lay” women postmigration is also high, given that more is required of them in the absence of some of the resources (employment experience, education, ability to speak the language of the host country) that professional participants may take for granted.

The changing nature of gender roles within the home

The change in gender roles and social status experienced by refugees and asylum seekers is described above in terms of public factors such as employment status. However, these changes may have an even greater impact in the private sphere of relationships within the family and in particular the marital unit. As Bermudez (2013; quoting Matsuoka and Sorenson, 1999) points out: “if refugee experiences can lead to changes in gender roles and relations, like other studies point out, these changes ‘are lived most intensely within the context of the household’” (Bermudez, 2013, p. 1168).

For married couples, the changing relationship dynamics caused by women entering the workforce for the first time can potentially bring about tension within the marriage. In cultures where there has traditionally been a firm distinction between women’s and men’s work there can be resistance to change; and where refugee women enter the outside workforce, a traditionally male sphere, this does not automatically mean that her male partner will take on some of her previous household duties. Somali women living in the US described this new division of labour as a primary source of conflict in their relationships, also highlighting the fact that in Somalia a woman would have had a community of friends and family around to help with the workload.

> But here is just husband and wife only, and they have to work outside and they have to come back and work inside the house. So it is very difficult if all this work only women do and it will be conflict, the couple who married and they start argument, yelling and the end will be divorce. (Connor et al., 2016, p. 15)

Guruge, Khanlou and Gastaldo (2010), studying Sri Lankan Tamils now living in Canada, found that younger couples found it easier to negotiate these role changes and share household tasks more equitably. Bermudez (2013) also found that older age and lower socioeconomic class was a predictor of how difficult participants in her study found it to adapt from the roles that they were used to. The Columbian men she interviewed expressed that their wives were now more demanding and that they were held more accountable to them, rather than being independent and free to come and go as they wanted as they had previously. Some of these men consciously resisted such change: “We don’t let English customs be imposed on us…women here try to dominate us, and they presume that they have more rights here. This has happened to me on several occasions but I try to control it" (Bermudez, 2013, p. 1170). What from the outside may appear to bring about greater liberation and empowerment of women, as they gain a more public role and greater financial control within their homes, may in fact result in their workload increasing dramatically with little to no support from their spouse, as well as an increase in conflict within the marriage (Bermudez, 2013). As well as the difficulties caused by negotiating workload, Somali women interviewed by Connor et al., (2016) highlighted the fact that their relationships had to adjust to much less time spent together and the distance this caused.

Male respondents across a number of studies discussed the psychological impact of losing their role within their family. For many, the role of provider was interchangeable with that of father or husband, and loss of the former led to a crisis of identity in relation to their relationships. In this sense, it may be suggested that the rigid and controlling behaviour evidenced by a refusal to adapt to new roles is not just an attempt to maintain their own status for some of these men, but also to protect valued relationship structures. Participants in Fidian-Quasmiyeh and Quasmiyeh's (2010) study discussed the boredom, frustration and lowered self-esteem that was associated with what the authors describe as "the close alignment between effective masculinity and effective fatherhood and productivity" (Fidian-Quasmiyeh and Quasmiyeh, 2010, p. 308). Even where women are not in employment, the common practice in many Western countries of making child related benefits payable to the mother results in her effectively controlling the family finances; leading one participant to state that the government "'is a better husband' to his wife and 'a better father' to his two daughters" (Fidian-Quasmiyeh and Quasmiyeh, 2010, p. 305) than he can be. This opinion was elaborated upon in a separate study of male African refugees resident in Australia, who explained that interdependence and collective identity was a feature of their traditional family structure and that greater independence for any individual threatened the cohesion of the family unit: “this kind of welfare assistance will create the independence between couples, will create a lot of independence in families” (Fisher, 2013, p. 840).

From a Western perspective, where independence is valued over dependence and collectivism, such an opinion may be difficult to understand. While a superficial understanding of the changes in marital relationships of refugees and asylum seekers may be characterised simply as women’s increasing freedom from patriarchal social rules and men’s inability to accept or adjust to this, studies that investigate the experiences of refugee and asylum seeking women add more nuance to this.

While many women interviewed felt their increased financial independence was a positive thing, they could empathise with the difficulty experienced by men in relation to their associated loss of status (Fisher, 2013). However, some women experienced this as detrimental to their own social status, a perspective that potentially adds further strife to their marriage. It must be recognised that refugee and asylum seeking women may also hold their traditional cultural values in high regard (Connor et al., 2016; Fiddian-Qasmiyeh & Qasmiyeh, 2010; Guruge et al., 2009), even where it may seem from a Western perspective that this is against their own best interest. Muftic and Bouffard (2008) point out that many refugee women seek to reconstruct familiar lifestyles in their new country of residence and may resent changes in gender roles brought about by economic necessity. This opinion is borne out by Sri Lankan women interviewed by Guruge et al. (2010) who emphasise that downward mobility for men also impacts the status of women. Within traditional Sri Lankan culture, arranged marriage is common and it is usual that women seek to increase their own status by marrying a man of higher educational and professional standing who can provide an associated high standard of living. The social status of the man therefore determines the social status of the woman, and increased economic equality may thus be experienced as a negative change even for its beneficiary. As one woman quoted explained:

> Here a woman lawyer can marry a chef and it is not a problem. But our society is set up to say that women should always marry up or someone who is doing a good job or is better than you professionally. So, when we come here, things become upside down. You don't know what it does to the family, not just to the man. (Guruge et al., 2009, p. 109)

Gender roles, culture and domestic violence

Conflict within relationships not only contributes to reduced psychological wellbeing for both the men and women involved, but can also at worst result in an increase in physical violence. Women from immigrant and refugee backgrounds have been shown to be particularly at risk of experiencing domestic violence (Fisher 2013; Perilla, 2003; Rees & Pease, 2008), although relatively little research distinguishes between the experiences of economic migrants and refugee or asylum seeking women.

Understanding the scale of the issue of domestic violence within immigrant and refugee populations is often hampered by participants' unwillingness to discuss the issue, as well as the difficulty of comparing pre-and-post migration risk factors. Fisher (2013) expanded on the difficulties of investigating domestic violence in women from immigrant and refugee backgrounds, pointing out that where domestic violence as a phenomenon is not recognised or named as such it effectively does not exist to that community.

Due to the difficulties in exploring the issue of domestic violence within refugee and asylum-seeking communities there are few studies that report first person experiences and perspectives. Muftic and Bouffard (2008) compared the experiences of domestic violence among a group of Bosnian women still resident in their country of origin and a group who had sought asylum in the United States and found that there were no real differences in the rates of such violence between the two groups, despite having predicted higher levels of violence to be experienced by the women still resident in Bosnia. They suggest that where domestic violence stems from entrenched patriarchal attitudes within a culture, transportation to a different environment does not necessarily transform that culture; and hypothesise that in fact traditional roles and attitudes may be strengthened in exile in an attempt to retain cultural identity. Within this narrative therefore, women who are at increased risk of domestic violence to begin with will remain so despite having migrated, with this risk potentially increasing as “the experiences of migration, adaptation and acculturation that go along with being a refugee produce additional stresses on a relationship that under “normal” circumstances were perhaps already strained, if not already abusive”. (Muftic & Bouffard, 2008, p. 186)

Guruge et al. (2009) found that the Sri Lankan women they interviewed tended to experience domestic violence for the first time following migration, concluding that “the relevance of the post-migration context in the production of intimate male partner violence should not be underestimated” (Guruge et al., 2009, p. 111). Fisher (2013) also states that “factors contributing to [domestic violence] in families from refugee backgrounds in Australia are almost all interrelated with refugee and resettlement experiences” (Fisher, 2013, p. 836). A number of intersecting factors that give rise to domestic violence in refugee and asylum-seeking communities are suggested by the literature base. These broadly fall into three areas: cultural beliefs and values; the impact of pre-migration trauma and resulting mental health difficulties; and ongoing stress caused by experiences of exclusion, racism and discrimination in the host country.

Male refugees and asylum seekers are frequently from traditional, patriarchal cultures where the father is the head of the household and the main breadwinner. As discussed above, arrival in a new country often changes this dynamic within families and leads to conflict Fisher (2013). Closely linked with the idea of traditional masculinity is the concept of "discipline". A number of the qualitative studies discussed here elicited the idea that it is a man's duty to maintain order and correct problematic behaviour in his family, something that was not considered to be domestic violence by its perpetrators despite the fact that the "discipline" was often physical (Guruge et al., 2009; Fisher, 2013; Connor at al., 2016). Changes in social roles and expectations, including increased autonomy and freedom for women in Western countries, were seen as increasing the need for men to enforce cultural values.

> When we were living in [name of suburb] she [wife] came home late with my daughter in the pram, so I said, "Look, where you coming from? "Oh, I can do anything, I can do anything." So I had to discipline her because I know my woman. (Male participant; Fisher, 2013, p. 843)

Women in a number of studies expressed that they had been empowered by the more equal society in their host country and that they were willing to draw upon legal resources to defend this if necessary. However, others expressed reservations about whether it was right to bring the law into domestic disputes. Connor et al. reported that a number of female participants discussed the intersection of culture and religion (all were Somali Muslims), expressing doubts over the relevance of their new legal rights to their circumstances: "You can't refuse if your husband called you to the bed. And it is sin. Do you understand? I know sometimes women do refuse, when their husband needs them, but still it is sin, and the religion doesn't allow." (Connor et al., 2016, p. 16)

Previous experiences of trauma have also been shown to impact on risk of domestic violence post-migration (Gupta, Acevedo-Garcia, Hemenway, Decker & Silverman, 2009; Guruge at al., 2009). James (2010) points out that post-traumatic stress disorder results in physiological hyperarousal and increased sensitivity to threat. Refugee men who have experienced trauma may therefore be more easily triggered to violent responses, especially where physical "discipline" of women was already an acceptable way of dealing with conflict. This risk may be exacerbated even further by self-medication with alcohol and other drugs. Sri Lankan participants interviewed by Guruge at al. (2009) linked men's traumatic experiences of being involved in war to increased hostility, suspicion and aggression towards family members even when safely resident in a new country: "Husbands being separated from wives (…) have been taken out for interrogation…having to always suspect another person, whether he is an enemy or not." (Guruge et al., 2009, p. 106). Women's pre-migration trauma is also likely to impact on their perception of and response to violence from partners. Women refugees and asylum seekers potentially have greater trauma histories upon arrival in a new country due to widespread sexual violence during war in their country of origin and in refugee camps along the way (Pittaway & Rees, 2006). This may result in an adjusted baseline for threat, so that "discipline" and other physical abuse within their marriage does not register as unsafe or frightening in comparison with what they have already been through (James, 2010). Despite this, Mason and Pulvirenti (2013, p. 404) caution that ongoing domestic violence "all too easily erodes" the resilience that has sustained refugee and asylum-seeking women through previous experiences and leaves them more vulnerable to post-migration stressors.

Mason and Pulvirenti (2013) also draw attention to the importance of resilience on a community level to ensuring the resilience of individual members. Both refugee men and women have an investment in the status and acceptance of their cultural community among the wider society of the host country. However refugee and asylum-seeking women may find that there is tension between their individual needs and the needs of their community, especially where minority communities face exclusion, hostility and discrimination. In addition there may be tension between their own needs, with fear of being ostracised by the community outweighing their fear of continued domestic violence. The vulnerability caused by these intersecting identities results in a collective papering over of violence toward women in minority refugee communities (Mason and Pulvirenti, 2013).

This papering over can also occur among the professionals who work with refugees and asylum-seekers. Fear of appearing racist, or of stigmatising an already vulnerable population, can result in professionals retreating into a position of cultural relativism that allows oppressive or illegal practices to go unchallenged (Meetoo & Mirza, 2007; James, 2010). James (2010) reflects that "As therapists, especially if we are outsiders to a culture, we walk a tightrope of respecting and recognising cultural difference of the one hand, and challenging unjust practices on the other" (James, 2010, p. 276).

Experiences of hostility, racism and exclusion have also been shown to directly impact upon cultural values for some individuals, which again increases the likelihood of harmful gendered practices. When a minority community feels under threat from the outside it is more likely to retreat into a defence of traditional cultural values and identity, including ideas of masculinity and gender roles (Pittaway & Rees, 2006; Fisher, 2013). This phenomenon was evident in a number of the studies discussed here, in which women as well as men were seen to reflect upon their cultural identity and how it can be preserved despite their lifestyle changes. Connor et al. (2016) described idealised memories of Somalia among refugees that appear to function as a protection from xenophobia and trauma. The authors note that participants have a tension between their newfound freedoms and their cultural identity, suggesting that some choose to adhere to traditional gender roles for the sake of maintaining a valued identity and community. A Palestinian woman interviewed by Fiddian-Qasmiyeh and Qasmiyeh (2010) described an increasing interest in Islam since being resident in the UK and an associated desire to mix more with other Muslim women. This was partly attributed to her realisation that she will be primarily responsible for teaching her children cultural and religious values as they grow up in a secular, western country. Muftic and Bouffard (2008) expressed surprise at their finding that Bosnian women, who had been living in the US for an average of 9 years, endorsed more conservative social attitudes than a matched group of women still resident in Bosnia. Franz (2003) also found that Bosnian refugee households practiced stricter gendered behaviours in their host country than in Bosnia. Even more notable, the Sri Lankan women interviewed by Guruge et al. (2009) were discovered to be particularly at risk of experiencing domestic violence if they were reliant upon their husband's family in the absence of their own relatives, with female in-laws frequently being named as the perpetrators of their abuse and/or the enforcers of patriarchal values. The authors draw attention to the fact that Tamil women are traditionally seen as having responsibility for transmitting cultural values across generations, suggesting that this role is also reinforced and given increased value in exile. These factors are all likely to impact upon refugee and asylum-seeking women's understanding of domestic violence, as well as their likelihood of accessing what help is available.

Discussion

Employment, culture and gender roles are "intricately intertwined" (Fisher, 2013, p. 839) in the first person accounts of refugees and asylum-seekers discussed here. The review demonstrates how forced migration causes changes in these areas and how such changes may be experienced differently by men and women, leading to individual psychological difficulties, interpersonal conflict and at worst resulting in violence directed towards women. The types of stress described by participants in the studies reviewed adds context to quantitative findings of poorer mental health among refugees and asylum-seekers post-migration, as well as the observed gender differences in wellbeing and functioning across time. It is not clear however, how the needs of refugee and asylum-seeking men and women can be supported by mental health professionals in their host countries in order to ensure optimal acclimatisation and wellbeing; and applied research and clinical practice in this area is limited. The United Nation High Commissioner for Refugees (2003) outlined six potential targets for interventions aimed at reduction of gender-based violence (GBV). These targets (reproduced below) address a number of the broader mediating factors described in this review, such as a focus on changing gender roles and expectations, strengthening community support and the need to consider both formal legal systems and their interplay with traditional cultural and/or religious codes of conduct.

1) Transforming socio-cultural norms, with an emphasis on empowering women and girls
2) Rebuilding family and community structures and support systems
3) Creating conditions to improve accountability systems
4) Designing effective services and facilities
5) Working with formal and traditional legal systems
6) Assessment, monitoring and documentation of GBV (UNCHR, 2003)

The recent UK Home Office and Ministry of Justice consultation and draft bill, “Transforming the Response to Domestic Abuse” (Home Office, 2019) broadens the statutory definition of domestic abuse, recognising the complex ways in which this can present. The bill acknowledges the particular ways in which refugees and asylum seekers may become vulnerable to abuse, for example via culturally motivated forms of domestic violence such as female genital mutilation, forced marriage and “honour” based punishment. The bill significantly recognises that immigration status may be used as a form of coercion and addresses the need for asylum seeking victims to have access to protection and legal recourse without concerns that this will affect their asylum claim (For discussion of the challenges relating to asylum seekers and refugees navigating the UK legal system see also Liberty’s “Response to the Government’s Consultation on the Domestic Violence and Abuse Bill

[Liberty, 2018]). Despite this positive development it appears that, to date, the UNHCR (2003) recommendations have not been engaged with to a significant degree by researchers or policy makers. Tappis, Freeman, Glass and Doocy (2013) conducted a review of the English-language evidence base for interventions targeting gender-based violence in refugee populations, using the UNHCR categories to structure their discussion. They identified only ten published articles that met these criteria, so chose to include a further thirteen articles looking at interventions in non-refugee contexts. The literature base on GBV in refugee populations was noted to focus more on the aftermath of sexual violence in wartime than on the impact of violence from partners, which remains under-researched in this population. In addition, many of the published studies focused on intervention programmes run in refugee camps, which involve a very different social context compared with residence in a safe country. The authors found that none of the articles presented robust, proven strategies for addressing gender-based violence and concluded that currently “guidelines for [GBV] prevention in humanitarian settings are either based on expert opinion or extrapolation of evidence from non-emergency affected populations” (Tappis, Freeman, Glass and Doocy, 2013, para. 32).

The identified UNCHR (2003) targets lend themselves well to the skillset of clinical psychologists; for example evaluating and transforming how existing services and procedures recognise and respond to gendered problems for refugee and asylum-seeking clients, designing and evaluating targeted psychosocial interventions, and advocating for a psychologically informed approach to asylum policy and integration on a wider scale. Nightingale et al. (2017) state that psychologists are still frequently understood to work at the level of the individual and accordingly to have little to offer in debates around wider societal or political problems such as migration, acculturation and structural social exclusion. However, as they also point out “We as psychologists have not always been effective at explaining how our research is relevant to the issue, yet these are all phenomena that clearly have a psychological component" (Nightingale et al., 2017, p. 58).

The review is limited in some ways as a consequence of the available source literature. The studies discussed here are heterogeneous, sampling participants from a variety of nationalities and cultural backgrounds, who are living in different host countries at the time of the study. However, heterogeneity of studies within qualitative reviews is often an advantage, especially when comparable findings can be seen across a range of studies with different methodologies and carried out in different contexts (Baumeister & Leary, 1997). Due to the small number of qualitative studies that explore gender roles post migration with this population, a systematic review could not be conducted and a narrative review was considered a more appropriate way of summarising the literature. A narrative review is non-prescriptive and necessarily subjective, however as more research is produced it may be possible in future to explore this topic in a more systemic manner. For now however, this review has attempted to summarise the evidence that is publicly available, in relation to theory; and where it goes beyond primary research it is intended to be transparent about this. The included qualitative studies are not representative of all refugees and asylum-seekers; and culture, socio-economic class and the political climate of the host country are all factors that are likely to impact upon individuals' experiences, resilience and wellbeing. In addition, it should be noted that for practical purposes, this review has had to treat gender as binary and absolute, despite acknowledging that this is not always the case. The same applies for individuals who do not identify as heterosexual: while the review acknowledges the interplay of sexual and gender identity, very little is known about the numbers or experiences of asylum seekers and refugees to whom this may apply. Both of these are areas that warrant future research.

Conclusion

This review is the first to the author’s knowledge to investigate the role of gender in the post-migration experience of refugees and asylum seekers that draws upon empirical evidence as a starting point. In doing so, it both adds clarity to the topic and highlights areas of ambiguity or where more research is needed. The review demonstrates that gender is an important factor in how refugee and asylum-seeking men and women navigate changes in individual identity, intimate interpersonal relationships and relationships to the wider community post-migration. Further descriptive research (i.e. research that seeks to critically explore the state of matters as they currently stand, as contrasted with that which tests a specific hypothesis) is required, in addition to design and evaluation of applied interventions that address known risk factors for poorer outcomes.

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Aims and scope

In one forum, *Journal of Loss and Trauma* brings together scholarship on personal losses relating to family, health, and aging issues. The journal addresses issues dealing with psychological and physical health and interpersonal losses relative to extended family, community life, and society as a whole.

In order to broaden the reader's perspective on loss and bereavement, the journal defines loss as a major reduction in a person's resources, whether personal, material, or symbolic, to which the person was emotionally attached. Types of loss covered include: death and dying; dissolution and divorce; loss of employment; life-threatening diseases and long-term disability; loss of possessions; homelessness; recurring and haunting memories; disenfranchisement and stigmatization; losses resulting from war and violence; and aging.

The *Journal of Loss & Trauma* highlights common as well as differing impacts of major losses while revealing commonalities of the various healing processes. Interdisciplinary in its approach, the journal publishes empirically-oriented papers, case studies with intervention strategies, point-counterpoint discussions, theoretical analyses, essays on concepts or links among relevant fields, and therapeutic approaches. Book reviews are also regular features.

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Papers may be submitted in any standard file format, including Word and LaTeX. Figures should be saved separately from the text. The main document should be double-spaced, with one-inch margins on all sides, and all pages should be numbered consecutively. Text should appear in 12-point Times New Roman or other common 12-point font. All titles should be as brief as possible, 6 to 12 words. Manuscripts should be no more than 18 pages in length, including tables and figures.

Style guidelines

Submissions to *Journal of Loss and Trauma* should follow the style guidelines described in the *Publication Manual of the American Psychology Association* (6 th ed.). *Merriam-Webster's Collegiate Dictionary* (11th ed.) should be consulted for spelling.

References

References should be cited parenthetically in the text by author surname(s) and year, in accordance with *APA Publication Manual* guidelines:

1 author	(Smith, 2010)

2 authors	(Smith & Jones, 2010)
3 to 5 authors	(Smith, Jones, & Smythe, 2010) first mention; (Smith et al., 2010) thereafter
6 or more authors	(Smith et al., 2010)

When available, page numbers should be included in citations of direct quotations (e.g., (Smith, 2010, p. 25)).

References should be listed in a separate section at the end of the main text. All references in the list should be ordered alphabetically by the first author's surname. Examples of common reference types appear below.

Journal article	Taylor, J., & Ogilvie, B. C. (1994). A conceptual model of adaptation to retirement among athletes: A meta-analysis. *Journal of Applied Sport Psychology, 6*(1), 1–20. doi:10.1080/10413209408406462
Book	Duke, J. A. (2001). *Handbook of phytochemical constituents of GRAS herbs and other economic plants*. Boca Raton, FL: CRC Press.
Edited book chapter	Gordon, S. (1995). Career transitions in competitive sport. In T. Morris & J. Summers (Eds.), *Sport psychology: Theory, applications and issues* (pp. 474–493). Milton, Australia: Wiley.
Online/Website	United States Census Bureau. (2014). *American housing survey: 2013 detailed tables.* Retrieved from http://www.census.gov/newsroom/press-releases/2014/cb14-tps78.html
Dissertation/Thesis	Allison, N. (1981). *Bacterial degradation of halogenated aliphatic acids* (Doctoral dissertation). Trent Polytechnic, Nottingham, UK.
Conference presentation	Alfermann, D., & Gross, A. (1997, January). *Coping with career termination: It all depends on freedom of choice*. Paper presented at the 9th Annual World Congress on Sport Psychology, Netanya, Israel.
Paper/Report	Grigg, W., Moran, R., & Kuang, M. (2010). *National Indian education study* (NCES 2010-462). Washington DC: National Center for Education Statistics.

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Section Two: Research Paper

How do specialist therapists understand and describe the therapeutic process in their work with traumatised survivors of torture?

Word Count: 7,997

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Abstract

Objective: The objective of this study was to explore the experiences of specialist therapists who work with survivors of torture in order to better understand the clinical needs of this population, which are not currently adequately met within statutory services.

Design: The study was qualitative in design.

Methods: Data was gathered from semi-structured, one-to-one interviews and analysed using Thematic Analysis.

Results: Analysis produced four themes: 1) Therapy versus therapeutic: Addressing complex needs; 2) The role of the therapist: Reparenting and bearing witness: 3) "Trauma" and the meaning of recovery and 4) When is it safe and necessary to end?

Conclusions: The results demonstrate the complexity of survivors' needs and the inadequacy of a narrow therapeutic focus on Post-Traumatic Stress Disorder symptomology. The results are likely to be of interest to clinical psychologists working with torture survivors within statutory services, or to clinicians considering the development of a dedicated service for this client group.

Practitioner points:

- Trauma-focused therapy with torture survivors must take a broad perspective on need, recognising the impact of external circumstances, continued threats to safety and ongoing loss upon readiness for therapy.
- Practitioners working with torture survivors are encouraged to take a multi-disciplinary team approach and/or to build links with local third-sector organisations in order to signpost clients effectively.

Current estimates suggest that torture is used against citizens of over 111 recognised countries, including some that are signatories of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Six to twelve per cent of immigrants from the countries known to use torture may have experienced this personally, with rates highest amongst refugees seeking political asylum elsewhere (Miles & Garcia-Peltoniemi, 2012).

Torture is both an international political issue and a domestic health and social care one. In committing torture, a country is in violation of international law, having abused their duty of care towards citizens. The victim is entitled to renounce his citizenship and seek the protection of another nation, who are required by the same law to offer him protection and provide what care he needs (Pettitt, 2011). The question of what the nature of, and limits to, this protection and care should be is contentious in United Kingdom politics, and one that has serious ethical and practical repercussions regarding healthcare provision for torture survivors resident here (Bacon, Bourne, Oakley & Humphreys, 2010; Silove, Steel & Watters, 2000).

The aftermath of torture is associated with a wide range of psychological, medical and social difficulties for survivors, of which the most disabling manifestation of mental health sequelae is Post-traumatic Stress Disorder (PTSD). Estimates of the rate of PTSD in survivors of torture have been suggested to be as high as 50 to 67% (Miles & Garcia-Peltoniemi, 2012). Spontaneous recovery from trauma related distress in survivors of torture is rare (Kira, 2002) and complex, enduring trauma is known to have a detrimental effect on survivors' ability to integrate into their host country. However, Craig (2010) claims that traumatised refugee and asylum-seeking survivors of torture resident in the UK face many barriers to getting the support that they need, both in relation to access to services and in the ability of such services to address their needs.

In practice, most survivors of torture who seek help in the UK are treated within specialist, third-sector services (Montgomery & Patel, 2011; Patel & Williams, 2014). Refugees and asylum-seekers who may have experienced torture or war related trauma are given special consideration as a subgroup in the National Institute for Clinical Excellence (NICE) guidelines for PTSD (2005). The guidelines acknowledge the complex nature of the trauma presentation in this group and the difficulty of separating psychological, medical, social and even legal needs, suggesting that services working with these clients should attempt to offer an integrated, client-led approach guided by a commitment to human rights. The NICE guidelines recognise that non-statutory organisations may supplement NHS services or even be best placed to take the lead in local service provision.

However, it is far from clear what constitutes an effective and sufficient treatment for survivors of torture. While specialist rehabilitation centres are well placed to gather and disseminate evidence about the clinical needs of traumatised survivors of torture many work from an integrative and holistic approach that creates challenges for designing valid methods of evaluation (Jaranson & Quiroga, 2011; Slobodin & de Jong, 2015). In addition, specialist rehabilitation centres struggle with limited resources in the face of high levels of clients need and as a result monitoring and evaluation of services have historically been deprioritised in favour of the core clinical task of providing treatment to those in crisis (Patel & Williams, 2014). Consequently, the considerable clinical experience amassed by such services has largely failed to translate into a useful wider evidence base (Silove & Rees, 2010; Montgomery & Patel, 2011).

A Cochrane review of evidence for interventions for torture survivors concluded that too little evidence exists, and that the existing evidence is too low-quality, for any particular treatment to be able to be recommended (Patel, Kellezi & Williams, 2014). The authors critically commented, both in the review itself and in a related paper (Patel, Williams and

Kellezi, 2016), on some of the challenges involved in interpreting and evaluating the results of the studies they identified. These issues, in line with those highlighted by other commentators (Jaranson & Quiroga, 2011; Slobodin & de Jong, 2015, are divided for clarity into three main areas: conceptual (for example the lack of consensus into what the needs of torture survivors actually are), methodological (for example how research can identify the active elements of a holistic service model, and how clinical outcomes are determined and measured validly) and ethical (for example the contentious issue of whether a control group should be used and the lack of clarity in identified studies around adverse outcomes and/or treatment dropout).

Recognition by the NICE guidelines of the important place that specialist service providers occupy should not be seen as an excuse for statutory services to avoid addressing their duty of care to survivors of torture (Kinzie, 2007). Patel and Mahtani (2007) state that “psychological services have been slow and reluctant to respond to the needs of refugee people. In particular, faced with survivors of torture, many psychologists are often overwhelmed and paralysed” (Patel & Mahtani, 2007, p. 165). The authors attribute this to their observations that psychologists in statutory services describe feeling personally unskilled, inexperienced and lacking the necessary resources to work with survivors of torture (Patel & Mahtani, 2007; Tribe & Patel, 2007). This view is supported by a review of the evidence for mental health intervention for traumatised refugees and asylum-seekers (including torture survivors) which criticised the continued “shortage of guiding frameworks available to investigators and clinicians who are interested in tailoring interventions to work with refugees and asylum seekers” (Slobodin & de Jong, 2015, p. 17). Lack of engagement into therapeutic interventions with traumatised survivors of torture by researchers and clinicians within statutory service is a factor in the continued marginalisation of this client group within mainstream services (Kinzie, 2007; Patel & Mahtani, 2007).

Specialist services also have a duty to engage in evaluations of their methods that engage critically with the conceptual, methodological and ethical issues identified by commentators here (Kinzie, 2007; Patel & Williams, 2014). Only by producing and participating in research into both method and outcome can specialist services for survivors of torture engage meaningfully with the conceptualisation of clinical needs and therapeutic change, which can then in turn improve mainstream awareness of the psychological needs of this marginalised client group.

The present study

For ethical, legal and pragmatic reasons it is imperative that clinical psychologists invest in researching effective interventions for refugees and asylum-seekers who have experienced torture. Relevant NICE and British Psychological Society (BPS) guidelines encourage collaboration with and learning from specialist third sector service providers (BPS, 2018; NICE, 2005). Therapists' perspectives have been described as central to understanding the therapeutic change process (Sexton, 2007; Sprenkle & Blow, 2007) and a necessary step towards better understanding of the clinical needs of torture survivors is to benefit from the experiences and expertise of clinicians working in these specialist services. The aim of this study therefore is to explore the clinical experiences of therapists based in a specialist service for torture survivors.

Herman (1992) described a three-part model of recovery from trauma that has become a classic reference within the field and which is used within the NICE guidelines for PTSD. The model, defines a common pathway that moves through the therapeutic tasks of 1) Establishing safety 2) Reconstruction of the trauma narrative 3) Restoring connections, although survivors may move back and forth through these stages during their journey to recovery. The results of this study are reported below and will then be discussed in relation to this classic model, as well as the broader evidence base and relevant ethical and methodological issues.

> Research Question: How do specialist therapists understand and describe the therapeutic process in their work with traumatised survivors of torture?

Method

Participants

Data collection took place via a registered UK charity that provides a holistic service to torture survivors, from practical help to psychological care and medico-legal reports. Seven participants volunteered to participate. Participants self-selected for inclusion and were recruited on a first-come-first-served basis until the recruitment period ended. All met inclusion criteria of having a recognised professional qualification in a therapeutic discipline and having worked in a therapeutic capacity with the organisation for a minimum of one year (or the part time equivalent). A variety of professional disciplines and therapeutic modalities were represented, although participants all worked in the capacity of Psychological Therapist within the organisation. Two of the participants were male and five female. Although detailed demographics will not be provided in the interests of anonymity, the participant group was representative of the wider staff group, which included therapists from a variety of nationalities and ethnic backgrounds. Some staff identified as being from a refugee background and in some cases of having been prior service users at the charity. A number had begun working with the charity in another role (e.g. interpreter, volunteer befriender) and had then gone on to train as a therapist.

Design

The study design was qualitative, with data gathered via semi-structured, one-to-one interviews with participants. All interviews were conducted by the chief investigator. These were audio recorded, transcribed individually and analysed using Thematic Analysis (Braun & Clarke, 2006).

Procedure

The study was publicised within the largest national branch of the charity by attendance by the chief investigator at two staff meetings and provision of printed information sheets. At all stages staff were reminded that participation was entirely voluntary and there would be no consequences of choosing not to participate, or of withdrawing consent at a later point. Interested parties were invited to contact the chief investigator directly via email or telephone for more information and/or to arrange an interview. Participants were offered a variety of options for interview location and timing, however all chose to be interviewed in their usual place of work during working hours.

Data collection took the form of a semi-structured interview, of approximately one hour in duration. Interviews covered the same core topics (see Appendix 2 for a sample interview schedule) but were flexible within this framework in order to further explore areas of interest raised by participants. A reflective journal was kept by the chief investigator following each interview in order to aid this process and supervision was utilised to discuss practical, conceptual and process issues arising during data collection. All decisions made regarding the developing interview schedule were similarly documented by the chief investigator. The interviews were audio-recorded, then transcribed and anonymised by the chief researcher.

Analysis

The interview data was analysed by the main researcher using Thematic Analysis (Braun & Clarke, 2006). Thematic Analysis is a widely used, flexible approach that allows for identification and detailed description of patterns across a data set, as well as for higher-level interpretation of these where appropriate and relevant to the research question. Thematic Analysis affords the researcher a considerable amount of freedom with regards to method and underlying assumptions. As a consequence, it is necessary to maintain transparency and accountability in the process, which was addressed in this study by the researcher following the five phase model described by Braun and Clarke (2006), keeping a reflective journal and seeking feedback from the research supervisor on a draft. It is important to recognise that the process is necessarily subjective and reflects the interests and assumptions of the person undertaking the analysis. This analysis can be described as an inductive, latent reading of the data: the themes that were developed were driven by the data and the research aim of exploring the topic, rather than confirming a theory. However, the themes do not represent a full (semantic) description of the data set but are rather a selective investigation of identified topics that relate most directly to the research question. Analysis of the data was approached from a social constructionist stance, which emphasises how power structures and language shape meaning and understanding. Appendices 3-6 contain more details on and examples of the analysis process.

Ethical Considerations

The study was approved by Lancaster University's Faculty of Health and Medicine Research Ethics Committee.

Confidentiality. In the interests of preserving the privacy of service users and staff within the organisation, participants were advised that other individuals should not be mentioned by name or otherwise discussed in a way that might make them identifiable. This was reviewed at the start of each interview. Any minor identifiers in the data were removed during transcription.

Results

Four themes were developed from the data: 1) “Therapy” versus “therapeutic”: Addressing complex needs; 2) The role of the therapist within the therapeutic relationship: reparenting and bearing witness; 3) “Trauma” and the meaning of recovery and 4) When is it safe or necessary to end?

1.“Therapy” versus “therapeutic”: Addressing complex needs

> **That is why I work here, because of the holistic work. I believe that we are not pieces- you can’t cut one part of a person and say “I’ll work with that”** (PT4)

Participants described a dual role in which they were not only therapists, but also held responsibility for overseeing clients’ wider needs such as liaising with immigration officials, legal aid, social services and GPs, spending considerable time negotiating a confusing and unwelcoming system on behalf of vulnerable clients. While participants all described this as a crucial aspect of providing help, there were differences apparent in how they conceptualised this dual role and how it manifested in their work. Participants discussed the challenges inherent in this way of working, its impact on the therapeutic relationship and the formal therapeutic work, and how their dual role related to the aims of the organisation.

Participants described many of the clients they worked with as having few material or social supports, struggling with basic needs such as housing and money in addition to the debilitating uncertainty and stress of negotiating an increasingly restrictive asylum system. Unsurprisingly, the complexity of clients’ practical needs, in the absence of other sources of support, were described as occupying a large amount of time in sessions: “I’ve got one client, I feel I’m his social worker! I’ve told my manager that’s what I’m doing and I think it’s valid because he’s got nobody else to do this”. (PT1)

In addition to a dearth of alternative sources of practical support, participants also described the client group they worked with as suffering from associated barriers to accessing mainstream therapeutic services: "…they don't realise the burdens these families are dealing with and they under-assess people anyway and they're too quick to assess them as not needing any further work" (PT1)

Providing practical support and carrying out "casework" (PT3) was described as both crucial in itself and a necessary foundation for more formal therapy to occur:

> If a person is homeless and he comes to me…I know that the goal is for him to be housed because if he is not housed, if he is not sorted in terms of benefits and support, there is no point to work with the person because the person is over occupied with these difficult practical things. So no therapy can work with that. (PT6)

While all participants emphasised the importance of attending to the holistic needs of their clients, differences emerged regarding whether practical help was a necessary condition for therapy (as in the quote above) or was therapeutic in its own right. Some participants felt that their dual role was difficult to negotiate and this distinction between "therapy" and "therapeutic" was frequently discussed:

> You may end up making phone calls and the hour is gone and we have done very little- which has probably been very therapeutic for the client, but I haven't done psychological therapy as such, if you see what I mean? (PT2)

Others did not express the same sense of inconsistency between such tasks but valued the practical aspect of their role in helping to build trust: "I'm not actually working consciously on building the therapeutic relationship, but I think some of those things, if I do them, do build up a therapeutic relationship, and people tell me that" (PT1). A number of participants built upon this idea and expressed that in their experience, the more that clients grew to understand and benefit from the formal aspects of therapy, the more they came to value this, to the point that some would eventually choose not to address practical needs during the therapy hour: 'some people don't want to bother, they say " The time of the session is so precious for me so I don't want to bother you with this thing, so I will go to the Red Cross or…" '(PT6).

Even those who expressed more ambivalence about the practical elements of the role had difficulty separating out the contribution made by practical and therapeutic interventions: "I think I have to see it as a whole… I think it's probably a combination, or both" (PT2).

All participants were clear that although a dual role was necessary, the formal therapeutic input took priority conceptually if not always in practice: 'we provide a package deal and the priority is the therapy, because practical help can be found somewhere else- but it is very important' (PT6). This tension between holding the belief that both elements of the work were crucial, while at the same time prioritising one, was described as one of the defining characteristics of the service model and what distinguished it in being able to respond to the needs of the client group.

A number of participants reflected on the changing sociopolitical context of their work and stated that harsher asylum criteria, longer delays in decision making and a more unwelcoming society were increasing the need for ongoing practical help and simply "maintaining people rather than helping them get better" (PT1).

The role of the therapist in the therapeutic relationship: reparenting and bearing witness

"That was my interpretation…it was as a mother she wanted me, to cry for her" (PT7)

The importance of the therapeutic relationship as a factor in the recovery process was highlighted by all participants. This was frequently discussed in parental (mainly maternal) terms, with some participants explicitly describing the therapeutic task as one of reparenting. This parental type relationship between therapist and client was described predominantly as providing a foundation for therapeutic work. Participants also described the importance of bearing witness to clients' experiences. Boundaries around this could be difficult to navigate due to the emotional impact of the work.

Participants all spoke at length about the importance of establishing a relationship of trust with clients. A number of participants discussed this in broadly familial terms, explaining that for clients who were culturally unfamiliar with the concept of therapy, likening themselves to an aunt or other older relative who could be confided in was a useful way of explaining what this might involve.

> In many societies, therapy, counselling, is not known- so what I do, I compare it to an auntie, a best friend, you know? To confide about issues that they will never disclose to anyone else…because there is no one here to confide in, I am placing myself in that position for them (PT7).

For the majority however it was a parental role that was most often described when reflecting on their clinical work: "…she saw me as a mother, she was from my own community..." (PT7). The pervasiveness of this theme throughout participant accounts was exemplified by a male therapist who, in reference to the role of physical touch in his work, explained "they're young men, they miss their mothers" (PT1), thus seeming to cast himself in this superficially incongruous maternal role.

As the opening quote of this theme additionally demonstrates, clients were also described as eliciting an emotional response from therapists, a form of bearing witness and shared mourning.

> It was a very heavy session…I couldn't leave him like that, I couldn't let him go like that. So we needed to acknowledge these people who gave their lives- innocent people, civilians- and we'll say the prayers and we'll contemplate it for a bit, after talking about them for a long time. (PT4)

The horrors of what clients have experienced meant that it could be difficult for participants to bear witness to their clients' stories while still holding the boundaries of the therapeutic relationship, and participants described feeling pulled into the shared emotional response clients wanted from them: "Initially it was so difficult …I was crying with clients, you know, listening to them, to their torture, when they were describing the torture and I was always emotional" (PT7). Clients from cultures where open shows of emotion were usual were described as expecting this type of response from participants and it could be difficult to demonstrate that therapists were genuinely moved without becoming unhelpfully unboundaried.

> But not crying, and that is very difficult because I could easily cry...if I cry the client will also feel responsible. But acknowledging the tears, the pain, the loss, it's very very important and that is…cos without showing your understanding and empathy the client will be alienated. (PT4)

A number of participants talked about their responsibility as advocates for their clients, to bear witness on a wider scale: "we don't see our role as only to see clients, but also to raise voice" (PT3), with the same participant also revealing her level of identification with her clients when she commented "these sort of cases we need to share but people don't want to hear the details, how much people suffer- and we do suffer as well sometimes." (PT3)

Participants talked about their awareness of vicarious trauma and how important reflection, supervision and peer support were in order to be able to manage the personal impact of the work, and to avoid either becoming "hardened" (PT7) or "haunted" (PT6).

3. "Trauma" and the meaning of recovery

> **"They come to the first session and they say 'I'm here for you to help me to forget, to wipe out what is in my mind'. Then we explain to them this is not our work, not our job."** (PT3)

Participants described clients' journey to recovery as complex, non-linear, and often complicated by continuing trauma as a result of their uncertain life circumstances. Recovery was defined in symptomatic terms, but also in more existential terms around identity, meaning and acceptance. All participants discussed the importance of clients developing outside relationships and goals as a sign that significant recovery had occurred.

As the above quote indicates, many clients perhaps had little understanding initially of what sort of help they were looking for. For this reason, participants described giving "the benefit of the doubt" (PT1) when assessing readiness for therapy. Early sessions often focused on helping clients to name what they were experiencing and to be able to make links between their current problems and what had happened to them: "I teach people, what do you call it? Psychoeducation. How they feel, to connect with their own body and the thoughts…and then the thing comes up, they say "I am having sleeping problems" and stuff like that" (PT3). Containment and encouragement to talk was key in the initial stages: "…being in an environment where he felt he was being listened to where he felt he could express himself in a way that didn't result in the other person panicking, so he wasn't overwhelmed…" (PT5), whereas when therapy progressed there was more of a focus on making sense of experiences:

> It is acceptance, isn't it? Sometimes people come and they don't know the difference in between reality and…our work is sometimes to make them connect with reality, accept the reality. She was working in a job and had a house and she won't be able to

> go back to her own house anymore, her children are with other people- so it is not easy to accept, but if she stayed there she would have been killed, you know? They see the reality there. (PT3)

There was divergence across accounts over whether the client's experiences of torture and the psychological consequences of these were necessarily the main focus of therapy. While all participants talked about client difficulties in terms of trauma some clearly equated the client's presenting problems with the torture experience and saw the relationship between these as the primary area for intervention: "People who have experienced trauma and torture present in particular ways that illustrate to me immediately that they have been profoundly affected by their experiences and one needs to engage with [those experiences]" (PT2). Others took a broader approach treating trauma resulting from the torture experience itself as one of a number of potential areas where intervention could be targeted. Grief and loss in particular were frequent themes in participants' accounts and were differentiated from the individual's torture experience: "That was so essential, to go through the grieving, all the stages of grief and I don't think I could even have addressed trauma because the grief was overshadowing so many other things" (PT2).

Although some participants used the psychiatric terminology of PTSD, this was rare and when asked to expand upon his mention of it, one participant explained that is was not particularly crucial to the work: "Here you don't have to have a diagnosis to get treatment. You have to have a history of torture and relevant problems that we think we can help that person with" (PT5)

Participants also frequently discussed the impact of practical insecurity and uncertain legal status as both barriers to meaningful engagement and potential tools that could aid clients to look to the future and engage more deeply with their emotions.

> those without the [refugee] status are yearning to have the status because they feel that this is THE obstacle between them and happiness and those with the status are now facing the music- which is life in the UK- or dealing with the real pain, the deep pain, which never disappeared. For that reason the status is something to play with. (PT6)

Participants also described existential issues around identity as prevalent for clients, both in relation to the experience of torture and in the personal meaning of their recovery. The cyclical and shifting nature of clients presenting problems highlighted the need for the service to have the flexibility to be responsive to this.

> She's used therapy really well, we've explored all of her traumatic experiences but almost she's now going through a new crisis of "Who am I now? Am I the old person I was before I came here?"…I was looking at her and I thought, actually, I know she's used therapy really well, I know she's been granted asylum, but she's not in a good place yet" (PT2)

Participants expressed the sense that the final stage of recovery was characterised by clients looking outwards once more, having found some supportive relationships and activities elsewhere, and having a sense of a future: "They've got the status and they start working or they find a new relationship outside and replace the relationship I've provided" (PT3).

4. When is it safe and necessary to end?

> **This is not "forever" therapy but if the client's needs are in that dire a situation we cannot close the case because they are still within our remit and time is irrelevant… for someone like that we can't close it.** (PT4)

This theme relates to the time that clients spend in the service and how clinicians make the decision to end therapy. The unique context of client's lives and the severity of the potential threats to their wellbeing was described as adding a further degree of difficulty to these decisions. Endings were described as difficult not only in a usual therapeutic sense, but also in terms of perceived withdrawal of protection and safety. Concerns were expressed that a trend towards shorter term ways of working would be detrimental to clients.

As the opening quote demonstrates, participants all described work that was dictated by the clients' needs and specific circumstances rather than by predetermined duration of therapy; and all expressed that this flexibility was crucial to working successfully with the client group. Duration of therapeutic contact was often lengthy: "Some we will be working with them for a year and they are more able, they are settled here, some two, some three, and in this case for four or five years because of what he is going through" (PT4). The political context was referenced as a factor affecting this over time: "it's how this organisation was set up, that it's supporting individuals through the whole process- and sadly we're seeing that that's become longer and longer" (PT5).

All participants talked about the importance of working with the idea of ending in mind and expressed that doing so was a therapeutic task in itself: "separation is the main issue here for all of us basically…you need to prepare everybody and there is no open-ended work- in the world, in a humans life" (PT3). However, the traumatic histories of loss that many of the clients had, meant that in this setting, ending could be exceptionally difficult to contemplate for both parties:

> I'm working with this young woman who has been very traumatised and I've been renegotiating endings so many times and it's like throwing a bombshell, she's very alone and very lonely in the world, and she was very traumatised from a very early age, a separated young person, and it's a real struggle. (PT2)

Participants referred to the reputation of the organisation as “a benign institution” (PT 5), a place where clients felt they were safe and cared for. The power of the organisation and its reputation was similarly drawn upon by therapists, with one participant using similar language of refuge and protection (in relation to challenging a legal ruling on behalf of a client): “…it is so important for me to be part of something here, just imagine if I had been part of a private practice- what could I do then? It’s only me in the wilderness!” (PT6).

This perceived power and protection meant that many clients wished to remain in therapy until their legal status (or other practical concerns) were resolved:

> …there are protection issues around, for them, about their fear of being sent back or if they’re going to be sent back, or killed, or tortured again…that probably is quite important rather than just talking about their existential problems or whatever. (PT5)

Participants all discussed the need to balance risk with ensuring that they do not inadvertently foster dependency among vulnerable clients: “they are so, you know, *depleted*, some of the clients that we see, that they want to stay forever here and I can understand that.” (PT7).

Most participants felt that the length of work they currently had the freedom to provide was under threat from a seemingly inevitable shift towards shorter term working; and expressed concerns that if this was not managed properly it would result in a way of working that would not be able to address clients complex, long-term needs:

> “There is kind of a feeling that the work we are providing is not good enough, because its unsustainable financially, and they are looking all the time about “evidence-based…” and I think it’s a very problematic route to go down…We need to provide therapy, good therapy, and we shouldn’t compromise. We should adjust to different, maybe, methods, but not to compromise about what we provide.” (PT6).

Discussion

This study is the first to attempt an inductive exploration of the clinical work of a specialist service for survivors of torture. The four themes that emerged from participant accounts can be seen as consistent with existing models of recovery from trauma. The results also further evidence the complexity of service users needs and in doing so support a broader understanding of how the psychosocial consequences of torture are conceptualised and treated than what is captured by a PTSD diagnosis alone. In addition, the socio-political context of the clinical work is referenced throughout participant accounts, with wider ethical and pragmatic implications for clinicians, service commissioners and policy makers.

Theme 1: “Therapy” versus “therapeutic”: Addressing complex needs

This theme primarily appears to mirror Herman’s (1992) first task of establishing safety and is perhaps where most difference can be seen in comparison with mainstream psychotherapy services. Participants’ description of service users’ practical and material needs has obvious parallels with the first two stages in Maslow’s classic hierarchy of human needs: physiological and safety needs (Maslow, 1943). Without these foundations being established, individuals cannot concern themselves with more abstract, higher order, issues. However, participants noted that restrictive asylum policies mean that these precursors to engagement in psychotherapy can be exceptionally difficult to establish.

Refugee and asylum-seeking survivors of torture experience multiple, cumulative traumas, wherein the trauma related to their experience of torture is compounded by subsequent experiences during migration and again by the ongoing stresses caused by an unwelcoming and re-traumatising asylum process. Therapists working with this population therefore have to carefully navigate the practical and ethical difficulties of guiding a client through the painful work of processing traumas while supporting them through ongoing adverse experiences. While therapists are cautioned not to rush into trauma-related work before the client feels safe enough to tolerate this (both in the therapeutic relationship and in their outside lives), they also run the opposite risk of allowing ongoing practical issues to become a means of indefinitely avoiding the more painful work of revisiting the client's torture narrative- an avoidance that both client and therapist can become complicit in (Herman, 1992). Striking the right balance in the pace and focus of trauma therapy is therefore complicated by political decisions that trap clients in an indefinite state of insecurity.

Participants took on an advocacy role in relation to their clients' needs, something highlighted previously as a crucial ethical responsibility of healthcare professionals working with refugees and asylum-seekers (Başoğlu, 1992; Kinzie, 1987; Gorman, 2001; Watters, 2001). While this theme was concerned with participants' distinctions between the core task of psychotherapy and these other therapeutic aspects of the service, Watters (2001) draws attention to the fact that such debates are more representative of the typical distinction made between health and social care in most Western countries than of any inherent contradiction in the work itself, or the client's perception of it.

Theme 2: The role of the therapist in the therapeutic relationship: reparenting and bearing witness

Theme two, describing the nature of the therapeutic relationship, relates to both Herman's (1992) stages of establishing safety and reconnection. While the importance of the therapeutic alliance is already well described as a factor in the effectiveness of a therapeutic intervention the social isolation of the client group, in this case, in addition to their limited access to other sources of support, means that therapists working with torture survivors may be the most stable and significant relationship in their clients lives at this time (Kinzie, 2001).

Herman (1992) states that the core experiences of deliberately inflicted trauma on an individual are that of disempowerment and disconnection from others. Recovery, therefore, must occur in the context of relationships that provide an alternative and healing experience. The issue of unequal power dynamics, again common to all therapeutic relationships, take on special significance here in light of the client's previous experience of vulnerability at the hands of someone who intends them harm. It is unfortunately also the case that psychological and medical practitioners are involved in the state-sanctioned torture of citizens in a number of countries (Başoğlu, 1992), and some survivors may associate professional roles and clinical settings with their torture experience as a result (Gorman, 2001). Prioritising the genuineness and safety of the therapeutic relationship is therefore crucial. Participants frequently described their role to their clients as similar to a relative or friend, in an attempt to address possible cultural unfamiliarity with the concept of therapy. It could be suggested that this approach also addresses the aforementioned issues of power and vulnerability in the therapeutic encounter, as well as being an explicit acknowledgement of the real life relationships that the client may no longer have to rely upon for support.

Participants described clients as requiring and eliciting a moral response from them. Attempting to treat the consequences of torture is itself a powerful political and moral statement against its acceptability (Başoğlu, 1992; Patel & Mahtani, 2007) and the therapeutic relationship in this setting may therefore take on additional significance for the client that it is important for the therapist to be aware of. A number of commentators (Piwowarczyk, 2005; Kinzie, 2001; Elsass, 1997) have described the need for therapists who work with torture survivors and otherwise severely traumatised refugees and asylum seekers to be open to, and comfortable with, engaging with spiritual issues in therapy. Torture is described as an experience that gives rise to existential questions about the nature of good and evil; and therapists must be able to support clients to come to terms with the fact that there may never be any external resolution or justice regarding what was done to them (Kinzie, 2001). While therapists do not themselves need to be religious, it is important to recognise that both loss and (re)discovery of faith may be significant in torture survivors' recovery (Piwowarczyk, 2005). These observations about the role of faith and meaning in recovery can be seen in the descriptions of participants here, most explicitly in the joint prayers described by Participant three.

Theme 3: "Trauma" and the meaning of recovery

The title quote captures a tension commented on by Herman (1992) between the twin compulsions for survivors of torture to both tell their story and to forget it. However, as the author ultimately states, the goal is to integrate what happened into one's sense of self. All three stages of Herman's model of trauma recovery can be seen in therapists' description of clients' recovery, with movement back and forth between the first and second stages as the client comes to new realisations and is affected by external events. Finally, reconnection with others and integration into wider society is indicative of a newly recovered quality of life for torture survivors.

Highlighted within this theme is the complicated issue of what we consider to be the limits of the psychological consequences of torture, and as such, the usefulness of a PTSD diagnosis in relation to this client group. While some therapists did not appear to draw distinctions between the issues that their clients were struggling with, others distinguished between trauma/PTSD, grief and existential questions around identity. This broad versus narrow conceptualisation of the nature of torture related trauma has consequences for research and evidence. Much of the published evidence base on effective interventions for traumatised torture survivors are based on PTSD symptomology (Horn & Keefe, 2016;

Montgomery & Patel, 2011). However it appear that the subjective experience of distress and clinician's understanding of need is broader than this; an inconsistency that has been described as one of the primary methodological challenges in researching interventions for torture survivors (Fernando, 2010; Montgomery & Patel, 2011).

Based on his experience Kinzie (2001) states that clinical work with torture survivors bears little resemblance to the specific PTSD-targeted interventions described in academic literature. Rousseau and Measham (2007) agree that a narrow diagnostic approach to the consequences of torture, expecting either specific symptoms of illness (PTSD), or resilience and health, is relatively meaningless clinically. Instead, they propose that the torture and surrounding experiences are better conceptualised as a transformative event that changes the ongoing trajectory of the individual's life, a process that may evoke both strengths and vulnerabilities. The idea of what recovery means in such a context becomes complicated, as the individuals self-identity and life circumstances may be so far removed from what they were prior to their experience of torture that there is no normal to return to. Using PTSD-related symptom reduction as a primary outcome measure is also likely to result in misleadingly low outcome effectiveness rates due to the "ceiling effect", wherein torture survivors' trauma and distress levels may be so high that generic and/or commonly used outcome measures cannot capture meaningful change (Montgomery & Patel, 2011). Self-reported and functional outcomes may therefore be more useful for this client group than existing standardised measures, something that also has implications for the validity of outcome research (Horn & Keefe, 2016). This complexity seems borne out by the descriptions of clients' recovery journeys given by therapists in this study, which support the idea of services organised around a broader, person-centred, understanding of clinical need.

Theme 4: When is it safe and necessary to end?

Theme Four highlights another area where the work described by participants differs from most mainstream services, with participants describing therapy of considerable duration and case by case variation. This theme has parallels with Herman's (1992) stages of (1) establishing safety and (3) restoring connections, with tangible outside threats to wellbeing and continued social deprivation cited as reasons why a client would continue to be seen rather than be discharged.

Criticism of the type of holistic approach followed by specialist centres for torture rehabilitation frequently focuses on the lengthy (and accordingly expensive) processes involved, arguing in particular that such extended duration of therapy has no evidence for being more effective in symptom reduction than short term interventions (Başoğlu, 2006). The continued use of lengthy, open-ended, holistic interventions is seen as unethical to both clients, who are not receiving an evidence-based treatment and are arguably maintained in an unnecessary state of disempowerment and dependency upon the service; and funders, whose money is being used in a wasteful and unaccountable manner. While criticisms relating to lack of evidence have been discussed in the introduction and are one of the drivers for this study being undertaken, this argument also touches upon the previous theme and the resulting discussion around broad versus narrow understandings of torture survivors needs. Although short-term interventions are effective for PTSD symptoms (Slobodin & De Yong, 2015) the ongoing distress of torture survivors as described by participants in this study appears to go beyond a PTSD diagnosis, both in terms of the changing nature of clients' concerns across time and continuing threats to their safety and stability. Kinzie (2001) observes that the shift in many domains towards increasingly time-limited ways of working has something of a self-reinforcing effect,

> very few clinicians have had the opportunity…to treat the same patients over a long time. This does give a unique and valuable perspective. Indeed, some of the issues

> addressed would not be clinically apparent in clinics that only provide short-term therapy or where there is a constant change in psychiatrists and therapists. (Kinzie, 2001, p. 486)

Limitations and further directions for research

While the results of this study go some way towards describing the holistic clinical approach of a UK-based specialist service for traumatised survivors of torture, there are other centres of expertise who may work effectively in other ways and it is beyond the scope of this study to examine these or make direct comparisons between methods. Further studies of existing models of intervention, particularly where these are holistic or integrative in nature, are required in order to allow meaningful comparisons to be undertaken. It is also important that such research is not confined to Western contexts: 85% of displaced persons worldwide are resident in developing countries (UNCHR, 2018) and there is likely to be much to learn from approaches to supporting survivors of torture from other cultural paradigms (Fernando, 2010).

A large proportion of refugees and asylum seekers who have experienced trauma (including torture and war-related violence) never seek formal help to manage the aftermath of their experiences (Bhugra, Craig & Bhui, 2010). Whether this is due to prolonged psychosocial sequalae, barriers to accessing support, or unacceptability of available options is unclear. Further areas for investigation, therefore, are the role of strengths and resilience factors in ongoing survival from torture; exploration of how survivors understand and make sense of their experiences; and the subjective experience (and acceptability) of evidence-based interventions.

Our understanding of the psychosocial consequences of torture and how these may best be treated is limited. A broad approach to research into clinical methods and outcomes, wherein plurality is welcomed and collaboration is encouraged between statutory and third sector organisations, would allow for development and evaluation of culturally appropriate services and for the development of a useful body of evidence (Montgomery & Patel, 2011).

Clinical implications

The results contribute towards our understanding of the complexity of the clinical needs of survivors of torture, as well as showing empirically that clinical work does not take place in a vacuum; socio-political issues become individual clinical concerns also. UK clinical psychology has increasingly taken an interest in matters of social justice (Kinderman, 2014; Psychologists for Social Change: http://www.psychchange.org/). In addition to the larger role played by clinical psychologists in managerial/leadership positions (British Psychological Society, BPS, 2007) this means that the profession is ideally placed to advocate for a more psychologically informed approach to asylum policy and relevant service commissioning (Nightingale, Goodman & Parker, 2017).

The findings of this study may be useful for clinicians in statutory services who work with traumatised refugees and asylum-seekers, by providing a framework for understanding the needs of the client group. This is timely in relation to recent guidance for psychologists working with refugees and asylum-seekers, which encourages mutually collaborative working with and learning from community organisations (BPS, 2018). While the complexity of this client group’s needs may mean that third sector services are best placed to remain the primary co-ordinator and source of support for many individuals, it is clear that a more joined-up approach with mainstream health and social care services would be beneficial to all parties. This would include sharing knowledge, practical and financial resources (perhaps via partnership working and commissioning of specific services); as well as in ensuring that the task of providing access to adequate and appropriate services for survivors of torture is not side-lined by statutory services. Although it is impractical for individual clinical psychologists in statutory services to work in the way described by participants here the holistic formulation of need can still be attended to, either via a multi-disciplinary team approach within dedicated services or by individual practitioners familiarising themselves with local third-sector providers in order to signpost clients for further support (BPS, 2018).

Conclusion

The results of the present study demonstrate the complexity of torture survivors' ongoing psychosocial needs, and the need for services and individual clinicians to be flexible and creative in response. The study also highlights the need for a joined-up approach to ongoing research and service development, consistent with what Mollica (1992, p. 35) describes as an "integrated triad" of applied research, advocacy and clinical practice in improving outcomes for survivors of torture. The four themes identified should guide clinicians venturing into this field with regards to what to expect when engaging with this groups of service-users.

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Appendix 1:

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Author Guidelines

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies and Registered Reports. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

All articles submitted to PAPT must adhere to the stated word limit for the particular article type. The journal operates a policy of returning any papers that are over this word limit to the authors. The word limit does not include the abstract, reference list, figures and tables. Appendices however are included in the word limit. The Editors retain discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length (e.g., a new theory or a new method). The authors should contact the Editors first in such a case.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words

- Review papers: 6000 words
- Special Issue papers: 5000 words

3. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

4. Submission and reviewing

All manuscripts must be submitted via Editorial Manager. The Journal operates a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the terms and conditions of submission and the declaration of competing interests. You may also like to use theSubmission Checklist to help you prepare your paper. If you need more information about submitting your manuscript for publication, please email Vicki Pang, Editorial Assistant at papt@wiley.com or phone +44 (0) 1243 770 410.

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5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.

- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use this template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the Project CRediT website for a list of roles.

- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and refer to any previous work in the third person.

- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

- All Articles must include Practitioner Points – these are 2-4 bullet points, in addition to the abstract, with the heading ‘Practitioner Points’. These should briefly and clearly outline the relevance of your research to professional practice.

- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide DOI numbers where possible for journal articles.

- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

- In normal circumstances, effect size should be incorporated.

- Authors are requested to avoid the use of sexist language.

- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

- Manuscripts describing clinical trials must be submitted in accordance with the CONSORT statement on reporting randomised controlled trials (http://www.consort-statement.org).

- Manuscripts describing systematic reviews and meta-analyses must be submitted in accordance with the PRISMA statement on reporting systematic reviews and meta-analyses (http://www.prisma-statement.org).

For guidelines on editorial style, please consult the APA Publication Manual published by the American Psychological Association.

Appendix 2: Sample semi-structured interview schedule

All interviews covered the same core structure but within this were guided by what the participant brought up. The main interview questions and some examples of possible prompts are reproduced below.

1. **Could you tell me a little about your professional background and how you came to work here?** (Prompts: What model did you train in? What appealed to you about this type of work? How much experience do you have with this organisation/client group?)
2. **Could you describe the process of taking on a new client?** (Prompts: How might someone be referred to this service? What do you look for when you assess someone? How do you talk to clients about what they want to get from the service?
3. **How would you describe your model of working?** (Prompts: Do you work in an open-ended or more structured way? What is your experience with setting therapeutic goals? Have you found there are common stages to therapy with this client group?
4. **What have you found to be challenges or barriers to therapy with this client group (if any)?** Prompts: What, in your experience, is the impact of culture/ gender/ language differences on therapy, if anything?
5. **What is your experience of ending therapy with this client group?** (Prompts: How might you know if a client was ready for therapy to end? What does improvement look like for this client group? How do you negotiate endings?
6. **How do you think your practice may have developed or changed across the time you've worked with this client group (if at all)?**
7. **Could you talk me through a particular clinical case that comes to mind?** (Prompts: Why do you think you chose that particular case to talk about? What went particularly well? What (if anything) might you do differently in retrospect?

Appendix 3: Overview of the 6 stages of Thematic Analysis process according to the Braun and Clarke (2006) model

The stages of analysis according to Braun and Clarke (2006) were followed as described below.

Phase 1: Familiarising yourself with your data

The chief investigator personally transcribed the interviews, which allowed for immersion in the data. The chief investigator then read and reread the interview transcripts before beginning coding.

Phase 2: Generating initial codes

The data was coded manually, on a line-by-line basis by the chief investigator. At this stage all data was coded in the same manner, although not all elements of the data set were used in subsequent theme development. Appendix 4 shows an excerpt from a coded transcript.

Phase 3: Searching for themes

The codes generated in phase 2 were organised manually, using post-it notes, mind maps and collation of codes into categories. As this was a latent rather than semantic exploration of the data the chief investigator focused on apparent themes that related to the research question rather than attempting a full semantic description of the data set. Appendix 5 shows an example of how initial codes were organised together to form a theme.

Phase 4: Reviewing themes

Candidate themes were reviewed and explored, both for consistency and robustness (for example ensuring the collated codes told a coherent story and that there was enough date to support the theme) and to ensure that there was no overlap between themes. As part of this process some themes were combined or broken down further and others discarded. Appendix 6 demonstrates this with a comparison between an early thematic map and a final version.

Phase 5: Defining and naming themes

The chief investigator began to write narrative descriptions of each theme, again reviewing whether each was internally consistent, clear and separate from other themes. The final titles of each theme was decided at this stage. The research supervisor provided feedback at this stage and modifications were made following discussions in supervision.

Phase 6: Producing the report

The narrative descriptions of each theme developed in phase 5 were expanded on, along with incorporation of extracts from the data that illustrated aspects of the themes further. The write-up of the results was then situated within the wider context of the research study here.

Appendix 4: Excerpt from a transcript with initial codes

Transcript (**I:** Interviewer **P:** Participant)	**Initial Codes** (and notes)
P:Well in general, with refugees there are so many different levels that one needs to assess, and I guess that's why we work in a very, why we use a holistic model, because there is the psychological needs, there is the welfare needs, there is the legal side of things and they're so intertwined and sometimes you can't just separate out one aspect of it because they're all interconnected but obviously…because in my particular role, because my expertise lies in psychological help, if it was purely the client needed something practical or wasn't interested in or really open to also address psychological needs and how they've been affected by trauma and torture I would need to question whether I can be helpful, because that's my particular expertise. People who have experienced trauma and torture present in particular ways that illustrate to me immediately that they have been profoundly affected by their experiences and one needs to engage with them, what aspects may be helpful initially to engage in order to be able to help them and to address things that are really most extreme, that can be from nightmares to reliving the traumatic experience to sometimes dissociating…sometimes obviously it varies as well, it would be very different if I'm talking to a young separated client as opposed to a mother with young children, and the element of risk, so that would be all so very different as well.	Different levels Holistic psychological needs legal needs welfare needs Intertwined interconnected "can't just separate" Participants role participants expertise Psychological help OR Solely practical needs "wasn't interested" "wasn't open" How client is affected Can participant be helpful? Questioning it/ questioning self Impact of trauma and torture "profoundly affected by" How to begin how to help Where to start- "things that are really most extreme"? Symptoms? Nightmares reliving dissociating Varies Clients circumstances Risk
I: How open do you find people are to the idea of therapy?	
P: I think it varies, it varies tremendously and it takes a long time for some people to be able to understand exactly what we offer because in other cultures they don't have that…they haven't conceptualised, or its difficult to understand the relationship…with some cases maybe other professionals have been negative, so, it takes a long time for some people to understand, and I mean some…also depending on the age group they immediately think going- not only by the age group but a lot of clients, they think "Do I really	Varies Understanding Cultural differences "haven't conceptualised" Difficult to understand THE RELATIONSHIP Bad experiences before Long time to understand Age difference?

want to address painful, traumatic memories, and am I going to get worse…?” They may question- people may agree but once you start they’re very ambivalent, so it’s never a straightforward process.	Ambivalence fear of getting worse? Agree but not sure? Start but then ambivalent? “never straightforward”
I: How do you explain what it is you do/ how you might be able to help?	
P: I use a lot of metaphor. Sometimes I explain, depending on the level of education, depending on their experiences, I ask them questions about other experiences that they may have of being helped before and what’s the difference. I sometimes go to the very basics, if you have pain in your leg you go to see a doctor and then a doctor will look for infection and then you need to clean it and…so I use a lot of metaphor depending on their experiences, depending on their level of education, depending on their age as well, depending on the gender. So I try to connect and engage depending on who I am with. Sometimes I draw, I do drawings, I…and I realise, if I check time and time again, that maybe they still haven’t got it so I need to go back to it, to really see whether they understood it.	Metaphors Education difference Relate to previous experiences Pain Doctor (professional, expert?) Need to clean it Education differences age differences gender differences Connect and engage differs by client Drawing Check and recheck understanding Check for understanding
I: How long might you see clients for?	
P: That’s a tricky one because it can vary tremendously, but in my experience also working…I can see the difference working in the NHS as well, that we do have more freedom in terms of length of time we can see clients, so it has to be, I would say, for longer periods of time. It can be one year, minimum, 2 years, 3 years…or even more, longer than that.	Varies Different from NHS More freedom Longer Minimum one year 2 or 3 years or longer
I: If you see someone who doesn’t yet have a good grasp on what therapy is, would you continue to see them?	
P: That’s a very good question, because you often feel as a therapist, particularly with refugee clients, that they do become very dependent on you and although you feel that therapy is not going to really make much of a difference, you explain that time and time again, people take that almost as a rejection, so…I obviously if I feel that this is not getting anywhere I won’t offer it, but it’s not as straightforward as that, the process. But yes, I will have to at some point say “This is really not working” and end and…	Personal feelings (about the work, about the client?) Refugee clients- different? Dependent “Not making much of a difference” Explain – checking for understanding Experienced as rejection Not getting anywhere Not straightforward Discussing with client Not working
I: Do you have goals in mind for therapy- implicitly or explicitly?	
P: I think again with this client group it’s amazing how you may start negotiating or having a particular therapeutic contract, and you feel you’re really going quite deep in therapy, and there is an external situation, be it housing, a refusal, news from their own country of origin, and it’s like a total	Amazing Negotiation contract Deep in therapy External situation Housing asylum/legal decisions news from home

setback, so the goals, they just go out of the window and it's like you have to start again and it's like constantly having to change gear. It's really unusual for goals to go really smoothly. **I:** Could you talk about the stages of therapy, if there are any in your opinion? (Clarification: how might you know when you can push a little more for example?) **P:** Sometimes by…the observations, sometimes by simply just gauging that, through non-verbal communication, sometimes by the content that the client brings, sometimes by using articular questions that I may…I may sort of use a particular technique which I call, well, it's not my techniques, called warming up the context, that I feel I can begin to ask the client "These may sound a bit difficult, but can I ask you this question? I think…Am I right?" so I double check with the client "Do you think that you're ready to hear something that I'm about to ask you, that I think might sound difficult, are you ready?" So it's quite consultative with the client, through consultation, and sometimes also use systemic techniques in terms of, if the clients has friends if they're a separated young person, or if they're in the context of the family I ask questions about the family members, what do they think about how they are, or I use sometimes scoring scales from 1-10, how do you think you are now in comparison to..so I do like a timeline of how do you think you are now in comparison to when you started…so I use a range of techniques to gauge how deep and how challenging I can go. **I:** What are some common barriers or difficulties to therapy/engagement? I think all the external factors that can become really unsettling, refusal makes people feel…refusal of their asylum situation continues, changes of their own accommodation, maybe their solicitor is not following what they're supposed to be doing, sometimes if they are with families and the children are struggling at school or if they are young separated people they can't go to university because of their asylum…these are external. But internally I think sometimes people may feel that they're not getting well enough as soon as they would like to and they still continue for a long time having a lot of nightmares, they remember their trauma, any external situation may be quite unsettling, they're all interconnected, the external and the internal.	Setback goals go out the window Start again "constantly having to change gear" Unusual- this is common Observing Non-verbal communication verbal communication, client-led Technique? "warming up the context"? Consent to ask Checking understanding Consent Client-led careful Considerate of client Consultation Systemic techniques Friends family What do others think? Scoring scales outcome measures? Assessing change "how do you think you are now in comparison…?" Range of techniques Assessing how much to challenge External factors barrier "unsettling" Refusal makes people feel what? Situation continues changes to living situation Problems with solicitor Problems with children and school Young separated people Options limited- can't go to university because of status Internal barriers "feel they're not getting well enough as soon as they would like to" Symptoms Nightmares remembering external situations unsettling (difficulty coping?) "All interconnected, the external and the internal"

Appendix 5: Abridged sample of codes contributing to a theme

Theme	Subtheme	Relevant codes and quotes
The role of the therapist	Reparenting	**Participant 1:** “attachment injury” Thinking about relationhips in familial terms similarities to work in childrens services? “helping people reconnect to people in their past whom they’ve loved” “separated or lost people” “people impute a position of wisdom”- looking for guidance? “missing their mums” His role- maternal “the major anchors in his life” Therapist as secure base “he said ‘I’m like a chick that’s just been hatched, a little fluffy chicken, and I feel like I’m being thrown out of the nest too early’- metaphor of growing up Age dynamic important **Participant 2:** “what it means to be separated from your family of origin, and wars and…” Loss. Separation. Aloneness Personal experience “a young separated client” Loss and vulnerability. Aloneness “dependent on you” “I’m always thinking about relationships within the family and more context of the family” “she’s very alone and very lonely in the world, and she was very traumatised from a very early age, a separated young person” “she was very very close with her mother, and the losses, the grief…” Absence of former relationships and support. Loss. Aloneness **Participant 3:** “very vulnerable young woman, and I couldn’t take the risk to leave her alone” Responsible, protective “He said it was like being naked. He said he missed the father all the time but later on he created a father” Searching for relationship Vulnerability Absence, loss- seeking “to find maybe the father” Object-relations- what the therapist represents “people leave with you, they take you in as a model” Guidance “they try to tell you, you know, good thing that we want to tell our mother!” Pride, sharing joy Therapist taking maternal role

		“I feel that if I say ‘I’m not your mother here…’ you know?” Difficulty managing transference. Role clients expect you to play “no parents around, no Good, and they become very angry”… “I say “I’m here” Taking place of parents. Guidance Loss “I allowed her, because her mother died when she was 7, you know…then I was trying to set boundaries” Boundaries difficult “she was crying like a child” Managing distress and clients needs Client as child “it was really my interpretation and they accepted it, it was as a mother she wanted me” Wanted therapist in maternal role. **Participant 4:** “they attach to you quickly because of their needs” Complex needs Attachment Client needs “We work with these kinds of people, their needs are very high, until whenever we feel like they are able to cope, look after themselves and until they’ve moved on in their lives. “ Description almost parental- growing-up, dependent to independent, Complex needs “what next for this person, either to move on to find a job and work and get married or whatever”- growing-up and moving on. Childhood metaphor Secure base “So when they reach that point we don’t need to be there like their mother and father, yes? We played that role for that period that they lost touch with everything in their life and then after that they are grown-up, they need to depend on themselves again” Explicitly parenting metaphor! Stepping into role Loss “most of these people don’t have families here, they don’t have no one here” Alone, vulnerable “Safe space” Secure base? **Participant 5:** “you’ve got to be very careful that you’re not confusing the role of the therapist with a paternalistic role or whatever.” Avoids parental role? “I worry about that dependency developing”- less accepted than other accounts? “you’re the person who could save them…and obviously you could fall into that role if you weren’t aware of it and act it out.” Role to be avoided “Wean them off” Infant metaphor Encourage independence

		“And they see it as home… they see it as sort of family and home” Attachment to organisation more widely. More comfortable than 1:1 attachment? **Participant 6:** “what he lost in the torture but what still remains, his childhood, the upbringing, is the thing to deal with” Attachment focus “because the torture ruined his trajectory into being something to fulfil his parents need” Work linked-relationships with parents impact later experience and recovery “they find a new relationship outside and replace the relationship I’ve provided” Growing up and moving on metaphor again “then we started talking about the father, what does it mean for her if she owes him” Recovery affected by parental relationships/attachment experiences **Participant 7:** “I compare it to an auntie, a best friend, you know…because there is no one here to confide in, I am placing myself in that position for them” Cultural understanding. Setting up expectations. Boundaries? “when I see clients from my own community, for example, they expect me to cry with them” “Some do not understand it, they say ‘Why she is behaving like…she is one of us’” Difficulty with using familial comparison. Boundaries not understood? “also I am a professional working professionally and they understand, they seem to understand it.” Contradiction? “so she was considered as an adult, but I saw her as a young person” Protective. Recognising need and vulnerability “probably she saw me as a mother” Explicit recognition of role “and I kept saying that yes, I do understand what you, I do see that you see me as a mum, you see me as your mother but you have to understand you’re all grown up now and you know, you should think of moving…” Explicit recognition of role. Trying to establish boundaries but not denying role. Growing-up metaphor “she saw me as a mother, she was from my own community” Cultural similarities help relationship “When clients say…that they are among a family, they feel that the group is their family, that’s why I start working here” Explicit use of family metaphor Attachment to wider organisation too “it is part of myself I see in the clients” Personal identification/relationship, not just a job “I discussed with my supervisor and she said ‘Well, she needs you, she is having a lot of issues but not being parented.’” Explicit use of parental role. Supervisor

		affirming role. Recognising client need. Absence of parents/family. “her relationship seems to be more close with me than her mum, so she was able to tell the mum, the distant mum, and she was not able to tell me, you know, the close mum that was there for her all the time” Breach in parental relationship confusing. Boundaries? Identification with parental role Explicit recognition of role “searching for love that she never had from her family?” Trying to understand client needs/motivations Searching for relationships “I would love them to stay, I will miss them, but I think it’s for their own good to leave and to start their own life.” Growing up metaphor again

Appendix 6: Evolution of themes

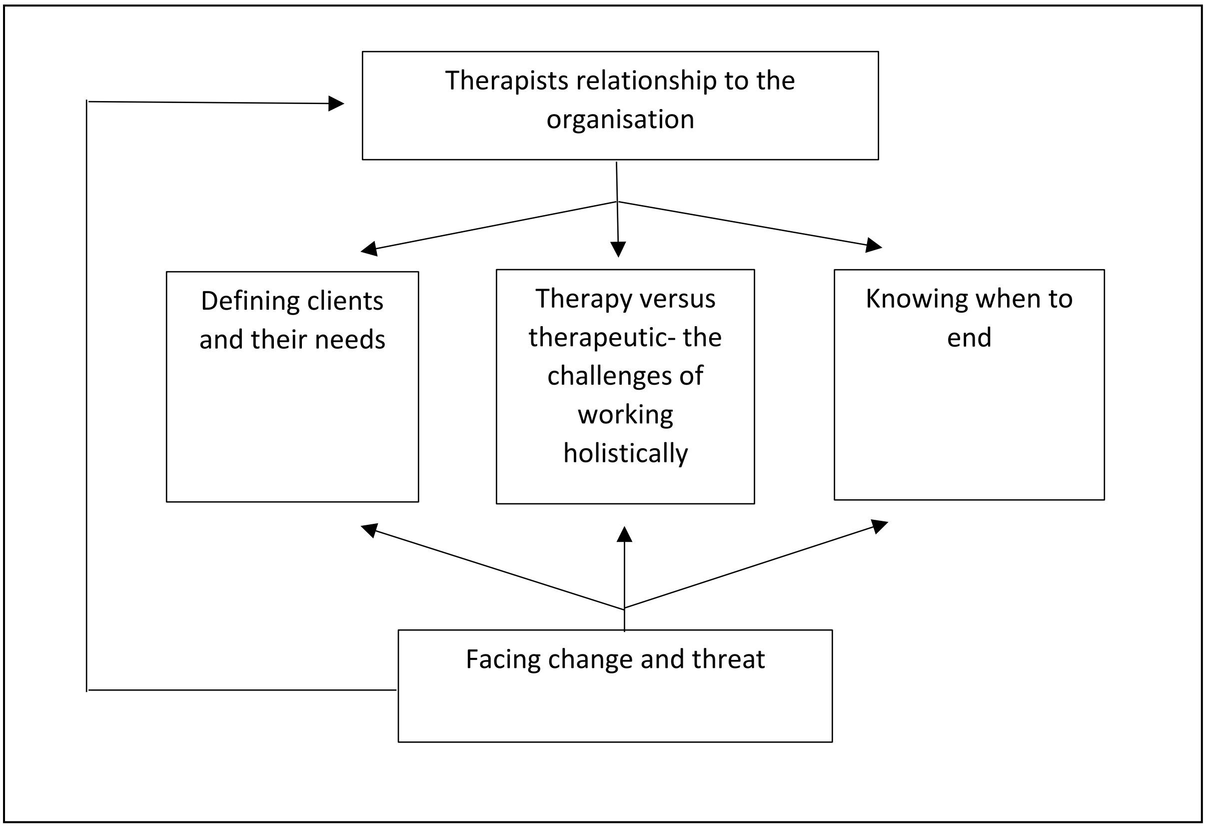

Figure 1. Early version of thematic map

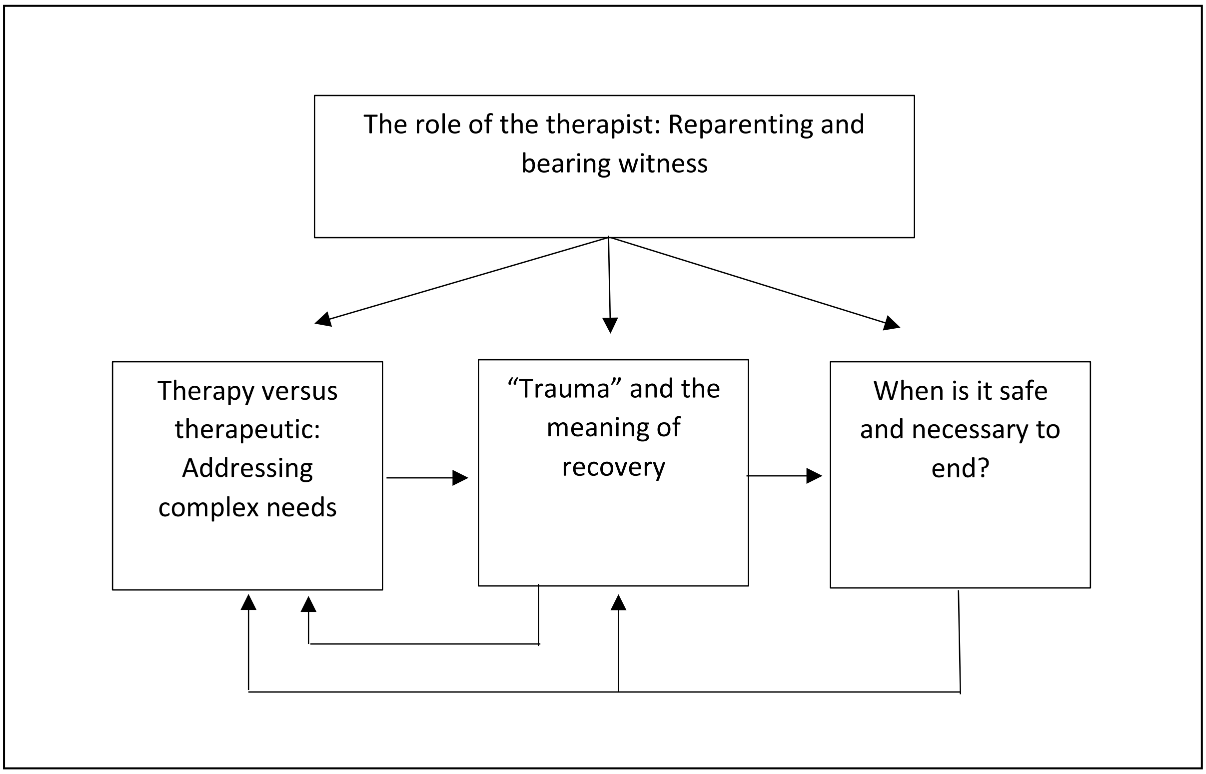

Figure 2. Final version of thematic map

Section Three: Critical Appraisal

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This critical appraisal comprises my reflections on the process of developing and carrying out the study. I focus on two main areas: reflexive and methodological issues inherent in developing the research study and my reflections on working with a third sector organisation.

Developing the study

Initial interest in the topic

The idea of exploring therapeutic interventions with survivors of torture came from my supervisor's voluntary work in a relevant third-sector organisation. During conversations about his work we identified that there was professional disagreement about how best to treat trauma within this client group; and a notable lack of any large-scale response from clinical psychology to the needs of refugees and asylum-seekers more generally. I was already interested in the issue of cultural differences in mental health and was planning a specialist placement in a third sector community psychology organisation that specialised in culturally adapted interventions, which seemed as though it would complement and provide a useful perspective on this as a thesis topic.

Relevance of the research to clinical psychology

As I started to read around the subject in order to narrow down a research question and a related topic for my literature review, I was struck by the volume of academic literature relating to some aspect of mental health in refugees and asylum-seekers and found this daunting to begin with. However it became clear that a much smaller proportion of the literature consisted of empirical studies and very little research was conducted by clinical psychologists. This observation was echoed by commentators (Nightingale, Goodman & Parker, 2017; Patel and Mahtani, 2007) who highlight the fact that clinical psychology in the UK has to date largely stayed away from engaging with issues of asylum policy and the healthcare needs of refugees and asylum seekers. This prompted challenging but useful supervision discussions about the relevance of my proposed research to clinical psychology, given that much of the literature I was basing my rationale for exploration of the topic on, came from other disciplines such as psychiatry, epidemiology, psychotherapy, social work, and nursing. I ultimately felt that the limited interest within UK clinical psychology in the needs of refugees and asylum-seekers was indicative of the wider neglect of this group within health and social care, and believed there was a clear ethical imperative for us to engage with the issues of what their clinical needs may be and how these may best be addressed. Nightingale et al., (2017) suggest that part of the reason for psychology not having more of a voice in issues of asylum is that we are still seen as solely operating on the level of the individual. I agree with the authors when they argue that a) as a profession we have skills that allow us to comment meaningfully on wider issues plus b) we lose sight of the fact that asylum-seekers and refugees are not just a depersonalised group but are a collection of individuals, many of whom have clear, unmet psychological needs that inarguably fall within our remit. The ability to provide a rationale for a new study, based on a review of existing research within the field, is a crucial part of developing a research project. However, I believe that too strict a focus on professional identity and its permitted boundaries can also limit exploration of novel topics and thus maintain a gap in the knowledge base. The limited previous research by clinical psychologists in this field did not feel like a reason not to explore the therapeutic needs of torture survivors, although this was perhaps proved more challenging in execution than research in a more populated field would have been.

My final research question, “How do specialist therapists understand and describe the therapeutic process in their work with traumatised survivors of torture?” was driven by a number of converging gaps in the evidence base: the criticism of holistic third-sector approaches to torture treatment worldwide for failing to define or evaluate their own processes sufficiently (Başoğlu, 2006; Slobodin & De Jong, 2015); the counter-argument that the more robust evidence-base for specific, short-term interventions with this group was based on a reductionist understanding of clinical needs and bore little resemblance to what it was like to work therapeutically with torture survivors (Jaranson, Jacobs, Kinzie & Quiroga, 2006; Jaranson & Quiroga, 2011; Kinzie & Fleck, 1987); and the absence of significant clinical psychology engagement with these issues despite the fact that the client group in question fall within our academic and clinical remit. Although a systematic review of the evidence base was not feasible within this study it was my hope that this thesis would begin to organise and explore some of the apparent gaps within existing research. This may direct future research in the field and allow for the evidence base to be described in a more structured and objective manner at a later point.

Qualitative research as an iterative process

From my initial conversations with my supervisors, my initial ideas were refined into a more specific focus. This was my first experience of developing a research idea from such an early stage. I found the process of developing initial ideas into a research question that would be relevant, novel and feasible in the timeframe to be challenging, mainly in relation to feeling frustrated when ideas did not work out and managing feelings of uncertainty and lack of confidence. Although I knew that qualitative research is an iterative process, it is only having experienced this I have been able to fully appreciate what that means. Something that I struggled with was feeling restricted by decisions I had made earlier in the study, for example my research question and choice of methodology. These decisions were made when I was writing my initial proposal for the study and applying for ethics approval, however as I became more familiar with the literature base I found these choices did not entirely reflect my research interests and no longer felt appropriate.

As I continued to read within my field of interest, interviewed participants and reflected on the themes that were starting to emerge in my analysis, I became clearer about what it was that I was interested in exploring. This made me concerned that I would have to either discard themes that were being developed from the data as being irrelevant to my initial question, even though they felt important and of interest, or that I would be imposing a predetermined framework on the data rather than being led by it. Agee (2009) points out that some qualitative researchers recommend waiting until the research is underway to even start formulating specific questions, however acknowledges that for practical reasons this purist approach is not always possible. She encourages researchers to see initial questions as a starting point for enquiry and states that: “First iterations of questions are tentative and exploratory but give researchers a tool for articulating the primary focus of the study”. Exploring this in supervision showed me that it was acceptable to make the changes of emphasis I felt necessary without significantly changing the remit of the research or affecting the terms of my ethics approval.

Srivastava and Hopwood (2009) discuss the challenges of engaging with a reflexive, iterative approach. They encourage researchers to own the subjective nature of qualitative analysis and state that

> The role of iteration, not as a repetitive mechanical task but as a deeply reflexive process, is key to sparking insight and developing meaning. Reflexive iteration is at the heart of visiting and revisiting the data and connecting them with emerging insights, progressively leading to refined focus and understandings. (Srivastava & Hopwood, 2009, p.77)

I also found the authors’ proposed iterative framework helpful in my analysis and in critiquing early drafts of my results. As I read more widely around the process of conducting qualitative research I felt more confident in my decisions and in understanding that rather than being a setback or mistake these changes of direction were a valuable part of engaging with the research study in a reflective, iterative way.

Choice of methodology

I considered a number of approaches in the process of refining my research question and eventually decided upon Thematic Analysis (Braun & Clarke, 2006). I am relatively new to qualitative research and had more familiarity with thematic analysis than any other method, therefore felt more confident in my ability to analyse and report on the data than I would if learning a new approach. Additionally I considered that this study was an exploratory and descriptive piece of research and accordingly wanted to analyse and describe the data in a simple, transparent manner with a minimum of overlying interpretation or theory. The apparent simplicity of thematic analysis is sometimes considered to be unsuitable for rigorous, academic research (Braun & Clarke, 2006). However, the lack of requirement of any attached underlying theory or epistemological position in thematic analysis does not mean that it does not require such considerations, merely that it is non-prescriptive and can (indeed should) be adapted to the position of the researcher. I considered the flexibility and clarity of thematic analysis to be particularly suitable for this study and felt that it fitted best with my epistemological stance. I consider myself to work from a social constructionist approach, which considers reality and meaning to be constructed societally. While I could have used Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) and considered it for some time, I ultimately felt that its phenomenological, realist underpinnings did not fit well with my epistemological position or allow for consideration of the wider socio-political context that informed my research interests. IPA would also have felt inconsistent with my literature review, which was informed by a feminist, constructionist reading of the literature. The final decision to switch from IPA to thematic analysis was made following discussion with my supervisor about an early draft of my results. I had found the process of analysis constraining and felt that the draft reflected the individual experiences of the participants and the organisational context more than what I was interested in, which was the wider question of what it is like to work with this particular client group. Supervision allowed me to recognise that the initial choice of methodology had been made at an earlier stage and had not been re-examined despite other changes to the focus of the study. Upon review of the interview schedule and the data already collected I felt that it would be possible to apply a thematic analysis approach without any inconsistency at this stage, and so began the process of organising and coding my data again according to the process described by Braun and Clarke (2006). The authors point out that there are no correct or incorrect methods but that: “What is important is that the theoretical framework and methods match what the researcher wants to know, and that they acknowledge these decisions, and recognise them as decisions”. Although I had some anxiety about changing the analysis method I feel confident that the decision was led by the research question; and that it was a considered and transparent choice.

However, despite my choice of thematic analysis as my research methodology, this study could conceivably have been carried out successfully using different approaches and these would likely have produced different results. Grounded theory (Glaser & Strauss, 1967) in particular could be a valuable way to take the findings of this study further by developing theories that would inform ongoing service development and outcome evaluations for torture survivors.

The choice of topic and methodology for my literature review were also arrived at in an iterative manner. Literature focusing on the clinical and therapeutic needs of torture survivors frequently referenced the postmigration social context as an ongoing source of stress that could inhibit recovery or become a source of trauma in its own right. While not all torture survivors are necessarily refugees or asylum seekers I was interested in the experiences of people who had left their country of origin under duress, as opposed to migrants for economic reasons. I envisioned the literature review as a general introduction to the difficulties inherent in life postmigration, without a particular focus on a clinical population. This would provide the context for exploration of the needs of the subgroup with the most severe levels of psychological distress. The focus on gender as a point of comparison within the review came from its salience as a topic of discussion within the early literature that I read, as well as my own interest in feminism and gender studies.

The role of supervision

Etherington (2004) highlights the importance of research supervision in reflexivity, stating that “students use their supervisory relationships to ‘tell the story’ of their research in order to process their learning and experiences” (p.99). This statement again fits my own experience of the project, where supervision was key to my decision making and growing confidence. During the course of the study there was a change to both my field and university supervisors, with the new supervisors bringing different perspectives and interests to the project. While this was a cause for some anxiety I found that the changes in supervision provided new insights and helped me to critically reflect on the process so far. This highlighted areas in which I lacked confidence and clarity, but was also a reminder of what was important and meaningful to me. Supervision therefore played a significant role in my growing confidence as a researcher more generally and in my sense of “ownership” over this study in particular.

Collaboration with a third-sector provider

Developing and seeking approval for the research

Meeting the directors of the charity early in the process helped me to refine my research further, prior to presenting a formal proposal to their internal research ethics board. Although inspiring, these conversations presented some challenges which I discussed in supervision throughout this part of the study development. Although I was keen to collaborate with this charity due to their extensive experience they are inundated with requests to conduct research and are understandably selective about which projects they approve, with projects that provide direct benefit to the organisation and/or its clients preferred. I found that I had to negotiate firmly at times to ensure I retained "ownership" over the project aims and that the goal of my research was wider dissemination of knowledge, in theory mainly to clinical psychologists working in statutory services. Although these discussions resulted in support for my research in retrospect I feel some differences in opinion persisted and may have had an impact on recruitment.

Recruitment

Once my project had ethical approval I visited the charity twice to meet with their clinical teams. I used this time to explain the rationale for the study, answer any questions and explain how interested parties could contact me. I provided attendees with the participant information at this time. I also circulated reminder emails with the study details via my field supervisor a number of times following these meetings. Seven therapists contacted me and went on to take part in the study during the available recruitment period. Although this was within the target I had set I was disappointed that more people had not volunteered to participate.

Although I feel that I gained extensive and detailed enough data to complete a meaningful analysis there are some changes I would make if I were to repeat the study, such as expand recruitment to the charity's other regional bases, or consider recruiting therapists from outside the organisation who had sufficient clinical experience with torture survivors. These strategies were not followed at the time as we had predicted higher levels of engagement from the branch that I recruited from, plus when it became apparent that it was unlikely more people would express interest there was no time to seek ethics amendments. Regardless of these practical issues that may have impacted on recruitment, I felt that there were less tangible issues that impacted on therapists' willingness to participate.

Attitudes towards the study

During my attendance at team meetings to publicise the study I encountered some unexpected questions and critical feedback. This fell into two main categories: a misperception that the proposed study was intended to evaluate therapist's work (and that this was unwelcome), and questions about why the organisation should share their expertise with other parties. Although these questions were in the minority it was a frustrating experience that I struggled to understand.

My previous experiences had been within National Health Service (NHS) or university settings, where participants were used to external research being conducted and where most healthcare professionals had conducted research as part of their own training. I initially considered whether I had made assumptions about the familiarity of other professions (particularly psychotherapeutic traditions with which I am not very familiar) with working in a scientist-practitioner modality and with differences between audit and exploratory research. As a result I chose to ask participants to discuss why they had volunteered in order to address any misgivings or lack of clarity about the nature of the study and thus ensure that people were participating with informed consent. Answers to this question were evenly split: some participants supported the idea of increased research into the therapeutic needs of the client group more generally and described welcoming the idea of feedback and an opportunity to critically reflect on their practice; whereas others focused on their desire to evidence the work that the organisation was doing and the need to continue working in this way. While there may still have been systematic differences between those who chose to take part and those who did not, questioning participants about their motivation thus showed a balance between therapists who were protective of, and more critical of, the service model.

I was also made aware that the service was in a stressful process of reorganisation and that that context may have influenced how the research was perceived. While I did not know the specifics of this the knowledge helped me to understand the critical reactions the study received from some of the potential participants. As part of my growing understanding of the field of interventions for torture survivors, I was able to formulate these experiences and consider how they informed the study, as well as to reflect on my own impact as a researcher.

Human rights approach versus "medical" model

Silove and Rees (2010) discuss the history of torture rehabilitation services and draw attention to the fact that they evolved from a human rights informed approach, explicitly positioned as an alternative to the mainstream "medical" model which was seen as inadequate to meet the needs of the torture survivors. Such services have continued to develop separately from mainstream and statutory healthcare providers, with continued ideological and practical separatism named as one of the barriers to shared understanding of the needs of torture survivors (Montgomery & Patel, 2011; Silove & Rees, 2010). Montgomery and Patel, (2011) describe specialist rehabilitation centres as frequently engaged in a struggle to continue providing high quality interventions in an unstable political and financial climate, something that can be seen in participant accounts here. Research and evaluation can become deprioritised in favour of the primary task of clinical work. This attitude towards research can become more explicitly negative however, with the authors acknowledging that

> “For some, research is viewed with deep suspicion, and dismissed based on views that research can be harmful, that it diverts valuable and scarce financial resources away from direct client care, and that research on torture victims is generally unethical” Montgomery & Patel, 2011, p.142)

Silove and Rees (2010) critique the unhelpful polarisation at the extremes of a human-rights versus medical spectrum that can occur in debates around this subject (Başoğlu, 2006; Jaranson et al, 2006), despite the fact that in reality most practitioners are somewhere in the middle. Leaning (2001) also highlights the fact that, for opponents of medicalisation of torture survivors, a more extreme “anti-science” ethos can develop that equates research with a narrow medical model.

Considering my own role

Understanding the historical and contemporary pressures on the organisation helped me to appreciate the context of the research more fully. My motivation for exploring this research idea was partly driven by the belief that there was value in the clinical experience of specialist therapists even though this was not reflected by existing outcome research. I had therefore been taken aback by the resistance to the idea of the study shown by some individuals. I now recognise this lack of shared understanding as an issue inherent to conducting research with ideologically driven organisations, and one that has previously been identified as a barrier to greater collaboration between specialist rehabilitation centres and statutory healthcare providers. If I were to repeat this study I would consider the context and my own role in this more carefully. Although I felt supportive of and interested in a human rights-based model of working, I can appreciate that to some potential participants I may have seemed like a representative of the mainstream statutory services that they exist as an ideologically driven alternative to. In light of financial pressures on third sector organisations I may also seem to have been approaching the research from a position of privilege, as an NHS employee with greater stability and access to resources. In retrospect I would have liked to spend more time building relationships with potential participants and understanding the service context before collecting data, perhaps via initial focus groups or scoping interviews. This may have resulted in greater investment in the study aims and therefore higher levels of participation.

Further directions

The recent British Psychological Society Guidelines for Working with Refugees and Asylum-Seekers (British Psychological Society (2018) were not published in time for me to draw on their guidance in the course of this research, but would have been useful as they touch on relevant issues. The guidelines firmly situate the psychosocial wellbeing of refugees and asylum-seekers within the remit of psychologists and highlight the importance of building working relationships with specialist third-sector organisations. The guidelines comment on the lack of confidence some psychologists have in working in a collaborative, community focused way with third-sector providers; and emphasise the importance of community partnership skills (recognising that these are rarely formally taught on training courses). The process of collaboration between specialist rehabilitation centres for torture survivors and statutory providers is a topic worthy of investigation in its own right, and I would suggest that others interested in the subject consider scoping exercises to explore this further.

My research was intended as an exploratory, descriptive account of the therapeutic needs of torture survivors, from the perspective of specialist therapists. This was in line with researchers and clinicians from varied perspectives who advised that such descriptive studies were a necessary first step towards shared understanding and the development of a robust evidence base (Başoğlu, 1992; Jaranson & Quiroga, 2011; Kinzie, 2007; Watters, 2001). The results provide an empirically derived, trans-modal framework for understanding and formulating issues that may arise in the course of therapy, and therefore may prove useful to clinical psychologists working with torture survivors, especially where they feel inexperienced with this client group. It is hoped that the results of this study, and reflections here on some of the process issues involved, encourage other clinical psychologists to build upon the findings with further collaborative research. Both the results and the process of this research highlight some of the challenges of engaging with the issue of therapeutic interventions for torture survivors, but, in line with other commentators (Horn & Keefe, 2016; Jaranson & Quiroga, 2011), also highlight the importance of starting to do so in a sustained manner even where the subject matter feels too large and too unclear to easily make a significant contribution to. It is only by doing so that we can create a robust literature base and ensure that torture survivors are receiving effective, comprehensive and culturally acceptable interventions.

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Section Four: Ethics section

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Faculty of Health and Medicine Research Ethics Committee (FHMREC) Lancaster University

Application for Ethical Approval for Research

Instructions

1. Apply to the committee by submitting
   - ✓ The University's Stage 1 Self-Assessment Form (standard form or student form) ***and*** the Project Information & Ethics questionnaire. These are available on the Research Support Office website: LU Ethics
   - ✓ The completed FHMREC application form
   - ✓ Your full research proposal (background, literature review, methodology/methods, ethical considerations)
   - ✓ All accompanying research materials such as, but not limited to,
     1) Advertising materials (posters, e-mails)
     2) Letters of invitation to participate
     3) Participant information sheets
     4) Consent forms
     5) Questionnaires, surveys, demographic sheets
     6) Interview schedules, interview question guides, focus group scripts
     7) Debriefing sheets, resource lists
2. Submit all the materials electronically as a **SINGLE** email attachment in PDF format. Instructions for creating such a document are available on the FHMREC website (http://www.lancs.ac.uk/shm/research/ethics/).
3. Submit one collated and signed paper copy of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the research ethics committee website http://www.lancs.ac.uk/shm/research/ethics. Applications must be submitted by the deadline stated on the website, to:

   Diane Hopkins
   Faculty of Health & Medicine
   B03, Furness College
   Lancaster University, LA1 4YG
   d.hopkins@lancaster.ac.uk

5. Attend the committee meeting on the day that the application is considered.

1. Title of Project:
Modelling an Effective Therapeutic Approach for Traumatised Survivors of Torture.

2. If this is a student project, please indicate what type of project by ticking the relevant box:

☐ PG Diploma ☐ Masters dissertation ☐ MRes ☐ MSc ☐ DClinPsy SRP

☐ PhD Thesis ☐ PhD Pall. Care/Pub. Hlth/Org. Hlth & Well Being ☐ MD ☒ DClinPsy Thesis

☐ Special Study Module (3rd year medical student)

3. Type of study

X Involves direct involvement by human subjects

☐ Involves existing documents/data only. Contact the Chair of FHMREC before continuing.

Applicant information
4. Name of applicant/researcher: Marie Winterson
5. Appointment/position held by applicant and Division within FHM: Trainee Clinical Psychology, Doctorate in Clinical Psychology (DClinPsych)
6. Contact information for applicant: E-mail: _m.winterson@lancaster.ac.uk Telephone:_07912284356____________________ Address:_c/o Programme Office, Room C16, Furness College, Lancaster University, LA1 4YG
7. Project supervisor(s), if different from applicant: Name(s): _Dr Stephen Weatherhead ____ E-mail(s): _s.weatherhead@lancaster.ac.uk __________________________________
8. Appointment held by supervisor(s) and institution(s) where based (if applicable): Lecturer in Health Research and Clinical Tutor, Doctorate in Clinical Psychology, Lancaster University.
9. Names and appointments of all members of the research team (including degree where applicable) [redacted]
The Project **NOTE**: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (maximum length 150 words).

Estimates of the rate of Post-traumatic Stress Disorder (PTSD) in survivors of torture have been suggested to be between 50 and 67%. The complex nature of the trauma presentation in survivors of torture, in addition to practical factors affecting their access to mainstream services, means that many are diverted to specialist third-sector centres for treatment.

The literature base is far from clear about what psychological treatments are effective for survivors of torture who present with PTSD; and it is thus crucial that expertise accrued by specialist services such as [redacted]ined and used to further inform our understanding of the needs of this marginalised client group.

This study will interview therapists working with [redacted]ical work in order to define and understand the interventions used. A theoretical service model currently exists, but this study seeks to understand how this informs the way in which therapists [redacted] [redacted] work on a session to session basis. Understanding this will aid the development of increasingly evidence-based interventions for the client group. The data from the study will be analysed qualitatively using Interpretative Phenomenological Analysis.

Primary research question: How do specialist therapists understand and describe the therapeutic process in their work with traumatised survivors of torture?

11. Anticipated project dates

Start date: October 2014 _________ End date: _May 2015 __________

12. Please describe the sample of participants to be studied (including number, age, gender):

A minimum of six and maximum of ten participants will be sampled for the study. All participants will be required to be current employees of [redacted] (in a directly therapeutic capacity); to have been in their current post for a minimum of one year or the part- time equivalent; and to hold a recognised professional qualification.

Exact breakdown of demographics is unknown at this stage, however all potential participants are over 18 years old and have full capacity to consent to involvement.

13. How will participants be recruited and from where? Be as specific as possible.

Potential participants are therapists working with [redacted]. The study will be publicised within the workplace by internal email (consisting of the participant information sheet) forwarded by the field supervisor and by attendance of the chief investigator at one or more staff meetings to introduce the study. To maintain confidentiality no expressions of interest will be sought at this time; however interested parties will be invited to volunteer to take part, or to find out more information, by directly contacting the chief investigator (contact details provided in the participant information sheet). Participants will be recruited on a first-come-first-served basis until adequate numbers are reached.

Currently it is expected that participants will be recruited from the [redacted] branch of [redacted] only, however it is possible that recruitment may occur across all their UK branches. This will be decided in conjunction with [redacted] Research and Development Department. Whether eventual recruitment is from a single base, or multiple, the targeted sample range will not change and the procedures detailed above will remain the same.

14. What procedure is proposed for obtaining consent?

Participants will initially self-select on the basis of interest in taking part, having been provided with information about the study aims and procedure. At this stage they will be given any further information, have the opportunity to ask any questions and sign a consent form that details the information and procedure already provided and indicates acceptance of these. Participants will be made aware that they can withdraw consent at any stage prior to the study being submitted for assessment to the Lancaster University Doctorate in Clinical Psychology programme. In the event of a participant withdrawing consent once all the data has been anonymised and pooled, all reasonable efforts will be made to identify and remove the data provided by the participant in question. This is detailed in the consent form that participants will be asked to sign.

15. What discomfort (including psychological), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.

Although the subject matter may involve recollection of distressing experiences this is not likely to cause more psychological discomfort than what the participant would experience in the course of their day-to-day work. In the event of a participant becoming distressed they will have the option of postponing the interview or of withdrawing from the study, and will be encouraged to utilise their usual supervisory and support systems in managing this.

No other discomfort or inconvenience is anticipated apart from the time burden of participating in an extended interview. This will be addressed via provision of full information in advance to the potential participant and informed consent being gained. Interviews will be scheduled at a time and place convenient to the participant, and they have the right to withdraw from involvement at any stage with no consequences.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, details of a lone worker plan).

The researcher will be carrying out one to one interviews, however these are predicted to be mainly conducted in populated work premises during normal working hours. There are no additional risks inherent from the proposed participant pool. As participants will also have the option of being interviewed at another location (such as Lancaster University, or their home address) outside of working hours, the Lancaster University Lone Worker policy will be followed where relevant. This can be found at http://www.lancs.ac.uk/depts/safety/files/fieldguidance.pdf. Of particular relevance is the guidance on establishing checking systems between the principal investigator and supervisor(s) and a contingency plan in the event expected contact is not established. The details of this will be arranged by the research team in the event of interviews being arranged outside of participants work premises (please note that in the event of participants choosing to be interviewed in working hours the responsibility is theirs to make any necessary arrangements with their line manager).

17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There are no direct benefits to participants from taking part in the study, although involvement may be interesting and the results may have wider benefits for the employing service.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

Travel expenses may be reimbursed in the event of data collection taking place outside of participants' normal working hours and thus requiring additional travel.

19. Briefly describe your data collection and analysis methods, and the rationale for their use

Each participant will be interviewed at a pre-arranged time and venue by the chief investigator (once consent has been gained). Data will be gathered in the form of semi-structured interviews, lasting for an expected minimum of one hour. A provisional interview schedule will be formulated in advance by the chief investigator in conjunction with the research team. This however will allow for flexibility or amendments if necessary, which is permitted by the chosen methodology.

The interviews will be recorded digitally and kept securely until transcribed by the lead researcher (Marie Winterson), which will take place as soon as possible following the interview. Once transcribed, the data will be anonymised. The anonymised interview transcripts will be analysed using Interpretative Phenomenological Analysis, which is a method that allows for deep investigation of meaning within individual accounts, as well as comparison across accounts where relevant. This will allow the results to incorporate the details of how individual therapists understand and describe the therapeutic interventions they use, with an overarching shared understanding of the therapeutic process.

The majority of the analysis will be undertaken by the chief investigator, however supervision around both general and specific aspects of this will be sought from the research supervisor.

20. Describe the involvement of users/service users in the design and conduct of your research. If you have not involved users/service users in developing your research protocol, please indicate this and provide a brief rationale/explanation.

Service users were not directly consulted in the development of the research protocol. However, the research aims were partly formulated due to developments from ongoing service-user involvement within [redacted]mmunicated by the field supervisor to the chief investigator in early discussions about the viability of the research project. Directly involving service users in the development of this project was discussed by the research team but was decided against on ethical grounds: the research team decided that there was no justifiable reason for seeking further input from the service-user representatives at this stage, as the feedback they had already provided via the organisation was both recent and relevant to the proposed project.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

Interviews will be recorded digitally. The data will be copied from the digital recorder at the earliest opportunity (as this cannot be encrypted) and stored as an encrypted file on a password-protected laptop belonging to the chief researcher. It will then be deleted from the recorder itself. The secure recordings will then be transcribed by the chief investigator, at which point the transcribed data will be anonymous. The audio recordings will be deleted at this stage and the interview transcripts will be saved electronically as an encrypted file. Any hard copies of transcripts, along with any participant information such as signed consent forms, will be kept securely in a locked cabinet until the research project is completed and submitted, after which they will be destroyed. Continued storage of electronic data (recordings, transcripts and scanned consent forms) will follow Lancaster University data management policy, which stipulates that research data be held securely for ten years following completion of the study. The relevant data for retention will remain encrypted at all times and will be transferred securely by the chief researcher to the Doctorate in Clinical Psychology programme using ZendTo file transfer software. The Research Director, Dr Jane Simpson, will act as official Data Custodian from this point. All data will be destroyed at the end of the required ten year retention period.

22. Will audio or video recording take place? ☐ no ☒ audio ☐ video

If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

Similar to above: Audio data will be copied from the digital recorder at the earliest possible opportunity (as this cannot be encrypted) and will be stored as an encrypted file on a password-protected laptop belonging to the chief researcher. It will then be deleted from the digital recorder. Once the interviews have been transcribed and all identifiers removed, the recordings will be deleted entirely. After the study is submitted and assessed, continued storage of the interview transcripts will follow Lancaster University data management policy, which stipulates that research data be held securely for ten years following completion of the study. The relevant data for retention will remain encrypted at all times and will be transferred securely by the chief researcher to the Doctorate in Clinical Psychology programme using ZendTo file transfer software. The Research Director, Dr Jane Simpson, will act as official Data Custodian from this point. All data will be destroyed at the end of the required ten year retention period.

23. What are the plans for dissemination of findings from the research?

ETHICS SECTION

The findings will be initially presented by the chief investigator as part of the assessment process for the Lancaster University's Doctorate in Clinical Psychology programme. Publication in a peer-reviewed journal will be pursued, as will further presentation at any relevant conferences.

24. What particular ethical problems, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek advice from the FHMREC?

Participants will be asked to talk about their clinical work in some detail and it is thus necessary to ensure that the confidentiality of service users is maintained. Participants are reminded in the participant information sheet that other individuals should not be named or discussed in a way that would make them identifiable. This reminder will also be reinforced verbally at the start of the interview and if necessary during the course of the interview. In the event of a safeguarding concern (i.e. potential harm, either past or future, to the interviewee or another individual) arising during the course of the study,

[redacted] Safeguarding policy will be followed. In the event of any other [redacted]rations apparent throughout the research process, supervision about how to proceed will be sought from the programme and field supervisor and documented accordingly.

It is expected that participants may choose, for convenience, to be interviewed in their working hours. This has evident implications for confidentiality regarding involvement in the study. The participant information sheet details this and states that it is the participant's responsibility to obtain any necessary agreement to use their work time to take part in an interview. Despite this, potential participants are assured that any data they provide will still be anonymous and their involvement will be treated with discretion. When the study reaches the analysis stage, the chief researcher will keep this in mind in order to ensure that participants will not be at risk of being made identifiable via demographic information or direct quotations.

Signatures: Applicant: ……………………………………………………………………

Date: ……………………………………………………………………………

Project Supervisor* (if applicable): ………………………………………………

Date: ……………………………………………………………………………

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review

Thesis Research Protocol

Name and affiliation: Marie Winterson
Trainee Clinical Psychologist
Lancaster University Doctorate in Clinical Psychology
Programme (2012 intake)

Contents

Appendices

1. Participant information sheet
2. Participant consent form
3. Lancaster University Lone Worker guidance

Modelling An Effective Therapeutic Approach For Traumatised Survivors Of Torture

Statistics indicate that 6% to 12% of immigrants from countries known to use torture may have experienced this personally, with rates highest amongst refugees seeking political asylum (Miles & Garcia-Peltoniemi, 2012). Torture is associated with a wide range of psychological, medical and social difficulties and yet these needs are not reliably identified by UK services (Bhugra, Craig, & Bhui, 2010). Estimates of the rate of Post-traumatic Stress Disorder (PTSD) in survivors of torture have been suggested to be between 50 and 67% (Miles & Garcia-Peltoniemi, 2012). These individuals, once resident in the UK, face many barriers to getting the support that they need (Bhugra et al., 2010), both in terms of access to services in the first place and in the ability of such services to address their needs effectively. Evidence indicates that spontaneous recovery from PTSD symptoms in survivors of torture is rare without therapeutic intervention (Kira, 2002), yet the existing literature base is far from clear about what constitutes an effective treatment for this group.

Survivors of torture are singled out for special consideration in the National Institute for Clinical Excellence (NICE) guidelines for PTSD (2005). The guidelines acknowledge the complex nature of the trauma presentation in torture survivors and the difficulty of separating out psychological, medical and social needs. As a consequence, the NICE guidelines recognise the importance of third-sector provision for survivors of torture and highlight the fact that a holistic, culturally-relevant specialist service may meet the needs of this group more effectively than existing NHS services. While such recognition of the unique needs of the client group is crucial to individuals receiving appropriately targeted support, Kinzie (2007) is clear that this should not be seen as an excuse for mainstream services to avoid addressing their duty of care to survivors of torture. He highlights the worldwide lack of high quality research into the efficacy of therapeutic interventions targeted towards survivors of torture as a factor in the continued marginalisation of this client group within mainstream services, which are of course funded on the strength of evidence-based guidelines such as NICE.

Evidence indicates that a number of discrete treatments, both pharmacological and psychological (Kira, 2002), have some success in helping survivors of torture. The validity, generalisability, and clinical usefulness of such findings have been called into question however, and no one treatment has emerged as a gold standard. Part of the difficulty in interpreting the results of these studies comes from factors such as the heterogeneity of the client group (particularly where cultural issues are concerned) as well as criticisms of how meaningfully clinical change is defined and measured (Bhugra, Craig & Bhui, 2010). Kinzie (2007) highlights the fact that, while specialist centres for survivors of torture are ideally placed to add to this research base, many appear to utilise an integrative and holistic approach that does not lend itself well to producing the clearly defined, easily replicable type of evidence preferred by guiding bodies such as NICE. Outcome results emerging from specialist centres are thus difficult to interpret due to lack of clarity about the exact interventions used to facilitate these, and accordingly the expertise of such services fails to translate into a useful clinical evidence base. Kinzie (2007) is clear that existing specialist services have a duty to engage in critical evaluations of their methods that seek to clearly define the intervention(s) used; an aim that has not yet been engaged with to any significant degree. Only by producing and participating in high quality research into both method and outcome can specialist services for survivors of torture ensure that they are providing evidence-based interventions, which can then in turn increase mainstream awareness of the psychological needs of this marginalised client group.

[redacted] is a registered UK charity that provides a variety of supportive services to torture survivors, through practical help to psychological care and medico-legal reports. They are also committed to a much-needed role in providing education and conducting research on issues relevant to their client group.

[redacted] have recently developed a comprehensive outcome tool (based in collaborative service user research) designed to accurately capture the totality of their clients' experience and to quantify meaningful therapeutic change. This study aims to add a further level of understanding to the process: to go beyond what is achieved in the course of therapy to examine how it is achieved. The study aims to investigate the therapeutic process via qualitative interviews with experienced therapists, in order to clearly define and understand the interventions used and where possible to form hypotheses about how these relate to improved outcomes. [redacted] provide training to statutory and third sector organisations in working with survivors of torture; and are piloting an accredited, stand-alone training programme for the first time. This study would ideally help to inform and support this aspect of [redacted] work, and in providing a valuable insight into the unique therapeutic needs of torture survivors presenting with PTSD in the UK may also be of relevance to other services, including the NHS.

Research Question: How do specialist therapists understand and describe the therapeutic process in their work with traumatised survivors of torture?

Method

Participants

The study will involve recruitment of six to ten staff working as therapists with [redacted] [redacted] This figure is based on examination of sample size in studies with a similar scope (i.e. previous theses submitted to the programme that also use qualitative methodology). There is some dispute among researchers as to what constitutes an appropriate number of participants for the selected methodology (Interpretative Phenomenological Analysis), with figures as low as three participants being suggested by some experts (Smith, Flowers & Larkin, 2009). The specified figure of six to ten participants should therefore be understood as a pragmatic guideline that acknowledges the necessary scope of a doctoral level thesis while also remaining true to the principles of the analysis methodology, which gives preference to detailed, in- depth understanding of a small number of accounts over a more shallow analysis of multiple accounts.

All participants must hold a recognised professional qualification and must have worked in this capacity for one year (or the part-time equivalent). Currently it is expected that participants will be recruited from the [redacted] branch of [redacted] only, however it is possible that recruitment may occur across all their UK branches. This will be decided in conjunction with [redacted] [redacted]Research and Development Department. Whether eventual recruitment is from a single base, or multiple, the targeted sample range will not change and the procedures detailed below will remain the same.

Recruitment and data collection procedure

The study will initially be publicised within the workplace by the chief investigator and field supervisor, who will jointly attend one or more staff meetings in order to briefly introduce the aims of the project and explain how interested parties can get in touch for more information. Participant information sheets (Appendix 1) summarising the information and procedure will be provided to staff at this meeting, but no actual recruitment or expressions of interest will be sought at this point. This meeting will be followed up by an internal email, again containing the participant information sheet, to all therapists on the staff team. This will be sent by the chief investigator to the field supervisor, with the request that it be forwarded to the staff team to act as a reminder and to reach staff members who may not have been present at the team meeting(s). At all stages staff will be reminded that any participation is entirely voluntary and there are no consequences of choosing not to take part. Staff who are interested in participating will be invited to contact the chief investigator directly, with contact details provided on the participant information sheet.

Interviews will be scheduled at a time and place convenient to the participant. It is expected that most of the interviews will take place during working hours. Participants may also choose to take part in interviews in the workplace immediately prior to or following their working time. In exceptional circumstances arrangements can be made to interview participants outside this environment if required, for example at their home. In the event of this occurring Lancaster University's lone worker policy (Appendix 3) will be followed. It will be made clear to participants that choosing to take part in the study during working hours will place responsibility on them to make any necessary arrangement for this with their manager; however the data they contribute will still be anonymous and confidential.

The interviews themselves are expected to last for approximately one hour, although this is flexible and may vary. The interview schedule will be semi-structured, so while the chief investigator will have some apriori defined areas of interest, the course of the discussion will be partly shaped by the information provided by the participant. The qualitative methodology used (Interpretative Phenomenological Analysis) allows the interview schedule to be a flexible, iterative process, with the researcher reflecting on how both the content and delivery of the questions asked may affect the information received and modifying this as necessary (Smith & Osborn, 2003). All decisions made regarding the developing interview schedule will be documented by the chief investigator and discussed in the eventual write-up where this aids transparency of the research process.

Interviews will be recorded digitally. The data will be copied from the digital recorder at the earliest opportunity and stored as an encrypted file on a password-protected laptop. It will then be deleted from the recorder itself. The secure recordings will then be transcribed by the chief investigator, at which point the transcribed data will be anonymous. The transcripts will similarly be saved electronically as an encrypted file. Any hard copies of transcripts, along with any participant information such as signed consent forms, will be kept securely in a locked cabinet until the research project is completed and submitted, after which they will be destroyed. Continued storage of electronic data (recordings and transcripts) will follow Lancaster University data management policy, which stipulates that research data be held securely for ten years following completion of the study. All participants will receive an information sheet detailing these procedures (Appendix 1) and all participants will be asked to sign a consent form (Appendix 2) in advance of interview.

Analysis

The anonymised interview transcripts will be analysed using Interpretative Phenomenological Analysis (Smith & Osborn, 2003). Interpretative Phenomenological Analysis is a qualitative methodology that allows the researcher to engage in in-depth analysis of how meaning is constructed within, and across, accounts. It is particularly suitable for samples wherein there is a high degree of homogeneity among participants'exposure to the factor of interest; in this case the experience of therapists working within the same organisation with the same client group. Interpretative Phenomenological Analysis positions the researcher as an integral part of the analysis process and encourages explicit attention to be paid to one's own assumptions and cognitive processes both in the data collection and its analysis (Smith, Flowers & Larkin, 2009).

The process has been described as the researcher's attempt to understand the participant's attempt to understand his/her lived experience; and as such fits well with the research aim of understanding how therapists conceptualise their work.

The majority of the analysis will be undertaken by the chief investigator, although some extracts from transcripts may also be analysed in parallel by the research supervisor in order to ensure as much consistency and objectivity of interpretation as possible.

The researcher's position

As chief investigator, I am not employed by [redacted] and I have not previously been associated with them in any way. I have previously worked with some individuals who have had similar experiences to those of the client group that [redacted] work with, however this was not in a directly therapeutic capacity. In order to minimise personal experiences and opinions affecting the data, either via the questions asked to participants, or via the interpretation of participants accounts, I will keep a reflective journal throughout the process and will regularly discuss issues arising with both programme and field supervisors.

Dissemination

The study will be submitted for assessment to the Lancaster University Doctorate in Clinical Psychology programme. Publication in a relevant peer-reviewed journal will also be pursued following successful completion of the assessment process, with decisions about this being made jointly by the research team. It is expected that some service-level dissemination will take place via clinical management and/or research development meetings; and a resulting therapeutic model will be made available for any desired future use by [redacted].

Costs

No major costs are anticipated beyond those of printing and postage for participant information. In the event of recruitment taking place across multiple bases then some travel costs for the chief investigator may be incurred.

Ethical considerations

The project is not expected to meet with ethical issues beyond those standard in anonymous research participation:

Confidentiality

It is necessary to preserve the confidentiality of service users and other staff, and participants are reminded in the participant information sheet (Appendix 1) that other individuals should not be named or discussed in a way that would make them identifiable. This reminder will also be reinforced verbally at the start of the interview and if necessary during the course of the interview.

Safeguarding

In the event of a safeguarding concern arising during the course of the study, [redacted] [redacted] Safeguarding policy will be followed. This is explained in the participant information sheet (Appendix 1).

In the event of any other ethical considerations becoming apparent throughout the research process, supervision about how to proceed will be sought from the programme and field supervisor and documented accordingly.

Planned timescale

September 2014- University ethics application and local R&D application made. October 2014- Interview schedule finalised and full literature review completed.

November 2014- Attendance at staff meetings, promotion of study and initial recruitment.

December 2014/ January 2015- Ongoing recruitment and data collection.

February/ March 2015- Analysis and initial draft write-up. April 2015- Final draft completed.

May 2015- Completion and submission.

References

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[redacted]

Participant Information Sheet

Modelling An Effective Therapeutic Approach For Traumatised Survivors Of Torture

My name is Marie Winterson and I am conducting this research as a student in the Doctorate in Clinical Psychology programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?

The purpose of this study is to investigate experienced therapists' understanding of how they work with traumatised survivors of torture, in order to create a model of the therapeutic process employed by [redacted] service model currently exists, I am interested in understanding how this relates to your session-by-session work with clients. Understanding how you work therapeutically with service users will contribute to what is known about the psychosocial needs of this group and may help to develop increasingly effective, evidence-based, interventions.

Why have I been approached?

You have been approached because the study requires information from qualified therapists who are trained (and currently working) within the therapeutic approach employed by [redacted].

Do I have to take part?

No. It's completely up to you to decide whether or not you take part. Even if you decide to take part and then later change your mind, you can withdraw from the study at any stage before the research has been submitted to Lancaster University for assessment.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to contact the main researcher, Marie Winterson (details below). We can then arrange a suitable time to meet for an interview about your experiences. This can be done in your working hours if this is most convenient for you. Alternately, the interview could be done at your workplace prior to or following working hours. If you would prefer a different option then please get in touch and we can discuss this. Please note that choosing to participate during working hours will require you to make any necessary arrangements for this with your manager; however your data will still be anonymous and confidential. The interview will last for approximately one hour and will be audio recorded until it can be transcribed. In the interview I will ask you to talk about various stages of your therapeutic work with clients, with a particular focus on your understanding of a client's needs at any given time and the specific intervention(s) you employ to meet these.

Will my data be confidential?

The data collected for this study will be stored securely and only the researchers conducting this study will have access to this data:

- Audio recordings will be stored securely as an encrypted file on a password-protected laptop. The chief investigator (Marie Winterson) will transcribe the interviews from these recordings and these transcripts will be anonymous.
- Hard copies of the interview transcripts will be kept in a locked cabinet until the study has been completed and will then be destroyed.
- At the end of the study, electronic copies of transcripts and audio recordings will be kept securely by Lancaster University for 10 years, which is the standard data management policy.
- The typed version of your interview will be made anonymous by removing any identifying information including your name. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.

Is there anything else I should know?

- There are some limits to confidentiality: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and follow [redacted] possible, I will tell you if I have to do this.
- You are asked not to discuss other members of staff or service users by name or in a way that otherwise may identify them. I will remind you of this at the start of the interview if you choose to take part.

What will happen to the results?

The results will be summarised and reported in a dissertation as part of assessment for the Doctorate in Clinical Psychology programme and may be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress during participation you are encouraged to inform the researcher as we can postpone the interview or you can decide to withdraw from the study.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed by the Faculty of Health and Medicine Research Ethics Committee, and approved by the University Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?
Please keep this information sheet for future reference. If you have any other questions about the study, please contact the chief investigator

Marie Winterson
m.winterson@lancaster.ac.uk
Tel: TBC
Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Bruce Hollingsworth
Head of Division
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG
Tel: (01524) 594154
Email: b.hollingsworth@lancaster.ac.uk

Or:
Professor Roger Pickup
Associate Dean for Research
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YD
Tel: (01524) 593746
Email: r.pickup@lancaster.ac.uk

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance:

Samaritans (confidential listening service)
Tel: 08457 909090
Email: jo@samaritans.org

Turn2Me (online support and counselling)
www.turn2me.org

Thank you for taking the time to read this information sheet.

Consent Form

Modelling An Effective Therapeutic Approach For Traumatised Survivors Of Torture

We are asking if you would like to take part in a research project that aims to understand the process of your work with service user [redacted] the evidence base concerning therapeutic interventions with this client group. Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Marie Winterson

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study. ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript. ☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
5. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication. ☐
6. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. ☐
7. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐
8. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk ☐

of harm to myself or others, in which case the chief investigator will need to follow the organisation’s Safeguarding Policy.

9. I understand that in the interview I should avoid naming service users or other members of staff, or talking about them in a way that might make it easy to identify them. ☐
10. I consent to Lancaster University keeping anonymous audio recordings and electronic transcriptions of the interview for 10 years after the study has finished. ☐
11. I consent to take part in the above study. ☐

Please initial box after each statement

Name of Participant ___________________ **Signature**______________________ **Date** ___________

Name of Researcher ___________________**Signature** ___________________ **Date**____________

Lancaster University Lone Worker Guidance

The below guidance comprises the relevant section of the Universities and Colleges Employers Association (2005). Guidance on safety in fieldwork. Full text is available at **http://www.lancs.ac.uk/depts/safety/files/Fieldwork.pdf**

GUIDANCE ON SAFETY IN FIELDWORK GUIDANCE ON SAFETY IN FIELDWORK

Schools must formulate clear guidelines on the scope of activities which may be undertaken alone, the types of terrain where these may take place, the supervisory arrangements (checking-in, emergency plans, etc.) and the training and experience required on the part of the student.

Because the lone worker may be at greater risk than a group member, it is important that an effective means of communication is established. Any safe system of work should include arrangements to determine the whereabouts of a lone worker and contingency plans in case of failure to make contact.

As well as the danger of personal injury, the possibility of exhaustion or hypothermia should be considered, although any such risk should have come to light during the risk assessment and would strongly mitigate against lone working. Checks on lone workers must be made on a regular and planned basis. The frequency should be dependent on the nature of the activities and the perceived hazards. Checks might take the form of periodic visits by the supervisor or regular communication by telephone or radio (see Appendix B).

If contact is made through intermediaries, Schools must ensure that these are reliable. It may be useful to arrange for messages to be relayed through University control centres especially when these provide 24 hour cover.

etter confirming ethical approval

Applicant: Marie Winterson
Supervisor: Dr Stephen Weatherhead
Department: OHR

24 October 2014

Dear Marie and Stephen,

Re: Modelling an effective therapeutic approach for traumatised survivors of torture

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, Debbie Knight (01542592605 ethics@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

S.C.Tayl

Sarah Taylor
Secretary, University Research Ethics Committee

Cc Fiona Aiken, University Secretary, (Chair, UREC); Professor Roger Pickup (Chair, FHMREC)

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