Therapist dilemmas in narrative exposure therapy with clients who have experienced multiple or prolonged trauma: A tape-assisted recall study

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

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Overview

The presenting problems of survivors of multiple or prolonged traumatic events, who are experiencing symptoms of PTSD, and have also faced forced migration, may be complicated by a number of factors. These can include the nature or severity of their symptoms and adversities in their current circumstances. This thesis aimed to explore the subjective experiences of therapists working with this client group with a view to better understanding the therapeutic process and its wider impact on those working in the field.

Part One is a systematic review and meta-synthesis of the findings of 14 qualitative papers exploring therapist experiences of working with multiple or complex trauma in forced migrant populations. Part Two is a qualitative study examining how therapists negotiated dilemmas in Narrative Exposure Therapy sessions with traumatised refugees or asylum seekers. It used Tape Assisted Recall (TAR) methodology to explore therapists' moment-by-moment perspectives of specific therapeutic interactions. Part Three is a critical appraisal of the research process in which the researcher's key observations, challenges and decisions are discussed relating to researcher reflexivity and the TAR procedure.

Impact Statement

No prior systematic reviews are known to exist focusing on therapist experiences of working with multiple or complex trauma in forced migrant populations. As well as contributing to the current research literature, the findings of the present review and qualitative meta-synthesis are relevant to the configuration and delivery of mental health services for traumatised forced migrants. They should therefore be of interest to policy-makers, commissioners, managers and supervisors.

More specifically, the synthesised findings demonstrate the significant impact that such work has on therapists undertaking it, touching many areas of their lives and leaving them changed both professionally and personally. This has immediate implications for the development of appropriate and effective training, supervision and support for therapists engaged in this work, and longer-term implications for staff performance, productivity and retention. The findings also provide a framework for current and future therapists to reflect upon their work with this client group, evaluate the risks and rewards, and consider external support and self-care strategies, enabling them to make an informed choice about this as a career option.

Additionally, the meta-synthesis found that therapists' work inevitably extends beyond designated client sessions to include a range of practical and advocacy support. Clients' holistic needs may be more efficiently met by specialist multi-disciplinary teams (comprising social workers and/or welfare officers, lawyers and/or paralegals, as well as physical and mental health specialists) thereby reducing the burden on individual professionals.

Compared with the systematic review, the empirical study was much narrower in focus. It explored how therapists negotiated dilemmas and made choices during Narrative Exposure Therapy (NET) sessions with survivors of multiple or

prolonged trauma experiencing symptoms of PTSD or complex PTSD. The Tape-Assisted Recall (TAR) methodology elicited detailed and nuanced accounts from therapists of how they experienced key therapeutic moments and provided a degree of specificity unachievable through more typical qualitative methods of data collection focusing on therapists' experiences of delivering NET generally.

The empirical study's findings contribute to the existing body of therapy process research, and increase our understanding of the practical application of the NET model, as well as the complexities of therapeutic change. More specifically, particular therapeutic strategies are emphasised as being important for therapists to reflect upon and develop while implementing the NET model. The findings also suggest possible areas in which the model might be adapted for specific client groups, such as survivors of trafficking and/or clients experiencing particularly entrenched or overwhelming appraisals or emotions (e.g. of self-blame or shame). The real-life clinical examples of therapists negotiating dilemmas in their clinical work could also potentially be used in the development of clinical training and supervision for NET therapists, and as a resource for trauma therapists negotiating dilemmas in their clinical work more generally. Furthermore, the study demonstrates the benefits of the TAR procedure as a unique and powerful tool both clinically (for enhancing self-reflection, supervision or facilitated reflective practice) and for generating rich and otherwise inaccessible research data.

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Part 1: Literature Review

Therapist experiences of working with multiple or complex trauma in forced migrant populations: A systematic review and meta-synthesis

Abstract

Aims: The number of displaced people worldwide is at unprecedented levels. Therapists working with traumatised asylum seekers, refugees and internally displaced people face many challenges due to the nature, and psychological sequelae, of their clients' experiences. In order to investigate these challenges, this review synthesises qualitative studies of therapists' experiences of psychological therapy with survivors of multiple or complex trauma in forced migrant populations.

Method: Fourteen papers met inclusion criteria. They were methodologically appraised and their findings synthesised using thematic analysis, informed by thematic synthesis.

Results: Three superordinate themes were developed in the meta-synthesis. Firstly, "Doing the work" described the emotional and cognitive toll on therapists, the professional challenges, and therapists' experiences that the work often goes beyond pure therapy. Secondly, "Making it bearable and keeping going" described various factors that therapists identified as antidotes to the intra-personal toll and professional challenges, and made the work sustainable. Thirdly, "Professional and personal growth" described how therapists developed their professional identity and new ways of working, and experienced personal growth.

Conclusion: Therapist experiences described in this review can inform the delivery and sustainability of mental health services for traumatised forced migrants. The meta-synthesis themes also provide a framework for therapists to reflect upon their work with this client group, evaluate the risks and rewards, and consider external support and self-care strategies. Further research is needed into specific therapeutic approaches for particular presenting problems, including PTSD and (the new diagnosis of) complex PTSD.

Introduction

We are currently seeing the highest number of displaced people on record. In 2018, 68.5 million people worldwide had been forced from their homes (compared with 42.7 million in 2007), comprising 40 million internally displaced people, 25.4 million refugees and 3.1 asylum seekers (Office of the United Nations High Commissioner for Refugees [UNHCR], 2018a). With conflicts continuing and, in some cases, situations deteriorating, this trend shows no sign of dissipating (UNHCR, 2018b). A small proportion of these displaced people have come to the United Kingdom (UK): at the end of 2017, there were 121,837 refugees and 40,365 pending asylum cases (UNHCR, n.d.-a). Host countries arguably have ethical, and some have statutory, obligations to provide adequate health care, including mental health services. For example, in the UK, refugees and asylum seekers (with active asylum claims) are entitled to free and full access to primary and secondary health care (Public Health England, 2018).

Terminology

The term 'forced migrant population' is used for the purposes of this review to mean refugees and asylum seekers regardless of their legal status (including, for example, undocumented migrants), as well as internally displaced people who have been forced to flee their homes due to war, persecution, violence or other human rights abuses. It includes survivors of armed conflict, massacres, bombardments, imprisonment, torture and human trafficking but does not include migrants leaving their home countries for purely economic reasons. It is acknowledged, however, that the concept of 'forced migration' is not unproblematic as it may blur the important legal distinction between refugees (defined and afforded specific protection under

international law), those asserting their human right to seek asylum, and migrants more generally (UNHCR, 2016).

International law defines a refugee as any person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (United Nations Convention Relating to the Status of Refugees, 1951, Article 1A.(2)). An asylum seeker is someone who has applied for asylum protection as a refugee and is awaiting a decision on their claim (UNHCR, n.d.-a). An internally displaced person is someone who is forced to flee their home for safety but who has not crossed an international border and so remains within their own country and under the protection of its government, even if the government is the reason for their displacement (UNHCR, n.d.-b).

Experiences of Forced Migrants

Forced migrants (and professionals working with them) face many challenges due to the nature, and psychological sequelae, of their experiences, not only in their countries of origin but also during their migration journey and in host countries. For such individuals, their experiences may include exposure to single, if not multiple, repeated or prolonged, traumatic events such as torture or trafficking. For their communities, the associated human rights violations and forced displacement of people can have a profound and long-lasting impact (Shauer, Neuner, & Elbert, 2011).

In addition to traumatic events, individuals who have undergone forced migration are likely to have faced multiple losses and separations that may include their home and possessions, family and friends, financial security and profession, culture, community, role and identity. Following long and often perilous journeys, stressors in the eventual country of re-settlement can also include poverty and destitution; policies of detention (which may have an independently deleterious effect on mental health (Robjant, Hassan, & Katona, 2009)); denial of access to work; uncertainty over the legal right to remain; and hostility, exclusion or overt discrimination from the local community (British Psychological Society [BPS], 2018) and even state institutions. Asylum applications determined by individual states are typically slow, bureaucratic processes, during which the threat of persecution, violence and/or death, upon return home, remains for claimants. Valid asylum claims may be rejected at first instance. In the UK, for example, many initially negative decisions are overturned on appeal (Refugee Council, 2018) leading to prolonged periods of heightened stress and uncertainty for individuals.

Mental Health Implications

As with any heterogenous group, there are myriad possible trajectories in terms of mental health for forced migrant populations, and the BPS warns against "the trap of psychologising or pathologising their suffering; for the majority of families, their current situation can be understood in terms of being a normal response to abnormal circumstances" (BPS, 2018, p. 6). However, given their pre-, peri- and post-migration experiences, asylum seekers and refugees have been found to be at greater risk of developing post-traumatic stress disorder (PTSD) than the general population (NCCMH, 2005; Steel et al., 2009), with many experiencing

comorbid depression (Turner, Bowie, Dunn, Shapo, & Yule, 2003), albeit that prevalence rates vary considerably across studies (Bogic, Njoku, & Priebe, 2015).

For those forced migrants who do develop PTSD (with its core symptoms of re-experiencing, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity (Diagnostic and Statistical Manual of Mental Disorders (5th ed.; [DSM-5]; American Psychiatric Association [APA], 2013)), their presenting problems may be complicated by a number of factors. These include the nature of their traumatic experiences (which may have been multiple, repeated or prolonged) and post-migration factors (including contending with numerous losses, as well as legal, economic, social and welfare issues). Indeed, post-migration factors have been found to be associated with PTSD symptoms and emotional distress (Carswell, Blackburn & Barker, 2011). More specifically, individuals who have experienced human rights abuses often experience particularly strong feelings of guilt or shame, and may experience more extreme symptoms, such as dissociation.

Distinct from PTSD with these 'complicating factors', the separate diagnostic syndrome of 'complex PTSD' has recently been recognised by the World Health Organisation (WHO) in the International Classification of Diseases 11th Revision (ICD-11) (WHO, 2018). A cluster of presenting problems long recognised by clinicians and researchers (Herman, 1992a, 1992b), particularly in those who have experienced developmental trauma (van der Kolk et al., 2009), complex PTSD may also develop in adults exposed to extreme circumstances such as combat, torture, domestic violence or highly aversive political unrest (McFetridge, et al., 2017). It is believed to follow from sustained exposure to repeated or multiple traumatic incidents, often of an interpersonal nature and occurring in circumstances where escape is impossible (Herman, 1992a; Mørkved et al., 2014; WHO, 2018). In

addition to meeting diagnostic criteria for PTSD, complex PTSD is characterised, in ICD-11, by (i) severe and pervasive problems in affect regulation; (ii) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and (iii) persistent difficulties in sustaining relationships and in feeling close to others (WHO, 2018).

Potential Interventions

The National Institute for Health and Care Excellence (NICE), in its recently updated guidance (NICE, 2018), recommends a number of interventions as effective treatment for adults with PTSD. These include cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy and prolonged exposure therapy, although it is not indicated which is the best option for survivors of multiple or complex trauma. The NICE guideline suggests various adaptations for clients with more complicated presentations, including complex PTSD, such as allowing extra time to develop trust and helping the person manage issues that might prevent engagement, such as dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception (NICE, 2018).

In relation to complex PTSD specifically, the UK Psychological Trauma Society (UKPTS), in its guideline for the treatment and planning of services for adults, states that "further research is urgently required to develop and evaluate therapeutic approaches for specifically addressing the core aspects of [complex PTSD]" (McFetridge et al., 2017, p. 47). The International Society for Traumatic Stress Studies (ISTSS) and the UKPTS currently support a phase-based approach to complex PTSD, which is echoed in the NICE recommendations for working with refugees and asylum seekers (National Collaborating Centre for Mental Health

[NCCMH], 2005), comprising (i) stabilisation and skills training; (ii) review and reappraisal of trauma memories; and (iii) consolidation of gains and re-integration (Cloitre et al., 2012; McFetridge et al., 2017). Yet debate continues over whether a period of stabilisation is an unhelpful delay (from a psychological perspective), the most effective trauma-focused therapy for the treatment of this client group (in stage (ii)) is currently unknown, and future research must address such questions of effectiveness and acceptability (McFetridge et al., 2017).

It must also be noted that an extensive critique exists in the literature disputing the validity of PTSD (and, by implication, complex PTSD) as an objectively discoverable and distinct category of psychopathology, that applies cross-culturally, and exists independently from its social and political construction in the USA following the Vietnam war (Summerfield, 2001, 1999). Patel (2003) argues that Eurocentric psychological theory, practice, and service delivery for asylum seekers and refugees, focused upon pathologising the distress of individuals who have experienced human rights abuses, may inadvertently compound their oppression and mean that their "voices… remain marginal or silent" (p. 30). Diagnosing and treating individual survivors risks de-contextualising and de-politicising distress (Patel, 2003), thereby diverting attention and resources away from achieving appropriate scrutiny of, reparation for, and ultimately prevention of, the social injustices and human rights violations that continue to occur throughout the world.

Therapists working with survivors of multiple or complex trauma in forced migrant populations must therefore balance numerous and (at times) competing considerations. This is emphasised by the four key principles emerging from the BPS's extended guidelines for psychologists working with refugees and asylum seekers (BPS, 2018), namely (i) the need for professional support and supervision of

colleagues; (ii) the need for professional interpreters, and developing appropriate competencies to work with them; (iii) the need to address context, past and present, which may include experiences of poverty, homelessness, racism, hostility and hate crimes that asylum seekers and refugees face; and (iv) the need to take a holistic perspective, recognising the diversity and resilience of asylum seekers and refugees and the survival strategies they possess.

Therapist Experiences

In terms of their subjective experiences, Richard Blackwell (1997), a psychotherapist, gives a vivid account of how therapists might experience encounters with survivors of torture and organised violence. He warns of the problem of helpfulness (or engaging in activities purporting to be helpful for clients), which tend to fulfill therapists' own need to be helpful and impede key therapeutic tasks of holding, containing and bearing witness. Blackwell acknowledges that therapists may be left with contrasting feelings: often very uncomfortable, "with a powerful sense of urgency that we must do something"; or alternatively "hopeless, helpless and useless, with a sense of futility and a belief that there is little or nothing we can do" (Blackwell, 1997, p. 85).

A body of literature has developed focusing on specific negative and positive effects that trauma work can have on those working with traumatised individuals (Cohen & Collens, 2013). Such effects include compassion fatigue and secondary traumatic stress (Figley, 1995; Hensel, Ruiz, Finney, & Dewa, 2015), which refer to the emotional and symptomatic responses to working with trauma survivors that can mirror those seen in people with PTSD; and vicarious traumatisation (McCann & Pearlman, 1990), whereby therapists' cognitive schemas and memory systems are negatively modified by engaging with clients' traumatic experiences, resulting in

distress and lasting changes in their beliefs, expectations and assumptions about the world, leading therapists to experience PTSD symptoms themselves. More recently, the potential for vicarious posttraumatic growth has been noted (Arnold, Calhoun, Tedeschi, & Cann, 2005; Brockhouse, Msetfi, Cohen, & Joseph, 2011; Gil, 2015; Linley, Joseph, & Loumidis, 2005), which relates to psychological growth following positive changes in trauma workers' perceptions of themselves and the world (Cohen & Collens, 2013), such as spiritual development, improved ability to understand, accept and connect with others, and a deepened appreciation for the resilience of the human spirit (Arnold et al., 2005).

Aims of the Present Review

Previous reviews of qualitative studies of the effects on therapists of trauma work have typically focused on specific constructs, such as vicarious traumatisation (Sabin-Farrell & Turpin, 2003; Sexton, 1999) and vicarious trauma and growth (Cohen & Collens, 2013). However, the intention behind the present review was to take a broader, phenomenological perspective on how therapists experienced their work without being constrained by pre-existing theory. Although one previous review (Karageorge, Rhodes, Gray & Papadopoulos, 2017) addressed staff (as well as client) experiences more broadly, it focused on psychotherapeutic services for refugees; in contrast, the current review focuses specifically upon therapist experiences of working with multiple or complex trauma in forced migrant populations. A review and synthesis of qualitative studies of how therapists experience work with this client group could inform the delivery of therapy, contribute to the debate about what interventions are most acceptable and sustainable, and help to develop appropriate training, supervision and support for therapists engaged in this work.

The overarching review question was therefore 'how do therapists subjectively experience the implementation of psychological therapy with survivors of multiple or complex trauma and forced migration?' More specifically, the review sought to obtain a detailed picture of any particular issues or challenges arising for therapists working with this client group, as well as possible rewards, both professional and personal. A meta-synthesis (also known as a qualitative meta-analysis) was the established procedure chosen for integrating and interpreting findings from numerous qualitative studies, including their ambiguities and differences (Levitt, 2018; Timulak, 2009). An assessment was also made of the methodological quality of included studies and taken into account in the synthesised findings.

Method

A review of qualitative studies was conducted in accordance with the guidelines set out in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA: Moher, Liberati, Tetzlaff & Altman, 2009) and the PRISMA Explanation and Elaboration Document (Liberati et al., 2009). The review protocol (see Appendix A), adapted from published guidance on developing a protocol for qualitative evidence synthesis (Harris et al., 2017) and specifying the proposed inclusion and exclusion criteria, search strategy and methods of analysis, was registered on PROSPERO: International Prospective Register of Systematic Reviews (Coope, Barker, Pistrang, & Brady, 2018).

The search strategy was designed to identify papers reporting qualitative studies of therapists' experiences of working with survivors of multiple or complex trauma in forced migrant populations.

Eligibility Criteria

Studies were included on the basis of criteria relating to the participants, intervention, study design and report characteristics.

1 *Participants*

1.1 Participants were therapists working with adult survivors of multiple and/or complex trauma in forced migrant populations.

1.2 Therapists included anyone delivering psychological therapy, whether qualified professionals (such as clinical or counseling psychologists, psychiatrists, psychotherapists, counsellors or social workers), trainees or lay people.

1.3 Their clients were adults (of 18 years and above) whose traumatic experiences might reasonably be expected to constitute multiple or complex trauma, for example they occurred in contexts such as war, imprisonment, torture, or human trafficking.

1.4 Additionally, such clients had experienced forced migration, namely refugees, asylum seekers or people displaced internally within their country of origin (in each case, regardless of their legal status).

2 *Intervention*

2.1 Studies focused upon therapy for the psychological sequelae of trauma, rather than on therapy for unrelated mental health difficulties, or on practical, welfare or legal support more generally (e.g. social work, occupational therapy or advocacy).

2.2 Such therapy followed any theoretical model (e.g. cognitive or cognitive-behavioural therapy; psychodynamic psychotherapy;

family therapy; or narrative therapy) and was delivered predominantly on an individual basis, or with a couple or family, rather than in a group of individuals.

2.3 Therapy could have involved an interpreter and been conducted in any setting, such as in the field (where original traumatic events occurred and/or in refugee camps) or in countries where clients had resettled.

3 *Study design*

3.1 Studies focused on therapists' perspectives of the therapeutic experience (rather than therapists' perspectives on their clients' experiences).

3.2 Studies were qualitative and used an established method of data analysis.

3.3 Single-case studies were excluded.

4 *Report characteristics*

4.1 Papers were written in English and published on or before 31 December 2017 in a peer-reviewed journal.

Search Strategy

Eligible papers were identified through electronic searches of three databases, PsycINFO, Ovid MEDLINE and Cinahl Plus, and hand searches of the reference lists of included papers and contents pages of key journals.

Initially, a scoping search of PsycINFO was conducted to identify key papers and search terms. Having refined the search terms, a systematic search of PsycINFO was then implemented using the terms set out in Table 1. Boolean operators 'or','and' and 'not' were used to combine specified terms. Truncation symbols (e.g.

Table 1

Search terms

Therapist, therapy or impact on therapist terms		**Client, client experiences or impact on client terms**		**Methodology terms**
therapist*/psychotherapist*/counsel?or*/psychologist*/psychiatrist*/social worker*/clinician*/mental health service*/mental health personnel/mental health provider*/mental health staff/health personnel attitudes OR psychotherapeutic process*/ therapeutic alliance/therapeutic relationship* OR vicarious experiences/vicarious trauma*/vicarious resilience	AND	refugee*/asylum seeking/asylum seeker*/prisoner? of war OR imprison*/torture*/organi#ed violence/systematic violence/genocide/human trafficking/traffick* OR complex PTSD/complicated PTSD/multiple trauma*/type II trauma*/type 2 trauma*/post?traumatic growth/resilience/survivor* NOT (cancer*/stroke*)	AND	interview*/group discussion*/focus group*/qualitative research/qualitative*

Note. Items within columns combined with OR; between columns linked by AND.

*) and wildcards were used to search for term variations and for British and American English spellings. Where possible, each term was searched using 'map to subject heading' and 'keyword' functions. Limits were applied to the database search, restricting results to papers written in the English language, published in a peer-reviewed journal on or before 31 December 2017, and reporting studies involving adult human participants.

A final PsycINFO search conducted on 6 February 2018 yielded 1,112 results. Equivalent searches conducted on the same day on Ovid MEDLINE and Cinahl Plus produced 630 and 465 results, respectively. Details of all searches in each database, and the corresponding results, are included in Appendix B. Hand searches of the reference lists of relevant articles produced one further result, whereas hand searches of the contents pages of key journals (namely, the Journal of Traumatic Stress; Traumatology; and Counselling and Psychotherapy Research) produced no further results. All searches combined produced 1,730 novel results after duplicates were removed.

Selection of Studies

Initially, titles and abstracts of identified studies were screened by the researcher and 1,629 studies were excluded on the basis that they were clearly not relevant to the literature review question. One hundred studies were retained and their full texts considered in light of the eligibility criteria described above. Following full text review, 87 studies were eliminated. Combined with the additional study identified through hand searching, 14 studies were therefore included in the meta-synthesis.

Random samples of 25% of studies at both the title and abstract screening, and full text review, stages were checked for eligibility by independent reviewers

(who were not members of the research team). Percentage agreements with the main researcher were high, at 95% and 92% respectively. Due to the highly skewed distributions, Cohen's κ was moderate in both cases (Landis & Koch, 1977): title and abstract, κ = .503 (95% CI, .326 to .679); full text, κ = .457 (95% CI, -.179 to 1.000). Disagreements between the researcher and reviewers were resolved by consensus and consultation with a third reviewer (one of the research supervisors) where necessary.

A PRISMA flow diagram of the selection process (adapted from Moher, Liberati, Tetzlaff, & Altman, 2009) is set out in Figure 1.

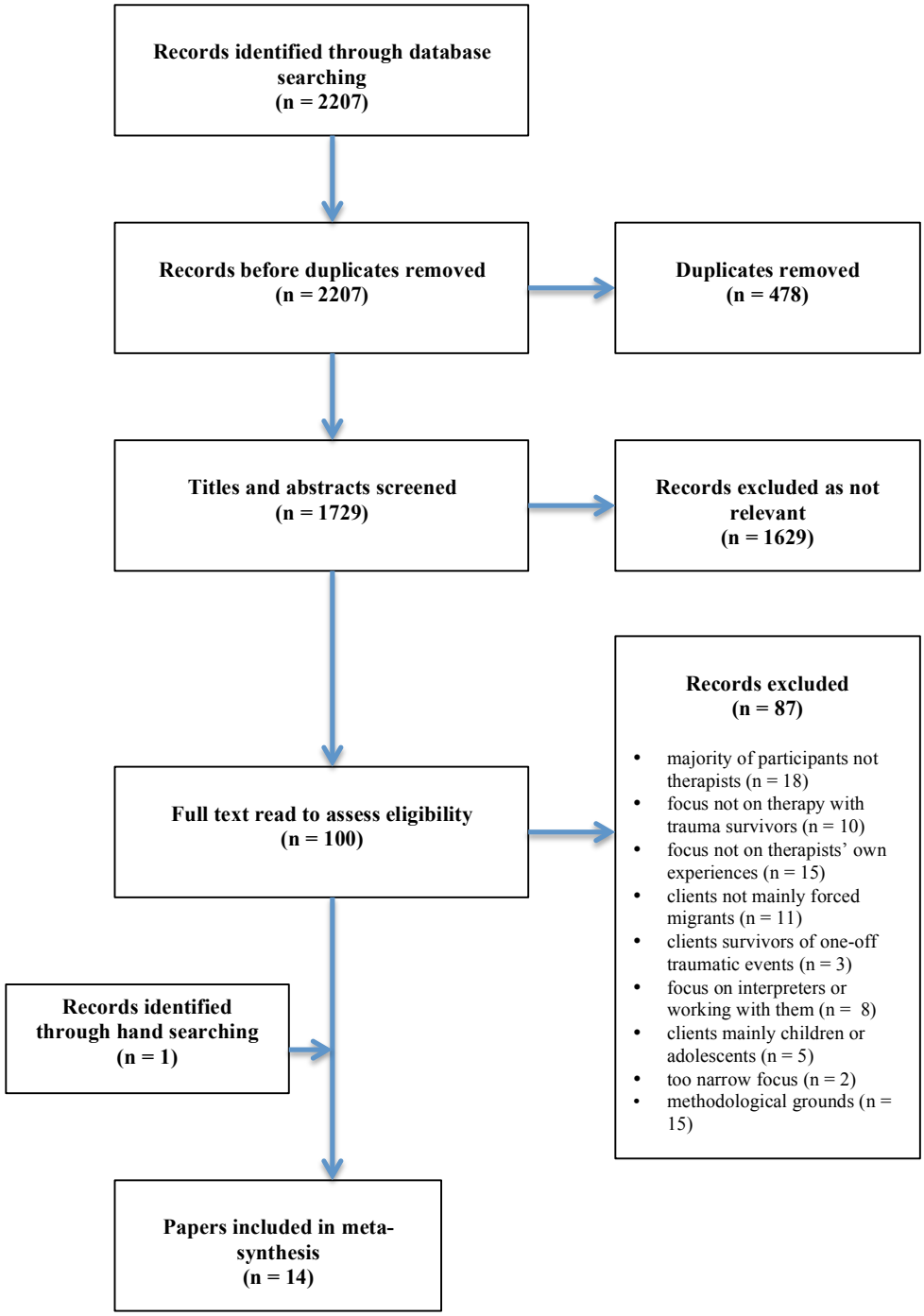
Excluded Studies

In the initial stage of study selection (title and abstract review), the vast majority of studies were excluded because they were not relevant to psychological therapists' experiences of working with traumatised clients who were forced migrants. Papers were retained for full text review if, upon reviewing the title and abstract, the answer to the question 'could this be a qualitative study of therapist experiences of working with traumatised clients who are forced migrants?' was either 'yes' or 'maybe' (erring on the side of inclusion in cases of doubt).

At the full-text review stage, studies were excluded if the majority of participants were not explicitly stated to be working as psychological therapists (or equivalent) (e.g. a non-clinical sample of the general population (Skalski & Hardy, 2013), client participants rather than clinicians (Gardner & Orner, 2009), and participants doing health and settlement work (Puvimanasinghe, Denson, Augoustinos, & Somasundaram, 2015) or social work (Lavi, Nuttman-Shwartz, & Dekel, 2017; Lindsay, 2007; Pruginin, Findley, Isralowitz, & Reznik, 2017)). Other studies were excluded because they did not focus specifically upon psychological

Figure 1

PRISMA flow diagram of selection process (adapted from Moher, Liberati, Tetzlaff, & Altman, 2009)



therapy with survivors of trauma but focused instead upon (for example) primary health care for refugees more generally (Shrestha-Ranjit, Patterson, Manias, Payne & Koziol-McLain, 2017), organisations dealing with trauma (Pross & Schweitzer, 2010), psychotherapy work generally (De Lange & Chigeza, 2015) or counselling across a language gap (Stevens & Holland, 2008).

Studies were also excluded if they did not focus on therapists' perspectives on their own experiences of therapy (such as studies focusing on issues faced by therapists' clients, e.g. barriers to mental health care (Franks, Gawn, & Bowden, 2007; Griffiths & Tarricone, 2017; Rugema, Krantz, Mogren, Ntaganira, & Persson, 2015), clients' mental health beliefs (Savic, Chur-Hansen, Mahmood, & Moore, 2016), clients' coping skills (Juhasz, 1995), and continuous traumatic stress in clients (Higson-Smith, 2013). The review team discussed specifically the potential inclusion of Sveaass (2000), which explored psychological work in post-war Nicaragua. On balance, this study was excluded as it focused on what therapists did, and how they perceived their clients to experience this, rather than focusing on therapists' own subjective experiences of what it is like to do this work.

Given the focus of the present review upon work with forced migrant populations, studies focusing on therapists working mainly with other traumatised populations (typically, survivors of familial or domestic violence, such as child abuse or intimate partner violence) were excluded (Arnold, Calhoun, Tedeschi, & Cann, 2005; Bartoskova, 2017; Howlett & Collins, 2014; Killian, 2008; McCormack & Adams, 2016; McCormack & Katalinic, 2016; Pack, 2014; Reavey, Ahmed, & Majumdar, 2006; Reeves & Stewart, 2015; Sui & Padmanabhanunni, 2016; Yarrow & Churchill, 2009). Studies focusing on work with survivors of one-off traumatic events (such as natural disasters or isolated acts of terrorism), rather than multiple or

prolonged traumata, were also excluded (Day, Lawson, & Burge, 2017; Gao et al., 2013; James, Noel, & Roche Jean Pierre, 2014).

A number of qualitative studies in the trauma field focus on the experiences of, or of working with, interpreters. Such studies were excluded from the present review (Dubus, 2016; Engstrom, Roth, & Hollis, 2010; Gartley & Due, 2017; Splevins, Cohen, Joseph, Murray, & Bowley, 2010) because of the wide range of themes specific to this topic, such as interpreters' roles in therapy (and more widely), triadic therapeutic dynamics, linguistic or cultural barriers to (or facilitators of) therapeutic communication, and the impact of trauma work upon interpreters. Similarly, specific issues might also be expected to pertain to working with traumatised children and adolescents (as opposed to adult clients); hence such studies were also excluded (de Figueiredo, Yetwin, Sherer, Radzik, & Iverson, 2014; Hyatt-Burkhart, 2014; Silveira & Boyer, 2015).

Two further studies were excluded on the basis that they focused on too narrow an aspect of the psychological intervention, namely including the referring person in initial sessions as a way to engage refugee families (Sveaass & Reichelt, 2001) and using a cultural formulation during assessment of refugees (Rohlof, Knipscheer, & Kleber, 2009).

Finally, some papers were excluded on methodological grounds because they did not report empirical studies (e.g. interviews (Hankir & Sadiq, 2013); were opinion pieces (Kinzie & Fleck, 1987); failed to demonstrate that an established method of qualitative data analysis was used (Danieli, 1984; Groen, 2009; Kuo & Arcuri, 2014; Moosa, 1992; Peltzer, 2001; Straker & Moosa, 1994; Tauber, 2002, 2003); reported studies that were solely quantitative in design (and this was not completely explicit from the abstract) (Gil, 2015; McLaughlin, Keller, Feeny,

Youngstrom, & Zoellner, 2014); or were themselves review papers (Bryant-Davis & Wong, 2013; Cohen & Collens, 2013).

Data Extraction

A data extraction form was used to ensure key information about included studies was summarised consistently by the researcher (see Appendix C). Extracted information included study objectives and research questions posed; any key pre-existing theory/ies underpinning the study; characteristics of participants; recruitment setting and context; characteristics of clients; therapeutic modality and characteristics of intervention; mode of data collection; data analysis methodology; and key findings.

Assessment of Methodological Quality

Although it is generally accepted that systematic reviews of qualitative research should include a critical appraisal of the methodological quality of included studies, considerable controversy remains about how such appraisals should be performed (Carroll & Booth, 2015; Garside, 2014). The debate over what 'quality' criteria to use largely reflects the plurality of methodologies and epistemological stances within qualitative research regarding what is of interest (Dixon-Woods, Shaw, Agarwal & Smith, 2004). Additionally, commentators have argued for an end to 'criteriology' (Schwandt, 1996) and warned against overzealous and uncritical use of checklists in qualitative research (Barbour, 2001), which privilege prescribed methods over inherently more subjective (yet arguably more important) factors such as creativity, richness of description and compelling interpretation (Dixon-Woods et al., 2004). Finally, the lack of consistent reporting guidelines for qualitative studies and insufficient word counts in journal publications mean that it is often not possible

for qualitative researchers to demonstrate fully their systematic and rigorous methodology and data analysis processes.

Despite this controversy, the Cochrane Qualitative and Implementation Methods Group (the Cochrane Group) now recommends selection of a published and commonly used tool that focuses on the assessment of the methodological strengths and limitations of qualitative studies across specified domains (Noyes et al., 2018). These domains include clear aims and research question; congruence between the research aims/question and research design/method(s); rigor of case and/or participant identification, sampling and data collection to address the question; appropriate application of the method; richness/conceptual depth of findings, exploration of deviant cases and alternative explanations; and reflexivity of the researchers. The Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (CASP, 2017) maps onto the Cochrane Group's specified domains, applies generically to any qualitative research methodology, and is the most commonly used tool in qualitative evidence syntheses in Cochrane and World Health Organization (WHO) guideline processes (Noyes et al., 2018). It was therefore used to assess the methodological strengths and limitations of studies included in the present review.

The CASP checklist was not, however, used to generate an overall quality score for each study or to provide a rationale for excluding studies from the meta-synthesis. Instead (as recommended by the Cochrane Group and similarly to its use in other meta-syntheses of qualitative studies, e.g. Katsakou & Pistrang, 2018), the checklist provided a framework and set of guidelines for considering each study's contribution to the synthesised findings. Some small adaptations were made to how some of the CASP checklist items were applied, including (in question 9)

considering each study's findings in the context of its acknowledged limitations. A copy of the CASP checklist (indicating how it was adapted) is set out in Appendix D.

The application of the amended CASP checklist to a random sample of 25% of included studies was checked by an independent reviewer, resulting in 94% agreement with the main researcher. Cohen's κ was calculated and the strength of agreement between the two (controlling for chance) was considered to be substantial (Landis & Koch, 1977), κ = .767 (95% CI, .574 to .960). Differences in interpretations were discussed in detail between the researcher and reviewer, and resolved by consensus.

Researcher Reflexivity

Noyes et al. (2018) emphasise the importance of review authors making transparent their conflicts of interests, prior beliefs, and potential or actual prejudices, which may have an impact on data interpretation. As a clinical psychology trainee, I had a particular interest in working with asylum seekers and refugees and completed a six-month placement working in a charitable organisation with clients who had experienced multiple and/or complex trauma. Conducting this review, I was conscious of the potential for interpreting findings in line with my own clinical experience.

I tried to minimise the impact of my preconceptions about the challenges and rewards both professionally and personally of trauma-focused work with this client group, as well as the strengths and weaknesses of particular psychological therapies, by reflecting in detail upon my own expectations and beliefs before commencing data analysis. I had worked predominantly with western conceptualisations of 'trauma', 'PTSD' and 'complex PTSD', and had implemented 'evidence-based treatments' (typically, trauma-focused cognitive behaviour therapy and narrative

exposure therapy). While appreciating the significant benefits of such therapy models (both in terms of the potential for symptom relief and the importance of bearing witness to a person's traumatic experiences), I also shared broader concerns raised in the literature about over-reliance on psychiatric diagnosis and individualised treatment programmes de-contextualising and pathologising the impact of human violence on individuals (Patel, 2003; Summerfield, 1999, 2001).

During data coding, I noted explicitly where I perceived that underlying data aligned or conflicted with my own experiences and, in each case, verified that I was applying the coding principles consistently. During the synthesis process, I consciously attempted to ensure that I did not over- or under-weight such data and discussed in detail all emerging meta-synthesis themes (and the supporting data) with my research supervisors.

Method of Analysis

Choice of method

The synthesis of findings from the included studies was guided by the principles of thematic analysis (Braun & Clarke, 2006), as adapted by Thomas and Harden (2007, 2008) for use in systematic reviews of multiple qualitative studies (namely, thematic synthesis). This method of analysis was chosen over a purely aggregative approach (such as meta-aggregation) or a more constructivist approach (such as meta-ethnography) based on guidance from the Cochrane Group (Noyes et al., 2018; Noyes & Lewin, 2011). Thematic synthesis was developed to address questions relating to the appropriateness and acceptability (as well as the effectiveness) of interventions, and incorporates the methodological rigour of a systematic review (Barnett-Page & Thomas, 2009); hence it met the broader objectives of the present review. It also fitted with the critical realist, and broadly

phenomenological, stance taken in this review to explore the knowable reality of therapists' experiences as mediated by their idiosyncratic perceptions and beliefs (Barnett-Page & Thomas, 2009; Barker et al., 2016). Finally, thematic analysis (informed by thematic synthesis) was considered the most appropriate method to meet the researcher's aim of summarising and integrating qualitative studies (including both 'thin' and 'thick' levels of thematic description) into overarching analytic themes that reflected the underlying similarities, inconsistencies and contextual differences in the primary data while stopping short of new theory generation.

Initial considerations

A key initial consideration was what constituted data for the purposes of the meta-synthesis. In the absence of published guidance, the approach taken by Thomas and Harden (2007, 2008) was followed and all text in the 'results' or 'findings' sections (or equivalent) of included studies was treated as data.

Ideas and concepts presented within such findings were synthesised regardless of how they were labeled or categorised by the study authors. Such ideas were therefore reorganised into new superordinate themes and themes reflecting the aims of the present review. The original categorisations (in terms of superordinate themes, themes and subthemes in the primary studies) from which the synthesised themes were derived were systematically referenced to ensure transparency.

Where studies examined additional topics beyond the scope of this review, only data relevant to the review question were synthesised. For example, because studies focusing on interpreters were excluded from the review, any findings in included studies that related to therapists' experiences of working with interpreters were not analysed. Similarly, findings pertaining to clients' (rather than therapists')

experiences of therapy were not analysed. Thus, for example, data relating to therapists' views about their clients (such as how they formulated their clients' difficulties, or how they perceived clients to respond to specific therapeutic techniques) were not synthesised, whereas data relating to therapists' views about what they themselves found difficult in therapeutic encounters were.

A number of the included studies examined therapist experiences within an existing theoretical framework, for example specifically exploring constructs of vicarious trauma, vicarious resilience or vicarious post-traumatic growth, and presenting findings in relation to these. In contrast, this review took a more inductive approach, focusing on the fundamental meaning of included data and (as far as possible) setting aside such theoretical constructs during data analysis.

More weight was given during the analysis (and so greater representation in the final meta-synthesis) to concepts that appeared more frequently (i.e., were mentioned by many studies and many participants within those studies); had a high level of explanatory value (Noyes & Lewin, 2011); and featured in more methodologically robust studies. Concepts that appeared only once or twice; were poorly explained; or featured in methodologically weaker studies were treated with more caution and given less weight. Given the phenomenological stance of this review, participant quotations were treated as more compelling for the purposes of the meta-synthesis than author explanations, interpretations or recommendations.

Stages of analysis

The six phases of thematic analysis described by Braun and Clarke (2006) were used as guidelines, amended in line with Thomas and Harden's (2007, 2008) approach to thematic synthesis. In phase one, the researcher familiarised herself with the data by reading and re-reading the 'findings' sections of the studies and noting

down her initial ideas about potential codes. All included data were then uploaded verbatim into QSR International's NVivo qualitative data analysis software (Version 11; 2018) before subsequent phases of analysis. In phase two, the researcher worked systematically through the entire data set, coding each line or short segment of text according to meaning and content. At this stage, the researcher also identified and excluded any data not relevant to the review question. As each new study was coded, data segments were added to existing codes and new codes were developed as necessary. Each coded segment had at least one code applied but many were categorised using several codes. This facilitated the reciprocal 'translation' of concepts from one study to another, a technique originating from meta-ethnography (Barnett-Page & Thomas, 2009; Thomas & Harden, 2008). Before moving onto the next phase, the researcher re-examined all segments of coded data to check consistency of interpretation and determine whether codes should be consolidated or additional codes were needed. In phase three, the researcher looked for similarities and differences between the codes and started grouping them into a hierarchical structure of potential 'descriptive' themes, gathering together all data and codes relevant to each theme. In phase four, these descriptive themes were reviewed in detail to ensure each one accurately represented its constituent coded data, was distinct from the other themes, and that, together, such themes coherently reflected the entire data set. In phase five, the descriptive themes were considered in light of the review question. More abstract 'analytic' themes and superordinate themes were developed, named and defined that were considered to capture the essential features of therapists' experiences of working with multiple or complex trauma in forced migrant populations. In phase six, the synthesis was written-up. For each meta-synthesis theme, a vivid and compelling data extract was selected as a supporting

quote from an included study, and the underlying themes and sub-themes were referenced in detail.

To increase validity, two experienced qualitative researchers provided supervision throughout this process. In-depth discussions took place, particularly during phases three, four and five, about the labelling and classification of the initial descriptive themes and subsequent analytic themes and superordinate themes. Such discussions also allowed the main researcher to reflect upon, and (as far as possible) set aside, her own assumptions and preconceptions when interpreting the data set.

Results

Description of Included Studies

Fourteen papers met criteria for inclusion in the review. However, given the contextual and demographic similarities, it is assumed that Apostolidou (2015), Apostolidou (2016a) and Apostolidou (2016b) all report upon the same sample. Also, Barrington and Shakespeare-Finch (2014) report a longitudinal follow-up study of the same sample as in Barrington and Shakespeare-Finch (2013). While each of these studies will be referenced separately (save where otherwise specified), the fact that the published papers concern the same samples will be taken into account in the synthesis of findings.

The key characteristics of the 14 included studies are presented in Table 2 and summarised below.

Table 2

Study characteristics

Study	Aims	Sample	Setting and context	Index clients	Intervention	Data collection method	Data analysis method
Apostolidou (2015)[a]	To investigate how practitioners make sense of their professional identity when working with refugees	8 participants (comprising 2 clinical psychologists, 1 clinical psychologist and trainee psychoanalyst, 2 counselling psychologists, 2 psychotherapists and 1 psychotherapist and social worker)	NHS and charitable organisations in London, United Kingdom	Asylum seekers and refugees	Psychological therapy and counseling	Semi-structured interviews	Foucauldian discourse analysis
Apostolidou (2016a)[a]	To examine the emotional impact of working with asylum seekers and refugees by unpacking the constructions of risk and meaning among practitioners	8 participants (comprising 2 clinical psychologists, 1 clinical psychologist and trainee psychoanalyst, 2 counselling psychologists, 2 psychotherapists and 1 psychotherapist and social worker)	NHS and charitable organisations in London, United Kingdom	Asylum seekers and refugees	Psychological therapy and counseling	Semi-structured interviews	Foucauldian discourse analysis
Apostolidou (2016b)[a]	To explore the impact of supervision and the organisational context on practitioners working with asylum seekers an the way they experience their professional identity	8 participants (comprising 2 clinical psychologists, 1 clinical psychologist and trainee psychoanalyst, 2 counselling psychologists, 2 psychotherapists and 1 psychotherapist and social worker)	NHS and charitable organisations in London, United Kingdom	Asylum seekers and refugees	Psychological therapy and counseling	Semi-structured interviews	Foucauldian discourse analysis
Apostolidou & Schweitzer (2017)	To explore practitioners' perspectives on the use of clinical supervision in their therapeutic engagement with asylum seekers and refugees	9 participants (comprising 3 clinical psychologists, 4 general psychologists, 1 provisional psychologist and 1 community development worker)	Public sector and not-for-profit agencies specialising in the treatment of torture survivors in South Queensland, Australia	Asylum seekers and refugees	Counselling and psychotherapeutic services	Semi-structured interviews	Thematic analysis

Barrington & Shakespeare-Finch (2013)[b]	To explore the lived experiences of people working with survivors of refugee-related trauma	17 participants (comprising 13 frontline clinical and 4 administrative or managerial staff)	Queensland Program of Assistance to Survivors of Torture and Trauma (a not-for-profit organisation providing psychological services to people who identify as refugees, asylum seekers, displaced persons or migrants) in Brisbane, Australia	Survivors of refugee-related torture and trauma	Psychological services – no further details specified	Semi-structured interviews	Interpretive phenomenological analysis
Barrington & Shakespeare-Finch (2014)[b]	To explore the lived experiences of people working with survivors of refugee-related trauma across a one-year period	12 participants (comprising 9 frontline clinical staff and 3 administrative staff)	Queensland Program of Assistance to Survivors of Torture and Trauma (a not-for-profit organisation providing psychological services to people who identify as refugees, asylum seekers, displaced persons or migrants) in Brisbane, Australia	Survivors of refugee-related torture and trauma	Psychological services – no further details specified	Semi-structured interviews	Interpretive phenomenological analysis
Century et al. (2007)	To explore how counsellors experience working with refugee clients in primary care	13 participants (comprising counsellors, counselling psychologists, clinical psychologists and psychotherapists)	Primary care and community settings in north London, UK	Refugees	Short-term counselling (generally six to eight sessions)	Semi-structured interviews	Thematic analysis
Edelkott et al. (2016)	To further refine the concept of vicarious resilience, with a particular focus on therapists' perception of clients' resilience and therapists' awareness of how this affects the therapists themselves	13 participants (comprising psychiatrists, psychologists, social workers, marriage and family counsellors)	Three torture treatment centers (all members of the National Consortium of Torture Treatment Programs) in the West, East and Midwest of the United States of America	Survivors of torture, most of whom were refugees and asylum seekers	Not specified	Semi-structured interviews	Constant comparative analysis
Engstrom et al. (2008)	To further explore the presence of vicarious resilience with mental health providers working in the United States with torture survivors	11 participants (comprising psychologists, social workers and marriage and family therapists)	A torture treatment centre (a member of the National Consortium of Torture Treatment Programs) in San Diego, United States of America	Survivors of torture, including asylum seekers	Psychotherapy	Semi-structured interviews	Grounded theory

Hernández et al. (2007)	To explore whether therapists working with traumatised populations learn something about overcoming adversity from their clients – a proposed process called vicarious resilience	12 participants (comprising one psychiatrist and 11 psychologists)	Governmental and nongovernmental organisations in Bogotá, Colombia	Survivors of kidnapping, displacement and political violence	Psychotherapy	Semi-structured interviews	Grounded theory
Hernández-Wolfe et al. (2015)	To examine the co-existence of vicarious resilience and vicarious trauma and explore the inclusion of intersectional identities in trauma work with torture survivors in specialised programmes across the United States of America.	13 therapists (comprising psychologists, social workers and marriage and family therapists)	Torture treatment centres (all members of the National Consortium of Torture Treatment Programs) in the West, East and Midwest of the United States of America	Survivors of both torture and forced migration	Not specified	Semi-structured interviews	Grounded theory
Khawaja & Stein (2016)	To explore the challenges of providing services to asylum seekers in the community and understand how the practitioners culturally adapt mental health services for this group	7 participants (comprising 3 psychologists, 2 psychiatrists, 1 occupational therapist and 1 social worker)	A specialist multidisciplinary clinic offering services to asylum seekers and refugees in Brisbane, Australia	Asylum seekers	Components from cognitive behavioural, interpersonal, narrative, existential, and schema therapies	Semi-structured interviews	Thematic analysis
Satkunanayagam et al. (2010)	To explore the struggles and rewards of trauma work in Sri Lanka and the notion that individuals are changed in some way by the work they do with survivors of traumatic events	12 participants (comprising mainly counsellors, psychologists, psychiatrists and medical officers working in mental health)	Sri Lanka	Survivors of trauma, including violence, torture, displacement, war and/or natural disaster	Trauma work – no further details specified	Semi-structured nterviews	Interpretative phenomenological analysis
Schweitzer et al. (2015)	To examine therapists' conceptions of therapeutic practice and experiences of working therapeutically with refugee clients	12 participants (comprising psychologists, counsellors and social workers)	NGOs (resettlement services or specialist torture and trauma services) and one specialist transition high school, in Australia	Refugees	Not specified	Semi-structured interviews	Thematic analysis

[a] Given the contextual and demographic similarities, it is assumed that Apostolidou (2015), Apostolidou (2016a) and Apostolidou (2016b) all report upon the same sample.
[b] Barrington & Shakespeare-Finch (2014) reports a follow-up study of the same sample as in Barrington & Shakespeare-Finch (2013).

Study aims

By definition, all included studies explored therapists' experiences of working with multiple or complex trauma in forced migrant populations. However some had a more specific focus, narrower than the review question. For example, a number examined therapist experiences of working with either refugees or asylum seekers, such as working with refugees in primary care (Century, Leavey, & Payne, 2007); working with refugee-related trauma across a one-year period (Barrington & Shakespeare-Finch, 2013, 2014); working therapeutically with refugees (Schweitzer, van Wyk, & Murray, 2015); and providing services to asylum seekers in the community (Khawaja & Stein, 2016). In this latter study, therapists were asked about their clients' presenting problems, their application of culturally adapted assessment and treatment strategies, as well as their own experiences of working with asylum seekers, including personal and professional challenges. However, the findings were presented in such a way that those relevant to the therapists' own experiences (rather than their clients' experiences) were clearly extractable.

Apostolidou (2015, 2016a, 2016b) explored various aspects of working with both asylum seekers and refugees, including therapists' professional identities; the emotional impact of such work and how notions of risk and meaning are formulated; and the impact of supervision and the organisational context. More recently, Apostolidou and Schweitzer (2017) further explored therapists' perspectives on the use of clinical supervision in such work.

Four of the included studies were conducted by the research team led by Gangsei, Engstrom and Hernández-Wolfe, with the explicit aim of exploring and developing the construct of vicarious resilience whereby therapists working with traumatised populations (specifically, torture survivors) learn something about

overcoming adversity from their clients (Edelkott, Engstrom, Hernandez-Wolfe, & Gangsei, 2016; Engstrom, Hernández, & Gangsei, 2008; Hernández, Gangsei, & Engstrom, 2007; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). The notion that therapists are changed by the work they do with trauma survivors was also explored in Sri Lanka by Satkunanayagam, Tunariu and Tribe (2010).

Participating therapists and their index clients

Sample size in included studies ranged from seven to 17 participants (although only 13 of the 17 were clinicians), with a total of 139 participants across all studies and a median of 12[1]. Participating therapists were typically psychologists (clinical or counselling), psychiatrists, psychotherapists, family therapists, counsellors or social workers. Further demographic information was sparse.

Index clients were all survivors of trauma (often torture-related) and typically refugees, asylum seekers or internally displaced people.

Setting and context

The majority of included studies were conducted in jurisdictions in which trauma survivors were seeking (or had sought) asylum: five in Australia, three in the United States of America, and four in the United Kingdom. Of the two remaining studies (involving therapists working with internally displaced people), one was conducted in Colombia and the other in Sri Lanka. Participants were recruited from a range of settings, including governmental and non-governmental or charitable organisations, typically specialising in working with traumatised individuals, although one study focused on therapists working in non-specialised primary care (Century et al., 2007).

[1] For the descriptive statistics about the sample sizes, Apostolidou, 2015, 2016a and 2016b were treated as one sample but Barrington & Shakespeare-Finch, 2013 and 2014 were treated as two.

Nature of therapeutic intervention

The types of interventions provided by participating therapists were described as short-term counselling (generally six to eight sessions) (Century et al., 2007), individual, couples' or family psychotherapy (Engstrom et al., 2008; Hernández et al., 2007), psychological therapy and counselling (Apostolidou, 2015, 2016a, 2016b), counselling and psychotherapeutic services (Apostolidou & Schweitzer, 2017), and as including elements of cognitive behavioural, interpersonal, narrative, existential and schema therapies (Khawaja & Stein, 2016). The remaining six studies provided little or no detail about such interventions (Barrington & Shakespeare-Finch, 2013, 2014; Edelkott et al., 2016; Hernández-Wolfe et al., 2015; Satkunanayagam et al., 2010; Schweitzer et al., 2015). No further details were provided in any of the studies about the duration, format or content of interventions.

Data collection and analysis method

Data were collected through individual semi-structured interviews in all studies and analysed using a variety of methods. Four studies used thematic analysis; three took a grounded theory approach, with another related study using the constant comparative analysis method (part of grounded theory method); three studies used interpretive phenomenological analysis (IPA); and a further three used Foucauldian discourse analysis.

Methodological Quality of Included Studies

As described in the Method, the 10 questions (and associated considerations) on the CASP checklist (CASP, 2017), amended as set out in Appendix D, were used to assess the methodological strengths and limitations of included studies. Table 3 summarises the findings of this process for each study. Although there was some variation, on the whole studies were methodologically sound. Overall (and solely on

the basis of the published papers), Century et al. (2007) and Edelkott et al. (2016) met all of the methodological criteria of the amended CASP checklist, whereas Satkunanayagam et al. (2010) met the fewest criteria. Importantly, however, only five studies provided particularly "thick descriptions" (Geertz, 1973) of the explored phenomena synthesised in a conceptually meaningful way (Apostolidou, 2015, 2016a, 2016b; Schweitzer et al., 2015; Apostolidou & Schweitzer, 2017).

Research aims, methodology and design

The first three questions on the CASP checklist assess the clarity of the research aims and the appropriateness of a qualitative approach, as well as the chosen qualitative methodology and research design, in light of such aims.

All reviewed studies identified clear aims and explained why such aims were considered important and relevant. Given that all studies took an exploratory approach, focusing upon participants' subjective perspectives and experiences, such aims were considered congruent with qualitative approaches.

Almost all studies provided further justification for the specific qualitative methodology and/or research design used, with the exception of Hernandez-Wolfe et al. (2015). This was a follow-up study (with a new sample) to prior studies (also included in the review) into the construct of vicarious resilience (Engstrom, et al., 2008; Hernández, et al., 2007). Like the earlier studies, it used grounded theory, presumably for similar reasons of seeking a discovery-oriented theoretical understanding of participant's views on how clients' resilience had affected them.

Table 3

Summary of Assessment of Methodological Quality using Amended CASP checklist (CASP, 2017)

Study	Apostolidou (2015)[a]	Apostolidou (2016a)[a]	Apostolidou (2016b)[a]	Apostolidou & Schweitzer (2017)	Barrington & Shakespeare-Finch (2013)[b]	Barrington & Shakespeare-Finch (2014)[b]	Century et al. (2007)	Edelkott et al. (2016)	Engstrom et al. (2008)	Hernández et al. (2007)	Hernández-Wolfe et al. (2015)	Khawaja & Stein (2016)	Satkunanayagam et al. (2010)	Schweitzer et al. (2015)
CASP questions														
1. Was there a clear statement of the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
2. Is a qualitative methodology appropriate?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
3. Was the research design appropriate to address the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓
4. Was the recruitment strategy appropriate to the aims of the research?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓✗	✓✗	✓	✓✗	✓
5. Was the data collected in a way that addressed the research issue?	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓✗	✓
6. Has the relationship between researcher and participants been adequately considered?	✗	✓	✓	✗	✗	✓	✓	✓	✗	✓	✓	✓	✗	✗
7. Have ethical issues been taken into consideration?	✓[c]	✓	✓[c]	✓✗	✓[d]	✓	✓	✓	✗	✓✗	✗	✓	✓✗	✓
8. Was the data analysis sufficiently rigorous?	✓✗	✓✗	✓✗	✓✗	✓	✓✗	✓	✓	✓	✓✗	✓✗	✓✗	✓✗	✓

9. Is there a clear and balanced statement of findings?	✓✗	✓	✓✗	✓	✓	✓	✓	✓	✓	✓	✓✗	✓	✓✗	✓✗
10. How valuable is the research?	✓✗	✓	✓✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓✗	✓

Note. ✓ means all considerations met; ✓✗ means considerations partially met; ✗ means considerations not met.

[a] Given the contextual and demographic similarities, it is assumed that Apostolidou (2015), Apostolidou (2016a) and Apostolidou (2016b) all report upon the same sample.

[b] Barrington & Shakespeare-Finch (2014) reports a follow-up study of the same sample as in Barrington & Shakespeare-Finch (2013).

[c] While all ethical issues were not expressly discussed in these published papers, they were fully discussed in Apostolidou (2016a), hence this consideration was deemed also to have been met by Apostolidou (2015, 2016b).

[d] Although this published paper did not explicitly refer to ethics committee approval, Barrington & Shakespeare-Finch (2014) did, hence this consideration was deemed also to have been met by Barrington & Shakespeare-Finch (2013).

Participant identification, sampling and recruitment

The fourth question on the CASP checklist considers whether the recruitment strategy was appropriate to the aims of the research. Given the specialist nature of the research aims of the studies in the present review, it was unsurprising that all included studies adopted non-probability sampling techniques, typically purposive sampling (Apostolidou, 2015, 2016a, 2016b; Apostolidou & Schweitzer, 2017; Century et al., 2007; Edelkott et al., 2016; Engstrom et al., 2008; Hernández, et al., 2007; Khawaja & Stein, 206) snowball sampling (Barrington & Shakespeare-Finch, 2013, 2014), or a combination of the two (Schweitzer et al., 2015).

All bar one of the included studies (Hernández, et al., 2007) provided at least some details of the inclusion or exclusion criteria for selecting participants. While most studies outlined the recruitment process, two provided no details (Hernández-Wolfe et al., 2015; Satkunanayagam et al., 2010). None provided details of any issues with recruitment (such as why some people chose not to take part), although Barrington and Shakespeare-Finch (2014) did comment upon participant attrition across their study's longitudinal design.

Data collection

The fifth question on the CASP checklist assesses whether data were collected in a way that addressed the research issue. All studies justified the use of semi-structured interviews as the means of data collection. Only Satkunanayagam et al. (2010) failed to provide any further details of the form of such interviews (e.g. interview schedule) or how they were conducted. This study also provided no details of the setting for data collection beyond the wider context of civil conflict and natural disaster in Sri Lanka, ostensibly to protect the anonymity of participants given the small community of trauma workers from which they were recruited.

A minority of three studies explicitly referred to the principle of saturation as guiding the cessation of data collection (Hernández, et al., 2007; Hernández-Wolfe et al., 2015; Schweitzer et al., 2015). One additional study (Khawaja and Stein, 2016) stated that recruitment continued until "all themes that had been raised were fully explored" (p. 465).

Reflexivity of researchers

The sixth question on the CASP checklist relates to reflexivity and asks whether the relationship between the researcher and participants has been adequately considered. Key considerations are whether the researchers critically examined their own role, potential for bias and influence at each stage of the research process.

Most studies provided only a limited acknowledgement of researcher reflexivity, although this was perhaps curtailed in final reports by publishing conventions. Three studies explicitly acknowledged the potential for bias as a result of the researchers' own clinical experiences meaning that they were sensitised to certain topics that might arise in participant interviews and thus might influence their findings (Apostolidou 2016a; Century et al., 2007; Hernández et al., 2007). A further study acknowledged as a limitation the influence of previous research on the formulation of research questions, which may, in turn, have influenced participants' responses (Edelkott et al., 2016).

Methods cited to counteract such biases included keeping a diary of the researcher's feelings and observations after each interview (Century et al., 2007); including an external auditor and using triangulation techniques (Hernández et al., 2007); debriefing techniques (Hernández-Wolfe et al., 2015); constant reflection (Barrington & Shakespeare-Finch, 2014); and reflexive dialogue to ensure all themes were uncovered (Khawaja & Stein, 2016).

Five studies contained little or no examination of the researchers' own roles, potential for bias and influence, or relationships with participants (Apostolidou & Schweitzer, 2017, Barrington & Shakespeare-Finch, 2013; Engstrom et al., 2008; Satkunanayagam et al., 2010; Schweitzer et al., 2015).

Ethics

The seventh question on the CASP checklist asks whether ethical issues have been taken into consideration. This is, however, difficult to determine definitively from a review of published papers since such issues are not always reported upon.

Four studies in the present review failed to discuss any ethical issues raised by the study or provide sufficient details of how the research was explained to participants to enable an assessment of whether ethical standards were maintained (Apostolidou & Schweitzer, 2017; Engstrom et al., 2008; Hernández-Wolfe et al., 2015; Satkunanayagam et al., 2010). Three studies also omitted to state whether ethics committee approval had been granted (Engstrom et al., 2008; Hernández et al., 2007; Hernández-Wolfe et al., 2015).

Analysis and presentation of findings

The final three questions on the CASP checklist assess the rigour of data analysis, the presentation of the findings and the overall value of the research. In relation to data analysis, all studies indicated that an established qualitative method had been used (this was one of the review's inclusion criteria). However, studies varied in the quality of their descriptions of such methods.

For example, Barrington and Shakespeare-Finch (2013, 2014) provided particularly detailed descriptions of each stage in the analytic process including how decisions were made, and consensus reached, about initial coding, as well as deriving constituent and superordinate themes from the data. Apostolidou (2016a, 2016b) also

provided a full description of the stages of Foucauldian discourse analysis undertaken (based on Willig's six-stage model (2009, 2013)) while acknowledging the study's overarching social constructionist epistemological stance.

Other studies provided much more limited descriptions, in generic terms, of developing codes, themes and sub-themes (Century et al., 2007), theme analysis and reduction (Hernández et al., 2007); and constant comparison of data with emerging categories using a consensus process (Hernández-Wolfe et al., 2015).

Findings in studies taking a thematic analysis approach (in the broadest sense) tended to constitute thorough summaries of the range of ideas expressed by participants, logically presented and with some commentary on patterns identified across the data, albeit that emergent themes were not necessarily theoretically inter-related (Apostolidou & Schweitzer, 2017; Century et al., 2007; Satkunanayagam et al., 2010; Schweitzer et al., 2015). The identified themes and sub-themes were explained particularly comprehensively in Barrington & Shakespeare-Finch (2013, 2014). However, these studies aimed to explore the pre-existing constructs of vicarious traumatisation and vicarious post-traumatic growth in therapists, and their findings focused less on the phenomenology of participants' experiences, and how participants made sense of them, than might have been expected of studies using IPA.

The grounded theory studies examining the construct of vicarious resilience, while narrower in focus, typically provided a more theoretically coherent account of the data (Engstrom et al., 2008; Hernández et al., 2007; Hernandez-Wolfe et al., 2015).

Five studies stood out as providing particularly 'thick descriptions' (Geertz, 1973) of the explored phenomena synthesised in a conceptually meaningful way,

namely, discourses permeating participants' interviews (Apostolidou, 2015, 2016a, 2016b); and themes relating to therapists' conceptions of therapeutic practice (Schweitzer et al., 2015), and how therapists make use of clinical supervision in their therapeutic engagement (Apostolidou & Schweitzer, 2017). In contrast, the findings in Khawaja and Stein (2016) were particularly poorly presented in that they mirrored the interview questions, with no underlying analytic narrative, and were insufficiently supported by direct quotations from participants.

While all remaining studies included sufficient data to support their findings, contradictory data were only explicitly taken into account in half (Apostolidou, 2016b; Barrington & Shakespeare-Finch, 2013; Century et al., 2007; Edelkott et al., 2016; Engstrom et al., 2008; Satkunanayagam et al., 2010; Schweitzer et al., 2015). All except four studies (Apostolidou, 2015, 2016a, 2016b; Satkunanayagam et al., 2010) referred to at least one credibility check (most commonly, having more than one analyst and/or respondent validation).

All included studies stated their findings explicitly and discussed them in relation to the original research question. However, a number of studies failed to expressly consider alternative explanations for such findings or specific limitations of the particular study (Apostolidou, 2015, 2016b; Hernandez-Wolfe et al., 2015; Satkunanayagam et al., 2010; Schweitzer et al., 2015).

In terms of their overall value, all studies considered the contribution of their findings to existing research literature and/or current practice and, with one exception (Satkunanayagam, Tunariu, & Tribe, 2010), discussed the transferability of findings to other populations or contexts and identified new areas for research.

Meta-synthesis

The findings from the 14 studies were synthesised into ten themes clustered into three interconnected superordinate themes. The first superordinate theme, "Doing the work", comprises three themes that describe different aspects of what the work is like for therapists with clients who have survived both multiple or complex trauma and forced migration. The second superordinate theme, "Making it bearable and keeping going", comprises five themes that describe ways in which therapists cope with the challenges such work presents, as well as what motivates them to keep doing it. The third and final superordinate theme, "Personal and professional development", comprises two themes describing how therapists perceive themselves to grow and develop both personally and professionally as a result of doing such work.

Table 4 shows the corresponding superordinate themes, themes or subthemes in the included studies that contributed to the synthesised themes in the present review. In some cases, themes developed in the meta-synthesis do not appear to relate to theme labels in the included studies. For example, the theme "Altered spirituality" in Edelkott et al. (2016) does not obviously relate to the theme "Emotional and cognitive toll of bearing witness" in the meta-synthesis. However, relevant data in the included studies were often distributed across several themes and, as stated in Method of Analysis above, this meta-synthesis focused on the key concepts presented in included studies, regardless of how they were labelled or organised by the study authors.

Superordinate theme 1: Doing the work

All studies contributed to the first superordinate theme of what it is like for therapists to do the work with survivors of multiple or complex trauma and forced

Table 4

Meta-synthesis themes of therapists' experiences of working with multiple or complex trauma in forced migrant populations and corresponding themes from included studies

Meta-synthesis superordinate themes and themes	**Most relevant superordinate themes, themes or subthemes in included studies**
Superordinate theme 1: Doing the work	
Theme 1.1 Emotional and cognitive toll of bearing witness – "it's not like reading about it in the newspaper" (Barrington & Shakespeare-Finch, 2014, p. 1693)	**Evidence from 13 studies:** *Apostolidou (2016a)*[a b]*:* The emotional impact of clinical work *Apostolidou (2016b)*[a b]*:* The importance of supervision in insuring that clinicians do not become overwhelmed *Apostolidou & Schweitzer (2017):* Supervision promoting self-care and protecting practitioners from burnout *Barrington & Shakespeare-Finch (2013):* Vicarious trauma; Meaning making *Barrington & Shakespeare-Finch (2014)*[c]*:* Strong emotional reactions; Intrusive images; Disruption to existing beliefs; Hearing clients stories; Adjustment issues; Self-care *Century et al. (2007):* Clients' competing practical and psychological needs; Emotional impact *Edelkott et al. (2016):* Altered spirituality *Engstrom et al. (2008):* Alteration of perspectives on the therapists' own life *Hernández et al. (2007)*[d]*:* Witnessing and reflecting on human beings' immense capacity to heal *Hernández-Wolfe et al. (2015):* Increase in self-care practices; Increased resilience and perspective taking on one's own challenges; Sleep disruption; Fearfulness; Irritability; Flashbacks, intrusive thoughts *Khawaja & Stein (2016):* Personal and professional issues: challenges; qualities and experiences *Satkunanayagam et al. (2010):* What it feels like doing trauma work; Participants' own understandings of the notion of 'secondary trauma' *Schweitzer et al. (2015):* The role and characteristics of the effective therapist; Impact of work on the therapist; Managing the difficulties of work: the role of supervision

Theme 1.2 Professional challenges and dilemmas for therapists – "how can I help this person who has so many problems in all areas of their lives?" (Century et al., 2007, p. 28)	**Evidence from 7 studies:** *Apostolidou (2015)* [a]: Conceptualisation of clients' difficulties within a psycho-social discourse; Conceptualisation of practitioners' roles within a psycho-social discourse *Apostolidou & Schweitzer (2017):* Clients' profound level of needs, boundaries and supervision; Supervision as the space for exploring the impact of the political system *Barrington & Shakespeare-Finch (2014):* Client-related challenges; System-related challenges; Organisation-related challenges; Intrapersonal-related challenges *Century et al. (2007):* Limitation of resources; Language; Culture; Clients' competing practical and psychological needs; Emotional impact *Hernández-Wolfe et al. (2015)* [e]*:* Trauma work is both a source of stress and joy *Khawaja & Stein (2016):* Personal and professional issues: challenges; Recommendations for improving mental health services for asylum seekers *Schweitzer et al. (2015):* Therapy as a relational experience; Role of context in informing therapeutic work with refugees; Managing difficulties of the work: the role of supervision
Theme 1.3 Beyond pure therapy: working for and against 'the system' – "I am social worker, I am a lawyer, I am everything else you can think of" (Apostolidou, 2015, p. 500)	**Evidence from 12 studies:** *Apostolidou (2015)* [a b]*:* Constructs of socio-political experience; Constructions of psychosocial work *Apostolidou (2016b)* [a b]*:* Organisational context: a psychosocial and systemic way of practising *Apostolidou & Schweitzer (2017):* Clients' profound level of needs, boundaries and supervision; Supervision as the space for exploring the impact of the political system; Supervision normalising feelings of powerlessness in relation to the political context promoting self-care and protecting practitioners from burnout *Barrington & Shakespeare-Finch (2013):* Meaning making; Changes in life philosophy; Changes in interpersonal relationships *Barrington & Shakespeare-Finch (2014)* [c]*:* System-related challenges; Organisation-related challenges *Century et al. (2007):* Limitation of resources; Clients' competing practical and psychological needs; Emotional impact *Edelkott et al. (2016):* A more informed worldview; Moral clarity; Change in the general belief in practice models *Hernández et al. (2007)* [d]*:* Reaffirmed commitment to work *Hernández-Wolfe et al. (2015):* Increased racial, cultural, and structural consciousness, and awareness of relative privilege, marginalization, and oppression; Intersectional identities and trauma work *Khawaja & Stein (2016):* Personal and professional issues: challenges *Satkunanayagam et al. (2010):* What it feels like doing trauma work *Schweitzer et al. (2015):* Therapy as a relational experience; Role of context in informing therapeutic work with refugees

Superordinate theme 2: Making it bearable and keeping going	
Theme 2.1 Personal connection with client – "I'm often astonished again and again by most of the clients who come in" (Edelkott et al., 2016, p. 717)	***Evidence from 6 studies*** *Barrington & Shakespeare-Finch (2013):* Meaning making *Barrington & Shakespeare-Finch (2014)*[c]*:* Strong emotional reactions; Feeling privileged *Century et al. (2007):* Limitation of resources; Clients' competing practical and psychological needs *Edelkott et al. (2016)*[f]*:* How rewarding the work with torture survivors felt *Engstrom et al. (2008):* A recognition of the human capacity to thrive; Altering perspectives about one's life; Reaffirming the value of therapy *Hernández-Wolfe et al. (2015)*[e]*:* Professional, personal and ethical challenges
Theme 2.2 Witnessing clients overcoming adversity – "That's what keeps you going is the wonder of resilience" (Engstrom et al., 2008, p. 18)	***Evidence from 11 studies*** *Apostolidou (2016a)*[a b]*:* Constructions of meaning: helping people rebuild their previously shattered sense of trust; Constructions of meaning: the process of witnessing and experiencing positive change *Apostolidou (2016b)*[a b]*:* Organisational context: a psychosocial construction of clinical work *Barrington & Shakespeare-Finch (2013):* Meaning making *Barrington & Shakespeare-Finch (2014)*[c]*:* Witnessing client change; Receiving positive feedback; Cognitive restructuring *Century et al. (2007):* Clients' competing practical and psychological needs *Edelkott et al. (2016)*[f]*:* Witnessing clients overcoming adversity; Motivation and energy; A shift in the therapists' understanding of their own role; A new or renewed confidence in a strengths-based approach *Engstrom et al. (2008):* A recognition of the human capacity to thrive; Altering perspectives about one's life; Reaffirming the value of therapy *Hernández et al. (2007)*[d]*:* Witnessing clients overcoming adversity; Reaffirmed commitment to work *Hernández-Wolfe et al. (2015):* Increased hopefulness and client-based inspiration; Change/impact on spiritual beliefs and practices vis-à-vis the therapeutic process *Satkunanayagam et al. (2010):* Positive aspects of trauma work *Schweitzer et al. (2015):* Role of context in informing therapeutic work with refugees
Theme 2.3 Boundaries and self-care – "I just need to shut the world out and do something that is reconnecting for me" (Barrington & Shakespeare-Finch, 2014, p. 1694)	***Evidence from 7 studies*** *Apostolidou & Schweitzer (2017):* Clients' profound level of needs, boundaries and supervision *Barrington & Shakespeare-Finch (2013):* Meaning making *Barrington & Shakespeare-Finch (2014)*[c]*:* Self care; Work-life boundaries *Edelkott et al. (2016):* Modified thoughts about self-care *Hernández-Wolfe et al. (2015):* Increase in self-care practices *Khawaja & Stein (2016):* Personal and professional issues: qualities and experiences *Schweitzer et al. (2015):* Managing difficulties of the work: self-care

Theme 2.4 Support from others – "The boxer can't box by himself, he needs a team, he needs a doctor there or a coach ready to motivate him" (Apostolidou & Schweitzer, 2017, p. 79)	***Evidence from 8 studies*** *Apostolidou (2016b)*[a]*:* Supervision as a source of support; Supervision as 'difficult' *Apostolidou & Schweitzer (2017):* Shifting perspective on therapeutic goals; Clients' profound level of needs, boundaries and supervision; Supervision as the space for exploring the impact of the political system; Supervision normalising feelings of powerlessness in relation to the political context; Supervision promoting self-care and protecting practitioners from burnout *Barrington & Shakespeare-Finch (2013):* Meaning making *Barrington & Shakespeare-Finch (2014)*[c]*:* Supervision; Collegial support; Positive work environment; Relational support *Century et al. (2007):* Limitation of resources *Hernández-Wolfe et al. (2015):* Fearfulness; Sources of vicarious resilience[e] *Khawaja & Stein (2016):* Personal and professional issues: qualities and experiences *Schweitzer et al. (2015):* Managing difficulties of the work: The role of supervision
Theme 2.5 Socio-political motivation – "I think it's a way of contributing in the face of kind of human destruction" (Apostolidou, 2016a, p. 284)	***Evidence from 6 studies*** *Apostolidou (2015)*[a b]*:* Constructs of socio-political experience *Apostolidou (2016a)*[a b]*:* Constructions of meaning: connectedness and contribution to the world *Barrington & Shakespeare-Finch (2013):* Changes in life philosophy *Edelkott et al. (2016):* Motivation and energy *Engstrom et al. (2008):* Reaffirming the value of therapy *Hernández et al. (2007)*[d]*:* Coping with the stress of work; Community-level resilience processes therapeutic for therapist; Social and legal validation of the truth

Superordinate theme 3: Professional and personal growth	
Theme 3.1 Developing professional identity and new ways of working – *"It has been really good for me in terms of my confidence, I think, working with refugees"* (Barrington & Shakespeare-Finch (2013, p. 99)	***Evidence from 10 studies*** *Apostolidou (2016b)*[a]*:* Organisational context: a psychosocial and systemic way of practicing *Apostolidou & Schweitzer (2017):* Deconstructing cultural assumptions; Calibrating a cultural lens; Employing culturally appropriate ways of practising; Shifting perspective on therapeutic goals *Barrington & Shakespeare-Finch (2013):* Changes in self-perception *Barrington & Shakespeare-Finch (2014)*[c]*:* Adapting therapy; Professional and personal development; Professional development *Century et al. (2007):* Culture; Emotional impact *Edelkott et al. (2016):* Moral clarity; Motivation and energy; Altered spirituality; A shift in the therapists' understanding of their own role; Change in the general belief in practice models; Strengthened trust in clients' spirituality as a resilience factor; A new or renewed confidence in a strengths-based approach *Hernández et al. (2007)*[d]*:* A more effective overall approach to professional work; Therapists' own learning processes *Hernández-Wolfe et al. (2015):* Intersectional identities and trauma work *Khawaja & Stein (2016):* Interventions; Personal and professional issues: challenges, qualities and experiences *Schweitzer et al. (2015):* An emphasis on meaning making; The role and characteristics of the effective therapist; The use of an integrative approach; Therapy as a relational experience; The role of context in informing therapeutic work with refugee clients
Theme 3.2 Personal growth – *"When one works in this field you live differently… you develop your potential"(* Hernández et al., 2007, p. 237)	***Evidence from 10 studies*** *Apostolidou (2015)*[a][b]*:* Constructs of socio-political experience *Apostolidou (2016a)*[a][b]*:* Constructions of meaning: a greater appreciation of life and an enhanced ability to create emotional and meaningful connections; Constructions of meaning: a discourse of connectedness and contribution to the world *Barrington & Shakespeare-Finch (2013):* Meaning making; Changes in life philosophy; Changes in self-perception; Changes in interpersonal relationships *Barrington & Shakespeare-Finch (2014)*[c]*:* New possibilities; Appreciation of life; Relating to others; Spiritual change; Personal strength *Edelkott et al. (2016):* Reframing of therapists' personal issues; Patience; A more informed world view; Moral clarity; Altered spirituality; Modified thoughts about self-care *Engstrom et al. (2008):* A recognition of the human capacity to thrive; Altering perspectives about one's life *Hernández et al. (2007)*[d]*:* Reassessing the dimensions of one's own problems; Vicarious resilience *Hernández-Wolfe et al. (2015):* Increased resilience and perspective taking on one's own challenges; Increased racial, cultural, an dstructural consciousness, and awareness of relative privilege, marginalisation, and oppression *Satkunanayagam et al. (2010):* Positive aspects of trauma work; Personal growth through adversity *Schweitzer et al. (2015):* Impact of work on the therapist

Note. Supporting evidence cited at the most specific level expressed in included studies (i.e. subtheme rather than theme, where appropriate).

[a] This study used Foucaudian discourse analysis to analyse data hence the underlying evidence contained within this table contributing to meta-synthesis themes constitutes discourses rather than themes.

[b] Given the contextual and demographic similarities, it is assumed that Apostolidou (2015), Apostolidou (2016a) and Apostolidou (2016b) all report upon the same sample.

[c] Barrington & Shakespeare-Finch (2014) reports a follow-up of the same sample as in Barrington & Shakespeare-Finch (2013).

[d] This study did not explicitly name the themes discussed in the findings hence the closest approximation to a theme relating to the supporting data has been included in the table.
[e] The supporting data was not explicitly linked with any of the themes listed in this study (which related to 'vicarious resilience' and 'vicarious trauma') hence the closest approximation to a theme in the findings of the study has been included in the table.
[f] The supporting data was found in the initial paragraphs of the findings section of this study and not explicitly linked with any of the named 'vicarious resilience' themes hence the closest approximation to a theme in the findings of the study has been included in the table.

migration. The constituent three themes describe the emotional and cognitive toll on therapists of bearing witness to clients' traumatic experiences; the professional challenges and dilemmas for therapists most commonly reported across the studies; and therapists' experiences that the work inevitably goes 'beyond pure therapy' as they themselves negotiate 'the system' in which their clients find themselves.

Theme 1.1: Emotional and cognitive toll of bearing witness – "it's not like reading about it in the newspaper"[1]

Thirteen of the 14 studies discussed the impact on therapists of working with clients' trauma. In terms of what was most affecting, the impact of hearing first-hand detailed accounts of trauma and torture was most cited (Apostolidou, 2016a; Barrington & Shakespeare-Finch, 2013, 2014; Engstrom et al., 2008; Khawaja & Stein, 2016; Satkunanayagam et al., 2010; Schweitzer et al., 2015). Also, the nature of certain traumatic experiences (such as the killing of children, torture of relatives or family separation) could be particularly distressing (Apostolidou 2016b; Barrington & Shakespeare-Finch, 2014), as could therapists witnessing the darker side of human nature, or "the worst that a human being can do to another human being" (Apostolidou, 2016a, p. 281; Barrington & Shakespeare-Finch, 2013; Century et al., 2007; Edelkott et al., 2016; Hernández-Wolfe et al., 2015).

Four studies explored the impact on therapists within the existing theoretical framework of vicarious traumatisation (Barrington & Shakespeare Finch, 2013, 2014; Engstrom et al., 2008; Hernández-Wolfe et al., 2015), whereas the remainder considered how such work affects therapists in more general terms. The emotional impact was described as being "heart breaking", "shocking", "harrowing", and "overwhelming", and therapists spoke about having to manage their own emotions during client sessions. One study contrastingly indicated that therapists could also

[1] Barrington & Shakespeare-Finch, 2014, p. 1693

become overloaded by the work, and end up "cut off" from their own feelings (Apostolidou, 2016a, p. 281).

A minority of studies referred to therapists themselves experiencing symptoms of PTSD (e.g. flashbacks and nightmares) as a consequence of their work (Barrington & Shakespeare Finch, 2013, 2014), sometimes due to the re-triggering of their own traumatic experiences (Hernández-Wolfe et al., 2015; Satkunanayagam et al., 2010). Working with trauma also prompted cognitive processes in therapists, including personal reflection (such as "how would I have coped in that situation" (Barrington & Shakespeare Finch, 2013, p. 95)), and attempting to make sense of what they had heard and how it could have happened. This could lead therapists to think differently about the world, as well as grapple with existential issues such as the fragility and unfairness of life. Vivid examples were provided of therapists continuing to experience these cognitive and emotional effects well beyond the therapy room door, such as during a visit to the theatre (Apostolidou, 2016a) and while walking around a supermarket (Barrington & Shakespeare Finch, 2013).

Theme 1.2: Professional challenges and dilemmas for therapists – "how can I help this person who has so many problems in all areas of their lives?"[2]

Seven of the 14 studies discussed professional challenges or dilemmas faced by therapists beyond the intrapersonal cognitive and emotional impact. Studies conducted in the UK and Australia highlighted the deleterious effect that host countries' often-changing asylum systems could have on their clients' mental health, which presented additional challenges for therapists (Apostolidou & Schweitzer, 2017; Barrington & Shakespeare Finch, 2014; Schweitzer et al., 2015). Specific policies, such as dispersal or removal, created uncertainty around treatment planning (Century et al., 2007). Wider healthcare and welfare systems, and inter-agency

[2] Century et al., 2007, p. 28.

support, were also considered inadequate, increasing perceived pressure on therapists to meet all their clients' unmet needs (Barrington & Shakespeare Finch, 2014).

Therapists were confronted with the dilemma of how involved to become in practical, legal and welfare matters. Although providing such wider support is often seen as an inevitable part of the job with this client group (as explored further in the next theme, 1.3), therapists risked additional stress (Hernández-Wolfe et al., 2015) and becoming overburdened by the increased workload (Barrington & Shakespeare Finch, 2014; Khawaja & Stein, 2016) or potentially disillusioned by a lack of appreciation and the ultimate futility of their efforts at instigating systemic change (Schweitzer et al., 2015).

Traditional therapeutic boundaries were also challenged by clients' profound needs (Aposolidou & Schweitzer, 2017). Some therapists reported favouring a more flexible approach to engage clients (Century, 2007; Schweitzer et al., 2015). However, others warned against such "enactments of countertransference" or, more specifically, attempts by the therapist to prevent themselves being overwhelmed by the client's needs by becoming overinvolved with the client (Schweitzer et al., 2015, p. 113).

Only two studies identified specific challenges posed by the complexity of clients' presentations, namely managing risk and suicidality (Barrington & Shakespeare Finch, 2014) and emotional numbing impeding clients' ability to relate to others (Apostolidou, 2015). Two further studies identified that uncertainty and instability in clients' current contexts presented therapists with the dilemma of whether it was 'safe enough' for trauma-focused work (Century et al, 2007; Schweitzer et al., 2015). While the experience of working with interpreters is outside the scope of the present review, three studies (Barrington & Shakespeare Finch,

2014; Century et al, 2007; Khawaja & Stein, 2016) emphasised challenges that arise working cross-culturally, including establishing rapport when communication is limited, differing understandings of mental health and the process of therapy, having to adopt a slower pace and adapt therapeutic techniques, and needing further training and resources regarding the cultural-specific features of clients' presentations.

Organisational challenges were highlighted in four studies, including inadequate funding and resources and unmanageable workloads (Barrington & Shakespeare Finch, 2014; Century et al, 2007; Khawaja & Stein, 2016; Schweitzer et al., 2015). This reportedly led to inadequate provision for clients in terms of number of sessions, service instability and insufficient or non-specialist supervision for therapists.

Cumulatively, such professional challenges could lead therapists to doubt themselves and question their own competency (Barrington & Shakespeare Finch, 2014; Century et al, 2007; Schweitzer et al., 2015).

Theme 1.3: Beyond pure therapy: working for and against 'the system' – "I am social worker, I am a lawyer, I am everything else you can think of"[3]

Twelve of the 14 studies discussed how therapists inevitably became engaged with their clients' current socio-political contexts. In studies conducted in countries facing continued political and social violence, that context could be one of shared trauma whereby both client and therapist are victims of the "injustice" and "pointlessness" of community-wide suffering (Satkunanayagam et al., 2010). In the majority of studies conducted in host countries, that context comprised the legal, welfare and health systems, as well as the political and social environments, that asylum seekers and refugees must navigate.

[3] Apostolidou, 2015, p. 500.

Three such studies identified the inadequacy and injustice of the asylum system, "that's virtually accusing them of lying" (Century et al., 2007, p. 36), as a source of frustration, rage or powerlessness for therapists (Aposolidou & Schweitzer, 2017; Century et al., 2007; Khawaja & Stein, 2016). The majority of studies described therapists going beyond pure therapy work by providing practical assistance to clients, such as writing letters in support of legal, housing or benefits applications and linking clients in with other services (Apostolidou, 2015, 2016b; Barrington & Shakespeare Finch, 2014; Edelkott et al., 2016; Hernández-Wolfe et al., 2015; Khawaja & Stein, 2016). Some therapists expressly acknowledged that doing so counterbalanced their feelings of helplessness about their clients' current contexts (Aposolidou & Schweitzer, 2017; Century et al., 2007; Engstrom et al., 2008; Schweitzer et al., 2015).

In addition to offering practical support, a number of studies described therapists adopting a broader socio-political stance in consequence of their work (Apostolidou, 2015, 2016a; 2016b; Aposolidou & Schweitzer, 2017; Barrington & Shakespeare Finch, 2013, 2014; Edelkott et al., 2016; Hernández-Wolfe et al., 2015). Therapists tended to reflect upon their own privileges and acknowledged not only the perpetuation of human rights abuses worldwide but also the disenfranchised social reality for forced migrants in host nations. Therapists also typically became more politically or socially active, for example by raising awareness and advocating for the rights of asylum seekers and refugees more generally.

Several studies pointed to an inherent conflict that may arise for therapists engaging with the system in such ways. Particularly for those working for state institutions (such as the NHS) or NGOs connected with government, their clients may see them, or they may even see themselves, as part of the system they are

lobbying against, and so acutely aware both of its failings and the competing demands upon it (Apostolidou, 2016b; Aposolidou & Schweitzer, 2017; Century et al., 2007; Hernández et al., 2007).

Superordinate theme 2: Making it bearable and keeping going

All studies contributed to the second superordinate theme about what makes the work bearable and keeps therapists going. The constituent five themes describe the personal connections therapists feel for this particular client group; the rewards of witnessing clients overcoming adversity and demonstrating resilience; the value of boundaries and self-care; the importance of receiving support from others; and therapists' socio-political motivation to do the work.

Theme 2.1: Personal connection with client – "I'm often astonished again and again by most of the clients who come in"[4]

Six of the 14 studies explored the personal connection therapists felt with their clients who had survived multiple or complex trauma and forced migration. Three of these studies described clients inspiring genuine amazement and admiration in therapists, often for their courageous opposition of persecution and repression despite huge personal cost (Century et al., 2007; Edelkott et al., 2016; Engstrom et al., 2008). Although it was implicit in many studies that this personal connection with clients helped to make the work bearable and keep therapists going, this was made explicit in Edelkott et al. (2016) where, in response to people thinking that working with torture survivors was "terrible" and "draining", a participant said, "I will often tell them it's not unusual for me to get more from my clients than I give" (p. 717).

Other studies highlighted the profound sense of privilege and honour therapists felt when clients trusted them enough to shared their stories with them

[4] Edelkott et al., 2016, p. 717.

(Barrington & Shakespeare-Finch, 2013, 2014; Engstrom et al., 2008). In two further studies, therapists spoke about feeling more, or having greater empathy, for refugee clients (Barrington & Shakespeare-Finch, 2014; Century et al., 2007).

Contrastingly, Hernández-Wolfe et al. (2015) highlighted how therapists might also feel conflicted towards clients, specifically when working with perpetrators who had themselves experienced violence, and have to work harder to find empathy for their struggles and pain.

Theme 2.2: Witnessing clients overcoming adversity – "That's what keeps you going is the wonder of resilience"[5]

Eleven of the 14 studies described witnessing clients overcoming adversity or demonstrating resilience as one of the most rewarding and motivating parts of the job.

In the same way that hearing first-hand accounts of trauma and torture takes its toll on therapists, therapists described witnessing clients' strength, hope and capacity not only to survive but also move on with their lives as "energising, nourishing and enriching" (Edelkott et al., 2016, p. 718) and an infectious "life force" (Engstrom et al., 2008, p. 18) that made them want to keep going with their work (Barrington & Shakespeare-Finch, 2013, 2014; Century et al., 2007; Hernández et al., 2007; Hernández-Wolfe et al., 2015; Schweitzer et al., 2015). Other therapists emphasised their clinical interest in discovering multi-dimensional aspects of their clients (as both victims and survivors), and developing their understanding of the construct of resilience (Apostolidou, 2016a).

Additionally, providing relief from distress (Satkunanayagam et al., 2010), supporting clients to rebuild their own identity and trust in others (Apostolidou, 2016a) and seeing improvements in clients (Barrington & Shakespeare-Finch, 2014;

[5] Engstrom et al., 2008, p. 18.

Edelkott et al., 2016; Hernández et al., 2007; Hernández-Wolfe et al., 2015) enabled therapists to maintain their belief in the potential for recovery. More generally, therapists also described being rewarded and motivated by being able to help people (Apostolidou, 2016b), which they discovered either through receiving positive client feedback or by deliberately looking for the positives in their work (Barrington & Shakespeare-Finch, 2014). However, therapists also spoke about keeping their expectations low to avoid feeling ineffective in their work (Barrington & Shakespeare-Finch, 2014).

Theme 2.3: Boundaries and self-care – "I just need to shut the world out and do something that is reconnecting for me"[6]

Half of the 14 studies emphasised the role of boundaries and/or self-care in making the work sustainable. While traditional therapeutic boundaries may be challenged by clients' profound needs (as described in theme 1.2 above), two studies highlighted the importance of therapists asserting and maintaining boundaries between themselves and their clients, and between their work and home lives (Apostolidou & Schweitzer, 2017; Barrington & Shakespeare-Finch, 2014). This helped therapists (and their clients) recognise the limits of the therapist role, create a work-free protected space at home, and thereby sustain and cope with their clinical work.

Self-care strategies were mentioned in six studies, several of which presented these as being vital for therapists to continue meeting the demands of the job (Barrington & Shakespeare-Finch, 2013, 2014; Khawaja & Stein, 2016; Schweitzer et al., 2015). Another study (Hernández-Wolfe et al., 2015) described therapists having to develop self-care practices early on in their careers to counteract symptoms of vicarious trauma, such as sleep problems, intrusive thoughts, irritability and

[6] Barrington & Shakespeare-Finch, 2014, p. 1694.

avoidance. Some therapists alluded to self-care being a professional obligation, to which they had enhanced commitment since working with this client group (Barrington & Shakespeare-Finch, 2014). In another study, while therapists valued self-care, they admitted they did "not always leave enough space for it in their lives" (Edelkott et al., 2016, p. 719).

Examples of self-care strategies adopted by therapists included meditation, mindfulness and mind-body practices; developing self-awareness; eating healthily and exercising regularly; limiting exposure to violent or dramatised material outside of work; connecting with nature; maintaining outside interests such as sports or literature; and prioritising time for oneself.

Theme 2.4: Support from others – "The boxer can't box by himself, he needs a team, he needs a doctor there or a coach ready to motivate him"[7]

Eight of the 14 studies referred to therapists seeking support from others to help them cope with their work. Mainly, this was through clinical supervision but other forms of support, including collegial support, personal therapy and family friends, were also mentioned.

Therapists resoundingly valued good quality supervision (Hernández-Wolfe et al., 2015; Khawaja & Stein, 2016), which allowed them to reflect upon, normalise and contain their personal feelings about clients and the work (Apostolidou & Schweitzer, 2017; Barrington & Shakespeare-Finch, 2013, 2014; Schweitzer et al., 2015); helped to contextualise clients' difficulties and the clinical work in relation to the "bigger picture" (Apostolidou, 2016b); and provided comments or recommendations that increased specialist therapeutic skills (Barrington & Shakespeare-Finch, 2014; Schweitzer et al., 2015). However, the description in the studies was also more nuanced in that supervision had to be both accessible and

[7] Apostolidou & Schweitzer, 2017, p. 79.

appropriate (Apostolidou, 2016b; Century et al., 2007; Schweitzer et al., 2015). Therapists emphasised the necessity for specialist supervision, with "grounded knowledge" of the life situations and struggles faced by asylum seekers, refugees and displaced people, that took account of the "political" and "cross cultural" aspects of the work.

Some studies also emphasised the additional benefits provided by peer support from colleagues (often more immediately available than formal supervision), including empathic listening, normalising shared experiences, helping therapists make sense of their work, and creating a positive and accepting work environment and culture (Barrington & Shakespeare-Finch, 2013, 2014; Hernández-Wolfe et al., 2015). Therapists in the same studies also referred to personal therapy as helping them cope with the emotional impact of the work and try to understand human nature in the context of human rights abuses.

In only one study (Barrington & Shakespeare-Finch, 2014), therapists reported seeking emotional support outside of the profession from friends, family or community leaders.

Theme 2.5: Socio-political motivation – "I think it's a way of contributing in the face of kind of human destruction"[8]

As explained in theme 1.3, therapists typically adopted a socio-political stance and became more politically or socially active in consequence of their work. Six of the 14 studies also identified a socio-political motivation for therapists that kept them going with their work. They saw it as a way to "stand against" politically sanctioned human rights abuses occurring throughout the world (Apostolidou, 2015, 2016a; Engstrom et al., 2008), and "bring equality to this earth" (Barrington & Shakespeare-Finch, 2013), through "social and legal validation" (Hernández et al.,

[8] Apostolidou, 2016a, p. 284.

2007). Therapists described feeling better connected with the world through their work (Apostolidou, 2016a) and some described finding that the work was no longer a matter of choice but something they were compelled to do (Edelkott et al., 2016; Hernández et al., 2007).

Superordinate theme 3: Professional and personal growth

All studies contributed to the final superordinate theme about how therapists perceive themselves to develop professionally and personally. The constituent two themes describe how therapists develop their professional identity and new ways of working; and their experience of personal growth.

Theme 3.1: Developing professional identity and new ways of working – "It has been really good for me in terms of my confidence, I think, working with refugees"[9]

Ten of the 14 studies described ways in which therapists had developed professionally through working with multiple or complex trauma in forced migrant populations. In terms of professional identity, therapists gained more confidence in their therapeutic abilities, including working with people from different backgrounds or with difficult clients (Barrington & Shakespeare-Finch, 2013, 2014; Edelkott et al., 2016). Through professional training and learning, they developed specialist skills in trauma work (Barrington & Shakespeare-Finch, 2014; Khawaja et al., 2016). Three studies also emphasised how therapists' professional identities had been enhanced through learning directly from clients. For example, learning about what her client valued most in therapy enabled a therapist to develop and plan to disseminate her own therapeutic model (Hernández et al., 2007). Another client's continued faith in humanity enabled her therapist to work with clients she could not have previously worked with (Edlekott et al., 2016). Modeling by clients who, like the therapist, continued to live in unsafe conditions allowed a therapist to overcome

[9] Barrington & Shakespeare-Finch (2013, p. 99).

his own fears for himself and his family, and better handle the uncertainties brought by his work (Hernández et al., 2007).

Therapists also developed new ways of working with this client group, finding they had to "think again" and approach ethical decisions "anew" (Century et al. 2007). Seven studies described how therapists adapted their practice to work cross-culturally, including by exploring "their own cultural assumptions and biases" (Apostolidou & Schweitzer, 2017); reflecting upon their own privileges and talking with clients about how concepts of trauma and recovery are shaped by contextual factors such as power and privilege (Hernández-Wolfe et al., 2015); adopting a "curious" and "open stance" to issues of intersectionality (Century et al., 2007; Schweitzer et al., 2015); slowing the pace, being more flexible and adapting therapeutic metaphors and techniques to account for cultural differences (Apostolidou & Schweitzer, 2017; Barrington & Shakespeare-Finch, 2014; Century et al., 2007); and using extensive non-verbal cues to aid communication (Century et al., 2007) and more behavioural techniques (e.g. breathing exercises and deep muscle relaxation) that did not require literacy skills. Therapists from minority backgrounds tended to see that as advantageous when negotiating cultural issues and relating to their clients' experiences (Century et al., 2007; Khawaja & Stein, 2016).

Three studies described how therapists perceived the therapeutic relationship to be healing in itself with these clients (Edlekott et al., 2016; Schweitzer et al., 2015), with the goal being simply "not turning away from their pain" (Apostolidou & Schweitzer, 2017). Two studies explored how therapists increasingly brought client spirituality into their therapeutic work, noticing it was often a key factor in their survival and healing process (Edelkott et al., 2016), and opening up another "dimension" beyond just "psychological and social tools" (Hernández et al., 2007).

One study also described therapists stepping back and letting the clients take ownership of the process, for therapy to be successful (Edelkott et al., 2016). Finally, three studies emphasised how this work often resulted in therapists embracing new psychological models (Apostolidou, 2016b Edelkott et al., 2016; Schweitzer, et al., 2015), including adopting more systemic, narrative, person-centred, strengths-based or integrative approaches.

Theme 3.2: Personal growth – "When one works in this field you live differently… you develop your potential"[10]

Ten of the fourteen studies described how therapists believed themselves to have grown personally since working with forced migrants who had survived multiple or complex trauma. Many (but not all) studies examined this phenomenon of personal transformation explicitly through the pre-existing theoretical lens of constructs such as vicarious post-traumatic growth (Barrington & Shakespeare-Finch, 2013, 2014) or vicarious resilience (Edelkott et al., 2016; Engstrom et al., 2008; Hernández et al., 2007; Hernández-Wolfe et al., 2015).

Six studies emphasised how therapists experienced increased gratitude for their own lives (Edelkott et al., 2016; Hernández-Wolfe et al., 2015; Schweitzer et al., 2015), in particular their friends and family (Barrington & Shakespeare-Finch, 2013, 2014), and safety and political freedom (Barrington & Shakespeare-Finch, 2013, 2014; Engstrom et al., 2008). Linked with this, came an enhanced appreciation for the authorities in their own countries (Barrington & Shakespeare-Finch, 2013; Engstrom et al., 2008). Five studies described how their work made therapists reframe, gain perspective on, and often downgrade their own problems (Edelkott et al., 2016; Engstrom et al., 2008; Hernández et al., 2007; Hernández-Wolfe et al., 2015), for example by seeing them as "learning situations" (Barrington &

[10] Hernández et al., 2007, p. 237.

Shakespeare-Finch, 2013). While largely considered a positive thing, one therapist described this as "double-sided" as they felt they no longer had "the right to have a hard time" when compared to what their clients had endured (Edelkott et al., 2016, p. 717). Despite this, a number of therapists expressly said they felt "stronger" in consequence of their work (Barrington & Shakespeare-Finch, 2013, 2014; Engstrom et al., 2008).

Eight studies emphasised how therapists gained a deeper understanding of people and "the human condition" (Apostolidou, 2016a; Barrington & Shakespeare-Finch, 2013, 2014; Satkunanayagam et al., 2010), and an increased sense of "what's really going on" in the world (Apostolidou, 2015; Barrington & Shakespeare-Finch, 2014; Edelkott et al., 2016; Engstrom et al., 2008; Schweitzer et al., 2015). Therapists described a general broadening of their minds, as well as more specific changes such as becoming less judgmental of others and less black and white in their thinking about right and wrong (Barrington & Shakespeare-Finch, 2013, 2014). Even more fundamentally, five studies reported that therapists experienced a shift in their life philosophy, values and priorities (Barrington & Shakespeare-Finch, 2013, 2014; Edelkott et al., 2016; Hernández-Wolfe et al., 2015; Satkunanayagam et al., 2010). This led therapists to become "less self-centred", and want to live more simply and limit their social circles to (or build a community comprising) those who they truly connected with and shared similar beliefs or values (Barrington & Shakespeare-Finch, 2013; Edelkott et al., 2016; Satkunanayagam et al., 2010).

The work also prompted spiritual change for some therapists (Barrington & Shakespeare-Finch, 2013, 2014; Edelkott et al., 2016). Some described finding spirituality for the first time, or that their faith deepened, while others reported questioning their religious beliefs or moving away from organised religion to less

formal expressions of spirituality. Regardless of the direction of change, studies framed this spiritual growth as a further aspect of personal development.

Discussion

This review sought to appraise and synthesise the findings of 14 qualitative studies examining therapist experiences of working with multiple or complex trauma in forced migrant populations. On the whole (although there was some variation), studies were found to be methodologically sound, and all studies yielded insights contributing to each of the three superordinate themes of the meta-synthesis.

The synthesis demonstrated that such work has a significant impact on therapists undertaking it, touching many areas of their lives and leaving them changed both professionally and personally. Three inter-connected superordinate themes were developed in the meta-synthesis reflecting various aspects of therapists' experiences. The first superordinate theme, "Doing the work" described the emotional and cognitive toll of trauma-focused work on therapists, as well as the professional challenges posed by working with forced migrants with such profound levels of need, and suggested that therapists find their work inevitably goes beyond pure therapy as they engage with their clients' (and their own) socio-political contexts. The second superordinate theme, "Making it bearable and keeping going" described various factors that therapists identified as antidotes to such intra-personal toll and professional challenges, and made the work sustainable for them. These comprised their personal connection with clients; witnessing clients overcoming adversity; implementing boundaries and self-care strategies; support from others; and their own socio-political motivation. Finally, the third superordinate theme, "Professional and personal growth" described how therapists perceived their

professional identities to develop; discovered new ways of working; and believed themselves to have grown as a person in consequence of their work.

Findings about therapists' negative emotional responses to hearing traumatic material support those of previous qualitative meta-syntheses of trauma workers' experiences generally (Sabin-Farrell & Turpin, 2003; Sexton, 1999). Such emotional (and cognitive) impact is perhaps inevitable given the multiplicity of forced migrants' traumatic experiences, which are often human perpetrated. While a minority of the included studies referred to therapists themselves experiencing PTSD symptoms (e.g. flashbacks or nightmares), the impact of confounding factors such as personal trauma histories and ongoing political unrest were insufficiently explored for such findings to fully support the potential for secondary traumatic stress (Figley, 1995). Likewise, and as previously found (Sabin-Farrell & Turpin, 2003), although therapists engaged in cognitive processes to make sense of what they had heard, and what that meant about the world and existential issues, such findings generally stopped short of describing the level of schematic and memory change required for vicarious traumatisation (McCann & Pearlman, 1990).

The meta-synthesis theme of "Personal growth" overlapped considerably with the existing construct of vicarious post-traumatic growth (Arnold, Calhoun, Tedeschi, & Cann, 2005; Brockhouse, Msetfi, Cohen, & Joseph, 2011; Gil, 2015; Linley, Joseph, & Loumidis, 2005). Indeed a number of included studies presented their findings within this framework, or that of the similar (but distinct) construct of vicarious resilience, whereby witnessing clients' resilience in overcoming adversity can result in positive meaning-making, growth and transformations in the therapist's own experiences (Hernández-Wolfe et al., 2015). However, the synthesised findings suggest a broader range of possibilities for growth might exist for therapists engaged

in this work than has been acknowledged previously in the context of vicarious post-traumatic growth. These include developments in terms of their professional identity and finding new ways of working (particularly cross-culturally), as well as personal growth beyond purely psychological changes (in terms of life philosophy and values) to choosing to live differently, such as reconfiguring their social circles in line with such values. That the emotional and cognitive toll on therapists can co-exist with an experience of professional or personal growth aligns with Cohen and Collens' (2013) finding (in their meta-synthesis of vicarious trauma and vicarious posttraumatic growth) that emotional distress does not preclude growth. This adds weight to the suggestion that 'growth' in this context (whether vicarious post-traumatic growth, vicarious resilience or otherwise) aligns better with the construct of 'self-actualisation' (Maslow, 1962) than simply an increase in positive or pleasurable experiences (Cohen & Collens, 2013).

The present review was unique in exploring therapist experiences of trauma work with forced migrant populations specifically. Previous research has implicated the deleterious mental health effects on clients of post-migration stressors, such as detention, social isolation and unemployment (Gorst-Unsworth & Goldberg, 1998; Hermansson, Timpka & Thyberg, 2002; Miller et al., 2002; Robjant et al., 2009; van Velsen, Gorst-Unsworth & Turner, 1996). This meta-synthesis demonstrated that their clients' contexts in exile also have a significant impact on therapists, both in terms of the therapeutic challenges presented and forcing therapists to engage (to a greater or lesser degree) with the asylum system and socio-political infrastructure within their own countries. Several studies described therapists providing practical assistance and/or advocacy support to clients despite challenges such as increased workloads, overstepping traditional therapeutic boundaries, and the potential conflict

of interests for therapists working in state-funded services. Such psycho-social support fits with the first and third stages of the three-phase model of psychological treatment for complex trauma (first described by Herman (1992b) and mirrored in the NICE recommendations for working with refugees and asylum seekers (NCCMH, 2005)). Addressing current life stressors to achieve safety and stability in the present is a component of phase one, the stabilisation phase, and re-establishing social and cultural bonds a component of phase three, the reintegration phase. Yet it remains a challenging and nuanced task for therapists (however well-intentioned) attempting to use their professional capital to further their clients' social capital (D. Summerfield, personal communication, December 14, 2018) while simultaneously fostering client empowerment through self-efficacy (Codrington et al., 2011; Karageorge et al., 2017).

Implications for practice and policy

The detailed description of therapists' experiences in this review is relevant to questions of acceptability and sustainability of mental health services for traumatised forced migrants, and should be of interest to policy-makers, commissioners, managers and supervisors. It also provides a framework for therapists to reflect upon their personal motivation to work with this client group, evaluate the potential risks and rewards, and consider the external support and self-care strategies they might need, thereby enabling them to make an informed choice about this as a career option.

Employers in the UK have a legal duty of care to protect the health, safety and welfare of their employees, including conducting risk assessments for workplace stress and taking all practicable measures to prevent or sufficiently reduce that risk (Health and Safety Executive, n. d.). There are also huge potential benefits of

supporting staff effectively in terms of productivity, performance and retention. The findings of this meta-synthesis suggest that therapists are not immune to their clients' traumatic histories, and that the work presents a number of professional and personal challenges. Therapists need opportunities to reflect upon and process the emotional and cognitive impact of the work during their working days. Adequate access to appropriate clinical supervision is essential, and supervision should attend explicitly to the intrapersonal impact (that may tend to be overlooked due to the profound needs of clients). Therapists particularly valued supervisors with experience in the field, offering expertise in working cross-culturally and taking into account the socio-political contexts facing forced migrants. Peer support also has a unique and important role, as does the overall culture of services, in providing a safe, accepting and supportive environment for staff that mirrors the therapeutic space created for clients. Such findings echo Herman's (1998) recommendations regarding professional support for trauma therapists: "the guarantee of [the therapist's] integrity is not her omnipotence but her capacity to trust others. Therapists who work with traumatized people require an ongoing support system. Just as no survivor can recover alone, no therapist can work with trauma alone" (p. 146).

Further, the meta-synthesis found that therapists' work inevitably extends beyond designated client sessions to include a range of practical and advocacy support, including letter and report writing and inter-service liaising. As Carswell et al. (2011) also suggest (whose study emphasises the relationship between post-migration factors and the psychological well-being of traumatised refugees and asylum seekers), commissioners and managers should consider how services are best configured to meet clients' legal, welfare, housing, physical health, and social, as well as their psychological, needs. While therapists are best placed to offer

psychological support, clients' holistic needs may be most efficiently met by specialist multi-disciplinary teams (comprising social workers and/or welfare officers, lawyers and/or paralegals, as well as physical and mental health specialists) thereby reducing the burden on individual professionals.

Limitations of this review

As with previous systematic reviews, this meta-synthesis aimed to minimise biases in the review process and in the primary research contained within it (Thomas & Harden, 2008). It is, however, a challenging and complex task to synthesise findings and identify themes (that highlight consistencies and preserve discrepancies) across primary studies taking different qualitative methodological approaches and focusing on different aspects of the therapeutic experience (both from each other and the review question itself). Synthesis arguably de-contextualises the findings of primary studies and the present review is limited by their strengths and weaknesses. While Table 2 summarises the underlying settings and contexts, descriptions were often scant in the included studies with little or no reflection of the impact of contextual factors on the studies' findings.

The amended CASP checklist (CASP, 2017) used in this review provided a framework and guidelines (against the backdrop of broader Cochrane Group recommendations for the appraisal of the methodological strengths and limitations of qualitative studies) for considering each study's contribution to the synthesised findings. Although including only peer-reviewed papers reporting studies that used an established method of data analysis provided some degree of indirect quality control, the CASP checklist was not used as a tool to exclude methodologically poorer studies. Further, the CASP checklist appraised primary studies only on their own methodological merits, and not on their suitability to answer the review question

(i.e. the degree to which study findings represented therapists' experiences of working with multiple or complex trauma in forced migrant populations). Thus studies were included in the review despite some methodological shortcomings, and this may limit the validity of the meta-synthesis findings.

In particular, the findings of many included studies constituted summaries (rather than particularly in-depth or nuanced explorations) of the ideas expressed by participants, with little or no theoretical or analytic narrative linking the identified themes. Additionally, reporting of researcher reflexivity was limited at best in the majority of studies, meaning that there was considerable potential for researcher bias to influence the findings, particularly in studies aiming to explore pre-existing theoretical constructs, e.g. vicarious trauma, vicarious post-traumatic growth or vicarious resilience. Although data from more methodologically robust studies, with findings demonstrating a richness of conceptual depth, were given greater weight, this review was limited by the fact that a formal sensitivity analysis (Dixon-Woods et al., 2006; Thomas & Harden, 2008) was not conducted.

This review was also limited by its inclusion and exclusion criteria, specifically the exclusion of therapist experiences of working with interpreters and/or with traumatised children and adolescents who have experienced forced migration; both of these are pertinent and important topics that merit their own specialist review.

Lastly, the review was limited by the fact that the main researcher designed the inclusion and exclusion criteria, developed the search strategy, selected included studies, conducted the methodological appraisal and analysed included data for the purposes of the meta-synthesis. Although the main researcher consulted extensively with two experienced qualitative researchers and one senior clinician working in the

field (the research supervisors), and study samples were cross-checked at the selection and critical appraisal stages, the review would have been methodologically sounder had more than one researcher conducted the entirety of the review process.

Areas for further research

Little commentary was provided in included studies on therapist experiences of working with specific mental health disorders, such as depression, PTSD, or indeed presenting problems characteristic of complex PTSD. This is perhaps surprising since the cluster of symptoms (long recognised by clinicians and researchers), including affect dysregulation; persistent negative beliefs and feelings about oneself; dissociative symptoms; and difficulties in inter-personal relationships, might be expected to have an impact upon the therapeutic process. Such omission may represent therapists' reluctance to pathologise their clients' distress, as much as the fact that complex PTSD has only just been included as a diagnosis in ICD-11 (WHO, 2018).

Similarly, the included studies provided little (or no) description of the particular therapeutic models and specific interventions used by therapists. Thus this meta-synthesis was unable to address questions of acceptability and sustainability of specific trauma-focused therapies, their perceived strengths and shortcomings, their impact on therapists, and the challenges or opportunities that they present for therapists. To meet the urgent need identified by UKPTS (McFetridge et al., 2017), further research is required to develop therapeutic approaches addressing the core aspects of complex PTSD, and to evaluate their acceptability, sustainability and effectiveness with this client group.

Finally, despite critical psychology's view of PTSD diagnosis and individualised treatment as decontextualising and pathologising distress and

diverting resources away from tackling social injustice, politicised violence and human rights violations (Patel, 2003; Summerfield, 2001, 1999), therapists' in the reviewed studies generally had different perceptions. Despite largely (albeit not exclusively) working in specialist trauma services for asylum seekers and refugees in Western host nations, therapists participating in the included studies typically perceived their clients' difficulties as heavily contextualised, and their work to be essentially psycho-social (and often systemic) in nature. Therapists were personally motivated by socio-political factors and committed to advocacy and social action in the interests of their clients. Future research would be of value into, not only specific therapeutic approaches, but also whether such professional sentiment and psychological thinking, together with client-led initiatives, might be better harnessed into more effective collective action against oppression.

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Part 2: Empirical Paper

Therapist dilemmas in narrative exposure therapy with clients who have experienced multiple or prolonged trauma: A tape-assisted recall study

Abstract

Aims: Narrative exposure therapy (NET) is currently recommended in the UK for treating adults with post-traumatic stress disorder (PTSD). This study examined how therapists negotiated dilemmas in NET sessions with clients with symptoms of PTSD or complex PTSD, following exposure to multiple or prolonged trauma, all of whom were refugees or seeking asylum (or other humanitarian protection) in the UK. It aimed to contribute to the development of the therapy model, clinical training and supervision.

Method: Eight tape-assisted recall (TAR) interviews were conducted with NET therapists at a UK human rights charity. The interviews explored their moment-by-moment perspectives of specific therapeutic interactions. Transcripts were analysed using thematic analysis (Braun & Clarke, 2006).

Results: Therapists gave detailed accounts of the ways in which they negotiated the dilemmas they experienced implementing the NET model with this client group. These included determining why there were gaps or inconsistencies in the narrative; helping clients to engage with their emotions and supporting their emotional expression; assessing clients' emotional and cognitive processing; challenging their own avoidance; using their own empathic response; and carefully considering pacing and ending of sessions.

Conclusion: Dilemmas experienced by therapists in the study are considered in light of the existing NET literature, and possible areas for further reflection and/or model adaptation (including in relation to specific client groups, such as survivors of trafficking) are suggested. The TAR procedure's potential as a tool for clinical process research is emphasised.

Introduction

Narrative exposure therapy (NET) was developed for the treatment of post-traumatic stress disorder (PTSD) resulting from exposure to "multiple and continuous traumatic stressors" (Schauer et al., 2011, p. 33). Such experiences, referred to in this study as 'multiple or prolonged trauma' (as distinct from 'one-off' traumatic events), have typically been encountered by survivors of childhood sexual or physical abuse, domestic violence, war, torture, genocide campaigns, and/or human trafficking.

While there is no single trajectory in terms of the psychological implications of multiple or prolonged trauma, individual survivors are vulnerable to a range of stress responses. Approximately 25-30% of people experiencing one traumatic event go on to develop PTSD (National Institute for Health and Care Excellence [NICE], 2018), and it has been repeatedly shown that cumulative exposure to traumatic stress is correlated with susceptibility to, and severity of, PTSD symptoms (Kolassa & Elbert, 2007; Mollica, McInnes, Pool, & Tor, 1998; Neuner et al., 2004). For those who do develop PTSD, core symptoms include re-experiencing, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity (Diagnostic and Statistical Manual of Mental Disorders (5th ed.; [DSM-5]; American Psychiatric Association [APA], 2013). For individuals whose human rights have been violated, their presenting problems may be further complicated by a number of factors, including the nature of their traumatic experiences and potentially having been forced to flee from the perpetrators. Survivors, for example, often experience strong feelings of guilt or shame, and may experience more extreme symptoms, such as dissociation. They may also find themselves displaced within their own countries or forced to seek asylum (or other humanitarian protection) in other countries,

thereby facing numerous losses, as well as legal, economic, social and welfare issues. Such post-migration factors have been found to be significantly associated with PTSD symptoms and emotional distress (Carswell, Blackburn & Barker, 2011).

Distinct from PTSD with these 'complicating factors' (in terms of the nature or severity of symptoms and/or other adversities in current circumstances), the World Health Organisation (WHO) has recently recognised a separate diagnostic syndrome of 'complex PTSD' in the International Classification of Diseases 11th Revision (ICD-11; WHO, 2018). In addition to meeting diagnostic criteria for PTSD, complex PTSD in ICD-11 involves (i) severe and pervasive problems in affect regulation; (ii) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event; and (iii) persistent difficulties in sustaining relationships and in feeling close to others (WHO, 2018). It is believed to follow from sustained exposure to repeated or multiple traumatic incidents, often of an interpersonal nature and occurring in circumstances where escape is impossible (Herman, 1992a; Mørkved et al., 2014; WHO, 2018).

Current Treatment Recommendations

NET is one of a number of interventions recommended by NICE in its recently updated guidance as effective treatment for adults with PTSD (NICE, 2018). Although the NICE guideline does not indicate the best treatment option for survivors of multiple or prolonged trauma specifically, it suggests various adaptations for clients with more complicated presentations, including complex PTSD, such as allowing extra time to develop trust and helping the person manage issues that might prevent engagement such as dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception (NICE, 2018).

Following Judith Herman's original three-phase model (1992b), the UK Psychological Trauma Society (UKPTS) and the International Society for Traumatic Stress Studies (ISTSS) currently recommend overlapping phases of treatment for complex PTSD, comprising (i) stabilisation and skills training; (ii) review and reappraisal of trauma memories; and (iii) consolidation of gains and re-integration (Cloitre et al., 2012; McFetridge et al., 2017). However, debate continues over whether a stabilisation phase represents an unhelpful delay; and the most effective trauma-focused therapy for complex PTSD (in phase (ii)) is as yet unknown, with research needed to address questions of effectiveness and acceptability (McFetridge et al., 2017).

Narrative Exposure Therapy

NET is a manualised, short-term therapy originally designed with the pragmatic aim of being delivered in conflict and crisis settings by trained non-professionals (Robjant & Fazel, 2010). Various studies have demonstrated its effectiveness across a range of populations, including refugees and/or asylum seekers in host countries (Hensel-Dittmann et al., 2011; Stenmark, Catani, Neuner, Elbert & Holen, 2013); former child soldiers (Ertl, Pfeiffer, Schauer, Elbert & Neuner, 2011); and survivors of different, multiple or continued trauma with co-morbid borderline personality disorder (Pabst et al. 2012, 2014). NET also appears to be a feasible treatment for PTSD in victims of trafficking for sexual exploitation who have been subjected to repeated, multiple trauma (Robjant, Roberts & Katona, 2017). A number of reviews support NET's emerging evidence base, particularly with asylum seekers, refugees and survivors of mass violence and torture (Crumlish & O'Rourke, 2010; McPherson, 2012; Nickerson, Bryant, Silove & Steel, 2011; Robjant, & Fazel, 2010).

That said, the evidence base for NET must be considered in light of the continued controversy around the validity of cross-cultural PTSD diagnosis (Summerfield, 2001, 1999) and the risk that diagnosing and treating individual survivors of war, torture and social injustice de-contextualises and de-politicises distress (Patel, 2003). Indeed it is argued that the construct of 'trauma' itself (essentially the psychological scars left by traumatic events) has as much a moral and political genealogy as a medical one (Fassin & Rechtman, 2009). Summerfield (1999) seeks to challenge various assumptions behind psychological trauma programmes (such as NET) in conflict-affected areas, and raises questions over how the Western psychological construct of PTSD is measured and whether Western talking therapies ignore the largely social impact of conflict and undermine culturally-specific ways of coping. Others argue that the evidence base for NET has been over-stated (Mundt, Wünsche, Heinz & Pross, 2014; Patel, Williams & Kellezi, 2016) and that the potential for bias in published NET studies due to therapist allegiance to the model has been insufficiently accounted for (Patel et al., 2016).

Theoretical basis for NET

Disordered memory representations are thought to lie at the core of PTSD (Brewin, 2001; Brewin, Dalgleish & Stephen, 1996; Brewin, Gregory, Lipton & Burgess, 2010; Ehlers & Clark, 2000; Elbert, Schauer & Neuner, 2015), and are key to understanding its most distinct symptom of re-experiencing the traumatic event in the form of flashbacks.

Memories stored during traumatic events, when the mind and body are extremely aroused and focused on survival, comprise mainly sensory and perceptual information (e.g. the sound of gunfire or the smell of alcohol). These sensory elements, together with contemporaneous cognitive, emotional and physiological

responses, form often-fragmented representations of the traumatic event that are stored in the form of a 'hot memory' (Elbert et al., 2015; Metcalfe & Jacobs, 1996; Schauer et al., 2011). The concept of a 'hot memory' is similar to that of a 'situationally accessible memory', or 'sensation-based memory' and 'S-reps', in Brewin's dual representation theory (Brewin, 2001; Brewin et al., 1996; Brewin et al., 2010). It is distinct from that of a 'cold memory', which stores autobiographical and contextual information (similar to 'verbally accessible memory', or 'contextual memory' and 'C-reps (Brewin, 2001; Brewin et al., 1996; Brewin et al., 2010)).

Flashbacks in PTSD result from the creation of a hot memory related to the traumatic event (or S-reps), without the usual association to a corresponding cold memory (or C-reps), that may be activated by environmental stimuli (e.g. a smell or noise) or internal cues (e.g. a physical sensation) prompting an individual to perceive themselves (sensorily and affectively) to be back in the traumatic situation (Brewin et al., 2010; Elbert et al., 2015). In NET, it is thought that hot memories from multiple traumatic experiences become integrated within fear/trauma networks (drawing on Foa & Kozak's (1986) 'fear networks') comprising interconnected sensory, cognitive, emotional and physiological elements (Schauer et al., 2011). A reminder of one event can therefore lead to the activation of multiple trauma memories within the entire network.

Drawing on story-telling traditions pervasive throughout human culture, NET claims to be culturally universal (Schauer et al., 2011). It incorporates components of other evidence-based therapeutic approaches (Robjant & Fazel, 2010), namely prolonged exposure and habituation (Foa, Hembree, & Rothbaum, 2007), the elaboration and contextualisation of trauma memories (Ehlers & Clark, 2000), as well as the giving of testimony (and bearing witness of the therapist) to the abuses

endured (Cienfuegos & Monelli, 1983). Perhaps NET's most distinctive feature is the emphasis on contextualising and embedding all traumatic events throughout the lifespan within an autobiographical narrative (Mørkved et al., 2014).

NET is considered suitable for treating those with complex PTSD, in particular, because it is "a shame-reducing approach" designed for working with multiple traumas (McFetridge et al. 2017, p. 40). Also, it draws on an evolutionary, biological model of dissociation (Schauer & Elbert, 2010), whereby peri-traumatic parasympathetic responses are repeated when trauma memories are triggered, inducing a shut-down dissociative state, and the model suggests techniques to mitigate dissociation during memory processing (McFetridge et al. 2017; Schauer et al., 2011).

Process of NET

Following diagnostic interviews and one session of psychoeducation to describe, normalise and legitimise trauma reactions and related symptoms, and explain the therapeutic procedure (and ensure informed client consent about participation in the treatment), NET begins with a 'lifeline session' (Schauer et al., 2011). During this session, the client lays out the story of their life along a piece of rope or string in a ritualised or symbolic way. The client is invited to identify briefly (in terms of time, place and content) the major positive events or relationships (represented by flowers laid on the lifeline) and the major negative events, hardships, losses, or stressful experiences (represented by stones) over the course of their lives in chronological order. The lifeline then serves as a guide for the remaining NET sessions during which the client narrates chronologically each flower and stone on their lifeline.

Particular time and attention is given to the narration of each trauma stone, during which the therapist guides the highly detailed exploration of, and exposure to, sensory perceptions, thoughts, emotions and body reactions experienced both peri-traumatically and in the moment during the therapy session. Experiences at the time of the trauma and in the present moment are explicitly compared and contrasted, and contextual information is explicitly incorporated into the narration to facilitate integration of the autobiographical memory (Robjant et al., 2017). At the end of each session, the therapist writes an account of the client's narrative and re-reads this account at the start of the subsequent session. The client is invited to correct or add any details into the written narrative, and the re-reading serves as another opportunity for exposure, emotional processing, and reflection. In the final session, the entire written narrative is read to the client, all final corrections are made, the client, interpreter (if any) and therapist sign the written narrative, and the client is given the signed copy (Schauer et al., 2011).

Qualitative Process Research

Qualitative process research can provide a unique and rich perspective on the complexities of effective therapeutic interventions, including how and why change happens (Barker, Pistrang, & Elliott, 2016; Elliott, 2010). There are, however, relatively few qualitative studies on the experience of trauma-focused therapy generally and those that exist predominantly focus on the perspective of the client (e.g. Shearing, Lee, & Clohessy, 2011; Vincent, Jenkins, Larkin, & Clohessy, 2012). Yet NET therapists working with survivors of multiple or prolonged trauma may face numerous dilemmas during the course of a session, which can affect the approach they take with particular clients.

NET requires the therapist to guide the narration (and therefore exposure through the event) in a much more directive manner than in other therapies (Robjant, et al., 2017). The therapist's intentions must always to be clear as to whether they are facilitating exposure (fully reliving the traumatic event(s) and sensory, cognitive, emotional and physiological elements of the trauma memory) or closure (ending the exposure and remembrance of the traumatic scene and supporting the client's arousal level to return to normal) in any given moment (Schauer et al., 2011). Yet, how a therapist forms and implements their intentions in practice is less clearly defined and warrants closer exploration. Indeed, the manual (Schauer et al., 2011) identifies specific challenges that may arise during NET, including the client or therapist attempting to avoid full exposure to trauma memories; the client dissociating during sessions; and working with emotions other than fear in relation to the trauma memory (e.g. shame, guilt, and disgust).

Tape-assisted recall

Tape-assisted recall (TAR) (Elliott, 1986; Elliott & Shapiro, 1988) is an established qualitative methodology to acquire detailed accounts of participants' experiences of conversations. It involves audio recording an interaction, playing back the recording to one or more of the participants, and eliciting information about how they experienced specific segments of the interaction (Pistrang, Picciotto, & Barker, 2001). In this way, TAR provides retrieval cues to participants intended to permit closer and more accurate access to their subjective experiences than retrospective self-report methods relying upon free recall. In its original incarnation, TAR was known as interpersonal process recall (Kagan, 1980), and its main application has been in the training of clinical and counselling psychologists and as a tool for therapy

process research (Barker, 1985). It has been called the 'jewel in the crown of psychotherapy process research' (McLeod, 2001, p. 81).

Whereas some TAR studies focus on the experiences of both participants (e.g. communication of empathy in couples (Pistrang et al., 2001); and consultations between GPs and patients (Cape et al., 2010)), psychotherapy studies have typically focused on the experiences of clients (as opposed to therapists) (e.g. Rennie, 1994, Levitt, 2001). Yet there is also much to be discovered from the therapist's perspective of specific interactions, and how in-session phenomena present dilemmas and shape therapist intentions and decision-making in the moment.

The Present Study and its Aims

The present study examined how therapists negotiated dilemmas during NET sessions with survivors of multiple or prolonged trauma experiencing symptoms of PTSD or complex PTSD. TAR interviews were conducted with participating therapists in relation to specific NET sessions with their clients, all of whom were refugees or seeking asylum or other humanitarian protection (including via the national referral mechanism for victims of human trafficking) in the UK. During these interviews, audio recordings of selected extracts where the therapist faced a dilemma or choice during the NET session were replayed, and the therapist's moment-by-moment thoughts, feelings, intentions, motivations and decision-making processes explored.

The study aimed to answer the following question: *how do NET therapists negotiate dilemmas and make choices during sessions with survivors of multiple or prolonged trauma?* By facilitating cued recall of therapists' experiences that might otherwise be inaccessible, it was hoped to produce insights into the therapeutic process with this client group. The findings were intended to elucidate how the

theory of NET is implemented in practice, with potential implications for model development. As well as contributing to the research literature, the study aimed to be a resource for trauma therapists negotiating dilemmas in their clinical work, as well as for the development of clinical training and supervision.

Method

Research Setting

The research took place in a human rights charity in the UK supporting adult refugees and asylum seekers who had experienced extreme human cruelty, such as torture and human trafficking. The charity provided a holistic model of care, offering specialist psychological care, a GP advisory clinic, expert medico-legal documentation, safeguarding, welfare and housing support, creative arts and employability skills programmes.

The study was conducted with the charity's psychological therapy team, which included qualified and trainee clinical psychologists, and psychotherapists. Following an initial psychological assessment, clients presenting with PTSD or complex PTSD were offered a phased-based package of therapeutic support. This typically comprised, firstly, initial stabilisation sessions (usually with an assistant psychologist) where the client was given information about PTSD and learned some skills and techniques for managing symptoms. In accordance with NICE and UKPTS guidelines, additional needs (such as emotional regulation) of clients with more complicated presentations, including complex PTSD, were also addressed (McFetridge et al. 2017; NICE, 2018). Assistance was also provided by other team members (where needed) to address social needs (such as homelessness and destitution), legal needs or other health needs. Secondly, the client was offered

trauma-focused therapy with a trainee or qualified therapist (usually NET or trauma-focused cognitive behaviour therapy (TFCBT)). Thirdly (depending upon need), the client was offered further support (from other members of the organisation) with a view to securing legal protection and access to education and employment, and facilitating community integration.

Ethical Approval

Ethical approval for the study was given by the UCL Research Ethics Committee (see the approval letter in Appendix E).

Recruitment

All NET therapists working at the research setting were invited to take part in the study provided they met the following inclusion criteria:

1. Therapists were currently working with one or more client/s:
    a. who had survived multiple or prolonged trauma, and
    b. with whom the therapist was (or would be) doing NET

    (the index client/s).
2. NET sessions between participating therapists and their index clients were (or would be) conducted either in English or in another language via an interpreter.

The researcher aimed to recruit a heterogeneous sample in terms of participating therapists' level of experience providing NET (and trauma-focused therapy generally), including both trainee and qualified therapists. It was hoped that this would provide a broad set of dilemmas, intentions and decision-making strategies for analysis.

Initial emails introducing the study and attaching the participant information sheets (for both therapists and their clients; see Appendices F to H respectively) were

sent to all therapists asking them to indicate if they were interested in taking part. The researcher then met individually with all interested therapists to explain more about the study, provide an overview of the procedure (see Appendix I), answer any questions and, if the therapist was willing (after allowing time for consideration), seek informed written consent to participate (see Appendix J).

Therapists were then requested to explain the study to their potential index client/s, provide the information sheet for clients (see Appendix H) and obtain informed written consent to audio-record an upcoming therapy session, for extracts to be replayed during a research interview with the therapist and for background information about the client to be used in the study (see client consent form at Appendix K). Index clients were not themselves required to listen back to their recorded therapy session, fill out any additional forms, or be interviewed by the researcher.

Of the 14 therapists invited to take part, 12 indicated an initial interest, and seven of those took part. Of the five expressing initial interest, two did not have an eligible index client to whom they were delivering NET, and three declined because of particularly heavy workloads during the period of data collection.

Eight TAR interviews were conducted (in relation to eight different clients) with seven therapists. Therapists were initially invited to take part in two separate interviews in relation to two different index clients (ideally in different stages of treatment). However, of the seven therapists who participated in the study, only one participated in two interviews in relation to two clients. Due to workload constraints, the remaining six therapists participated in just one interview in relation to one client.

Participants

All participating therapists were female, with an age range of 27 to 50 (mean = 35.57). They comprised five clinical psychologists and two trainee clinical psychologists. Two identified their ethnic group as White British, one White Irish and four White other. Post-qualification experience ranged from zero (for those participants still in training) to 19 years (mean = 6.86 years). Experience of providing NET specifically ranged from four months to nine years (mean = 3.19 years).

Participating therapists' index clients comprised six women and two men, with an age range of 24 to 60 (mean = 36.88). They originated from seven different countries in three continents: three from Africa, four from Asia and one from Europe. As with all clients at the research setting, index clients had typically experienced extreme human cruelty, including sexual or physical abuse in childhood, domestic violence, torture, and/or human trafficking, and were seeking (or had sought) or had been granted asylum or humanitarian protection in the UK. They all met diagnostic criteria for PTSD; some presented with additional symptoms of complex PTSD.

Further details of specific participating therapists and their index clients are not provided to preserve their anonymity.

TAR Procedure

An overview of the key steps in the study procedure is set out in Figure 1 and a more detailed description is provided in the overview of study procedure for therapists in Appendix I.

Recorded NET sessions

Participating therapists were asked to record an upcoming NET session with their index client/s in which they expected to face some dilemmas. The initial lifeline NET session was excluded on the basis that it might present unique dilemmas not otherwise arising in the remaining majority of NET sessions. Recorded NET sessions lasted approximately 90 minutes each.

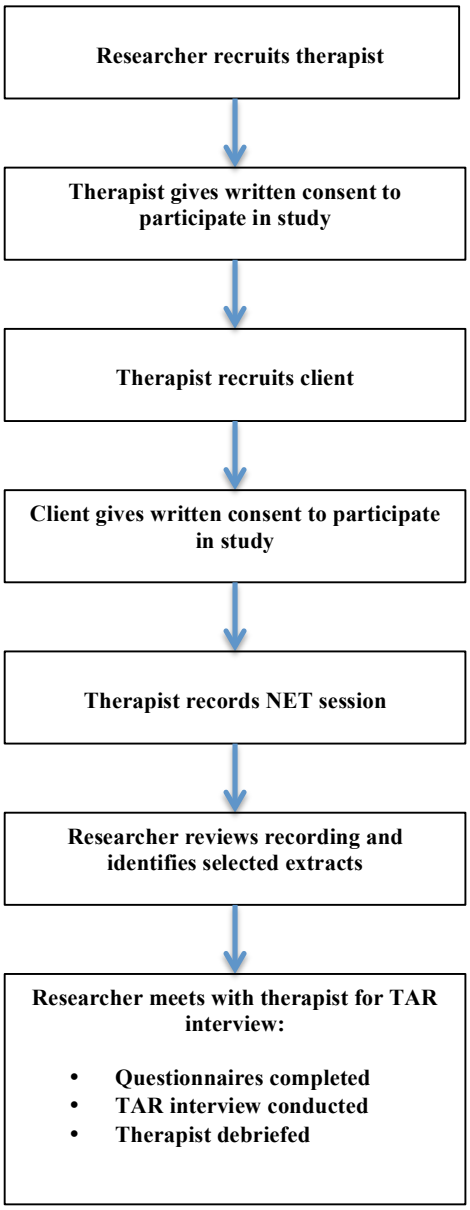
Selection of NET session extracts

Immediately after the recorded NET session, participating therapists were asked to describe briefly (in e-mail format sent to the researcher) any moments that they found particularly challenging, or where they felt they faced a dilemma or choice about how to respond to the client, or which direction to take the session. Therapists in five out of the eight TAR interviews identified such dilemmas or choice points in advance. The three therapists who had not previously identified any dilemmas or choice points were asked to do so at the start of their TAR interview. All three described such moments from memory and, in each case, these had already been selected by the researcher to be played back in accordance with the selection procedure set out below.

Before the TAR interview, the researcher listened in full to the audio recording of the therapy session and identified four or five extracts, of approximately one to two minutes, to play back during the TAR interview. The researcher identified extracts on the following basis:

Figure 1

Flow diagram of study procedure



1. where possible, the extracts contained the dilemmas or choice points that the therapist had identified immediately after the session;
2. only if necessary (e.g. where the therapist had not identified any (or enough) dilemmas in advance), the researcher selected further extracts that appeared to comprise therapist choice points during the session.

The following steps were taken to ensure that (where necessary) the researcher's selection of extracts (not identified by the therapist in advance) was carried out as systematically as possible.

When identifying therapist choice points, the researcher chose extracts that included a 'therapist interjection' and/or a 'client interjection'. A 'therapist interjection' was something that the therapist did that was distinct from purely facilitating the flow of the client's narrative (e.g. asking the client for more details about the contextual background, or sensory, cognitive, emotional, or physiological elements, of a particular memory; moving the narrative between the past and present; slowing down or speeding up the pace of the narrative; reassuring the client or reinforcing reality to keep the client grounded in the present; or bringing the narrative to a close). A 'client interjection' was something that the client did distinct from pure narration (e.g. becoming distressed or angry; demonstrating signs of dissociation; or not responding to a therapist's question, answering "I don't know" or talking about something not directly related to the narrative itself).

As there were too many therapist and client interjections for them all to be played back in the TAR interview, the researcher firstly selected those that were closest temporally to the part/s of the session during which a 'hot memory' (Elbert et al., 2015; Metcalfe & Jacobs, 1996; Schauer et al., 2011) was being narrated. This

often corresponded to the part/s of the session where the client was narrating those elements of the trauma memory that they found most disturbing.

Secondly (and only if sufficient extracts had not already been selected), the researcher selected extracts comprising therapist choice points (including therapist and/or client interjections) that involved what the researcher considered to be potential therapist dilemmas. The NET treatment manual (Schauer et al., 2011) was consulted, in particular the section on specific challenges that may arise during sessions, to aid the selection of appropriate extracts in this respect. Additionally, the researcher held an informal focus group with two senior clinicians and the clinical director at the research setting before starting data collection during which clinicians' views were sought on the types of therapist dilemmas that would be the most useful to examine. A particular area of interest for the clinicians consulted was whether therapists were presented with specific challenges depending upon the nature or content of certain trauma memories (e.g. the death of a child as opposed to a physical assault) and/or the nature of the emotions or visceral reactions associated with trauma memories. The researcher aimed to hold these examples in mind when selecting TAR extracts while also focusing upon those therapist dilemmas or challenges that seemed most salient in the particular session.

Overview of TAR interview

The researcher met with the therapist at the research setting for the TAR interview typically within a week of the recorded session and, in all except one case (due to therapist unavailability), before the therapist met the client for a subsequent session. Interviews lasted approximately one hour.

At the start of the interview, participating therapists completed a demographic questionnaire (see Appendix L) and *The Working Alliance Inventory –*

Short Revised Therapist Version (WAI-SRT; Hatcher & Gillaspy, 2006; see Appendix M).

During the main part of the TAR interview, the researcher played back the four or five selected extracts from the audio-recorded NET session to the therapist. Following a semi-structured interview schedule described in more detail below, the researcher invited the therapist to reflect upon how they experienced each selected extract during the session.

At the end of the TAR interview, therapists were debriefed and invited to reflect on their experiences of the interview and participating in the study more generally. Therapists were asked if they would be willing to review the researcher's initial draft findings, following data analysis, as a form of credibility check.

Semi-structured TAR interview schedule

A semi-structured interview schedule (see Appendix N) was developed, based on ones used in previous TAR studies (Mann, 2014; Pistrang et al., 2001). Initially, the researcher asked the therapist some general questions about where they were in the course of NET with their client, what they were doing in the recorded session specifically, and how challenging they found the session overall.

The therapist and researcher then listened to the four or five selected extracts. For each extract, the researcher asked the therapist about (i) what they were trying to do at that point in the session; (ii) what dilemmas they were facing or decisions they were making and, in each case, what options they had; (iii) their own thoughts, feelings, motivations and intentions at that time during the session; (iv) what influenced their decision about what to do next; and (v) whether they had any different thoughts or feelings about the extract after listening back to it. The interview schedule itself was used flexibly and adapted between interviews.

The researcher's aim during the TAR interview was to elicit as much information about the therapist's subjective experience as possible and for this not to be influenced by the researcher's prior knowledge or own views. Thus the researcher explicitly assumed a naïve stance and encouraged the therapist to "'state the obvious' and thus give voice to otherwise implicit assumptions and expectations" (Willig, 2013, p. 30). Following guidelines for semi-structured interviewing in qualitative research (Barker et al., 2016), open-ended questions were used initially (e.g. "can you tell me about what was going on for you at that point in the session?") followed by a series of prompts and/or more focused questions to encourage the therapist to elaborate and reflect (e.g. "what impact did it have on you when the client said/did [that]?"). Closed questions were used sparingly, at the end of the discussion about each TAR extract, to clarify ambiguities or invite therapists to consider ideas arising in earlier interviews.

Background Measures

Demographic questionnaire

Participating therapists were asked to complete a demographic questionnaire (see Appendix L), including details about their gender, age, ethnicity, professional training, and years of experience (including providing trauma-focused therapy, and NET specifically).

The Working Alliance Inventory – Short Revised Therapist Version

The Working Alliance Inventory – Short Revised Therapist Version (WAI-SRT; Hatcher & Gillaspy, 2006; see Appendix M) is a 12-item self-report questionnaire, developed from the original Working Alliance Inventory (WAI; Horvarth & Greenberg, 1989), which measures the quality of the therapeutic relationship between therapist and client. A sample item is 'We are working towards

mutually agreed upon goals'. Each item is scored on a 5-point Likert scale (ranging from '1 = Seldom' to '5 = Always'). It covers three aspects of the therapeutic alliance (reflecting Bordin's (1979) model): (i) agreement on tasks, (ii) agreement about goals and (iii) therapeutic bond. The WAI-SRT was administered to provide contextual information about how the therapist perceived their alliance with their index client across these three domains. It was hoped such context would be useful to reflect upon during data analysis, and provide background information about the therapist's selection of that particular client to take part in the study.

The WAI-SRT has good psychometric properties, and a confirmatory factor analysis found an acceptable to good fit with Bordin's bond-task-goal model (Hatcher & Gillaspy, 2006; Munder, Wilmers, Leonhart, Linster & Barth, 2010). Internal consistency of each of the sub-scales was good (Cronbach's $\alpha > .80$) and excellent for the WAI-SRT total score (Cronbach's $\alpha > .90$) (Munder et al., 2010). Convergent validity was also good: namely, total score correlations (of $r > .74$; Hatcher & Gillaspy, 2006) with the Helping Alliance Questionnaire (HAq; Luborsky et al., 1996) and the California Psychotherapy Alliance Scale (Gaston & Marmar, 1994); and total score and sub scale correlations (of $r > .64$; Munder et al., 2010) with the relationship items of the HAq (Luborsky, 1996). Permission to use the WAI-SRT in the study was granted by the Society for Psychotherapy Research (see Appendix O).

Data Analysis

TAR interviews were audio recorded and transcribed following established guidelines (Barker et al., 2016), including the NET session extracts played back during the interviews. Transcripts of each of the eight TAR interviews were then uploaded into QSR International's NVivo qualitative data analysis software (Version 12; 2019).

TAR interview transcripts were analysed using thematic analysis (Braun & Clarke, 2006) with the aim of identifying patterns in therapists' accounts of their dilemmas and how they negotiated them during selected NET sessions. Thematic analysis was chosen as a theoretically and epistemologically flexible method of qualitative data analysis that can provide a rich and detailed account of complex data (Braun & Clarke, 2006; Willig, 2013). It fitted with the critical-realist and phenomenological stance of the study to explore therapists' conscious reality of their experiences while acknowledging that this will be shaped by their pre-existing assumptions and beliefs. Although primarily data-led, thematic analysis was conducted within, and informed by, the theoretical framework of NET, pursuant to the principles outlined by Braun and Clarke (2006).

A recursive approach to data analysis was adopted, whereby the researcher moved back and forth through six phases (Braun & Clarke, 2006). During phase one, the researcher familiarised herself with the data by reading and re-reading the TAR interview transcripts and noting down her initial ideas about potential meanings and patterns. In phase two, the researcher worked systematically through the entire data set allocating initial codes to each short segment of text according to meaning and content. Thus data were coded describing a range of therapists' perceived experiences, including their intentions and aims during underlying NET sessions;

specific dilemmas or choice points they had experienced; contextual information about the particular session or client that affected these experiences; and their options, motivations and decision-making processes when negotiating identified dilemmas.

In phase three, the researcher looked for similarities and differences between the codes with a view to developing them into potential themes. Given the research question and focus of the TAR interviews, and to simplify subsequent analysis, the specific dilemmas that therapists described experiencing during selected NET sessions were grouped into clusters. Coded dilemmas were grouped by reference to which aspect of the NET process they related, yielding three clusters: (i) 'when the narration did not go wholly to plan'; (ii) 'when deciding "have we done enough?"'; and (iii) 'when other things arose'. The researcher then compared and contrasted associated codes and data across transcripts, and started developing tentative sets of themes from the ways in which therapists described negotiating dilemmas and making choices within each cluster.

In phase four, the researcher reviewed the tentative themes in detail to determine how they inter-related. Transcripts were re-read to ensure each theme accurately represented the constituent data in terms of context and meaning, and that, together, such themes reflected the entire data set. Themes were selected on the basis of their salience to therapists during the TAR interviews, although frequencies were also recorded. In phase five, the researcher finalised, named and defined each theme, and identified compelling supporting extracts from the underlying data. The researcher then integrated the final themes into a coherent analytic narrative, which was written up at phase six. An example of the initial coding and tentative themes

developed from a sample of one of the TAR interview transcripts is included in Appendix P.

Credibility checks

Although coding and data analysis was undertaken solely by the main researcher (due to resource constraints), various procedures were incorporated into the process to verify its credibility in line with good practice guidelines for qualitative research (Elliott, Fischer & Rennie, 1999; Barker et al., 2016).

A self-reflective journal was kept throughout to record the rationale for decisions taken, reflect upon observations, reactions and experiences during the study processes, and track the development of ideas and themes and how they influenced data interpretation (Morrow, 2005). Each phase of data analysis was discussed in detail with the research supervisors, both of whom had considerable experience in qualitative research. More specifically, the supervisors reviewed a sample transcript, as well as summaries of the initial coding for each TAR interview. Once the initial clusters of dilemmas, and preliminary sets of themes for how therapists negotiated them, had been developed, these were reviewed by, discussed and refined with the supervisors to ensure that they adequately captured the underlying data and formed a meaningful pattern in relation to the whole data set (Braun & Clarke, 2006).

Additionally, the researcher sought respondent validation by sending an initial draft of the results section to participating therapists. Feedback was requested on how accurately their ideas had been represented, and on how the researcher had organised them into themes. All seven therapists responded and indicated that they considered the themes to be "logical" and explained in a way that captured their

experiences. One participating therapist suggested some minor corrections to the draft results.

Researcher's perspective

The analysis and interpretation of qualitative data, and describing its patterns of meaning, is an inherently subjective process. Acknowledging this, the researcher engaged in a continuous "dual bracketing process" (Fischer, 2009, p. 584) whereby she: (i) explicitly reflected upon her own relationship with the study, her expectations of it and investment in what may be discovered by it (Willig, 2013), before setting them aside so far as possible; and (ii) iteratively re-examined her understanding in light of emerging insights throughout data collection and analysis. The researcher has also attempted to make her own background, perspective and pre-conceptions explicit below so that the reader may take them into account when evaluating the interpretations made and conclusions drawn in this paper.

I am a White British woman, in my late 30s, from a middle class background. I conducted this research during a doctorate in clinical psychology. I had a particular interest in working clinically with trauma survivors, as well as with asylum seekers and refugees. I had worked with clients with PTSD following single-event trauma during my first year and, later in training, had worked with survivors of childhood sexual abuse in a health setting rather than a designated trauma service. My experience had been mainly in cognitive behavioural therapy (including TFCBT and 'third wave' models such as compassion-focused therapy). While I saw the value in collaboratively developing idiographic formulations (acknowledging the impact of early experiences and attachments) to make sense of clients' current difficulties, I also sought to emphasise social, political and cultural contextual factors, highlight opportunities for individual empowerment, and attend closely to the therapeutic

relationship. Additionally, I recognised the need for a model, such as NET, specifically designed to address PTSD symptoms in survivors of multiple or prolonged trauma.

During the data collection phase of the present study, I was on a six-month clinical placement at the research setting. The core work involved conducting psychological assessments (including diagnostic assessments for PTSD) and implementing trauma-focused therapy (typically NET) with refugees and asylum seekers presenting with PTSD or complex PTSD. I was therefore simultaneously learning about the NET model and client group myself during the period in which I was conducting interviews with NET therapists about the dilemmas they experienced and how they negotiated them.

Given my lack of personal experience in the NET model, I had relatively few preconceptions about its strengths or weaknesses, or potential dilemmas implementing it, during the initial planning stages of the study. As data collection and analysis progressed (and my own clinical experience increased), however, I became more primed to recognise and construe dilemmas that I myself had experienced during NET sessions or had discussed during previous TAR interviews. Increasingly deliberately and actively, I assumed and re-assumed an explicitly curious and naïve stance as researcher. The highly structured process for selecting TAR extracts, and emphasis in the TAR interview schedule on open-ended questions designed to explore therapists' subjective experiences, was helpful in this respect. During data analysis, I expressly considered similarities with, and differences from, my own ideas and experiences, as well as upon other possible interpretations, to ensure that my presentation of findings accurately captured the explicit meaning within participating therapists' accounts. Additionally, throughout the research

process, I was conscious of my dual role as a researcher and trainee clinical psychologist within the research setting. In particular, I reflected (both individually and with my supervisors) upon how this may have affected the dynamic with different participants, and attempted to position myself as neutrally as possibly during the recruitment process and TAR procedure with a view to exploring as wide a range of therapist experiences as possible.

Results

The themes from the TAR interviews focusing on therapists' dilemmas during selected NET sessions, and the ways they negotiated them, are presented below. Prior to this, a brief overview of the NET sessions selected by therapists for the TAR interviews is presented to provide contextual background. Also included are descriptive data from the WAI-SRT (Hatcher & Gillaspy, 2006) about how therapists perceived their working alliance with their chosen clients.

Overview of Selected NET Sessions and Working Alliances

NET sessions selected by therapists for the TAR interviews occurred at various points in the course of therapy: two were earlier sessions, in the first half of treatment; three were mid-way through; and three were later sessions, in the second half of treatment. Two of the eight NET sessions were conducted through an interpreter.

In the majority of cases (six out of eight TAR interviews), therapists selected sessions during which the client narrated a life-threatening traumatic event (i.e., in NET terminology, a trauma 'stone', rather than a 'flower', laid on their lifeline) that was contributing to their current PTSD symptoms. One of the remaining two therapists selected a session during which she re-read the narrative of a major loss in

the client's life (which was highly connected with her traumatic experiences and thought to be maintaining many of her PTSD symptoms) and the client then narrated a stone representing a particularly adverse event she had faced. Finally, one therapist selected a session during which she re-read the previous session's narrative covering a trauma stone and a stone representing a significant and ongoing loss for the client (moving away from her children).

Most therapists (in five out of eight TAR interviews) described their selected sessions as moderately challenging; two described the session as less challenging and one as more challenging than usual.

Therapists' scores on the WAI-SRT (Hatcher & Gillaspy, 2006) indicated strong working alliances between therapists and their index clients (mean = 43.71 (60 being the strongest), s.d. = 3.04). Therapists typically responded positively (answering '4 = Very often' or '5 = Always') to the majority of the 12 items on the questionnaire. Average responses on the subscale relating to the therapeutic bond were the highest (mean = 4.93), followed by those relating to agreement about goals (mean = 4.14) and those about agreement on tasks (mean = 3.86).

Therapist Dilemmas and Ways of Negotiating Them

During analysis of the TAR interview transcripts, dilemmas arising for therapists in their selected NET sessions were grouped into three clusters: (i) when the narration process did not go wholly to plan; (ii) when deciding "have we done enough?"; and (iii) when other issues arose. Each cluster comprised several types of decision point where the therapist experienced having to make a choice about how to respond to the client or what to do next in the session. The analysis of the ways in which therapists negotiated these dilemmas produced several themes, described below and summarised in Table 1.

Table 1

Clusters of dilemmas and themes of ways in which therapists negotiated them.

Cluster of dilemmas	How therapist negotiates dilemmas
1. When the narration process did not go wholly to plan (8)	1.1 Determining why there were gaps or inconsistencies in the client's narrative (3)
	1.2 Helping the client to engage with their emotions (5)
	1.3 Monitoring, normalising and managing dissociation (3)
	1.4 Pacing sessions and finding a "good enough" place to end (5)
2. When deciding "have we done enough?" (5)	2.1 Assessing the client's level of emotional and cognitive processing (5)
	2.2 Making all the necessary contextual connections (2)
	2.3 "Fighting my own avoidance" (2)
3. When other issues arose (8)	3.1 Keeping focused on the narrative (5)
	3.2 Diverting from the trauma narrative and supporting emotional expression (7)
	3.3 Working with one's own "empathic response" (5)
	3.4 Considering drawing on other models for a targeted intervention (5)

Note. Numbers in parentheses denote the number of TAR interviews in which the particular dilemma or theme arose (out of a possible maximum of eight).

Each theme is illustrated by therapists' accounts from the TAR interviews (in italics) of the specific dilemmas they faced, and how they negotiated them, during their chosen NET sessions. Direct quotations have been edited for readability and to remove major disfluencies. Alpha-numerical IDs are used to distinguish between participating therapists (T1), their index clients (C1), and the researcher (R).

First cluster of dilemmas: When the narration process did not go wholly to plan

In NET, the therapist supports extended exposure to trauma memories, and associated emotional processing and contextualisation, through the client narrating their experiences of such events chronologically and in detail (Schauer et al., 2011). The client is encouraged to describe the context of the traumatic event before talking through slowly, from the beginning to the end of the event, their perceptions of what happened (including their own thoughts, emotions, physiology, and actions at the time) and distinguishing them from their emotional, physiological and behavioural responses during the exposure (Robjant et al., 2017).

However, therapists identified during the TAR interviews a number of dilemmas that can arise during the narration process. As explained further below, these included the client giving a sparse account of a traumatic event, jumping ahead or diverting from the narrative. Depending upon their client's presentation, some therapists found they needed to help clients fully engage with their emotions past and present and/or prevent them from dissociating during the narration (since this could impede exposure to and contextualisation of the trauma memory). Prolonged or repeated traumatic events also required therapists to make decisions about when to slow down and when to speed up through the narrative, as well as which point in the narrative was a "good enough" place to end the session.

Four different ways in which therapists negotiated dilemmas during the narration process are presented below, namely determining why there are gaps or inconsistencies in the client's narrative; helping the client to engage with the emotion; monitoring, normalising and managing dissociation; and pacing sessions and finding a "good enough" place to end.

Theme 1.1: Determining why there are gaps or inconsistencies in the client's narrative

Three therapists described dilemmas arising from their client giving a sparse account of a traumatic event, or being unable to remember particular details. They all explained that the key question in such circumstances was the reason for the gaps in the narrative since "*you have a different approach depending on which it is*" (T6). Therapists hypothesised that their client might be unable to remember certain parts because they dissociated or actually lost consciousness during the trauma. Alternatively, while details of what happened may be cognitively accessible to the client, they may be (consciously or unconsciously) avoiding articulating them.

During one NET session (about three quarters of the way through the course of treatment) a client had been narrating in some detail his experience of witnessing a natural disaster. At the moment that he thought he was about to die, the therapist tried to explore how he was feeling emotionally and physiologically but the client said that he could not remember. The therapist described her reaction as follows:

> *At that point I did think, oh no, am I missing something? Like, have I missed some part of this experience and there's more to it than he's able to tell me? Or is it a sign of dissociation, perhaps? Like a slight dissociation in that moment, because he feels like there are gaps that he doesn't remember, or…? I think there were all these different scenarios running through my mind and also I felt that doesn't really fit. You've just told me quite a lot of things and we've had to slow you down but we have got there. So I guess I was feeling a bit confused.* (T7a[11])

[11] T7 participated in two TAR interviews about two different clients. "T7a" denotes her comments in relation to her first client, [C7], whereas "T7b" denotes her comments in relation to her second client, [C8].

The therapist referred to such gaps or inconsistencies in the narrative as "*a kind of red flag*" (T7a), which indicated to her that they needed to slow down the pace of the narration even more. She reassured her client that he had been remembering many details, and encouraged him to take more time to recall and reconnect with how he had felt in that particular moment.

Another therapist highlighted that there was a further opportunity to develop a more complete narrative during the re-read at the beginning of the subsequent NET session. Her client had been able to remember very few details of the rape she experienced 20 years previously, and the therapist explained:

> *I couldn't quite figure out whether [the narrative] was relatively sparse because she was avoiding things or she was dissociating, as in she dissociated during the trauma. She also has a recollection of what might be a regaining consciousness during the trauma. So, we didn't know if she actually lost consciousness.* (T6)

The therapist also described the related dilemma of not knowing whether her client had narrated moments she directly recalled happening or that she had subsequently pieced together "*because the evidence [of a cigarette burn] was there on her body afterwards*" (T6). During the re-read, the therapist talked slowly through the details of the rape that her client had been able to remember, and used pauses and silences to see if her client could elaborate further. She explained that it was a "*difficult balance*" because:

> *You want it to flow like a helpful conversation rather than an interrogation. And you're trying to figure out what's tolerable for the person? What's respectful towards the person without potentially going too far away from what you really need to do to see some change?* (T6)

Having considered whether to probe her for more details but deciding that, in this case, her client had disclosed everything accessible to her, Therapist 6 drew on her prior experience of working with this particular client, whom she perceived to have fully understood the rationale for, and had wholeheartedly consented to, the process

of narration. She described her client as "*quite low in avoidance*" and noted that she had been inclined to volunteer extra information, where it was available to her, during the narration of previous traumas.

Theme 1.2: Helping the client "to engage with the emotion"

Five therapists talked about dilemmas they experienced when their client diverted from the narrative, sped up, skipped ahead, or did not answer direct questions about their experiences of the traumatic event. Therapists were concerned that their clients would not be connecting sufficiently with their emotions at the time of the trauma for re-exposure and habituation to occur during the session, or for such implicit experiences to be verbalised, contextualised and stored as a more coherent trauma memory.

One of the TAR interviews focused on an early NET session with a client who was narrating her experience of rape as a young woman. Towards the beginning of the session, the therapist encouraged the client to take her mind back to the particular day and describe the context of her relationship with the perpetrator. However, the client continued to reflect upon her own naivety at the time (which was typical for girls in her culture) and how she had not understood about sexual intercourse at that time. The therapist explained her dilemma:

> *I mean, she was clearly avoiding my questions. And a big challenge with this client, which I find very interesting about her, is most of the sessions I do end up learning a lot about [her country of origin and its] history and the culture. And she likes telling me these things and it's quite hard to interrupt her... [R: What is it that makes it hard to interrupt her in those moments?] Well, the interpreter doesn't help because (pause), interrupting her through an interpreter, I always feel like takes away some of the rapport. And she's just such a likeable person, and she lights up when she's actually talking about culture, rather than something awful like the rape.* (T2)

The therapist then described how she closely monitored changes in her client's body language, and her interactions with the interpreter, so that she could name and discuss what she had noticed happening in the room:

> *I wanted to get to a point where I could acknowledge the fact that she was getting anxious and that she was trying to avoid it. And it was really quite prominent how much she was grasping her bag and clutching it towards her, and she doesn't normally do that. Normally she's quite open in her body language. So something had shifted. And I wanted to make all of us aware of that to then perhaps talk about why she wanted to avoid the question so much.* (T2)

A key way in which therapists described negotiating the dilemma of their clients skipping ahead or diverting from the narrative was by slowing down and encouraging the client to focus on their emotional experience at the time, particularly during "*the hottest part of the memory*" (T2). However, some therapists noted that their index clients found it particularly hard to articulate their feelings. They attributed this to a range of cognitive, developmental and cultural factors, as well as a language barrier. Therapist 2 explained: "*I think it's quite difficult when we haven't done much work on recognising and labelling emotions to then ask her such difficult questions*". To assist this process, therapists described being explicit about the rationale for asking clients to reflect upon their feelings, being clear and specific in the phrasing of their questions and, where necessary, offering suggested emotional labels and seeing how well they fitted for their clients.

Contrastingly, another therapist, who explained that her client repeatedly reported "*the same constellation of three or four things that she was feeling*" (T4), spoke about respecting her client's limits in terms of emotional literacy (i.e. her ability to identify and translate her own feelings into language), provided emotional processing was still occurring:

> *Experience has taught me… I'm not going to get any further with that, and we could be banging our heads against a wall for a bit, so that's when I tend to move on.* (T4)

The extent to which therapists found themselves needing to help clients engage with their emotions very much depended on the particular client. Another therapist, who described her client as "*very bright*", explained how he tended to "*intellectualise*" and "*come out of the emotional experience of the trauma that he is describing*" (T7a). During the selected NET session, she focused upon helping him to connect with his emotions. However, she explained that, with other clients, she might instead have to help them to moderate their emotions (and, as described in the following section, prevent them from dissociating) during the narrative process:

> *I guess for other clients you might find that you are trying to moderate the impact of those emotions rather than trying to intensify them. So for other clients you might bring them back much more to the here and now… I think it is about having sensitivity to what's in front of you, and trying to kind of modulate it and make sure that… they are in the window where they can optimally experience that emotion to process it but it is not so overwhelming that it's causing other difficulties. And he dips in and out of that window, at the bottom end… So that's what I'm constantly trying to do in this session, is get him up there so he can process it a bit… Whereas with other clients I might be more about bringing them down rather than bringing them up.* (T7a)

Theme 1.3: Monitoring, normalising and managing dissociation

In three of the TAR interviews, therapists described dilemmas over whether their clients dissociated at some point during the traumatic event. Such dilemmas typically arose when the client said something interesting or unusual during the narrative. For example, one client referred to feeling "like my body travelled" (C3) while she was being raped. In addition to being important information about her client's traumatic experiences, and a possible explanation for any gaps in her memory (as described in more detail in 1.1 above), the therapist explained how she was keen to normalise dissociation and make it understandable for her client:

> *When I am writing somebody's narrative, I really want it to be an understandable story for them, and for them to see why things happened, so it doesn't feel like a confusing, unknown experience. And I would really like if she can understand that her spirit travelled because the threat was so enormous. And it [was] the only way for her in that moment, it was probably the only way that she could survive… I would like in her narrative to be able to say, my body, mind, protected itself by travelling away. And this is normal. It happens to lots of people.* (T3)

Although she explicitly named her client's experiences as dissociation, Therapist 3 explained, "*the word doesn't matter… I really try to use people's words as much as I can*".

Peri-traumatic dissociation can also increase the risk of dissociation during the narration, prompting therapists to monitor clients for prodromal markers in the therapy room. Referring to a NET session about mid-way through treatment, Therapist 7 described her client (C8) becoming very still, looking down, not responding to her question and taking a gasp of breath. She therefore decided to take "*pre-emptive action*" (T7b) and deploy some grounding strategies to bring her client back to the present moment and allow her to continue with the narrative. The therapist explained that this scenario presented less of a dilemma than it might have with another client, earlier on in therapy:

> *I think knowing that I knew how best to respond for her. We have an agreed plan about what will happen if she dissociates. I know that it's worked in the past. I know that she knows it's worked in the past. So I guess I'm feeling, even if there [are] some risks here, that I can manage them.* (T7b)

Theme 1.4 Pacing sessions and finding a "good enough" place to end

Selected NET sessions often involved the narration of prolonged traumatic events by clients who had experienced multiple traumas or events that were of extended duration and/or occurred in circumstances that were inescapable. Five therapists identified dilemmas associated with pacing the narration and/or finding a "*good enough*" (T1) place to end the session.

One therapist described the dilemma of pacing sessions (which typically lasted one and a half hours) in general terms:

> *The other dilemma that I perpetually wrestle with is how much to dwell on a particular aspect of anything. I've gone to both extremes, where you micro-bury into the detail, and then clog things up a bit with that. Or you move at a reasonable pace through, but you might be missing... something that's quite important.* (T4)

Another therapist, whose client was narrating a particularly lengthy instance of rape by multiple perpetrators during a period in which she was being held for the purposes of sexual exploitation, explained the predicament in more detail:

> *It was very long and it was difficult to me to try, without knowing what the content of the trauma was a priori, to speed through the bits that were maybe less relevant… and really slow down and process… the bits that were perhaps more significant in terms of… maintaining her symptoms in the present. It was challenging in that particular way. It was hard to know, I had to pace it, without knowing.* (T1)

Pacing became increasingly challenging as the session progressed, and Therapist 1 was aware (although the client did not appear at all fatigued) that she felt quite fatigued herself, as they had been going for some time.

In negotiating this dilemma, Therapist 1 spoke about the importance of assessing, before the narration, which parts of "*this whole horrible drawn out trauma night*" came back to her client in flashbacks. As her client had been unable to provide a complete breakdown of the most disturbing moments beforehand, she intently monitored her client's physiology and affect in the room, as well as her ability to

narrate coherently and comprehensively, to determine where to speed up and where to slow down. For example, she described why, during one extract, she decided not to intervene and slow the narrative down:

> *It seemed to me, and even listening back to it now… there wasn't any arousal in the room as she was describing it... It seemed that… actually she had extremely vivid recall of all of these events. It didn't seem like the memory was fragmented in a PTSD trauma kind of way. She was able to talk about it… It was horrible, content wise, but not traumatic in the sense of the unprocessed memory that might be contributing to her symptoms… It seemed the way she was talking about it that it didn't seem particularly upsetting to her in the now.* (T1)

Three of the five therapists also noted that it was not always possible to end the NET session when their client had reached a place of relative safety after the traumatic event. Therapist 4, whose client remained extremely vulnerable and experienced further traumas shortly afterwards, explained:

> *I think I was just aware that a whole other lot of problems [were] going to open up, because I know what the next thing [on her lifeline was]. And I just thought… is that where it's helpful to stop, or is it helpful to stop later? I think there was no right answer there, in terms of where would be best.* (T4)

The therapist continued by acknowledging that it is good practice to agree in advance with clients where they would end the session but reflected that this approach was not a panacea:

> *The difficulty with that is you can sometimes take the narrative forward in a way that's unhelpful and you don't really want to do that either. Sometimes it's best to use a bit of art and science to work out where to cut off.* (T4)

Therapist 1, whose client (at that point in her narrative) was being held for a prolonged period of sexual exploitation, also emphasised the importance of validating and bearing witness to the reality of her client's experiences, "*because the truth is, it wasn't over yet, it did go on for another 15 days, and even then you're weren't safe*" (T1). She described an unresolved "*tension between*":

> *…on the one hand wrapping it up, as it were, so it feels ok enough to finish for today. But also not trying to sugar-coat things, because that's*

> *inconsistent, I think, with… modelling… I can hear this and this is what actually happened and we're not going to… Other people are trying to silence your voice, but here we're going to hear how it really was. The reality is, it wasn't safe.* (T1)

Second cluster of dilemmas: When deciding "have we done enough?"

The continuous process of activating and narrating hot memories in NET is thought to lead to habituation, the formation of 'cold' declarative memories comprising contextual and autobiographical information about traumatic events, and a decrease in emotional impact, physiological arousal and re-experiencing symptoms over time (Schauer et al., 2011). The second cluster of dilemmas described by therapists during TAR interviews concerned the central question of whether they had "done enough" in the session to support this process or whether more 'processing' needed to be done.

Therapists described three main ways of determining this key question: assessing the client's level of emotional and cognitive processing; ensuring that the client had made all the necessary contextual connections; and challenging their own avoidance of discussing the details of the traumatic material.

Theme 2.1 Assessing the client's level of emotional and cognitive processing

In five of the TAR interviews, therapists described assessing their client's emotional and cognitive processing of the traumatic event to determine whether or not they needed to repeat parts of the narrative and talk it through with them in more detail. During the initial narration, therapists monitored their client's level of processing with a view to keeping them grounded, knowing when they had started to habituate to the emotion, and allowing their arousal to reduce before ending the session.

After her client narrated the worst part of her memory of her traumatic miscarriage late in pregnancy, one therapist explained how she negotiated her dilemma of whether they could move on or not:

> *We had talked about this bit for several minutes and I think her distress had peaked and come down a little. And she was able to access, for example, some more updating thoughts… which I think indicates she was definitely grounded… She was then going on to talk more about her general feelings of loss relating to the baby and her emotional distress had come down maybe a little. Enough to give me an indication that we had sat with the very intense part of the experience...* (T7b)

However, Therapist 7 emphasised that she would only be able to determine the question of "*have we done enough*" (T7a) definitively in the following session:

> *I will have to assess with her whether we have talked through this in enough detail for us to be able to move on… I think that is something that you can really only know when you see the person [in the following session] as to whether or not you need to review the stone again and talk through some of it in more detail.* (T7b)

In particular, therapists considered whether there had been any shift between sessions in their client's thoughts and feelings about the traumatic event, or their level of PTSD symptoms in relation to it.

In terms of affect, therapists assessed whether their client's level of distress had reduced when reading back the narrative in the subsequent session (compared with the narration session itself), as well as the nature of their expressed emotions. During one of the selected NET sessions, the client started crying during the re-read of the narrative of a rape she had experienced, and her therapist explained that the nature of her sadness provided useful information about how well she had processed that particular memory:

> *She'd started crying. And sometimes that can be very useful in terms of giving you information that certain emotions have come up that maybe are directly connected to that memory. But when [pause], the quality of the crying was not really a re-experiencing, it was a sadness. An appropriate sadness, I would say, as distinct from how I would have expected her to feel at the time.*

> *So, I didn't feel that the crying added anything in terms of being able to develop the narrative further.* (T6)

Had her client's expressed emotion, or body language in the room, suggested that she was still experiencing "*a sense of fear*" during the reading back of the narrative (such as she might have experienced peri-traumatically), Therapist 6 explained this might have indicated that her trauma memory was still fragmented and required more work. Indeed, a number of therapists acknowledged the benefit of working closely with clients in NET, and being able to get to know, and monitor, their responses over time.

In terms of cognitions, therapists assessed their client's self-critical, self-blaming or strongly negative beliefs during the following session as possible indicators that further trauma-focused processing was needed. Contrastingly, therapists saw their clients' ability to distinguish between past and present, look back and reflect upon traumatic events and their wider consequences, and (importantly) access updated thoughts (e.g. "*the fact he survived the event*" (T7a)), as evidence of more adaptive levels of processing.

Therapists also assessed clients' PTSD symptoms in the following session, including any intrusions to the traumatic event or signs of dissociation. Therapist 4 noted that her client's "*sense of avoidance*" had reduced significantly, as she was able to talk about her mother's murder during the reading back of the narrative, and contrasted this with her initial lifeline session when she had omitted to mention this event until prompted as she was unable to "*even hold [it] in mind*" (T4).

Theme 2.2 Making all the necessary contextual connections

Another way in which two therapists sought to determine whether they had done enough was by considering the context in which the traumatic event took place and eliciting all potential layers of interpretation from their client. In relation to her client's narration of her experience of traumatic childbirth, one therapist identified her potential dilemma of "*whether the person has thoughts and feelings about the trauma that you're missing because you haven't taken that wider context into account*" (T6). She elaborated by explaining:

> *…with her, there's clearly that fear that she has at that moment, and that fear for her own life, fear for the baby's life. But the important secondary fear is about the other two children. And that, I think, is connected to the husband becoming less and less reliable. She doesn't feel like they're safe… So, I think there's a risk that I might have missed that or not understood that if I hadn't been also thinking about what else is going on at the time.* (T6)

To negotiate this dilemma, the therapist ensured that she asked about the worst moments of the trauma and invited other thoughts, feelings and recollections throughout. She highlighted three opportunities in NET for these connections to be made: during the initial lifeline session; during the narration and during the re-reading of the narrative, and explained:

> *The interesting thing about trauma-focused work is, unless there's something a person is really avoiding telling you, stuff comes out. Because there is that sense of wanting to get some relief from it, and that sense of these things linking together.* (T6)

To determine when she had gathered enough information, the therapist asked herself "*whether, in my own mind, the level of distress, the thoughts and the feelings all fit together with that context and… with that trauma*" (T6).

Another therapist's client made a connection between seeing dead bodies covered with white sheets following a natural disaster, and the white shroud covering his mother's body at her cremation. The therapist said that this helped her understand

why "*that particular part of the memory was so emotive [for] him*" (T7a). She also had the dilemma, however, of whether her client had made this connection peri-traumatically or post-traumatically:

> *I was trying to identify [whether] the memory of his mother [was] present at the time of the experience of that trauma, if that makes sense? Did he have images of his mother at that time? Is it part of the network for that memory? Or is it something that's coming as a secondary connection, in terms of the memory network? Is it just linked because of the similarities in terms of the emotional experience but also the sensory experience in terms of seeing a white sheet and dead bodies etcetera?... So does that image belong to the past, or does that image belong to now?* (T7a)

Had the client made the connection during the trauma itself, the therapist explained she would have spent more time exploring his peri-traumatic thoughts and feelings during the session. However, as her client had only made the connection afterwards (during the NET session itself), the therapist decided not to explore it further there and then as they had already discussed his mother's death in an earlier session. She believed, however, that it was helpful for her client to have made and expressed that connection, as a way of "*disentang[ling] the emotional experience*" and making sense of why such appraisal might have been "*keeping that [traumatic memory] going*" (T7a).

Theme 2.3 "Fighting my own avoidance"

A final way in which two of the therapists described negotiating the question of "have we done enough" was by monitoring and challenging their own avoidance. During one of the selected therapy sessions, a client reported that she often saw the image of her baby whom she had miscarried. The NET model requires the therapist to support the client in talking through, in great detail, all of her sensory experiences in that moment, as well as her thoughts, feelings and physical sensations. Therapist 7 explained that she was "*fighting my own avoidance*" at that point in the session:

> *I think it was a particularly difficult thing to ask somebody to focus on. I think always that something that's very gruesome, in addition to the emotional content – obviously seeing something that you loved so much die, can be very difficult to ask that person to really sit with that experience. Because I think physiologically it brings up quite a lot of physical experiences of horror and disgust and all sorts of things… And so I think trying to make sure that I don't avoid it because it's something that's very visceral for the therapist when someone's describing something like that.* (T7b)

In tackling her own avoidance, the therapist found it helpful to understand her own personal reaction to certain kinds of traumatic events, and why she might find them particularly difficult to talk through with clients. She also referred to needing to be prepared that the narration process might prompt physiological responses (in both clients and therapists), as well as emotional distress or dissociation.

Another therapist described actively monitoring her own avoidance as an inherent part of determining whether enough trauma processing had been done:

> *…you're always trying to make sure, the therapist, that you're not trying to avoid elements of trauma detail by deciding oh, that's processed already, and moving on. And… with that session, I was thinking, is it definitely the case that I got as much as could be there, or is there a possibility I just didn't want to distress her anymore? So, it's one of the things I've been thinking about… was I just not in the mood to hear more about that myself on that day?* (T6)

She acknowledged that therapists might be more or less susceptible to "*collud [ing] with avoidance*" (T6) on any given day depending on their own personal state of mind. Hence it was an ongoing process for therapists to consider this possibility both during and between sessions.

Third cluster of dilemmas: When other issues arose

The main focus of NET treatment is the "fear of the most threatening part of the traumatic event" (Schauer et al., 2011, p. 64). However, some guidance is provided about formulating and working with emotions other than fear, including the client's primary emotions (experienced peri-traumatically) such as shame and disgust, and secondary emotions (experienced post-traumatically) such as guilt or grief. Essentially, narration remains the key mode of treatment with the goal of eliciting such emotional responses, integrating them within the client's autobiographical context and facilitating a correctional experience through validation within a safe, non-rejecting and trusting therapeutic relationship (Schauer et al., 2011).

The third cluster of dilemmas related to moments during NET sessions where something important arose other than the client's fear of the most threatening part of a trauma memory. Specific dilemmas included how therapists worked with clients' other emotions (e.g. shame, guilt, disgust, grief or anger), themes central to clients' lives (such as identity and loss), and events that were not traumatic in a diagnostic sense but were of fundamental autobiographical significance. Also, therapists faced dilemmas about how to respond to their own feelings during sessions.

Therapists described four main ways in which they negotiated these sorts of dilemmas: keeping focused on the narrative; diverting from the trauma narrative and supporting emotional expression; working with their own "empathic response"; and considering drawing on other models for a targeted intervention.

Theme 3.1 Keeping focused on the narrative

Five therapists described various ways in which keeping focused on the narrative helped them negotiate dilemmas when other things arose during NET sessions. They found that the process of "*keeping moving*" (T6) through the client's lifeline could be containing for the client and helpful for maintaining the focus of sessions on targeting their PTSD symptoms.

Towards the start of one of the selected NET sessions, a therapist was talking with her client about how he spent the previous evening to establish the context for his traumatic experiences the following day. The client's memories of that evening prompted him to reflect upon his own identity and feelings of responsibilities towards his family. The therapist had to decide whether to explore these themes further or to re-focus their discussion onto the narrative of the traumatic event that followed. She described her dilemma as follows:

> *I think it is difficult because… this theme of identity and responsibility to his family is something that is a constant struggle for him in his day-to-day life. I also think he is quite prone to rumination about that. So I think there was part of me that was like, oh this is really important, it's coming up again. There was another part of me that was like, no, we have dealt with this and we need to keep the focus, rather than maybe getting drawn into some of these conversations that I'm not sure how helpful they are to have them over and over again.* (T7a)

Although the therapist acknowledged that a broader aim of NET is to help the client to establish a more "*integrated sense of himself*" (T7a) through developing a coherent autobiography, she emphasised that the focus of treatment was on addressing his PTSD symptoms. In this moment, Therapist 7 decided to "*gently close down*" her client's train of thought and move him on to talking about his trauma memories. In so doing, she found it helpful that her client (who was about three quarters of the way through treatment) was used to the NET model and structure of sessions, as well as her sensitively directing him to keep them on task.

Another therapist described a similar dilemma when, after re-reading the narrative of the previous session's trauma, her client reflected upon her sadness about the loss of her teenage years when she was forced into prostitution:

> *When somebody's expressing a belief or an interpretation of what's happened, that's bringing a lot of emotion, I'm always tempted to go off track of what I think the task of NET is, and focus on grief or shame.... The dilemma is how much to keep going, to go into it at those moments, or how much for me to clock the themes that are coming up, and hope that we can talk about it at the end.* (T3)

In this instance, Therapist 3 negotiated her dilemma by expressly acknowledging the significance of her client's loss, that they were not going to be able to give it the time it deserved in that moment, and suggesting they return to it towards the end of therapy. She considered it probably "*more containing*" for clients to work through all of their trauma memories before "*starting down another track*" (T3). Other therapists also found the "*journey of the model*" (T6) helpful at times and noted that by working through someone's entire life story you have the opportunity to "*build a narrative*" (T5), emphasising a client's strengths and resilience, in a way that might help with other themes.

Theme 3.2 Diverting from the trauma narrative and supporting emotional expression

Despite the benefits of keeping going with the trauma narrative in some circumstances, all therapists acknowledged that at times they diverted from it to bear witness to their client's experiences and support their emotional expression.

During one NET session, a therapist was re-reading the narrative of the adverse circumstances that led to her client's decision to move away from her children. Despite initially claiming that she had "no regrets" (C6), having acted in her children's best interests, the client became very distressed near the end of the session about this ongoing separation. The therapist explained that she often faced the dilemma, when working with clients who had been trafficked and exploited,

about how much time to spend on events that were not necessarily life-threatening but involved huge "*sadness and loss*" (T6). In negotiating this dilemma, she considered such events:

> *...really important for you to be bearing witness to as a therapist and giving space and time to think about it. Because those events can contribute to and feed into the effect of the direct traumatic memories as much as being difficult in their own right. So, in terms of treating PTSD, this lady's traumatic experiences will end up linking to that loss of the children and loss of daily life with them.* (T6)

The therapist further elaborated on her natural response, on a human level, to her client's distress in the moment:

> *My first point was how do you respond as a normal person to the sadness? You know, as a person who'd just had a conversation with somebody even distinct from being a professional. I also believe that, as much that we want to really do everything properly with the model, sometimes a situation arises and you have to respond to it there and then. And actually sometimes you can respond to it once, there and then, and it offers some relief.* (T6)

The therapist reflected that her decision about how to respond was made easier by the fact that they weren't discussing "*an overt trauma*" (i.e. in NET terms, the conversation related to a loss-related stone rather than a trauma stone) so there wasn't a risk of inadvertently talking about something that led the client to experience increased flashbacks or nightmares. While supporting the client to "*give voice*" to her sadness, the therapist also respected her boundaries (since the loss was "*part of her daily reality*") and allowed her to close down the conversation by talking also about how she manages the separation in the here and now.

Other therapists also spoke about wanting their clients to be able to "*voice*" (T7b) particular experiences and "*have the experience of being heard*" (T4). For example, this was a motivating factor for two therapists to divert briefly from the main trauma narrative and allow their clients to talk about emotionally salient dreams. Another therapist also described her dilemma about whether or not to divert

from the narrative when her client reflected that his current circumstances (as an asylum seeker in the UK) made him think he would prefer to be in his home country "to die or to fight" (C5). She explained:

> *There is a lot of hopelessness sometimes about his current situation – not being able to work, not being able to have money or influence in any way, and feeling that his life has no meaning.* (T5)

The therapist explained that she wanted to validate her client's current feelings by "*holding that hopelessness*" (T5) rather than trying to resolve them.

Three therapists spoke about experiencing dilemmas when working with their client's feelings of shame. During one NET session, about mid-way through treatment, a client was narrating her experience of rape by multiple perpetrators, who spoke in an extremely derogatory and degrading way to her, making her feel both terrified and ashamed at the time. The therapist explained her dilemma that she was concerned that the 'exposure' component was challenging when working with memories strongly associated with feelings of shame and humiliation, as opposed to fear. She reflected on how she might adapt her focus during such parts of the session:

> *I think other ingredients, bringing it out into the daylight is how I often think of these things that people are very ashamed about. It can be just sharing things with someone can be hugely beneficial and therapeutic. But it often does invoke a lot of negative emotion in people as well...* (T1)

At another point in the session, Therapist 1 described supporting her client to express her feelings of anger towards, and apportion blame to, the perpetrators as a "*healthy*" alternative to shame and self-blame. Other therapists also described taking opportunities to explore and validate their clients' current feelings of anger (where such feelings were accessible to them), as something to be encouraged (as the NET model suggests). Therapists typically considered anger to be an appropriate and adaptive response, allowing clients to externalise their feelings about what was often the "*complete failure for [their] rights and needs to be respected*" (T6).

Theme 3.3 Working with one's own "empathic response"

Perhaps inevitably, hearing clients' stories often provoked strong emotional reactions in therapists. Five therapists discussed dilemmas associated with their own feelings arising during sessions and explained the ways in which they worked with them.

During one NET session, a therapist described feeling infuriated about the injustice of her client's working conditions that led her to being unnecessarily vulnerable on the night she was raped while travelling home. The therapist explained that her initial dilemma when strong feelings of her own arose (which other therapists echoed) was determining how much they reflected her own personal response and how much she was picking up from the client:

> *I would normally try to think about what part of it is me? And what part of it might be themes that she's raising? Because of course you can have all your own bees in your bonnets about things that are nothing to do with what she's bringing into the room… based on your own ideas about things. But… sometimes the emotions that you start feeling are a reflection of something that that person is bringing to the room.* (T6)

In negotiating this dilemma, the therapist described using her own feelings to make a tentative reflection to the client about the unfairness of the situation as a way of testing out whether this resonated with her and opened up further discussion. In assessing whether such reflections were pertinent or not to her client, the therapist explained:

> *Usually, if you go down a road that's not relevant to the person, they generally don't have that much to say about it. Whereas, if you happen to tap into something that's really key, the person responds to it in a variety of ways. It might be by providing information; it could be how they appear in terms of their affect; or in general how they respond... But I think, in terms of trying to make sure that you're keeping it as strongly to their themes and their agenda as much as you can, is to be tentative and… curious… You might have ideas about what might be the worst bit, or what might be the bit that you need to work on, but they're only ideas until the person has shared the thing with you.* (T6)

Another therapist described the powerful personal impact of realising (during her client's narrative) that the client had had nowhere to live safely at that point in her life.

> *For me, actually, it was quite interesting, because no matter how much you do this work, when you hear something like that you think, oh my god. And that sense that she literally could not walk away from that house and go anywhere else... it's a really key example of why people who have been trafficked are just so vulnerable.* (T4)

Similarly to Therapist 6, she described noticing her own "*empathic response*" (T4), and using her sense of anger about the injustice of her client's position, to tentatively explore her client's feelings about it.

A third therapist described how she experienced a "*parallel track of horror*" (T1) during her client's narration of being raped by multiple perpetrators. She faced the dilemma of how to show "*enough feeling*" while also staying "*moment-by-moment*" with her client through the session. In negotiating this, the therapist aimed to strike a balance between embodying her empathy, while actively demonstrating that she could hear her client's story, in a way that did not distract from the narrative process:

> *That's the bit that you can't see, through my body language and through my face, and through my tone of voice – try to show as much empathy as I can. Without saying, oh my God, I'm so sorry that's happened to you, that sounds awful. Without distracting from the process. Just trying to embody that empathy and to keep going... And not in any way… even if I am feeling really stirred up or upset by the image or idea of something, not to allow it to show and overwhelm the session or overwhelm the client and to, on any level… even unconsciously, for them to pick up on, this is too much, you're not able to hear this...* (T1)

Similarly to others who spoke about "*focusing on the task in hand*" (T3) to manage their own emotions during sessions, Therapist 1 explained that she erred on the side of "*matter of factness*" to demonstrate to her client that she had heard similar things

before, that they could be spoken about, and that the client did not have to worry about upsetting her.

Theme 3.4 Considering drawing on other models for a targeted intervention

Five therapists talked about a dilemma about whether or not to draw on trauma-focused CBT principles to make targeted interventions in relation to other emotional themes or specific cognitive appraisals that arose during NET sessions. For example, one therapist explained her dilemma when her client indicated that she blamed herself for the death of her unborn baby:

> *I'm thinking… should I have done a bit more to try and update that? You know… in NET you do have a bit more flexibility to [ask] is there anyone else who is to blame? But it's really… straying into cognitive restructuring from a more cognitive behavioural perspective. And I think the NET model really is not necessarily about trying to fix it, it's about trying to elicit it and help the person come to their own adaptive conclusions. In all honesty, I find that's not always quite enough, sometimes there is work that needs to be done.* (T7b)

The therapist continued by acknowledging that it can be "*a bit of a limitation*" of the NET model that a person's feelings of guilt, and self-blame, don't always change. She explained her general approach:

> *What I will normally do first is do NET as it should be done and see if that actually makes a shift itself. Because it does and it can be surprising how much it does. But I think you also have to use your clinical judgement to know when it's not working and when you might have to change model or when you might have to enhance it using other techniques from other models.* (T7b)

Similarly, another therapist reflected that she could have introduced some psycho-education to validate and normalise her client's peri-traumatic feelings of disgust:

> *We could have done a cognitive intervention… helping her to understand why she might have felt disgust in that time. Which is that it's a threat based response to push away something that's unacceptable and harmful to your body.* (T3)

Another therapist explained how she drew on other models when exploring her client's interpretations of dreams she had had since the previous session. The

dreams involved her client's mother, whose death she had narrated during the previous session, and for which she blamed herself. Although discussing a client's dreams in detail was not the therapist's usual approach in NET, she explained that she thought it was a meaningful process for this particular client (whose spiritual beliefs were very important) and provided valuable insight into her appraisals of self-blame:

> *She's mentioned dreams before… She's very spiritual, she's very religious. And I think that she uses that spirituality to make sense of things for herself… And I also know that she has very clear ideas about what things mean… So, there is a sense that we're sort of accessing something that's important or meaningful to her in a way that maybe we couldn't talk about it in another way.* (T4)

Discussion

Eight TAR interviews were conducted during which therapists gave detailed accounts of the dilemmas and choice points they experienced during selected NET sessions with survivors of multiple or prolonged trauma. These dilemmas, and the ways in which therapists described negotiating them, were grouped into three clusters. The first cluster of dilemmas arose when the narration process did not go wholly to plan; the second, when therapists were deciding "have we done enough"; and the third, when other issues arose during therapy sessions.

Dilemmas in the first two clusters related to the core psychotherapeutic elements of NET, namely extended exposure to trauma memories in order to modify the emotional network through detailed narration, while meaningfully integrating past and present physiological, sensory, cognitive and emotional responses with the client's autobiographical context (Elbert et al., 2015, Schauer, 2015, Schauer et al., 2011). There are relatively few published empirical studies into the process of trauma-focused therapy generally (although notable exceptions include Brady,

Warnock-Parkes, Barker & Ehlers, 2015; Shearing et al., 2011; and Vincent et al., 2013), and none on NET. However, therapist experiences in the present study were largely consistent with how the NET literature envisages this process and the sorts of challenges that may arise.

For example, therapists in this study experienced dilemmas about how to respond to gaps or inconsistencies in their clients' narratives or their attempts to go off topic. The ways in which therapists negotiated such dilemmas were well supported by the NET manual, which suggests various interventions to promote narrative development and emotional engagement, as well as to manage clients' (and therapists') understandable attempts to avoid discussing traumatic material (Schauer et al., 2011). Similarly, therapists' descriptions of determining whether they had "done enough" by assessing their client's emotional and cognitive processing, and the integration of all necessary contextual information, fitted with the manual's guidance on "habituation" (pp. 52-53, 69-70) and "cognitive restructuring" (p. 54) between sessions (Schauer et al., 2011). Therapists emphasised the structure of the NET model as particularly helpful in this respect, which (reflecting its roots in testimony therapy (Cienfuegos & Monelli, 1983)) provides multiple opportunities to develop as full and coherent a narrative as possible of the most salient events in a client's life, and allows therapists to work closely with clients enabling them to monitor their emotional and cognitive responses over time.

Some therapists in the present study experienced dilemmas arising from clients having dissociated at the time of their trauma, and sought to keep them grounded during therapy (since in-session dissociation can prevent exposure to and contextualisation of the trauma memory (Schauer & Elbert, 2010; Schauer et al., 2011)). Indeed just more than half of over 200 practising psychologists surveyed in

the US historically endorsed dissociation as a significant contraindication for the use of exposure-based treatments for PTSD (Becker, Zayfert, & Anderson, 2004). However, current evidence demonstrates that the existence of dissociative symptoms of depersonalisation and derealisation generally (as distinct from unmanaged dissociation during therapy sessions) do not substantially moderate the treatment outcomes of NET with severely traumatised asylum seekers and refugees (Halvorsen, Stenmark, Neuner, & Nordahl, 2014). Much has been written about formulating and preventing dissociative shutdown during NET with survivors of multiple or prolonged traumas (Elbert et al., 2015, Schauer & Elbert, 2010, Schauer et al., 2011). In keeping with its conceptualisation within an evolutionary framework (Schauer & Elbert, 2010), therapists in the present study sought to normalise peri-traumatic dissociation for their clients as an adaptive survival response. Their descriptions of monitoring prodromal signs and symptoms, and managing them through pre-emptive grounding strategies, were also consistent with recommendations for continuous attentional shifting between trauma-related material and the present context by prompting the client to recall their current circumstances, engaging sensory stimulation in the here and now and, where necessary, promoting motor activation using applied muscle tension to prevent dissociative shut down (Schauer & Elbert, 2010).

Less guidance is provided in the existing NET literature about how some of the other dilemmas experienced by therapists in the study should be negotiated. For example, some therapists described working with clients who found it particularly hard to identify and articulate their feelings in words. This potentially impeded their ability to provide a verbal account of their experiences, which is important for updating the neural network. While the NET model recommends therapists invite

clients to perceive and help put into words their emotional experiences without judgment, including by suggesting possible emotional labels to clients (as therapists in the study indicated that they did), no more explicit guidance is given on how to achieve this (Schauer et al., 2011). There may be many reasons why clients struggle to name their own emotional responses, including those who lacked developmental support to do so and/or experienced childhood trauma. Given the focus in NET on eliciting and contextualising clients' implicit experiences past and present, and the crucial role of emotional engagement in exposure therapy (Jaycox, Foa & Morral, 1998), it is worth considering (with particular clients) whether time should be taken to identify and agree upon meaningful emotional terminology, and/or find other ways to assess emotional activation (e.g. assessing physical signs of arousal) during narration.

Several therapists in the study (including more experienced ones) described dilemmas associated with pacing and ending sessions involving the narration of prolonged and/or repeated traumatic events. While they found an element of pre-planning could be helpful (e.g. mapping out details of the traumatic event, assessing current intrusions to particular moments, or agreeing an ending point in the narrative with the client in advance), therapists also acknowledged the need to remain flexible and constantly monitor their clients' presentation in the room, and their ability to narrate coherently and comprehensively, to determine where to speed up and where to slow down. In terms of ending sessions, therapists also highlighted the importance of validating the reality of their clients' experiences (in keeping with the model), particularly when their trauma continued beyond one specific event in circumstances that were inescapable. The NET manual provides relatively limited guidance on the nuanced task of ending sessions in this context. It recommends moving on to the

immediate aftermath of the traumatic event and ensuring that the client has "enough emotional distance from the last… hot memory" (Schauer et al., 2011, p. 54). Thus, further opportunities (perhaps in supervision) would be valuable for therapists to reflect upon how they negotiate ending sessions in these circumstances and consider the impact both on their clients and themselves.

Perhaps most challenging for therapists were the dilemmas they experienced (in cluster three) when something important arose not specifically related to the client's fear of the most threatening part of a trauma memory. For example, therapists highlighted that certain client groups, such as those who had been trafficked, had typically experienced numerous autobiographically significant life events involving hardship and loss, which were not necessarily traumatic in a diagnostic sense, but were of fundamental importance in understanding and contextualising their life history. There was a sense from therapists that they should "bear witness" to such events (as Blackwell, 1997, suggests), and give them "time and space" within sessions. In this respect, therapists found the narrative journey of the NET model containing for clients and helpful for illuminating, where relevant, their vulnerability to exploitation, as well as their particular strengths and resilience, over their life's course. Yet dilemmas arose about how much time should be spent and how much detail elicited from the client about such events, compared with life-threatening traumas where exposure is the key therapeutic component. It is also worth considering whether adaptations need to made to the treatment protocol, for example to include specific elements of psychoeducation for particular clients (such as discussing the process and aims of torture with survivors to shed light on perpetrators' wider motivations (Basoglu, 1992; Grey & Young, 2008)). It may also be beneficial to talk with survivors of trafficking (who often remain confused or

ambivalent about their relationship with their traffickers) about typical patterns of exploitation and the potential motivations of traffickers with a view to helping them make sense of their own experiences and increasing their awareness and inter-personal safety going forwards (Robjant et al., 2017).

Therapists also described dilemmas associated with clients' more entrenched peri- or post-traumatic appraisals and overwhelming emotional responses (other than fear). For example, strong feelings of shame are commonly experienced by people who have been sexually exploited, tortured or abused. As Robjant et al. (2017) explain, in NET, shameful events are treated in the same way as other traumatic events. Therapists support exposure to memories of the event while closely attending to the client (e.g. by maintaining eye contact) and responding empathically. Thus, the client experiences acceptance and compassion, rather than rejection (as they might anticipate). By taking an explicit stance, as an advocate for the client's human rights, the therapist facilitates the expression of emotions that the client was unable to experience and express at the time (Robjant et al., 2017). In keeping with the views of therapists in the present study, anger is considered to be "a powerful antidote to shame" (Robjant et al., 2017, p. 3; Schauer & Elbert, 2010). Yet, for some therapists, dilemmas remained about whether narration in the sessions was sufficient for such powerful emotions to shift, and some therapists considered incorporating elements of other models to work with particular cognitions (e.g. those relating to self-blame). Further research is needed to determine whether, for specific client groups, shame simply takes longer to reduce following narration of the event (perhaps beyond the course of treatment). Subsequent to the conduct of the present study, recommendations on addressing shame through the NET model have been

further elaborated (Schauer, Robjant, Elbert & Neuner, in press), which may go some way to addressing the dilemmas experienced by the therapists in this study.

Study Strengths and Limitations

The major strength of the TAR method used in this study was that it elicited detailed and nuanced accounts from therapists of how they experienced key moments during NET sessions. This provided a degree of specificity unachievable through more typical qualitative methods of data collection (such as semi-structured interviews focusing on therapists' experiences of delivering NET generally). The study contributes to the existing body of process research, increasing understanding of the application of a specific model of treatment, as well as the complexities of therapeutic change, and contributing to theory development, training and supervision (Llewelyn & Hardy, 2001).

However, the study design also involved a number of limitations that affect the generalisability of its findings. The study was conducted in just one research setting, with therapists working with clients who were either refugees or seeking asylum (or other humanitarian protection) in the UK. Hence the findings are specific to this client group. Also, the sample size of seven therapists who participated in eight TAR interviews (in relation to eight different clients) was relatively small, although not atypical compared with other TAR studies (e.g. Elliott et al., 1994; Pistrang, Barker & Rutter, 1997; Rennie, 1994; Rober, Van Eesbeek, & Elliott, 2006). While participating therapists had different levels of professional experience, the sample was highly homogenous in terms of gender and ethnicity. This potentially limited the range of perspectives explored in the study and failed to reflect the diversity of the client groups at which NET is targeted.

Potential for bias was also inherent in the processes for selecting index clients, NET sessions and TAR extracts. Participating therapists were asked to identify (and seek consent from) clients who met the inclusion criteria for the study, as well as to select the particular NET session that they audio-recorded. Although the logistics of recruitment and therapist availability influenced which NET session was recorded, it is possible that therapists also selected clients with whom they had particularly good working relationships and NET sessions that they anticipated being relatively straightforward. Indeed, the WAI-SRT (Hatcher & Gillaspy, 2006) scores indicated that therapeutic alliance was invariably strong between participating therapists and clients. Thus the dilemmas therapists faced may have been less challenging than might otherwise have been the case and may have involved fewer inter-personal process issues.

Although the majority of NET session extracts replayed during TAR interviews were selected by participating therapists themselves, a minority were selected by the researcher. As described earlier, a number of steps were taken to ensure that the selection of extracts (not identified by therapists in advance) was carried out as systematically as possible. However, it is possible that the researcher's preconceptions about what constituted a choice point or dilemma for therapists also influenced this process. Similarly, although various measures were taken to enhance credibility (including frequent discussions with supervisors, participant validation of findings, and researcher reflexivity and dual bracketing processes), a degree of subjectivity was inevitable during data collection and analysis. The specific questions asked during TAR interviews, and themes identified during data analysis, were developed by a single researcher operating in a dual role in the study setting (as

both researcher and trainee clinical psychologist) and hence not wholly independent of her preconceptions and beliefs.

A further limitation concerns the accuracy and validity of therapists' accounts during TAR interviews. Ideally, interviews would have been conducted within 48 hours of the underlying NET sessions so that therapists' memories of the original interactions remained accessible (Elliott & Shapiro, 1988). However, due to therapist availability, TAR interviews were typically conducted a week after the relevant therapy session (and, in one case, an intervening session had occurred before the TAR interview could take place) hence therapists may have been more susceptible to forgetting and inaccurate recall. Indeed, despite the particular strength of the TAR procedure in accessing participants' conscious perceptions of specific interactions, individual abilities to recount their experiences retrospectively may be compromised (Barker, 1985) and involve an element of reconstruction after the event. Despite specific guidance during the interview process, it is also impossible to wholly exclude factors such as social desirability and fabrication from therapists' accounts (Elliott, 1986).

Clinical, Research and Policy Implications

The findings highlight particular therapeutic strategies for therapists to attend to and develop while implementing the NET model. These include eliciting sufficient narrative detail about the client's traumatic experiences; supporting clients to articulate and engage with their more implicit emotional and physiological experiences past and present; engaging in ongoing assessment of individual clients' cognitive and emotional processing of traumatic memories; and monitoring and managing dissociative symptoms, as well as both the client's and therapist's (conscious and unconscious) attempts at avoiding exposure work.

Clinicians may also benefit from reflecting in supervision on how best to approach pacing and ending individual sessions with clients who have had repeated or prolonged traumatic experiences taking place in inescapable circumstances. NET with this client group inevitably evokes strong emotional reactions in even experienced professionals (as therapists in this study found), and therapists should be afforded a reflective space in which to formulate and process their individual reactions, as well as consider ways of utilising such empathic reactions in their work with clients.

The findings also suggest possible areas in which the NET model might be adapted for specific clients, such as survivors of trafficking and/or those experiencing particularly entrenched or overwhelming appraisals or emotions (e.g. of self-blame or shame). Targeting individual clients' clinical needs accords with the wider movement towards 'personalised treatment' for mental (as well as physical) health problems. The ISTSS cites this (in its recently published position paper on complex PTSD in adults (n.d.-a)) as part of the rationale for the organisation of trauma symptoms into two distinct disorders in ICD 11, and the principle underpins its recommendations for future research on effective interventions for complex PTSD.The present study focused on therapists' perspectives of dilemmas during NET sessions with survivors of multiple or prolonged trauma. It would be particularly elucidating to use the TAR procedure in future research to examine clients' reciprocal experiences (of therapist-identified dilemmas, or client-identified challenges during therapy, and how particular therapists negotiated them). However, the ethical issues of asking clients to listen back to, and reflect upon, extracts from trauma-focused therapy sessions (which can themselves be experienced as difficult

and painful, albeit achievable (Shearing et al., 2011)) would have to be carefully considered beforehand.

Only two of the selected NET sessions in this study were conducted through an interpreter. Yet the triadic dynamic of working with an interpreter presents unique challenges and the TAR procedure would lend itself particularly well to a focused investigation (ideally, from the therapist, client and interpreter's perspectives) of such process issues during NET sessions.

The therapeutic encounter also involves numerous non-verbal communications, as emphasised by many therapists in the study who closely monitored their client's body language throughout sessions (e.g. for signs of avoidance, dissociation, emotional processing) and used their own to convey empathy and acceptance. To explore this further, future research using video (rather than audio) recordings would provide an additional layer of detail in the cued recall of specific therapeutic interactions.

The TAR procedure could be used by therapists to incorporate small-scale process studies into their clinical practice, as well as providing a useful tool for supervision and self-reflection. Empirical findings could be used to support the development of clinical guidelines and training programmes, and enhance the acceptability of interventions, for example by making them less stressful for clients and therapists.

In addition, the present study has implications for the future development of mental health services for traumatised individuals, and forced migrants specifically. NET was originally devised with the intention of being delivered in refugee camps by non-mental health professionals (Robjant & Fazel, 2010). In its briefing paper on trauma and mental health in forcibly displaced populations, the ISTSS recommends

the involvement of 'experts by experience' in both programming and implementation of treatment, including 'in a task-shifting capacity as cultural mediators and lay therapists' (n.d.-b, p. 19). The present study supports this aim by providing a detailed exploration for would-be lay therapists of how they might negotiate key challenges in the therapeutic process, as well as flagging areas for careful consideration, such as how they might manage their own emotional response to, and potential avoidance of, aspects of the work. Several therapists in the study found that they faced dilemmas when supporting their client to engage emotionally with traumatic material: a critical aspect of NET. How an individual identifies and articulates their emotions is a culturally laden process and one in which experts by experience acting as cultural mediators might help bridge the gap between therapists' ethnocentric emotional constructs and clients' subjective experiences.

Collection and analysis of data in a study such as this inevitably involves the co-construction of meaning by researcher and participants. Such co-construction will have been shaped by the potential intentions behind the study (as perceived by the participating clinical psychologists, and the researcher herself) to focus upon the clinical application of the NET model. The study findings must therefore be situated within this disciplinary, as well as the wider historical, cultural and political, context.

Given that the researcher, all participating therapists and the majority of their clients (who had often experienced sexual violence) identified as female, taking an explicitly feminist epistemological standpoint might have allowed greater reflection on the role of gender as an organising principle in the therapeutic process and made the study more targeted at progressive social change (Sprague, 2016).

An even more fundamental contextual consideration is how 'trauma' itself and its ramifications are construed, not only within the fields of psychology or

psychiatry, but more broadly in contemporary society. Taking an anthropological perspective, Fassin and Rechtman (2009) propose that the 'irrefutable reality' (p. 6) of trauma and its psychological traces is 'more a feature of the moral landscape serving to identify legitimate victims than it is a diagnostic category' (p. 284). This is not to question the validity of PTSD or complex PTSD diagnosis for any particular individual. Rather it is to suggest that the construct of trauma has moral and political implications, for instance, reparation, testimony or certification (Fassin & Rechtman, 2009). Mental health professionals (including therapists and researchers) might seek to make more explicit the moral and political implications of the decisions they make. These include deciding to adopt highly structured interventions, such as NET, targeted at helping individuals 'recover' from the prescribed view of 'trauma', as well as case-by-case decisions, e.g. about which events in a person's history to focus upon during a course of treatment. Similarly, moral and political issues arise for trauma services more generally, e.g. when deciding whether or not to treat individuals who have experienced traumatic events but present with prior pathologies (Fassin & Rechtman 2009) or for whom psychiatric outcomes other than PTSD are the main problem (as is often the case in the minority of survivors who are affected (Bonanno, Brewin, Kaniasty & La Greca, 2010)). By overtly acknowledging the moral and political drivers at play in the field of trauma, it is hoped that other inequalities or injustices will not be obscured.

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Part 3: Critical Appraisal

This critical appraisal addresses some of the key methodological issues that arose while planning and conducting the literature review and empirical study. In the first section, on researcher reflexivity, I set out further details of my epistemological and ontological stance. I reflect upon how my own assumptions, views and beliefs may have influenced, and been influenced by, the research process. I also expand upon a particular aspect of personal reflexivity and consider some of the specific benefits and challenges presented by my 'insider' position in the research setting. In the second section, I elaborate upon my experiences using the tape-assisted recall (TAR) procedure for data collection, including its strengths and weaknesses, and some of the specific challenges I encountered during the TAR interview process.

Researcher Reflexivity

The qualitative approach taken in this thesis puts the subjective experiences and understandings of its participants, as well as the subjectivity of the researcher, in the foreground (Barker, Pistrang & Elliott, 2016). Researcher reflexivity acknowledges the "researcher's contribution to the construction of meanings throughout the research process", and the "impossibility of remaining 'outside of' one's subject matter" (Willig, 2013, p. 10). Two types of reflexivity have been identified: epistemological and personal (Willig, 2013), both of which will be explored below.

Epistemological Reflexivity

Epistemological reflexivity involves making explicit underlying assumptions about the world and what is 'knowable', and reflecting upon how they have inevitably shaped the specific research questions, design and data analysis, and the kind of knowledge they aim to produce. Both the literature review and research questions were underpinned by the principles of 'critical realism' (Barker et al.,

2016; Bhaskar, 1975; Roberts, 2014). They sought to explore the knowable reality of how trauma therapists experience their work. Yet it is acknowledged that both the findings of existing studies, and freshly collected data, may not provide direct access to this reality (Willig, 2013), are historically and contextually situated, and mediated by individual idiosyncratic perceptions and beliefs (Barnett-Page & Thomas, 2009).

The research study was broadly phenomenological in orientation. It sought to explore participants' "perceived meanings" (rather than observable facts or events); and pursue an "understanding" of individual experiences, intentions and actions, from "multiple perspectives" (all of which were equally valid and of interest), as well as the "presuppositions" (implicit assumptions about ourselves, others, and the world) upon which such individual perceptions were based (Barker et al., 2016, p. 78).

In the literature review, these phenomenological assumptions particularly influenced how I determined what constituted data, and which aspects of the included data I emphasised in the synthesised findings. Thus, I decided to focus on therapists' subjective experiences of working with survivors of multiple or complex trauma and forced migration (rather than, for example, how therapists understood and formulated their client's experiences). In my synthesised themes, I decided to prioritise meanings derived from direct participant quotations rather than author explanations, recommendations or interpretations based upon pre-existing theories.

A key aim of the empirical study was to explore a particular aspect of therapist experiences of implementing a specific therapeutic model with a specific client group, i.e. the ways in which therapists negotiated dilemmas during narrative exposure therapy (NET) sessions with survivors of multiple or prolonged trauma. I therefore needed to balance being open to the full range of therapists' experiences (in

keeping with a phenomenological stance), with the study's focus upon a particular aspect of them within a pre-determined theoretical framework.

This balance was not always easy to strike and I constantly reflected on how best to achieve it. In particular, I encouraged therapists, as far as possible, to identify moments themselves during their NET sessions when they experienced dilemmas to be replayed and explored during TAR interviews. I only selected extracts to be replayed myself when participants failed to do so themselves (typically due to time constraints). As described in the empirical paper, I aimed to do this as systematically as possible by drawing on NET theory and the views of the informal clinical focus group I consulted during the planning stage about particularly interesting dilemmas for NET therapists.

Also, my questions during the TAR interviews were designed to tap into therapists' phenomenological experiences (rather than focusing entirely on their views about applying the NET model). Thus, I asked open-ended questions about their intentions and motivations during therapy sessions; their subjective perceptions of (and how they personally experienced) the dilemmas and choices they faced; their specific moment-by-moment thoughts and feelings; and the factors that influenced the decisions they made in their particular context.

Perhaps inevitably, given the explicit focus of the study and the therapy model they were working within, I found that therapists tended to reflect upon their experiences using NET theory and terminology as their frame of reference. I too adopted this approach during data analysis by construing therapists' dilemmas within the context of the NET model and by making potential deviations from the model explicit. That said, I took an "empathic", rather than "suspicious", approach to the interpretation of data (Willig, 2013, p. 66). I attempted to focus on "manifest

meanings" (independent of my own views, preconceptions and theoretical leanings), reflecting the explicit (rather than latent) content of what participants said (Willig, 2013, p. 66). When developing my themes, I aimed to be primarily data-led, and prioritised ways of negotiating dilemmas that seemed most salient to participants during TAR interviews, rather than allowing NET theory to shape the analysis.

Personal Reflexivity

Personal reflexivity involves researchers reflecting upon how their own values, experiences, interests, beliefs, politics and social identities shape, and are shaped, by research (Willig, 2013). I will firstly consider the impact of my own clinical experiences, interests and beliefs on the research process; secondly consider the specific benefits and challenges presented by my 'insider' position in the research setting; and thirdly consider the personal impact of the research process on me as a clinician.

The impact of my experiences, interests and beliefs on the research process

As noted in the literature review and empirical paper, during my clinical psychology doctorate, I had a particular interest in working with survivors of trauma, and with asylum seekers and refugees specifically. Clinically, I was interested in how human beings respond psychologically to extreme adversity and how they are best supported therapeutically. From a socio-political perspective, I was motivated to work with disempowered groups at a time when dominant discourses are increasingly anti-migration. I welcomed the opportunity to learn about different political regimes, cultures and societies. I was also conscious of a moral imperative to "bear witness" (or give recognition) to people's experiences, including the atrocities they have faced (often at the hands of fellow human beings), and the political processes involved (Blackwell, 1997, p. 7).

As stated in the empirical paper, during data collection I was completing a six-month clinical placement in the research setting, a charitable organisation that (amongst other things) provided psychological therapy (including NET) to asylum seekers and refugees with PTSD or complex PTSD. This placement immediately preceded the data analysis phases of the literature review and empirical study. I was aware of the possibility that I would (consciously or unconsciously) be tempted to pursue conversations during research interviews, and develop themes in my write up, that resonated with my own clinical experiences. In view of this, I drew on the principles of Fischer's (2009) "dual bracketing process" (p. 584) and explicitly reflected, throughout the research process, upon my own expectations of, and investment in, the potential findings of the present study.

For the purposes of the literature review, I reflected upon how I had experienced trauma-focused therapy with traumatised refugees and asylum seekers myself. Hearing clients' first-hand accounts of their traumatic experiences, and how they had survived them, had a profound personal impact upon me, prompting a powerful empathic response. I also became more acutely aware of my own privileges as I witnessed clients struggling to navigate the UK's asylum, health and welfare systems, being prohibited from working, and facing ongoing reporting obligations and the possibility of detention and/or deportation. I was therefore perhaps particularly drawn to findings in the reviewed studies about how other trauma therapists understood, and managed, the personal impact of their work, as well as how they negotiated the wider socio-political implications of working with forced migrant populations. Having identified these vested interests at the start of the synthesis process, I could make a more deliberate attempt to 'set aside' my personal views when I recognised similar themes in the studies reviewed.

As I had no personal experience of delivering NET at the outset of the empirical study, I initially reflected upon my clinical experiences more generally and how they influenced my expectations of the sorts of dilemmas that NET therapists might experience and how they might negotiate them. Up to that point in training, my individual client work had typically involved collaboratively implementing formulation-driven interventions based on cognitive behavioural therapy (CBT) principles, including 'third wave' approaches such as compassion-focused therapy. However, my theoretical leanings were pluralistic, and I aimed to position my work within a systemic framework, explicitly acknowledging with clients the multiple levels of embedded context (including social, cultural and political factors), which influence, and give meaning, to their actions and position within the world (Burnham, 1992; Pearce & Cronen, 1980). I was therefore particularly interested in dilemmas NET therapists might experience about how to account for wider contextual factors in clients' personal narratives. Also of paramount importance to my own clinical work was attending to the therapeutic relationship. In so doing, I was particularly influenced by humanistic principles of the centrality of empathy and the transformative power of clients' own resources (Rogers, 1961, 1975). I was therefore primed to want to explore how therapists ensured their clients felt that their emotional experiences had been fully heard, understood, and accepted, and had agency in their own recovery, while maintaining focus on the tasks of a highly structured and targeted therapy model.

Subsequently, during data collection and analysis, I reflected upon how my own increasing clinical experience of the NET model affected these processes. Over time, I found myself more often anticipating what therapists might be about to say about a particular dilemma or the potential strengths or limitations of the NET

model. There were also instances where participants described experiencing dilemmas that I myself had encountered clinically and discussed in my own clinical supervision. Specific examples included how best to end sessions in the context of prolonged traumatic events, and dilemmas around working with clients' particularly entrenched appraisals and overwhelming feelings of disgust and shame.

To counteract these potential personal biases, I aimed to be as participant-led as possible during TAR interviews to ensure I captured their subjective phenomenological experiences. When similar issues were (or had the potential to be) discussed, I tried to ensure that I adhered closely to the interview schedule and remained tentative and curious in my follow-up questions, using them purely for clarification purposes rather than to lead the discussion in a particular direction. Throughout data analysis, I aimed to compare and contrast my interpretations of meaning within participants' accounts with my own ideas and clinical experiences. It was not always easy to unpick my own developing ideas from the views participants expressed during interviews. I wondered about the extent to which certain ideas should be 'bracketed' or were a product of the ongoing process of analysis and interpretation of the research data. I attempted to resolve this by re-reviewing participant transcripts and sticking as closely as possible to their expressions of meaning in my presentation of findings. I also regularly discussed the development of themes, and potential alternative ways of interpreting and organising the raw data, with my supervisors. Of particular importance, was seeking participant validation from therapists that my draft results accurately reflected their views and experiences rather than my own.

The benefits and challenges of my 'insider' position in the research setting

Throughout the research process, I was conscious of my dual role as a researcher and trainee clinical psychologist. As previously mentioned, during the data collection phase of the empirical study, I was simultaneously undertaking a six-month clinical placement at the research setting and learning to deliver NET with clients of my own. As researcher, I therefore had some personal experience of the studied topic. Concurrently, I was also a member of the therapy team at the research setting and, therefore, the colleague and, in some cases, the supervisee of participating therapists. As Barker et al. (2016) highlight, while my 'experiential knowledge' (Borkman, 1990) afforded certain benefits in the research process, it also presented some challenges in maintaining the necessary critical detachment.

The concept of 'experiential knowledge' has been used in a healthcare setting to denote knowledge gained by those with lived experience of a condition, as opposed to 'professional knowledge' derived from professional training and practice (Borkman, 1990). In a research context, the terms 'insider' and 'outsider' are often used to delineate circumstances where researchers themselves have experiential, as opposed to purely professional, knowledge of the research topic (Hoffman & Barker, 2017). In the present study, the experiential versus professional divide is potentially confusing since participants were clinicians rather than clients. In the following commentary, I use the term 'insider' to denote my position as a clinical psychology trainee and practising NET therapist myself, albeit that such experience was gained in a professional (rather than purely personal) context.

As Berger (2015) aptly describes, there can be both advantages (including "a head start in knowing about the topic, and understanding nuanced reactions of participants", p. 223) and disadvantages (including "risks of blurring boundaries"

and “projection of biases”, p. 223) when researching from an ‘insider’ position. I noticed this particularly when conducting the TAR interviews for the empirical study and reflected upon the issues raised by my own experiential knowledge of NET and working as a trainee clinical psychologist in the research setting with the particular client group. As has previously been noted in the context of studying a health condition that the researcher has also experienced (Hoffman & Barker, 2017), my impression was that participants generally felt able to speak freely with me, with less need for explanation or elaboration. For example, my training in clinical psychology, and NET specifically, meant that we could focus on more detailed analysis of their moment-by-moment experiences without my needing to interrupt to seek clarification on basic points of theory. That said, I was aware of the risk of making my own assumptions about participants’ meanings, and therefore encouraged therapists to be as explicit as possible in the links they were making between theory and practice.

Due to my own clinical experiences, I believe I was able to empathise more strongly with certain experiences described by participating therapists. One striking example was when a therapist reflected upon how painful she found it to hear her client say that she still felt “dirty” and “ashamed” about what had happened to her, despite knowing that it had not been her fault. I felt better able to understand the nuanced personal impact of working with clients’ feelings of shame having supported my own clients expressing similar sentiments. However, I chose not to disclose clinical examples of my own (as I did not want to divert the focus from the participant), and aimed to remain curious about the therapist’s subjective meaning while conveying my level of understanding through eye contact, body language and other non-verbal communications.

I was also aware of the risk of over-identifying with participating therapists, making assumptions about their experiences, and losing critical objectivity. I noticed this particularly during TAR interviews with fellow trainee clinical psychologists, who were grappling with similar issues implementing the NET model to those I experienced myself. I found it helpful to state this at the start of interviews and emphasise that the intention was to reflect upon each therapist's subjective experiences rather than my own. I explicitly assumed a non-expert stance, aiming to listen and reflect without offering my own examples or suggestions. I sought to distinguish the TAR interview process from that of peer supervision, explaining that the aim was not to resolve any outstanding issues and acknowledging that this might feel unsatisfactory.

Contrastingly, I noticed that another TAR interview, with a more experienced therapist, felt more similar to that of clinical supervision. I became aware of the need to bracket my own interest in learning about the NET model and to ask more about possible alternative considerations, as well as the therapist's personal thoughts and feelings in particular moments, to encourage greater reflection and make more explicit how she negotiated dilemmas and took particular decisions.

Finally, I considered how my 'insider' role might have affected participants' accounts. It is possible that my position as a trainee clinical psychologist may have encouraged therapists to present a more socially desirable account, e.g. in terms of their adherence to the model, to a fellow (albeit trainee) professional than they might had I been a wholly independent researcher.

The impact of the research process on me as a clinician

Conducting the empirical study added to my reflections upon the strengths and weaknesses of the NET model. NET is highly structured (perhaps even more so

than other trauma-focused therapy models) with the focus of sessions being upon the narration of key traumatic events on the person's lifeline. Given my own formulation-driven and theoretically integrative approach to clinical work, I initially assumed that this structure had the potential to feel constraining. However, the interviews with participating therapists helped me to appreciate that the structured nature of the model could be experienced as containing, by both clients and therapists. When coupled with detailed conversations about the rationale for, and focus of, treatment and the obtaining of informed consent from clients (as the model requires), NET offers a clear roadmap for the challenging work of trauma-focused therapy and clarity about how to approach clients' complex needs.

The development of a coherent and contextualised autobiographical narrative, allowing connections to be made between past and present experiences, also struck me as a particularly powerful representation of the therapist's 'bearing witness' to the client's experiences. Equally, the emphasis on eliciting individual emotional and cognitive experiences (and for them to be heard and responded to within an overtly compassionate and human rights-focused therapeutic relationship), rather than actively intervening to 'restructure' them, aligned with my own humanistic leanings and belief in people's innate transformative capacity. That said, I remained curious about how broader systemic and liberation psychology (Martín-Baró, 1996) principles might be incorporated into therapeutic work with survivors of multiple or prolonged trauma (including those who have experienced forced migration), to more explicitly acknowledge the influence of social and political structures over individual subjugation and more actively seek opportunities for resistance and empowerment (Afuape, 2011).

More personally, I felt uniquely privileged to hear therapists' reflections about the NET process, including the dilemmas they experienced, at such a pertinent time in my own clinical training. I found participating therapists' thoughts about working with their own empathic response particularly meaningful. Having considered the extent of one's own personal response, as opposed to what might be being picked up from the client, therapists described making tentative reflections as a way of opening up further exploration of the client's emotional experiences. Rather than being something to be controlled or managed during sessions, I more fully appreciated how one's empathic response as a therapist could be used therapeutically while concurrently demonstrating to the client that you (as therapist) are not overwhelmed by such response.

TAR Procedure

As explained in the empirical paper, the TAR procedure is designed to facilitate cued recall of participants' conscious but unspoken experiences of inter-personal interactions. By playing back short segments of audio-recorded conversations between therapist and client during NET sessions, I was hoping to prompt therapists to reflect upon their specific thoughts, feelings, intentions and motivations when negotiating dilemmas in the moment in greater detail and with more accuracy than would be possible through an unassisted qualitative interview.

In terms of my general observations, similarly to other researchers and commentators (Barker, 1985; Larsen, Flesaker & Stege, 2008; Mann, 2014), I found the TAR procedure to be a unique and powerful research tool, and was struck by the richness of the data it evoked. Despite the potential limitations noted in the empirical paper regarding the accuracy and validity of participants' accounts, including the fact that TAR interviews typically took place one week (rather than within the

recommended window of 48 hours (Elliott & Shapiro, 1988)) after the recorded NET session, participants seemed to have clear recollections of the replayed extracts. Indeed, my impression was that the occurrence of any of the specific issues outlined below had less to do with any recency effect and more to do with individual differences between participating therapists. From a pragmatic perspective, I found conducting TAR interviews to be relatively technologically complex. It was necessary to co-ordinate both recording and re-playing audio equipment (including speakers), as well as locate selected TAR extracts quickly and unobtrusively, so as not to interrupt the flow of the interview. These procedures merited practice in advance so that I was able to maintain my focus during interviews on asking appropriate questions and responding to participants' accounts in the moment.

More specifically, during TAR interviews, I noticed that participating therapists initially tended to focus on the substantive content of what was being discussed during NET sessions rather than the therapeutic process. For example, therapists often digressed to explain more about their client's traumatic experiences or presenting problems, especially when they were particularly emotive for the client and/or therapist. This was perhaps unsurprising given that everyday conversations tend to focus on content rather than the conversational process (Larsen et al., 2008). Also, therapists' clinical training and supervision tends to concentrate upon formulating their clients' difficulties, and speculating about clients' thoughts and feelings during sessions (Barker, 1985) rather than their own. After validating and reflecting back my understanding of the contextual content, I aimed to re-focus the conversation gently on process-related topics and ask therapists about their subjective thoughts and feelings during the excerpt, e.g. by saying: "what went through your mind when your client said that?". As individual TAR interviews

progressed, I found therapists increasingly able to make the shift towards reflecting upon process, rather than content-related, issues.

During TAR interviews, participants are encouraged to take an observer role as they review the recorded excerpt (Elliott, 1986). As Larsen et al. (2008) explain, this requires participants separating out their current thoughts (during the TAR interview) from their remembered experiences of the therapy session. For example, participating therapists sometimes commented about how they were feeling in the present moment, while listening back to the selected extract during the TAR interview. In such circumstances, I tried to re-focus their attention onto their contemporaneous experiences, e.g. by asking "do you think that was how you were feeling at the time?". Coupled with this, I found that some therapists were more likely to seek to self-evaluate their clinical skills or adherence to the NET model after the event. In addition to stating expressly at the outset that that was not the purpose of the TAR interviews, I found it necessary to intervene specifically, e.g. by saying "taking a step back from evaluating yourself, can you tell me a bit more about what factors were influencing you in that moment?". By encouraging participating therapists to focus on articulating their subjective experiences, I was drawing on the principles of collaborative meaning making with participants in qualitative research (Charmaz, 2006; Rubin & Rubin, 2005). I tried to engage therapists as "investigative partners" (Larsen et al., 2008, p. 24) in the shared process of examining, and making explicit, their implicit, in vivo experiences during NET sessions.

At the end of each TAR interview, I asked therapists how they had felt about taking part. They invariably described the experience as a positive one, with one participating therapist referring to it as "a good reflective exercise". Another described the process as "validating for a clinician". Having been able to access her

thoughts and intentions in the context of the specific dilemma she had experienced during the NET session, the therapist reflected that she was able to make sense of how she had negotiated the dilemma at the time, and realise that she hadn't needed to "ruminate on it when [she] got home that night".

This highlights the value of TAR as a method of guided reflection upon specific moments during therapy sessions. The non-judgmental exploration of therapists' dilemmas often yielded information crucial to a client's formulation or the therapeutic process with a particular client. I was struck by how different conversations during TAR interviews were from those that might take place during clinical supervision (when the focus might be much more upon the development of specific clinical skills or the application of a particular therapy model). Assuming an 'observer position' in relation to one's own clinical work seemed to facilitate (rather than shut down) self-reflexivity and provide an invaluable opportunity to scrutinise one's own inter-personal impact (Barker, 1985). The TAR procedure has benefits, therefore, not just as a tool for self-reflection but as a potential adjunct to peer supervision or facilitated reflective practice.

The challenge remains about how to harness TAR's full potential as the 'jewel in the crown of psychotherapy process research' (McLeod, 2001, p. 81). It is well-suited for generating practice-based evidence (Barkham, Hardy & Mellor-Clark, 2010). The practice-based evidence movement encourages the use of accessible research methods within everyday clinical services to address problems directly relevant to improving the delivery of therapy to that service's clients. Although the TAR procedure requires some expertise, it draws on clinicians' existing interviewing skills and might be used collaboratively with other therapists (each taking the role of interviewer and interviewee) to examine particular areas of clinical practice. As in

the present study, TAR can be used in focused ways to understand how therapists might better work with difficulties arising in the therapeutic process. It can also be used to understand clients' perspectives on what characterises more, and less, helpful responses from their therapists. TAR can therefore assist in de-mystifying the ways in which positive therapeutic change may occur at an individual level and contribute to establishing a more comprehensive and balanced evidence base for psychological interventions overall.

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Appendices

Appendix A: Protocol for Systematic Review

Protocol for Systematic Review

Therapist experiences of working with multiple or complex trauma in forced migrant populations: A systematic review and meta-synthesis

Main researcher: Natalie Coope, DClinPsy, UCL

Research supervisors: Professor Chris Barker, UCL; Professor Nancy Pistrang, UCL; and Dr Francesca Brady, [redacted]

Date: 20 April 2018

Protocol for Systematic Review[12]

1. Title

Therapist experiences of working with multiple or complex trauma in forced migrant populations: A systematic review and meta-synthesis.

2. Research Team

- Natalie Coope (UCL; main researcher)
- Professor Chris Barker (UCL; research supervisor)
- Professor Nancy Pistrang (UCL; research supervisor)
- Dr Francesca Brady (Helen Bamber Foundation; research supervisor)

3. Background

Trauma therapists working with forced migrant populations face unique challenges due to the nature, and psychological sequelae, of their clients' experiences. The terms 'forced migrant population'[13] is used here to mean refugees and asylum seekers (regardless of their legal status), as well as internally displaced people who have been forced to flee their homes due to war, persecution or other human rights abuses. It includes survivors of armed conflict, massacres, bombardments, imprisonment, torture and human trafficking.

For individuals, such experiences may involve 'complex trauma', defined as sustained exposure to repeated or multiple traumatic incidents, often of an interpersonal nature, occurring in circumstances where escape is impossible (Herman, 1992; Mørkved et al., 2014). For their communities, the associated human

[12] Adapted from published guidance on developing a protocol for qualitative evidence synthesis (Harris et al., 2017).

[13] It is acknowledged that the concept of forced migration is not unproblematic as it may blur the important legal distinction between refugees (defined and afforded specific protection under international law), those asserting their human right to seek asylum, and migrants more generally (Office of the United Nations High Commissioner for Refugees [UNHCR], 2016).

rights violations and forced displacement of people can have a profound and long-lasting impact (Shauer, Neuner & Elbert, 2011).

While there is no single trajectory in terms of mental health, given their experiences (both pre- and post-migration) forced migrants are at greater risk of developing post traumatic stress disorder (PTSD) than the general population (NCCMH, 2005), with many experiencing comorbid depression (Turner, Bowie, Dunn, Shapo, & Yule, 2003). Complex PTSD can also follow from complex trauma, which according to expert consensus involves the core symptoms of PTSD (re-experiencing, avoidance, hyper-arousal, and numbing) in conjunction with increased difficulties regulating emotions, problems with relationships, alterations in attention and consciousness (e.g. dissociation), adversely affected belief systems, and somatisation (Cloitre et al., 2012). Complex PTSD is expected to be included as a separate diagnosis within the International Classification of Diseases (ICD-11) when it is published by the World Health Organisation (WHO) in final form in 2018 (WHO, 2016).

The National Institute for Health and Care Excellence (NICE) currently recommends trauma-focused cognitive behaviour therapy (TFCBT) and eye movement desensitisation and reprocessing (EMDR) as effective first-line treatments for PTSD (NICE, 2005). Yet such treatments often focus on a single traumatic event, and are not necessarily the best options for survivors of multiple or complex trauma. Instead, the International Society for Traumatic Stress Studies (ISTSS) and the UK Psychological Trauma Society (UKPTS) support a phase-based approach to complex PTSD (which is echoed in NICE's recommendations for working with refugees and asylum seekers (NCCMH, 2005)), comprising (i) stabilisation and skills training; (ii) review and reappraisal of trauma memories; and (iii) consolidation of gains and re-

integration (Cloitre et al., 2012; McFetridge et al., 2017). Additionally there is emerging evidence for the use (in phase (ii)) of Narrative Exposure Therapy (NET; Schauer, Neuner, & Elbert, 2005/2011), which was developed for the treatment of survivors of complex trauma, with asylum seekers and refugees (Robjant, & Fazel, 2010).

Qualitative research can provide a unique and rich perspective on the complexities of effective therapeutic interventions, including how and why change happens and the acceptability of different therapies (Barker, Pistrang, & Elliott, 2016; Elliott, 2010). A review and synthesis of qualitative studies of how therapists experience their work with multiple or complex trauma in forced migrant populations will contribute to the debate, not only about what is most effective, but also what is most acceptable and sustainable for this client group, and will help to develop appropriate training and support for therapists engaged in this work.

4. Objectives

The aim will be to review and synthesise qualitative studies of therapists' subjective experiences of psychological therapy for multiple or complex trauma in forced migrant populations.

5. Search Methods

5.1. Criteria for selecting studies

Studies will be included on the basis of criteria relating to the participants, intervention, study design and report characteristics.

5.1.1. Types of participants

5.1.1.1. Participants must be adult therapists working with multiple and/or complex trauma in forced migrant populations, namely refugees, asylum seekers or internally displaced people (regardless of their legal status).

5.1.1.2. Participating therapists may include anyone delivering psychological therapy, whether qualified professionals (such as clinical or counselling psychologists, psychiatrists, psychotherapists, counsellors or social workers), trainees or lay people.

5.1.1.3. Their clients must be adults (of 18 years and above) whose traumatic experiences might reasonably be expected to constitute multiple or complex trauma, i.e. they occurred in contexts such as war, imprisonment, torture, or human trafficking.

5.1.2. Types of intervention

5.1.2.1. Studies must focus upon therapy for the psychological sequelae of trauma, rather than more generally on mental health, legal or practical support.

5.1.2.2. Such therapy may follow any theoretical model but must predominantly have been delivered on an individual basis, or with a couple or family, rather than in a group of individuals.

5.1.2.3. Therapy may have involved an interpreter and could have been conducted in any setting, including both in the field (in countries where the original traumatic events occurred and/or in refugee camps) and in countries where clients have resettled.

5.1.3. Types of studies

5.1.3.1. Studies must focus upon therapists' perspectives of the therapeutic experience (rather than therapists' perspectives on the clients' experiences).

5.1.3.2. Studies must be qualitative in methodology and indicate that an established method of qualitative data analysis was used.

5.1.4. Types of report

5.1.4.1. Papers must have been published in a peer-reviewed journal, on or before 31 December 2017, and written in English.

5.2. Search strategies for identifying studies

5.2.1. Electronic search strategy

5.2.1.1. Relevant studies will be identified from searches of the following databases:

5.2.1.1.1. PsycINFO

5.2.1.1.2. Ovid MEDLINE

5.2.1.1.3. Cinahl Plus

Initial scoping searches will be conducted to identify and develop key search terms relating to the inclusion criteria specified above.

5.2.1.2. It is anticipated that a combination of search terms will be used relating to:

5.2.1.2.1. therapists and the therapeutic process (e.g. therapist?/psychotherapist?/counsel?or?/psychologist?/psychiatrist?/social worker?/clinician?/psychotherapeutic process*/ therapeutic alliance/therapeutic relationship?/vicarious experiences);

5.2.1.2.2. clients and the nature of clients' traumatic experiences (e.g. refugee?/asylum seeking/asylum seeker?/prisoner? of war/imprison*/torture*/organi#ed violence/systematic violence/genocide/human trafficking/traffick*/ complex PTSD); and

5.2.1.2.3. qualitative methodology (e.g. interview*/group discussion?/focus group?/qualitative research).

5.2.1.3. Where possible, each term will be searched using 'map to subject heading' and 'keyword' functions.

5.2.2. Searching other sources

Reference lists of relevant articles, and contents pages of key journals, will also be hand searched for additional papers that meet the inclusion criteria.

5.3. Screening procedure

5.3.1. Study selection phase 1

The main researcher will initially review titles and abstracts of identified papers and eliminate ones on the basis of duplication, irrelevance or failure to meet the inclusion criteria. A PRISMA flow diagram will be drawn up contemporaneously showing studies retained and eliminated at each stage.

5.3.2. Study selection phase 2

The main researcher will then obtain and read the full text of retained papers and consider them against the eligibility criteria outlined in section 5.1 above. Reasons for eliminating papers at this stage will be recorded and entered into the flow diagram.

5.3.3. Study selection phase 3

Random samples of 25% of studies at both phase 1 (title and abstract screening) and phase 2 (full text review) will be checked for eligibility by an independent reviewer (who is not a member of the research team). Disagreements between the main researcher and reviewer will be resolved by consensus and consultation with the research supervisors where necessary.

6. **Assessment of Study Quality**

The Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (CASP, 2017) will be used as an aid to appraise the methodological strengths and limitations of included studies. This checklist will not be used to generate an overall quality score for each study or to provide a rationale for excluding studies from the meta-synthesis. Instead (similarly to its use in other meta-syntheses of qualitative studies (e.g. Katsakou & Pistrang, 2017)) the checklist will provide a framework for the research team to consider each study's contribution to the review.

7. Data Extraction

Data will be extracted by the main researcher, who will discuss any queries with the rest of the research team. A data extraction form will be used. Collected information will include study objectives and research questions posed; any key pre-existing theory/ies underpinning the study; characteristics of participants; recruitment setting and context; characteristics of clients; therapeutic modality and characteristics of intervention; mode of data collection and data analysis methodology.

All text in the results sections (or equivalent) of included studies (including quotations) will be treated as data for the purposes of the meta-synthesis. However, where studies examine additional topics beyond the scope of this review, only data relevant to the review question will be analysed.

8. **Synthesis Approach**

Findings from included studies will be synthesised using thematic analysis (as described by Braun & Clarke, 2006), with reference to how such an approach has been adapted for use in systematic reviews of multiple qualitative studies (namely, thematic synthesis (Thomas & Harden, 2007, 2008)).

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Appendix B: Electronic Database Searches

Searches		Results
PsychINFO (1806 to January Week 5 2018; searched on 6 February 2018)		
1.	exp THERAPISTS/	30683
2.	therapist?.mp.	85883
3.	1 or 2	97164
4.	exp PSYCHOTHERAPISTS/	17234
5.	psychotherapist?.mp.	18498
6.	4 or 5	27320
7.	exp COUNSELORS/	12688
8.	counsel?or?.mp.	45362
9.	7 or 8	45362
10.	exp PSYCHOLOGISTS/	30543
11.	psychologist?.mp.	90218
12.	10 or 11	90218
13.	exp PSYCHIATRISTS/	11088
14.	psychiatrist?.mp.	40161
15.	13 or 14	40161
16.	exp Social Workers/	11465
17.	social worker?.mp.	25641
18.	16 or 17	25641
19.	exp CLINICIANS/	8973
20.	clinician?.mp.	85422
21.	19 or 20	85422
22.	exp MENTAL HEALTH SERVICES/	39085
23.	mental health service?.mp.	48297
24.	22 or 23	48338
25.	exp MENTAL HEALTH PERSONNEL/	48228
26.	mental health personnel.mp.	11136
27.	mental health provider?.mp.	2035
28.	mental health staff.mp.	478
29.	25 or 26 or 27 or 28	50447
30.	exp HEALTH PERSONNEL ATTITUDES/	21369
31.	health personnel attitudes.mp.	17756
32.	30 or 31	21390
33.	exp PSYCHOTHERAPEUTIC PROCESSES/	48791
34.	psychotherapeutic process*.mp.	36860
35.	therapeutic alliance.mp.	6843
36.	therapeutic relationship*.mp.	8282
37.	33 or 34 or 35 or 36	55505
38.	exp VICARIOUS EXPERIENCES/	748
39.	vicarious trauma*.mp.	760
40.	vicarious resilience.mp.	28
41.	38 or 39 or 40	1252
42.	3 or 6 or 9 or 12 or 15 or 18 or 21 or 24 or 29 or 32 or 37 or 41	425476
43.	exp REFUGEES/	4939
44.	refugee?.mp.	7483
45.	43 or 44	7483
46.	exp ASYLUM SEEKING/	384
47.	asylum seeker?.mp.	1063
48.	46 or 47	1163
49.	exp PRISONERS OF WAR/	485
50.	prisoner? of war.mp.	716
51.	imprison*.mp.	3548
52.	49 or 50 or 51	4216
53.	exp TORTURE/	1198
54.	torture*.mp.	2699
55.	organi#ed violence.mp.	163

Searches		Results
56.	systematic violence.mp.	17
57.	53 or 54 or 55 or 56	2813
58.	exp GENOCIDE/	2079
59.	genocide.mp.	1700
60.	58 or 59	2761
61.	exp HUMAN TRAFFICKING/	684
62.	traffick*.mp.	4760
63.	61 or 62	4760
64.	exp COMPLEX PTSD/	157
65.	complex ptsd.mp.	407
66.	complicated ptsd.mp.	9
67.	multiple trauma*.mp.	492
68.	type II trauma*.mp.	23
69.	type 2 trauma*.mp.	3
70.	64 or 65 or 66 or 67 or 68 or 69	917
71.	exp POSTTRAUMATIC GROWTH/	1096
72.	post?traumatic growth.mp.	2089
73.	71 or 72	2089
74.	exp RESILIENCE (PSYCHOLOGICAL)/	11145
75.	resilience.mp.	22167
76.	74 or 75	22167
77.	exp SURVIVORS/	12623
78.	survivor*.mp.	28202
79.	77 or 78	28202
80.	cancer*.mp.	55769
81.	stroke*.mp.	31670
82.	80 or 81	86507
83.	79 not 82	20216
84.	exp INTERVIEWS/	12300
85.	interview*.mp.	352200
86.	84 or 85	352200
87.	exp GROUP DISCUSSION/	3608
88.	group discussion*.mp.	11025
89.	focus group*.mp.	30113
90.	87 or 88 or 89	36948
91.	exp QUALITATIVE RESEARCH/	7734
92.	qualitative*.mp.	149192
93.	91 or 92	149192
94.	86 or 90 or 93	447277
95.	45 or 48 or 52 or 57 or 60 or 63 or 70 or 73 or 76 or 83	62467
96.	42 and 94 and 95	2254
97.	limit 96 to english language	2197
98.	limit 97 to human	2179
99.	limit 98 to peer reviewed journal	1368
100.	limit 99 to adulthood <18+ years>	1115
101.	limit 100 to yr="1860 - 2017"	**1112**

Ovid MEDLINE (1946 to present; searched on 6 February 2018)

1.	therapist*.mp.	33488
2.	psychotherapist*.mp.	2649
3.	Counselors/px [Psychology]	24
4.	counsel?or*.mp.	8057
5.	3 or 4	8057
6.	psychologist*.mp.	13160
7.	psychiatrist*.mp.	22505

Searches		Results
8.	Social Workers/px [Psychology]	87
9.	social worker*.mp.	8691
10.	8 or 9	8691
11.	clinician*.mp.	188466
12.	Mental Health Services/	29711
13.	mental health service*.mp.	54378
14.	12 or 13	54378
15.	mental health personnel.mp.	89
16.	mental health provider*.mp.	1014
17.	mental health staff.mp.	310
18.	15 or 16 or 17	1405
19.	Attitude of Health Personnel/	108713
20.	health personnel attitudes.mp.	7
21.	19 or 20	108717
22.	Professional-Patient Relations/	24682
23.	psychotherapeutic process*.mp.	1391
24.	therapeutic alliance.mp.	2006
25.	therapeutic relationship*.mp.	2591
26.	22 or 23 or 24 or 25	28963
27.	vicarious trauma*.mp.	148
28.	vicarious resilience.mp.	8
29.	1 or 2 or 5 or 6 or 7 or 10 or 11 or 14 or 18 or 21 or 26 or 27 or 28	430052
30.	Refugees/	8342
31.	refugee*.mp.	11417
32.	30 or 31	11417
33.	asylum seeker*.mp	1186
34.	Prisoners of War/	471
35.	prisoner? of war.mp.	953
36.	imprison*.mp.	2099
37.	34 or 35 or 36	3021
38.	Torture/	1991
39.	torture*.mp.	2734
40.	organi#ed violence.mp.	87
41.	systematic violence.mp.	15
42.	38 or 39 or 40 or 41	2803
43.	Genocide/	91
44.	genocide.mp.	528
45.	43 or 44	528
46.	Human Trafficking/	203
47.	traffick*.mp.	49289
48.	46 or 47	49289
49.	complex ptsd.mp.	172
50.	complicated ptsd.mp.	4
51.	multiple trauma*.mp.	13720
52.	type II trauma*.mp.	16
53.	49 or 50 or 51 or 52	13906
54.	post?traumatic growth.mp.	765
55.	Resilience, Psychological/	3539
56.	resilience.mp.	16811
57.	55 or 56	16811
58.	survivor*.mp.	93263
59.	cancer*.mp.	1506052
60.	stroke*.mp.	248781
61.	59 or 60	1748193
62.	Interview, Psychological/ or Interview/	42086
63.	interview*.mp.	328310
64.	62 or 63	328310
65.	Focus Groups/	23617

Searches		Results
66.	group discussion*.mp.	10787
67.	focus group*.mp.	40206
68.	65 or 66 or 67	43281
69.	Qualitative Research/	36396
70.	qualitative*.mp.	232001
71.	69 or 70	232001
72.	64 or 68 or 71	512018
73.	Survivors/	21303
74.	58 or 73	93263
75.	74 not 61	63517
76.	32 or 33 or 37 or 42 or 45 or 48 or 53 or 54 or 57 or 75	159171
77.	29 and 72 and 76	1073
78.	limit 77 to english language	1042
79.	limit 78 to humans	902
80.	limit 79 to "all adult (19 plus years)"	630
81.	limit 80 to yr="1860 - 2017"	**630**

Cinahl Plus (1993 to present; searched on 6 February 2018)

1.	therapist*	48,865
2.	(MH "Psychotherapists") OR (MH "Psychotherapist Attitudes")	3,089
3.	psychotherapist*	3,910
4.	S2 OR S3	3,910
5.	(MH "Counselors")	2,833
6.	counsel?or*	2,094
7.	S5 OR S6	4,510
8.	(MH "Psychologists")	3,093
9.	psychologist*	7,478
10.	S8 OR S9	7,478
11.	(MH "Psychiatrists")	2,231
12.	psychiatrist*	7,422
13.	S11 OR S12	7,422
14.	(MH "Social Workers") OR (MH "Social Worker Attitudes")	7,795
15.	social worker*	14,255
16.	S14 OR S15	14,255
17.	clinician*	75,385
18.	(MH "Mental Health Services") OR (MH "Community Mental Health Services")	36,153
19.	mental health service*	43,615
20.	S18 OR S19	43,615
21.	(MH "Mental Health Personnel")	3,314
22.	mental health personnel	3,546
23.	mental health provider*	1,766
24.	mental health staff	1,086
25.	S21 OR S22 OR S23 OR S24	6,025
26.	(MH "Attitude of Health Personnel")	35,043
27.	health personnel attitudes	35,084
28.	S26 OR S27	35,084
29.	(MH "Psychotherapeutic Processes")	363
30.	psychotherapeutic process*	436
31.	(MH "Professional-Patient Relations") OR (MH "Professional-Client Relations")	32,301
32.	therapeutic alliance	1,050
33.	therapeutic relationship*	2,591
34.	S29 OR S30 OR S31 OR S32 OR S33	35,094
35.	vicarious trauma*	193

Searches		Results
36.	vicarious resilience	14
37.	S35 OR S36	199
38.	S1 OR S4 OR S7 OR S10 OR S13 OR S16 OR S17 OR S20 OR S25 OR S28 OR S34 OR S37	249,493
39.	(MH "Refugees")	5,610
40.	refugee*	6,592
41.	S39 OR S40	6,592
42.	asylum seeker*	831
43.	prisoner? of war	122
44.	imprison*	700
45.	S43 OR S44	821
46.	(MH "Torture") OR (MH "Torture Survivors")	776
47.	torture*	1,066
48.	organi#ed violence	42
49.	systematic violence	191
50.	S46 OR S47 OR S48 OR S49	1,286
51.	Genocide	226
52.	(MH "Human Trafficking")	387
53.	traffick*	2,232
54.	S52 OR S53	2,232
55.	complex ptsd	136
56.	complicated ptsd	30
57.	multiple trauma*	3,982
58.	type II trauma*	30
59.	type 2 trauma*	57
60.	S55 OR S56 OR S57 OR S58 OR S59	4,218
61.	post traumatic growth	254
62.	resilience	7,640
63.	(MH "Survivors") OR (MH "Child Abuse Survivors") OR (MH "Torture Survivors")	12,278
64.	survivor*	40,482
65.	S63 OR S64	40,482
66.	cancer*	319,298
67.	stroke*	93,101
68.	S66 OR S67	410,084
69.	S65 NOT S68	19,566
70.	(MH "Interviews")	128,866
71.	interview*	259,852
72.	S70 OR S71	259,852
73.	(MH "Focus Groups")	36,267
74.	focus group*	43,300
75.	group discussion*	8,738
76.	S73 OR S74 OR S75	47,118
77.	(MH "Qualitative Studies")	89,730
78.	qualitative*	133,979
79.	S77 OR S78	133,979
80.	S72 OR S76 OR S79	330,119
81.	S41 OR S42 OR S45 OR S50 OR S51 OR S54 OR S60 OR S61 OR S62 OR S69	41,342
82.	S38 AND S80 AND S81	995
83.	Limiter - Language: English	990
84.	Limiter - Peer Reviewed	949
85.	Limiter - All Adult	468
86.	Limiter - Published Date: 19930101-20171231	**465**

Appendix C: Data Extraction Form

Data Extraction Form

Article Title	
Author/s	
Year	
Journal	
Study objective/s	
Research question/s	
Any pre-existing theory/ies underpinning study Hint: Is study introduced and framed by reference to pre-existing theories or a pre-existing evidence base?	
Characteristics of participants Hint: - Sample size - Inclusion/exclusion criteria - Demographics (including professional background and experience)	
Recruitment setting and context Hint: - Service/s from which participants recruited - Wider mental healthcare system within which such services exist - Geographic location - Wider political landscape in terms of mental health provision, legal protection and welfare support for forced migrant populations	
Characteristics of clients Hint: - Sample size - Legal and welfare status - Country of origin - Nature of trauma experiences - Presenting mental health problems	
Therapeutic modality	
Characteristics of intervention Hint: - Individual / couple / family format - Length and typical number of sessions	
Mode of data collection Hint: - Semi-structured interviews / focus groups - Any other data collected?	
Data analysis methodology	

Key findings	
Researcher comments	

Appendix D: Amended Critical Appraisal Skills Programme (CASP)

Qualitative Research Checklist

Amended Critical Appraisal Skills Programme (CASP) Qualitative Research Checklist (2017)

10 questions to help you make sense of qualitative research

	Question	Considerations
1	Was there a clear statement of the aims of the research?	• What was the goal of the research? • Why was it important and relevant?
2	Is a qualitative methodology appropriate?	• If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal?
3	Was the research design appropriate to address the aims of the research?	• If the researcher has justified the research design • E.g. have they discussed how they decided which qualitative methodology to use?
4	Was the recruitment strategy appropriate to the aims of the research?	• If the researcher has explained how participants were selected (i.e. the inclusion and exclusion criteria) • If the researcher has justified such selection criteria in light of the research aims • If the recruitment strategy is described and any issues identified (e.g. why some people chose not to take part)
5	Was the data collected in a way that addressed the research issue?	• If the setting for data collection was justified • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.) • If the researcher has justified the method of data collection (e.g. semi-structured interviews with open-ended questions) in light of the research aims • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or is the interview schedule described?) • If the form of data is clear (e.g. tape recordings, video material, notes etc) • If the researcher has discussed saturation of data (or other reasons for ceasing data collection)
6	Has the relationship between researcher and participants been adequately considered?	• If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions; (b) data collection, including sample recruitment and choice of location; and (c) data selection and analysis[15]

[15] Consideration of potential for bias in data selection and analysis moved to question 6 in amended CASP checklist from question 8 in original checklist.

7	Have ethical issues been taken into consideration?	• If there are sufficient details of how the research was explained to the participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed ethical issues raised by the study (e.g. informed consent, confidentiality or how effects of the study on participants were managed during or afterwards) • If approval was sought from an ethics committee
8	Was the data analysis sufficiently rigorous?	• If there is an in-depth description of the analysis process • If thematic analysis is used, is it clear how the categories/themes were derived from the data? • If sufficient data are presented to support the findings • To what extent contradictory data are taken into account • If the researcher has referred to any credibility checks (e.g. triangulation, respondent validation, more than one analyst)[16]
9	Is there a clear and balanced[17] statement of findings?	• If the findings are explicit and discussed in relation to the original research question • If there is adequate discussion of the evidence both for and against the researcher's arguments • If the limitations of the study are evaluated[18]
10	How valuable is the research?	• If the researcher discusses the contribution the study makes to the existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature? • If they identify new areas where research is necessary? • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

[16] Consideration relating to credibility checks moved to question 8 in amended CASP checklist from question 9 in original checklist.
[17] The words 'and balanced' added to question 9 in amended CASP checklist.
[18] Consideration of study limitations added to question 9 in amended CASP checklist.

Appendix E: Approval letter from the UCL Research Ethics Committee

UCL RESEARCH ETHICS COMMITTEE
ACADEMIC SERVICES

27th September 2017

Professor Chris Barker
Department of Clinical, Educational and Health Psychology
UCL

Dear Professor Barker

Notification of Ethics Approval with Provisos
Project ID/Title: 10529/001: Therapist decision-making in narrative exposure therapy with clients who have experienced complex trauma. A tape-assisted recall study

I am pleased to confirm in my capacity as Joint Chair of the UCL Research Ethics Committee (REC) that the data collection phase of the study has been ethically approved by the UCL REC until **31st December 2018**. Ethical approval is not required for the subsequent data analysis or publication of the results.

Ethical approval is subject to the following proviso.

Participant Information Sheet
If participants decide to withdraw, include an assurance that all the data they have provided up to that point will be destroyed.

Approval is also subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'
http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report
At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: http://www.ucl.ac.uk/srs/governance-and-committees/resgov/code-of-conduct-research

- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

[redacted]

Dr Lynn Ang
Joint Chair, UCL Research Ethics Committee

Cc: Natalie Coope & Professor Nancy Pistrang

Appendix F: Initial recruitment e-mail

From: Coope, Natalie
Sent: Friday, February 16, 2018 5:02 PM
To: REDACTED
Subject: UCL DClinPsy Research Study: Therapist decision-making in NET

Hello everyone

For those of you whom I haven't yet met, I'm a clinical psychology trainee at UCL and will be doing my research, and (from mid-March) on clinical placement, at **REDACTED**.

I would very much like to invite you all to take part in my research study looking at therapists' experiences of interactions with survivors of multiple or complex trauma during NET. More specifically, the study will explore the dilemmas and choices faced by NET therapists during sessions, and examine how therapists negotiate them.

Essentially, if you decide to take part, I will ask you to audio record one NET session with (ideally) two clients (in different phases of therapy). After each recorded session, you (but not your client) would then take part in a follow-up interview with me about the session.

I attach information sheets about the study for both you as therapists and your clients. The study should place minimal burden on your clients - they will be asked to consent to their session being recorded and some of their, routinely collected, background information being used in the study.

I'd very much like to explain more about the study, and answer any questions that you may have, in person. Please do send me an email if you are interested and we can arrange a convenient day and time.

Looking forward to meeting you all!

Best wishes

Natalie

Natalie Coope
Trainee Clinical Psychologist

Doctorate in Clinical Psychology Course
Research Department of Clinical, Educational and Health Psychology
University College London
Gower Street
London WC1E 6BT

Tel: 020 7679 1897 (Main Office)

Appendix G: Information sheet for therapists

Version date: 08/06/18

Therapist decision-making in Narrative Exposure Therapy: A tape-assisted recall study

Information sheet for therapists

We would like to invite you to take part in the research study described in this information sheet. You should only take part if you want to. Before deciding whether to participate, it is important for you to understand why the research is taking place and what will be involved in taking part.

Please read the following information and let us know if anything is not clear or if you have any questions. Please discuss it with others if you wish. If you decide to take part in the study you will be given this information sheet to keep and asked to sign a consent form.

What is the study about?

We are interested in therapists' experiences of interactions with survivors of multiple or complex trauma during Narrative Exposure Therapy (NET). The proposed study will use tape-assisted recall (a well-established qualitative methodology) to explore the dilemmas and choices faced by NET therapists during sessions, and examine how therapists negotiate them.

Who is conducting the study?

The study is being conducted by Natalie Coope, Trainee Clinical Psychologist and Researcher, and will form part of her Doctorate in Clinical Psychology at University College London (UCL). Details of the full research team are set out below.

Who is invited to take part?

We are inviting all therapists currently providing NET at [redacted] to participate in the study. Whether or not you decide to take part in the study will not affect your role with [redacted] in any way.

Will there be any burden on my clients?

It is intended that this study will place minimal burden on your clients. The clients you identify will be asked to consent to the audio recording of one of their therapy sessions with you and to the use in the study of background information routinely collected by the [redacted] (see separate information sheet and consent form for clients). Clients will not be required to be interviewed themselves or to listen back to their therapy sessions or to fill out any additional forms.

What will taking part involve?

If you decide to take part in this study, you will be asked to audio record one session of NET with two or more consenting clients. You will be asked to provide each recording to the researcher as soon as possible after the relevant session, and invited to identify any specific moments during the session that you found particularly challenging, or in which you faced a dilemma or choice about how to respond to the client or what direction to take the session.

The researcher will then arrange a time, ideally within a couple of days of the recorded session, to meet with you for a tape-assisted recall interview. During the interview, the researcher will ask you some general questions about the session, play back to you some selected extracts from the session, and invite you to reflect upon these moments in more detail, including your specific thoughts and feelings at the time. With your permission, this interview will be audio recorded and later transcribed. You will also be asked to complete some brief background questionnaires.

The tape-assisted recall interview will last about an hour, and will take place at [redacted]. Afterwards, the researcher will send you a summary of your interview to review and comment upon to ensure that we have an accurate understanding of what you said.

What will happen to the information collected?

All data you provide will be treated as confidential and collected and stored in accordance with all applicable data protection legislation.

Personal data such as your name, contact details and consent form will be stored securely and separately from the other information that you provide to us. Questionnaire data will be anonymised and linked to a unique code allocated by us to each participant.

The audio recording of your interview with the researcher, including the extracts from the therapy session played back during this discussion, will be transcribed. The transcription will be pseudonymised and all identifying information will be removed so that neither you nor your client can be identified. Once the study is complete, the original recordings will be erased.

During the study, the original audio recordings will be stored electronically and protected through password and encryption. No one outside of the research team will be allowed access to the recordings save for the limited circumstances where transcription of interviews is sub-contracted by the researcher to a third party. In such a case, the audio recording would initially be shared with a subcontractor for the sole purpose of transcription. Any subcontractor would be required to agree to keep the audio recording confidential and to delete it immediately following transcription.

Quotations from your interview, and your recorded therapy session, may be included in the final write up of the study (as well as any subsequent publications and presentations resulting from the study) but all identifying information will be removed so that neither you nor your client can be identified.

What are the risks of taking part?

It is possible that you will find it upsetting or uncomfortable to talk about your experiences during therapy sessions. If this happens, you can take a break or stop the interview altogether at any time.

The aim of the study is not to evaluate you as a therapist or the quality of the therapy provided but rather to explore dilemmas and choices faced by therapists during NET sessions. There are no right or wrong answers during the interview and you do not have to answer any questions that you do not wish to.

What are the possible benefits of taking part?

You may find talking about key moments during therapy sessions interesting, giving you an opportunity to reflect upon the dilemmas and choices you faced and your moment-by-moment thoughts, feelings and intentions about how to negotiate these. We hope that the findings of the study will be helpful for all trauma therapists negotiating dilemmas in their clinical work, and have implications for the development of NET as a therapeutic model, as well as for the development of clinical training and supervision more generally.

Data Protection Privacy Notice

The data controller for this project will be University College London (UCL). The UCL Data Protection Office oversees UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk. UCL's Data Protection Officer can also be contacted at data-protection@ucl.ac.uk.

In this study, the following legal bases apply to the processing of personal data:

- Your personal data will be processed for the purposes of performing a task in the public interest.
- Your special category personal data will be processed for scientific and historical research or statistical purposes.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, please contact UCL in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

What will happen to the results of the study?

The results of the study will be written up and published (on UCL Discovery, University College London's open access online research repository) as part of the researcher's thesis and may also be submitted for publication in a scientific journal and presented at conferences. A summary of the main findings and a copy of the empirical paper will be made available to all participating therapists and their clients.

What do I do now?

If you would like to take part in the study, or if you have any questions, please contact the researcher, Natalie Coope, by email: natalie.coope.14@ucl.ac.uk

You do not have to take part in this study. If you decide to participate, you are free to withdraw at any time without giving a reason. This will not affect your role with [redacted] and all data you have provided will be destroyed.

Thank you for reading this information sheet and for considering taking part in this study.

Research team

Natalie Coope, Trainee Clinical Psychologist and Researcher (UCL)
natalie.coope.14@ucl.ac.uk

Professor Chris Barker, Principal Investigator and Research Supervisor (UCL)
c.barker@ucl.ac.uk
[redacted]

Professor Nancy Pistrang, Research Supervisor (UCL)
n.pistrang@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee (Project ID Number: 10529/001)

Appendix H: Information sheet for clients

Version date: 08/06/2018

Therapist decision-making in Narrative Exposure Therapy: A tape-assisted recall study

Information sheet for clients

We are conducting a study with therapists at [redacted]. As part of the study, we would like to audio record one of your therapy sessions. You do not have to consent to this and your decision will not affect the support you receive from [redacted] in any way.

Part 1 of this information sheet summarises the study and what you are being asked to do, and Part 2 describes how your information will be used. Please read this sheet and let us know if anything is not clear or if you have any questions. Please discuss it with others, including your therapist, if you wish.

If you consent to your information being used in the study, you will be given this information sheet to keep and asked to sign a consent form. You are free to withdraw from the study at any time without giving a reason, in which case all data you have provided will be destroyed.

PART 1: DETAILS OF THE STUDY

What is the study about?

We will be interviewing therapists about therapy sessions with their clients. We hope that the findings of the study will help us understand how best to support people who have experienced traumatic events and develop training and supervision for therapists.

What am I being asked to do?

The study will focus almost entirely on your therapist; it should place very little burden on you.
Your therapist will audio record one of your therapy sessions. If at any point you wish to stop recording, your therapist will do so and you do not have to give a reason.

So that we know a bit more about you, with your consent, we will also use some background information already collected by [redacted] (such as your age, whether you are a man or a woman, which country you have come from and what difficulties you are experiencing).

You will not be required to listen back to your recorded therapy session, or fill out any additional forms, and you will not be interviewed by the researcher.

PART 2: HOW YOUR INFORMATION WILL BE USED

All data you provide will be treated as confidential, and collected and stored in accordance with all applicable data protection legislation. For example, we will store identifiable information about you, such as your name and contact details, securely and separately from the other information you provide to us.

After your recorded therapy session, we will interview your therapist and play back some parts of your session to help them remember their specific thoughts, feelings and intentions at the time. With your permission, the research interview with your therapist (including the recordings played back) will be audio recorded. Later, a written version will also be produced so that it may be analysed for the purposes of the study.

During the study, audio recordings will be stored electronically and passcode protected. In the written version of the research interview, key identifiying details, such as your name, will be replaced with alternatives, and all other identifying information removed so that neither you nor your therapist can be identified. Once the study is complete, all original recordings will be erased.

No one outside of the research team will be allowed access to any data collected in the study, except where someone else helps to prepare the written versions of the research interviews. In such circumstances, the audio recording would be shared only for that purpose and the person assisting would be required to agree to keep it confidential and to delete it immediately afterwards.

Quotations from your recorded therapy session may be included in the final write up of the study (as well as any published articles or presentations about the study) but all identifying information will be removed so that neither you nor your therapist can be identified.

Data Protection Privacy Notice

The data controller for this project will be University College London (UCL). The UCL Data Protection Office oversees UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk. UCL's Data Protection Officer can also be contacted at data-protection@ucl.ac.uk.

In this study, the following legal bases apply to the processing of personal data:

- Your personal data will be processed for the purposes of performing a task in the public interest.
- Your special category personal data will be processed for scientific and historical research or statistical purposes.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, please contact UCL in the first instance at data-protection@ucl.ac.uk. If you remain unsatisfied, you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

Who is conducting the study?

The study is being conducted by Natalie Coope, Trainee Clinical Psychologist and Researcher, and will form part of her Doctorate in Clinical Psychology at University College London (UCL). Details of the full research team are set out below.

What will happen to the results of the study?

The results of the study will be written up and published as part of the researcher's thesis, and may also be published in a scientific journal and presented at conferences. A copy of the final paper will be given to all therapists and their clients who take part in the study.

Thank you for reading this information sheet and for considering taking part in this study.

Research team

Natalie Coope, Trainee Clinical Psychologist and Researcher (UCL)
natalie.coope.14@ucl.ac.uk

Professor Chris Barker, Principal Investigator and Research Supervisor (UCL)
c.barker@ucl.ac.uk
[redacted]

Professor Nancy Pistrang, Research Supervisor (UCL)
n.pistrang@ucl.ac.uk

This study has been approved by the UCL Research Ethics Committee (Project ID Number: 10529/001)

Appendix I: Overview of study procedure for therapists

Version date: 22/06/2018

Therapist decision-making in Narrative Exposure Therapy: A tape-assisted recall study

Natalie Coope
natalie.coope.14@ucl.ac.uk

Overview of procedure for therapists

Thank you for your interest in this study. This sheet sets out a step-by-step overview of what you and the researcher will do if you agree to take part.

1. Researcher invites therapists to take part in study and provides information sheet (therapist version)
2. Researcher answers any questions about the study and allows therapist time to consider whether they want to take part (approx. one week)
3. If therapist wishes to participate, therapist completes and signs consent form (therapist version)
4. Therapists identifies one or two current NET clients who have experienced multiple and/or complex trauma
    a. Ideally two clients will be identified: one client in the earlier stages of therapy; the other in the later stages.
5. Therapist asks client for consent to record their therapy sessions:
    a. Therapist explains that they are taking part in a research study about how they (the therapist) make decisions during their therapy sessions with clients
    b. Therapist gives information sheet (client version) to client and explains they would like to record one of their therapy sessions for the purposes of the study
    c. Therapist explains to client that only the recording, and some background information about them (already provided to [redacted]), will be used in the study. The client will not be required to listen back to their therapy session, or fill out any additional forms, and they will not be interviewed by the researcher
    d. Therapist explains to client that they do not have to consent, that they can ask for the recording to stop at any time, and that their decision will not affect the support they receive from [redacted] in any way
    e. Therapist provides client researcher's contact details should they have any further questions about the study
    f. Therapist allows client time to consider whether they agree to the recording of their therapy session (approx. one week)
    g. If client agrees, therapist asks client to complete and sign the consent form (client version), reminding them of point 5.d above
6. Therapist and researcher identify therapy session to be recorded and book time for follow up research interview, ideally within one week (or at least before the therapist sees the client again)
7. Therapist records selected therapy session

8. To enhance anonymity of recording, as far as possible:
    a. Therapist refrains from using client's first (or any) name during the session
    b. Therapist avoids referring to identifying geographical information
    c. Therapist places recorder close to the interpreter rather than the client (where relevant)
9. Therapist provides recording to researcher and identifies any dilemmas during session
    a. Therapist uploads audio file to [redacted] shared client drive, where possible in password-protected format, and e-mails hyperlink to researcher
    b. Therapist briefly identifies key dilemmas during the session descriptively (and anonymously) in an e-mail to the researcher
10. Researcher listens to recording and identifies any further dilemmas
11. Researcher conducts tape-assisted recall interview with therapist (lasting one hour), ideally within a week of the recorded session
12. Therapist collects client demographics directly from client management system at [redacted]
13. Process is repeated with therapist's other client
14. Researcher provides therapist with summary of key themes that emerge during the data analysis phase and invites therapist's comments

Appendix J: Consent form for therapists

Version date: 08/06/18

Therapist decision-making in Narrative Exposure Therapy: A tape-assisted recall study
Therapist consent form

Thank you for considering taking part in this study.

Please complete this form after you have listened to an explanation of the study and read the information sheet.

If you have any questions about the study, please ask the researcher before deciding whether to take part.

You will be given a copy of this consent form for your records.

	Please initial
I confirm that I have read and understood the information sheet provided for this study.	
I have had the opportunity to consider the information sheet and to ask any questions about what the study involves, including about audio recording.	
I understand that my participation is voluntary, that I am free to withdraw at any time without giving any reason, and that this will not affect my role with [redacted].	
I consent to the processing and storage of my personal information for the purposes of this research study. I understand that such information will be treated as confidential and handled in accordance with the provisions of all applicable data protection legislation.	
I consent to the audio recording of my selected therapy sessions and my interview with the researcher.	
I consent to the use of these audio recordings for the purposes of this study, including the transcription of my interview.	
I understand that my comments from my interview may be reported in quotations within the final report of the study or later publications, but in a way that will not be possible to identify me or my clients.	
I understand that pseudonymised quotations from the study may be subject to review by academic staff at University College London as the study forms part of the researcher's Doctorate in Clinical Psychology.	
I agree to take part in this study.	

Name of participant:..……..

Signature of participant:……..

Date:

Name of researcher:………………………………………………………………………………

Signature of researcher:…………………………………………………………………………….

Date:

Appendix K: Consent form for clients

Version date: 08/06/2018

Therapist decision-making in Narrative Exposure Therapy: A tape-assisted recall study

Client consent form

Thank you for your interest in this study.

Please complete this form after you have listened to an explanation of the study and read the information sheet. If you have any questions about the study, please ask your therapist or the researcher before deciding whether to take part.

You will be given a copy of this consent form for your records**.**

	Please initial
I confirm that I have read and understood the information sheet provided for this study.	
I have been able to consider the information sheet and to ask any questions about the study, including about the audio recording of my therapy session.	
I understand that I do not have to consent to my information being used in the study and my decision will not affect the support I receive from [redacted].	
I consent to the use and storage of my personal information for the purposes of this research study. I understand that such information will be treated as confidential and handled in accordance with the provisions of all applicable data protection legislation.	
I consent to the audio recording of my therapy session and to the audio recording of the research interview with my therapist during which parts of my therapy session will be played.	
I consent to the use of these audio recordings for the purposes of this study, including the production of a written version.	
I understand that what I say during my therapy session may be quoted in the final report of the study or later publications, but in a way that will not be possible to identify me.	
I understand that such quotations from the study may be subject to review by academic staff at University College London as the study forms part of the researcher's Doctorate in Clinical Psychology.	

Name of client:……..

Signature of client:……..

Date:

Name of person taking consent:…….

Signature of person taking consent:…….

Date:

Appendix L: Demographic questionnaire for therapists

Version date: 20/3/2018

Therapist decision-making in Narrative Exposure Therapy: A tape-assisted recall study

Natalie Coope, Trainee Clinical Psychologist and Researcher
natalie.coope.14@ucl.ac.uk

Demographic Questionnaire for Therapists

1. **Please choose a six-digit unique participant number?**

2. **What is your date of birth?**

3. **How would you describe your gender?**

4. **How would you describe your ethnic background?**

5. **What is your professional background (e.g. clinical psychology / counselling psychology / psychotherapy)?**

6. **Which year did you complete your professional training (please indicate if you are still in training)?**

7. **How long have you been providing trauma-focused therapy?**

8. **How long have you been providing Narrative Exposure Therapy?**

Appendix M: The Working Alliance Inventory – Short Revised Therapist Version

The Working Alliance Inventory – Short Revised Therapist Version (WAI-SRT; Hatcher & Gillaspy, 2006)

REDACTED

Appendix N: Semi-structured TAR interview schedule

Version 29/06/18

Therapist dilemmas in Narrative Exposure Therapy
Natalie Coope

Protocol and semi-structured schedule for tape assisted recall interview

Aim

The primary aim of the tape assisted recall (TAR) interview is to explore therapists' dilemmas, intentions and decision-making during Narrative Exposure Therapy (NET) sessions.

Preparation

Before the interview, the researcher will listen to a recording of the therapy session and select three or four extracts that represent challenges or dilemmas for the therapist, or where the therapist has a choice about how to respond to the client, or which direction to take the session. The therapist will also be invited to identify any such moments themselves. Ideally, the TAR interview will take place about two days after the therapy session.

Equipment

- Digital recorder (to record interview), laptop (to play audio file of previously recorded therapy session), spare batteries
- Self-report measures (Demographic Questionnaire; Working Alliance Inventory – Revised Short Form Therapist)
- Notepad and pen
- Encrypted USB (to save audio files)

Procedure

1. **Collect two written consent forms.** From client and therapist.
2. **Self-report measures.** The therapist will be asked to complete:

    a. A demographic questionnaire
    b. Working Alliance Inventory – Short Revised Therapist Version (WAI-SRT)

3. **Semi-structured interview.** The researcher will explain the aim of the interview and what to expect in terms of procedure.

    Aim

    'I am interested in moments in therapy that represent challenges or dilemmas for therapists, and how therapists experience and negotiate these. I am using a research technique called "tape assisted recall" or "TAR", which involves us listening to some extracts from your recent session and me asking you to reflect on each of these.

    We will consider these moments during the session in some detail and I will ask you about your specific thoughts and feelings at the time. There are no right or wrong answers. I am not evaluating what you say or do now, or during the session, in terms

of the quality of the therapy – my aim is not to criticise or find fault in any way. I am solely interested in how you experienced this session, with this particular client, and how you made the decisions you made. I hope that you will be able to talk freely and openly with me about this.'

Looking after yourself

'Please let me know if you find anything upsetting or uncomfortable during the interview. I am not expecting that to be the case but, if it does happen, we can take a break or stop altogether at any point. Also, please let me know if there is anything you don't understand and I will try to explain.'

Invite questions

'Do you have any questions or would it be helpful for me to explain anything in more detail at this stage? Please stop me at any time if you have a question or if anything is not clear.'

Recording of interview

'I will be audio recording our conversation and the TAR interview itself (so it can be transcribed later) and will start the recorder now if that is ok with you. Please do let me know if you want me to stop recording at any point.'

Start digital recording.

4. **General impression of therapy session.** Explore therapist's overall impression of the session before the TAR interview.

   3.1 'Before we listen to the extracts, please can you tell me about where you are in the course of NET with this client? What were you doing in this session specifically? [Prompts – was client narrating a flower / stone?] If narrating a stone, was it a stone representing a trauma or a loss or some other negative event? If a trauma stone, ask about how much that trauma is represented in client's current re-experiencing symptoms (both in terms of frequency and level of distress).'

   3.2 'Overall, How challenging was the session for you as a therapist?'

   3.4 **[If the therapist has not already identified such moments.]** *'Do you remember any particular moments in the session that were particularly difficult for you, or where you faced a dilemma?'*

   3.5 'Do you remember any particular moments in the session that were easier for you?'

5. **TAR interview.** Four to five extracts (of approximately one to two minutes) that are identified by the therapist and/or researcher as involving a challenge or dilemma for the therapist, or where the therapist has a choice about how to respond to the client, or which direction to take the session, will be selected and played during the interview.

   'I am going to play to you three or four extracts of your session (lasting no more than

a minute or two) one at a time and, after listening to each, I will ask you some questions. My questions might seem a bit obvious at times but I want to ensure I make no assumptions. I would just like to hear about how you experienced this point in the session and your thoughts and feelings at the time. Please remember there is no right or wrong answer.'

'This is the first extract. While we are listening, please try to remember what it was like for you at this point in the therapy session.'

Play the first extract. Then, for each extract, ask the following TAR questions.

4.1 *'Can you tell me what was going on for you at that point in the session?*'

Possible prompts: *'What were you doing or trying to do at that point?'*

'What were your intentions at that point?'

'Was there a particular part of the NET model you were applying or were other therapeutic principles influencing you?'

'Did you have any other aims?'

4.2 '*Were you facing any dilemmas during that extract?*

Possible prompts: '*In terms of your response/using a particular technique*…'

'*What options did you have in terms of what you did?'*

'Were you making particular decisions as you went along?'

Encourage links between dilemmas and underlying theory / motivating factors.

4.3 *'What impact did it have on you when the client [said/did [that]]?'*

Possible prompts: *'What went through your mind?'*

'*What was it that made you think that?'*

'How were you feeling at the time?'

4.4 *'What influenced your decision on which option to take?'*

Possible prompt: *'In terms of the theoretical model / previous experience / your clinical intuition?'*

4.6 *'Listening back to the extract now, do you have any different thoughts, feelings or intentions?*

Possible prompts: *'Do you notice any other dilemmas or options in terms of how you might have responded?'*

'Is there anything you would have said/done differently?

'Why?'

The same procedure will be followed for the remaining extracts.

6. **Debrief.**

'That was the final extract. Before we finish, do you have any further reflections on what we've spoken about? Now that perhaps your memory of the session is refreshed, do you recall any other dilemmas or challenges that you faced during the session with this client?

Thank you very much for taking the time to talk with me. How did you find the interview? And taking part in the study generally?

I would really like your feedback on the themes that I identify across participants during my analysis – would you be interested in reviewing these and, if so, how can I get in touch with you?'

Appendix O: Permission to use WAI-SRT

SOCIETY FOR PSYCHOTHERAPY RESEARCH

March 13, 2018

Nancy Coope
University College London
London UK

Dear Ms. Coope,

You have our permission to use the Working Alliance Inventory- Short Revised (WAI-SR) in your dissertation entitled 'Therapist decision-making in Narrative Exposure Therapy: A tape-assisted recall study'. Please be aware that we require publishing the following note at the end of the measure:

Reprinted by permission of the Society for Psychotherapy Research © 2016.

We wish you the best in your work. Please consider joining the Society for Psychotherapy Research, an international, multidisciplinary scientific association devoted to research on psychotherapy. SPR also plays an important role in providing opportunities for interaction and dialogue between researchers and clinicians interested in psychotherapy. You may read more about us at www.psychotherapyresearch.org.

Sincerely,

[redacted]

Marna S. Barrett, Ph.D.
Executive Officer
[redacted]

http://www.psychotherapyresearch.org · phone: 215-898-7253 · fax: 215-573-0759

Appendix P: Example of key phases in data analysis

Example of initial coding and tentative themes developed from excerpt from TAR interview transcript

Cluster of dilemmas: When deciding "have we done enough?"

Excerpt from TAR interview transcript	*Initial codes*	*Tentative themes*
R: Do you remember what it was like at this point in the session where you were, as you were saying, prompting what she did remember?		
T6: Yes.		
R: And you asked if there was anything more and she says, "no, I don't think so". Do you remember how you experienced that?		
T6: Yes. I mean, I suppose, because… She'd started crying. And sometimes that can be very useful in terms of giving you information that certain emotions have come up that maybe are directly connected to that memory. But when (pause), the quality of the crying was not really a re-experiencing, it was a sadness. An appropriate sadness, I would say, as distinct from how I would have expected her to feel at the time. So, I didn't feel that the crying added anything in terms of being able to develop the narrative further.	*Crying gives useful information* *Quality of crying/sadness not re-experiencing* *Appropriate sadness*	*Determining client's level of emotional processing*
Sometimes a person might express an emotion and you can then add more around, "oh, it sounds like this is how you're feeling, is that how you felt at the time do you think? Or is it more of a feeling that you have now looking back on it?" So, what I'm aiming to do is to try and make as much distinction as I can between now and then.	*Distinguishing feelings then and now*	
A little further on in transcript:		
R: And how much to probe her, I wonder. In terms of your decision not to probe further, you were basing that…?		
T6: Mainly on her presentation. That she looked like she was in the present. She was engaging with what I was saying without appearing to dissociate	*Assessing client's presentation / levels of*	

or to avoid. She was listening and nodding to everything that I'd said. So, there was a sense of that aspect of the memory not being re-experienced. I wasn't triggering anything that I would class as a re-experiencing symptom in naming that. So, I didn't think that there was necessarily lots of things that she wasn't telling me.	*dissociation and avoidance* *Memory not being re-experienced*	*Assessing client's PTSD symptoms*
R: And other than what you've just described in terms of what you were thinking.		
T6: Yes.		
R: Was there anything more that you haven't mentioned in terms of your experience of that moment? Anything you were feeling?		
P3: I guess, I was also thinking that I didn't get a sense of fear from her. And I got a sense of sadness in thinking back to her younger self. That was the qualitative feeling that I had.	*No qualitative "sense of fear"*	
A little further on in transcript:		
R: I was just wondering. When you said, "I didn't pick up, qualitatively, fear from her", if you could just say a little more about the importance of a fear response as compared to other responses.		
T6: Yes. So, a fear response, when I'm asking somebody to talk about a past memory, if that memory is processed, you wouldn't expect the person to feel fear now. You'd expect them to feel fear now if there was an element of memory that was unprocessed. Where it felt like, to some extent, even if it's in a very fragmented way, there's an element of a re-experiencing. That it's happening again now, even if it's only bits.	*No current fear = processed memory* *Current fear/re-experiencing = fragmented memory*	*Determining client's level of emotional processing*
So, normally, one of the things I'd be looking out for, usually, if I'm doing a session where we're going through a trauma memory, is are there any physical signs of fear? Are there any expressed signs of fear? Does the person say, God I feel really scared now that I'm talking about that.	*Assessing physical signs / expressions of fear*	