

Mental Health Care for Syrian Refugees: Shared Realities in the Context of
Conflict and Forced Displacement

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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 Syrian conflict has created mass forced displacement and severe humanitarian needs, including psychological needs. Training Syrian mental health professionals in specialised psychological support maximises resources and enables cultural sensitivity. The impact of its provision in the context of a shared reality and limited resources on Syrian mental health professionals is poorly understood.

Part 1 comprises a systematic review and meta-analysis of 15 randomised controlled trials of psychological, social and welfare interventions of torture survivors. It is an update of a previous Cochrane review. Results showed effects for psychological intervention versus comparator for PTSD symptoms and functioning at the end of treatment. These results were different to the previous review, and while the methodological quality of studies in this review was higher, confidence in the results are questionable for reasons discussed.

Part 2 is conducted in two parts. Part A uses quantitative methodology to investigate Syrian mental health professionals' quality of life overall using a well-established questionnaire that was translated to Arabic. Part B interviews forcibly displaced Syrian mental health professionals to explore their shared reality with clients, self-disclosure and the impact of providing therapy. Findings highlighted higher mean scores of secondary traumatic stress than samples in other studies. Similar characteristics allowed Syrian mental health professionals to better empathise with clients and understand the culture and language. All participants who made reference to difficult aspects of therapy also made reference to gaining satisfaction from helping clients.

Part 3 comprises a discussion of assumptions, reflections and learnings relevant to conducting research in this field.

Impact Statement

The insights presented in this thesis develop the scant literature both on psychological, social and welfare interventions on torture survivors and Syrian mental health. This research systematically reviewed and meta-synthesised randomised controlled trials in relation to torture survivors. The findings highlight the continued lack of social and welfare interventions for torture survivors, and the dominance of individualised psychological interventions. This is despite small to medium or no effects on post-traumatic stress disorder symptoms, depression and functioning, with a potential harmful effect of intervention on post-traumatic stress disorder symptoms at three months follow-up. Greater emphasis on participant-defined quality of life outcomes will enable interventions to be better tailored for torture survivors, while measuring the effect of these interventions meaningfully. The systematic review and meta-analysis, as well as a critical appraisal of relevant studies allows for an in-depth exploration of studies relevant to torture survivors.

The empirical work is the first study to explore Syrian mental health professionals' quality of life and is also the first to produce a validated Arabic version of a well-established professional quality of life measure. The Arabic version of this measure is likely to be of pragmatic value given the ongoing and widespread conflict within the Middle East which has led to a rise in mental health care provision by Arab health professionals. It is also the first study to explore shared realities with clients, mental health professional self-disclosure and the impact of therapy amongst Syrian mental health professionals. There is an ethical duty to widen research within this context given that there are both potential harmful and helpful impacts of working in such a way, but this is poorly understood. The findings point to the acceptability and

helpfulness of training mental health professionals in the community as a cost-effective, culturally sensitive and sustainable intervention for humanitarian disasters and conflicts. These findings also suggest the importance of the provision of adequate supervision, peer-support and the promotion of Syrian-led self-care interventions amongst professionals.

It is hoped that this research will generate understandings from mental health professionals within a context of trauma to raise awareness and enable participant-led knowledge to contribute to the literature on professional quality of life. This research will be disseminated within a non-governmental organisation which trains Arab mental health professionals in humanitarian settings and at an annual conference for Syrian mental health professionals so that the findings and insights can be integrated into their future training and supervision.

This study was awarded a UCL Grand Challenges Global Health Doctoral Students Grant of £1835 for multidisciplinary work in collaboration with UCL's Institute of Global Health. This paved the way for close collaborations with UCL's new Global Mental Health Working group, with my collaboration increasing psychological representation within the group.

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List of abbreviations

AW	Dr Amanda Williams (Research Supervisor)
KS	Dr Katrina Scior (Research Supervisor)

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My choice to do this project in Arabic so that I can effectively reach and capture the experiences of participants meant that, from the outset, I relied heavily on my wonderful supportive family. My mum, dad, uncle and partner Ibrahim collectively put a lot of hours in to make sure I was on the right track, advising me with their excellent Arabic skills. If it wasn't for my mum, dad and brother insisting on my speaking Arabic

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Part 1: Literature Review

Psychological, social and welfare interventions for torture survivors: an
updated systematic review and meta-analysis

Abstract

Background. Humanitarian reports show that torture is widespread with recent conflicts involving the detention and torture of civilians and armed groups. Research has focussed on psychological interventions and little attention has been paid to social or welfare interventions.

Aim. To extend a 2014 Cochrane review of randomised controlled trials to evaluate the beneficial and adverse effects of psychological, social and welfare interventions for torture survivors.

Method. The 2014 searches were updated to cover the intervening period. Six major databases and three trials registers were systematically reviewed and a meta-analysis was conducted.

Results. In addition to the previous nine studies, six studies were identified, all of psychological interventions. Small positive effects of psychological interventions relative to comparator arms were seen in reducing post-traumatic stress disorder symptoms and improving functioning at the end of treatment. The quality of evidence was relatively high in terms of large sample sizes and randomisation,

Conclusions. The number of eligible trials and their sample sizes were small. It is therefore difficult to draw firm conclusions about the efficacy of psychological treatments. However, there is a need to conduct randomised controlled trials with social and welfare interventions, and to take social stressors into consideration when conducting trials on psychological interventions.

Introduction

Background

Definition, legal and policy frameworks. The United Nations Convention Against Torture, and Other Cruel, Inhuman or Degrading Treatment and Punishment (UN CAT; 1984) defines torture in Article 1 as:

“...any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.”

International guidelines for documenting torture, the Istanbul Protocol (United Nations High Commissioner for Human Rights & United Nations Office of the High Commissioner for Human Rights, 2001), outline torture methods under the following categories: beatings and other blunt traumas, suspension and other positional tortures, beating of the feet (falanga), tooth torture, electrical shocks, asphyxiation, rape and sexual torture. Torture methods that leave no visible marks are common, such as threats to oneself or family, humiliation, being stripped naked, hooding, simulated drowning (waterboarding), sleep deprivation and mock executions.

Prevalence. Despite 164 state parties and 83 signatories to the UN CAT (accurate as of 18th May 2018) since its inception, torture is still widespread. An Amnesty International report (2014) found evidence of torture in 79 countries; all of whom had ratified the convention. Long-standing and ongoing armed conflict in

countries such as Syria, Iraq and Yemen at the time of writing this review has likely led to the increased use of torture since. Allansson, Melander & Themner (2017) identified 352,000 fatalities resulting worldwide from organised violence between 2014 and 2016 alone. Fatalities and prevalence of torture are likely much higher given the nature of the tactics used by perpetrators, such as the concealment of evidence, the difficulty of access to detention facilities and the political and societal barriers to disclosure.

Conflicts have also led to increasing numbers of forcibly displaced individuals seeking asylum and resettling in Western countries, likely increasing the number of torture survivors presenting to health services. In the UK 55% of Syrian refugees who have been given protection under a governmental resettlement programme are survivors of torture and/or other forms of violence (National Audit Office, 2016). Even in cases where healthcare systems are readily available, barriers to accessing healthcare occur at the individual (stigma, mistrust), provider (inadequate interpretation and cultural sensitivity) and system level (inadequate community support, financial and housing resources; see Asgary & Segar, 2011). In addition, resettled torture survivors often experience difficulties such as navigating complex legal systems, racism, xenophobia and micro-aggressions.

Impact. Torture can have both immediate and long-lasting effects, determined by multifaceted and interacting risk factors relating to the nature of torture, the environment and the individual. Torture can affect psychological, physical, social and spiritual wellbeing, and these effects may interact in diverse ways.

Psychological effects are well-documented; problems related to torture include post-traumatic stress, depression, anxiety and phobias (Patel & Granville-

Chapman, 2010) and studies have shown that being female, older and having unstable housing predicted greater severity of anxiety, post-traumatic stress disorder (PTSD) and depression (Song, Subica, Kaplan, Tol, & de Jong, 2018). The physical effects of torture are also widespread in the literature (for reviews see Jaranson & Quiroga, 2011; Montgomery & Patel, 2011).

PTSD (Diagnostic and Statistical Manual of Mental Disorders; 5th ed.; DSM–5; American Psychiatric Association, 2013) has been the dominant studied phenomena characterising the psychological distress experienced by torture survivors, as well as refugees and asylum seekers. Much research has criticised its dominance in that a diagnosis of PTSD does not capture the full experience of torture survivors, and often leads to over-medicalisation (see McFarlane & Kaplan, 2012). To make the assumption that Western-originated psychiatric categories such as PTSD are universal is to commit what Kleinman (1977) called a ‘category fallacy’; where by definition, diagnosis will find what is universal while systematically missing out what does not fit in tight parameters. This questions the simple extrapolation across cultures without validating or adapting according to a particular culture’s needs.

As well as direct emotional and physical impact, torture survivors often experience social and financial problems. These daily stressors contribute to and maintain mental health problems (see Miller & Rasmussen, 2010). Basic resources such as access to food, shelter and medical care as well as external risks such as being victimised in their community or at home significantly predicted PTSD, anxiety and depression in resettled torture survivors in the US (Song et al., 2018).

Torture by definition is intentionally inflicted by another individual. Its aftereffects cannot be conceptualised solely as an individual problem requiring

psychological and physical rehabilitation alone, as is often the focus of the literature. Torture often occurs against a backdrop of (inter)national power imbalances, war, malnutrition, precarious financial opportunities and the erosion of state welfare. It requires a holistic approach incorporating wider conceptualisations at multiple layers of the system, as well as the recognition of common experiences that torture survivors face of being excluded, stigmatised and shamed for their experiences, their disabilities or their mental health difficulties (Shannon, Wieling, Simmelink-McCleary & Becher, 2015).

Interventions. The available literature on interventions provided to torture survivors is limited. Jaranson & Quiroga (2011) describe a limited range of interventions, often offered in combination depending on individual, family and community needs. Included studies showed significant limitations such as limited sample sizes and no validation of measures. A greater understanding of what works in the rehabilitation and support for torture survivors is crucial, given that the majority of psychological interventions and measures are based on Western concepts of health and well-being, with no validation with torture survivors from diverse backgrounds. Psychological interventions are delivered to the individual, family, group or community with the aim of changing cognitive, emotional or behavioural outcomes (see Appendix 9 for a further definition).

A systematic review and meta-analysis of randomised controlled trials (RCTs), quasi RCTs and cluster RCTs was published by Patel, Kellezi & Williams in 2014. This review was inclusive of psychological, social as well as welfare interventions, in view of the aforementioned constraints of the individual focus on psychopathology, and the wide range of evidence that is relevant to the care and treatment of torture

survivors. Social interventions have the aim of improving interpersonal relationships, social involvement and participation, social integration of individual survivors and their families, and social cohesion. Welfare interventions have the aim of benefiting survivors' health and well-being by improving social conditions, addressing basic needs for food, clothing and adequate housing and meeting educational, employment or vocational needs; see Appendix 9 contains further definitions and examples.

Nine RCTs providing data for 507 adults showed no immediate benefits for psychological therapy for distress (as measured by depression symptoms), PTSD symptoms, PTSD caseness or quality of life. Four studies (comprised of 86 participants; of cognitive behavioural therapy; CBT; and narrative exposure therapy; NET) showed moderate effect sizes for intervention over control in reducing distress and PTSD symptoms. However, quality of evidence was deemed low due to small sample sizes and the use of non-standardised assessment methods with interpreters. No data were provided whether this symptom reduction led to improvement in quality of life, participation in community life or social and family relationship improvements. Although the search terms and criteria in Patel and colleagues' (2014) review were widely inclusive and extensive, the studies identified showed a lack of relevant information about participants, leading authors to make decisions about inclusion of studies using information about conditions of the country of origins of the survivors at the time, introducing a level of subjectivity and bias in the selection.

Since 2014, two reviews investigated outcomes of interventions relevant to torture survivors. Weiss and colleagues (2016) published a review of clinical trials with survivors of torture and other systematic forms of violence and concluded that CBT interventions produced the highest treatment outcome among those with PTSD

and/or depression. However, unlike in Patel et al. (2014), Weiss et al. (2016) did not use meta-analytic means, and was not restricted to RCTs therefore not controlling for the non-specific effects of CBT or any other reviewed interventions, such as listening, empathy and receiving resources which are likely to over-estimate effect sizes (see Williams, 2017). One can therefore not estimate overall effectiveness of these treatments without the use of RCTs.

Morina, Malek, Nickerson and Bryant (2017) conducted a meta-analysis of 18 interventions for PTSD and depression in low and middle income countries. Findings showed that there was a large aggregated pre-post effect size for all 18 trials for both PTSD and depression. However, when using RCTs and comparing to control conditions, post-treatment effect sizes were smaller; a large effect size was reported for depression and small to medium effect size for PTSD. Both Morina et al. (2017) and Weiss et al. (2016) did not restrict their inclusion criteria to torture survivors, and focused on psychological interventions using Western-based diagnoses.

Given the significant role of daily financial and social stressors, interventions should aim to target these stressors in addition to psychological interventions. One of the most widely endorsed global health guidelines for mental health and psychosocial support (MHPSS) in conflict settings recommends integrating MHPSS into livelihood programmes and states that livelihoods may act as key basic and community psychosocial support for all (Inter-Agency Standing Committee [IASC], 2007). Despite their potential, livelihood programmes as standalone components, or with integrated MHPSS remain unexplored (see Schininá, Babcock, Nadelman, Walsh, Willhoite, & Willman, 2016; Tejada, 2015). There is an increasing emphasis of the sharing of expertise and capacity building by training community mental health workers (CMHW)

within global mental health guides guidelines (e.g. Inter-Agency Standing Committee, 2007; World Health Organisation; WHO; 2010), therefore a recent increase in such interventions aimed at torture survivors may be expected.

Aim

This study aims to update the systematic review and meta-analysis conducted by Patel et al. (2014), given that it is the only review examining RCTs specifically with torture survivors, and given that there is an expected increase in trials with torture survivors. Given the aforementioned limitation of Patel et al.'s (2014) study, while the same search criteria were used, greater emphasis was placed on contacting authors of studies where relevant information about participants were missing to eliminate any bias in authors' selection of studies. In line with Patel et al. (2014), this review focuses exclusively on torture survivors and aims to evaluate the effectiveness of psychological, social and welfare interventions for psychological health and well-being of torture survivors.

Method

Search strategy

Electronic resources. The 2014 review searches were replicated and extended. RCTs of any psychological, social and welfare interventions were extracted from the PsycINFO, MEDLINE, EMBASE, Web of Science, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Cochrane Central Register of Controlled Trials (CENTRAL), the WHO International Clinical Trials Registry Platform (WHO ICTRP), Clinical Trials.Gov and the Published International Literature On Traumatic Stress (PILOTS). See Appendices 1-7 for specific search terms used for each database.

Other resources Searches were also conducted within the online library of DIGNITY (Danish Institute against Torture), using the search terms outlined in Appendix 8.

Reference lists of torture-specific reviews published on or after 2014, and reference lists emerging from the final set of included studies were also searched.

Where a reference was found (such as conference abstracts) but was not yet published, contact with authors was made. It was decided not to search the grey literature for the purposes of this review given that no additional sources were identified when searching the grey literature in the previous review.

Overall search strategy. The searches focused on the three and a half years since the review (June 2014 until January 2018) using the same strategy. Literature searches were conducted from either January 2014 or January 2013 (depending on which database, specified in the appendices relevant for each database) to capture any studies that were awaiting publication or classification during the time of the initial review. The search terms in Patel et al. (2014) were deliberately broad to capture studies conducted in non-Western or non-academic settings with diverse reporting structures.

Selection strategy. Titles and abstracts were initially screened against the inclusion criteria, with the aim of identifying potentially eligible studies, for which the full paper was obtained.

EndNote was used to manage the electronic searches. Duplicates were automatically removed using EndNote's deduplication function. The literature suggests that both auto- and hand-searching methods should be employed to find duplicates in systematic review (Qi, Yang, Ren, Jia, Wang, Han, & Fan, 2013). A hand-

searching method was also employed after the automatic function to remove any undetected duplicates. Following this, potential eligible studies were identified by screening titles and abstracts against the inclusion criteria. The full papers were obtained for these potential eligible studies, and each paper was read and selected against the selection criteria by one review researcher (AH). The final list was then read by another review researcher (AW).

Inclusion and exclusion criteria

To ensure an accurate replication of trials extracted from previous review, this study employed the same inclusion and exclusion criteria. Accordingly, studies were included if they:

- employed randomised controlled methodology
- included male and female participants of all ages and ethnicities
- included at least 50% of the sample as survivors of any type of torture, as defined by the study researchers, regardless of diagnosis
- included psychological interventions, social interventions or welfare interventions (see Appendix 9)
- included interventions undertaken with individuals or with families or groups
- had control comparisons, including waiting list, no treatment, (access to) standard care, attention control or alternative treatment that was likely to engender expectations of improvement in those allocated to that condition, such as psycho-education or peer support
- measured psychological distress as a primary outcome
- measured any of the following as a secondary outcome:

- change in psychological status (usually by way of change in symptoms or diagnostic category) or change in target behaviour (at a group or individual level)
- change in quality of life or well-being
- change in participation and functioning by way of engagement in education, training, work or community activity
- change of quality and/or quantity of family or social relationships
- other-reported psychological functions (others include clinicians , parents and teachers)
- use of health care resources
- ratings of the intervention itself (such as satisfaction with intervention and therapeutic alliance)
- measured outcomes immediately post treatment and/or up to around 3 months after the end of treatment, and if multiple follow-ups are used, the longest up to one-year were used

Where more than one outcome measure was included pertaining to the same domain of interest, and all described the domain adequately, primary preference was given to a measure also used in other studies included in the previous review, and secondary preference was given to any measure that authors stated was tested for suitability in the population included in the respective trial. Where there were poster abstracts, missing data or unpublished studies and contact details were available, authors were contacted for clarification.

Results of the search

An initial search of the electronic databases PsycINFO, MEDLINE, EMBASE, CENTRAL, CINAHL, Web of Science and PILOTS on 5th January 2018 and of WHO ICTRP, ClinicalTrials.gov and DIGNITY on 3rd April 2018 yielded 1183 references, and additional records identified 230 references. After deduplication, 673 records remained and were screened. 631 of those were excluded. See Figure 1 for study flow diagram.

An initial scope of all references by title and abstract revealed 36 potential studies for full-text review. Of these 36 studies, five were previously excluded in the 2014 review (Bass et al., 2013; Halvorsen et al., 2014; Hijazi et al., 2014; Rees, Travis, Shapiro, & Chant, 2013; Stenmark, Catani, Neuner, Elbert & Holen, 2013) and were therefore excluded from this review. One was previously included (Pokhariyal, Rono, & Munywoki, 2013). For the purposes of this update, Pokhariyal et al (2013) was not described here as one can refer to the previous review, but was included in the meta-analysis, as were all the remaining eight previously included studies.

Of the remaining 30 articles reviewed, 22 were full-text published articles, four were abstracts awaiting classification and four ongoing clinical trials. Of the 22 full-text articles, 16 were excluded and six were included (Bass et al., 2016; Bolton, Lee et al., 2014; Esala & Taing 2017; Puvimanasinghe & Price 2016, Wang, et al., 2016; Weiss et al., 2015). Of the four abstracts awaiting classification, two were included (Ekstrøm, Carlsson, Sonne & Mortensen, 2016; Vindbjerg, Klimpke, & Carlsson, 2014). Of the

four ongoing clinical trials, one was included (Hartman, 2018).

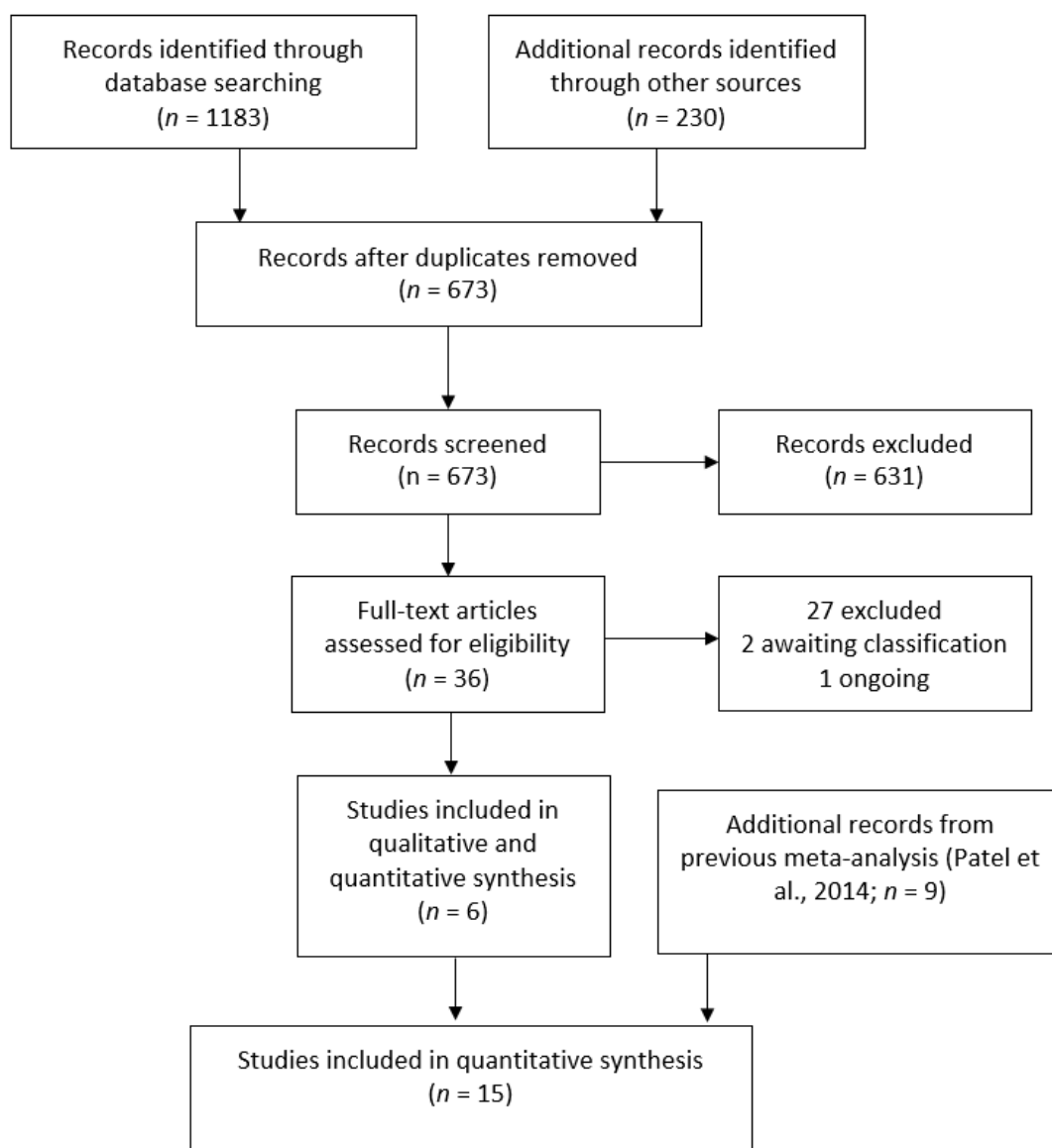


Figure 1. Study Flow Diagram

Excluded studies. Twelve studies were excluded on the basis of participant characteristics. One study was excluded (Bolton, Bass et al., 2014) given that, after contacting the authors to request clarification, the authors confirmed that in both intervention arms less than 50% of participants were direct survivors of torture. Ten studies did not include any survivors at all according to their samples (Acarturk et al., 2015; Acarturk et al., 2016; Azad & Hashemi, 2014; Böttche, Kuwert, Pietrzak &

Knaevelsud, 2016; Goodkind et al., 2017; Jacob, Neuner, Maedl, Schaal, & Elbert, 2014; McMullen, O'callaghan, Shannon, Black, & Eakin, 2013; Small, Kim, Praetorius, & Mitschke, 2016; Steinert et al., 2017; Weinstein, Khabbaz & Legate, 2016). One study did not mention torture survivors, but stated that 72% of participants were threatened with torture (ter Heide, Mooren, Van de Schoot, De Jongh, & Kleber, 2016).

Three studies were excluded on the basis of their intervention. One was predominantly a physical intervention (Kim & Yu, 2015) and two were predominantly medical interventions (Buhmann, Nordentoft, Ekstroem, Carlsson & Mortensen, 2016; Sonne, Carlsson, Bech, Elklit, & Mortensen 2016).

One study was excluded on the basis of its design, a prospective longitudinal multilevel modelling analysis of an excluded RCT by ter Heide et al. (2016; Haagen, Heide, Mooren, Knipscheer, & Kleber, 2017).

Ongoing studies. The WHO ICTRP revealed only one registered study since 2014, which was excluded on the basis of pain being the primary outcome (Kaur, 2017). The Clinicaltrials.gov website showed three trials registered since 2014. Two trials were excluded as their primary population was not torture survivors (Peltonen, 2015 & Singh, 2017). One study was included as it aimed to look at the combined impact of psychotherapy and physiotherapy in torture survivors in Kurdistan (Hartman, 2018).

Of the four studies awaiting classification, only abstract (Ekstrøm et al., 2016) or study protocol was available (Nordbrandt, Carlsson, Lindberg, Sandahl, & Mortensen, 2015; Vindbjerg et al., 2014), and one study was an RCT protocol, however, upon closer examination the primary outcome was quality of sleep, and so

it was excluded (Sandahl, Jennum, Baandrup, Poschmann, & Carlsson, 2017). The corresponding authors of all three relevant studies were contacted to request results or a timeframe for the results and two responded. Ekstrøm and colleagues (2016) stated that study results were expected to be published later in 2018, and Vindbjerg and colleagues (2014) stated that a manuscript was due to be submitted for review.

Data extraction and management

Descriptive data including participant characteristics, treatment mode and setting were collected. The primary area of interest for this review was outcomes in the domains of PTSD symptoms and caseness, distress, functioning and quality of life. PTSD symptoms were defined as the primary outcome given that the majority of identified reviews measured this. Distress was measured as a secondary outcome, in the form of depression symptoms. Depression was chosen to define distress as it is more of a distinct construct to PTSD than the alternative measure of distress, anxiety. As in Patel et al. (2014), functioning was measured by engagement in education, training, work or community activity and quality of life was defined as a change (positive or negative) in quality of life or well-being as measured by global satisfaction with life and extent of disability.

Data analysis

Due to varying data collection and reporting methods, this review included both continuous and dichotomous scales. Meta-analyses were conducted using Review Manager (RevMan) software (The Cochrane Collaboration, 2012). It was anticipated that there would be considerable heterogeneity in the data. Consequently, a random-effects model was applied.

For continuous scales, treatment effects were estimated using standardised mean differences. This requires the extraction of mean scores, standard deviations and sample sizes for each arm. Where standard deviations required for the analyses were not available, they were obtained using confidence intervals through conversion to standard error, as suggested in the Cochrane handbook (Higgins & Green, 2011). For dichotomous data, treatment effects were estimated using odds ratios by extracting the number of events and sample sizes.

The newly included studies were added to the nine previous studies in each analysis. Analyses were run for end of treatment and follow-up where available. End of treatment was defined as data collected within three months or less following the end of the trial. Follow-up was defined as more than three months following the end of the trial. Consequently, Weiss et al. (2015) data were counted as a follow-up, given that the mean time from the end of treatment until the follow-up interview among CETA participants (arm one) and CPT participants (arm two) was three and a half months and four months respectively.

Quality of studies

The risk of bias was assessed using the Cochrane guidance (Higgins & Green, 2011). The following were chosen to represent all five risk of bias categories suggested by the guidance: random sequence generation (selection bias), allocation concealment (selection bias), blinding of participants and personnel (performance bias), blinding of outcome assessment (detection bias), incomplete outcome data (attrition bias) and selective reporting (reporting bias). Therapist allegiance, treatment fidelity, therapist qualifications and other bias were also included. These characteristics were chosen to replicate those in the previous review for consistency.

Each study was classified for each of the aforementioned categories into either low risk, high risk or unclear risk, with justifications.

Measures of Treatment Effect

Studies where a psychological, social or welfare intervention was an active treatment of primary interest were investigated. Most studies used testimony therapy or a common elements approach (CETA).

Where studies included more than one arm within a trial, it was decided that, where both arms fell into the same category of intervention, i.e. psychological intervention, the intervention arm data were combined and comparator arm data were combined, given that the main area of interest of this research is the impact of intervention relative to control (such as in Weiss et al., 2015). In studies where both adjusted and unadjusted treatment effects for specific covariates were reported, the adjusted treatment effects were used (e.g. Bolton, Lee et al., 2014).

Assessment of Heterogeneity

Between-trial heterogeneity is calculated in RevMan and expressed using the I^2 statistic. I^2 values of below 25% indicate low heterogeneity, I^2 values of 25-50% indicate medium heterogeneity, and I^2 values above 50% indicate high heterogeneity.

Results

1. Included studies

Full characteristics of the six recent included studies and their associated risk of bias are detailed in Table 1 in Appendix 10. These six new eligible trials since the previous Cochrane review that reported PTSD or other distress as primary and secondary outcomes were added to the nine trials in the previous review (Bichescu, Neuner, Schauer & Elbert, 2007; Hensel-Dittmann et al., 2011; Igreja, Kleijn,

Schreuder, Van Dijk & Verschuur, 2004; Neuner, Kurreck, Ruf, Odenwalf, Elbert & Schauer, 2010; Paunovic & Öst, 2001; Pokhariyal, et al., 2013; Schaeur et al., 2006; ter Heide, Mooren, Kleijn, de Jongh & Kleber, 2011; Yeomans, Forman, Herbert & Yuen, 2010) making 15 trials in total. All trials represented a total number of 1373 participants at the end of treatment (mean per study = 91.53) out of the 1585 that started treatment. This equated to a mean study completion rate from point of entry to completion of 86.62% and ranged between 50% and 100% using data from all studies; 589 females and 784 males were included in studies.

Participants were recruited from various countries. Seven were conducted across Europe, including one in Albania (Wang et al., 2016); three in Germany (Hensel-Dittmann et al., 2011; Neuner et al., 2010; Schauer et al., 2006), one in the Netherlands (ter Heide et al., 2011), one in Romania (Bichescu et al., 2007), and one in Sweden (Paunovic & Öst., 2001). Three studies were conducted in Africa including one in Burundi (Yeomans et al., 2010), one in Kenya (Pokhariyal et al., 2013) and one in Mozambique (Igreja et al., 2004). Five studies were conducted in Asia; one in Cambodia (Esala & Taing, 2017) two in Iraq (Bass et al., 2016; Weiss et al., 2015), one in Sri Lanka (Puvimanasinghe & Price, 2016) and one in Thailand (Bolton et al., 2014).

Seven studies used waitlist control as comparator arms, involving monthly telephone calls (Bass et al., 2016; Bolton et al., 2014; Weiss et al., 2015), a daily multivitamin pill (Wang et al., 2016) and participation in a standard workshop (Yeomans et al., 2010). The protocol was not described in two studies (Esala & Taing, 2017; Puvimanasinghe & Price, 2016); one study used no treatment (Igreja et al., 2004); two studies used treatment as usual (Neuner et al., 2010; Schauer et al., 2006); and five studies used an active control, including psychoeducation (Bichescu et al.,

2007); stress inoculation while avoiding any element of exposure (Hensel-Dittmann et al., 2011); exposure alone (Paunovic & Öst., 2001); stabilisation (ter Heide et al., 2011); and conventional psychotherapy (Pokhariyal et al., 2013).

One study had four arms in total (Weiss et al., 2015), one study had three arms (Igreja et al., 2004; this third arm was excluded from the analysis in the previous review) and the remaining thirteen studies had two arms. All interventions were psychological, and no studies included social or welfare interventions as the treatment arm. A diverse range of approaches were used for the intervention arms. Four studies used narrative exposure therapy (NET; Bichescu et al., 2007; Hensel-Dittmann et al., 2011; Neuner et al., 2010; Schauer et al., 2006), two used CETA (Bolton, Lee et al., 2014; Weiss et al., 2015), one used testimony therapy (Igreja et al., 2004) and two used testimony therapy plus ceremony (Esala & Taing, 2017; Puvimanasinghe & Price 2016). NET involves the client, with the aide of a trained mental health professional, establishing a chronical narrative of his or her life, concentrating on mainly traumatic experiences but also incorporating some positive events. In doing so, the client builds a coherent autobiographical narrative. Testimony therapy is similar in that clients tell their full life stories including traumatic experiences. This narrative is then reflected in a detailed document which can be used and presented as a testimony of human rights violations. Other studies have included cognitive behaviour therapy (CBT; Paunovic & Öst, 2001) with prolonged exposure (Wang et al., 2015), supportive counselling (Bass et al., 2016), trauma healing (Yeomans et al., 2010), eye movement desensitisation and reprocessing (EMDR; ter Heide et al., 2011), and one study used a mixture of therapies under the name of 'trauma processing,' for which EMDR was a major

component (Pokhariyal et al., 2013). Weiss et al.'s (2015) second treatment arm included cognitive processing therapy.

Three studies stated that they culturally adapted and validated their instruments (Bass et al., 2016; Bolton, Lee, et al., 2014; Weiss et al., 2015) and one study used a locally developed scale for trauma-related distress (Puvimanasinghe & Price, 2016). Four studies provided details of their methodology for cultural adaptation (Bass et al., 2016; Bolton, Lee, et al., 2014; Esala & Taing, 2017; Weiss et al., 2015). Four studies culturally adapted their interventions (Bolton, Lee et al., 2014; Esala & Taing, 2017; Puvimanasinghe & Price, 2016; Weiss et al., 2015).

2. Data analysis

Of the six new studies, all provided analysable data after calculating the standard deviation from confidence intervals or standard errors using Cochrane guidance. Where neither confidence intervals nor mean scores were available (Weiss et al. 2015), the author was contacted and the mean and standard deviations for all outcomes but functioning were obtained. Where confidence intervals for mean differences were available, but no mean scores (Wang et al., 2016), authors were contacted and they provided the mean scores and standard deviations for all requested outcomes.

3. Measures used in analysis

All but one study used a specific measure of PTSD. Puvimanasinghe and Price (2016) used the Sri Lanka Index of Psychosocial Status (SLIPSS-A) which they describe as "a measure of psychosocial status that could reliably and accurately assess psychosocial functioning in Sinhalese Sri Lankans impacted by traumatic events". It has been found to be positively correlated with a PTSD checklist (Fernando, 2008). Of the

fifteen studies specifically measuring PTSD, seven used the Harvard Trauma Questionnaire (HTQ; Mollica, et al., 1992) to measure PTSD (Bass et al., 2016; Bolton, Lee, et al., 2014, Igreja et al., 2004; Wang et al. 2016, & Weiss et al., 2015 & Yeomans et al., 2010), Esala & Taing (2017) used the PTSD Checklist (PCL-5; Blevins et al., 2013) Bichescu et al. (2007) used Composite International Diagnostic Interview (CIDI; WHO, 1990); two studies (Hensel-Dittmann et al., 2011 & Paunovic & Öst, 2001) used the clinician-administered scale (CAPs; Blake et al., 1995) two studies (Neuner et al., 2010 & Schauer et al., 2006) used the Post-traumatic stress diagnostic scale (PDS; Foa, 1995), Pokahriyal et al. (2012) used the Stress State Inventory (SSI;) and ter Heide et al. (2011) used the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, Spitzer, Gibbon & Williams, 1995).

Four studies measured PTSD caseness at end of treatment (Bichescu et al., 2007; Hensel-Dittmann et al., 2011; ter Heide et al., 2011; Wang et al., 2016), and one study also measured caseness at follow-up (Wang et al., 2016).

All but three studies (Igreja et al., 2004, Pokharyal et al., 2013; Schauer et al., 2006) measured depression outcome. Eight studies (Bass et al., 2016; Bolton, Lee, et al., 2014; Esala & Taing, 2017; Neuner et al., 2010, Wang et al., 2016, Weiss et al., 2015, ter Heide et al., 2011; Yeomans et al., 2010) used the Hopkins Symptom Checklist-25 (HSCL-25; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). Puvimanasinghe and Price (2016) used the WHO-5, which has been recommended as a screening tool for depression (Henkel et al., 2003; WHO, 1998). Two studies (Bichescu et al., 2007; Paunovic & Öst, 2001) used the Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) and Hensel-Dittmann et al. (2011) used the Hamilton Depression Scale (Hamilton, 1960).

Four studies measured functioning (Bass et al., 2016; Bolton, Lee, et al., 2014, Wang et al. 2016, & Weiss et al., 2015). Two studies used a locally developed functioning scale described by Bolton, Bass et al. (2014; Bass et al., 2016 & Bolton, Lee et al., 2014), Weiss et al. (2015) used a locally developed scale described by Weiss & Bolton (2010) and Wang et al. (2016) measured functioning using the WHO disability assessment schedule (WHODAS 2.0; Üstün, Kostanjsek, Chatterji & Rehm, 2010). Analysable data were not successfully obtained from the Weiss et al. (2015) for functioning and were not included in the analysis.

Puvimanasinghe and Price (2016) reported data for the Participation scale (P-scale; Van Brakel et al., 2006), a measure of social participation. This was seen to reflect an aspect of quality of life; social quality of life measured by change in quality and/or quantity of family or social relationships. Ter Heide et al. (2011) was the only other study to compare intervention and comparator arms in terms of quality of life, using the WHO Quality of Life scale (WHOQOL; WHOQOL Group, 1995). The WHOQOL contains an overall score (global) and four subscales (physical, psychological, environment and social). The measure used in the previous review was the global score, but a decision was made to use the social subscale for this analysis for consistency with the Puvimanasinghe and Price's (2016) social quality of life measure.

4. Quality of studies

Table 1 in Appendix 10 contains a full outline of the six categories used to assess the quality of the evidence in each study. This only contains the six recent studies, as the quality of the nine previous studies has been outlined in detail in Patel et al. (2014). The quality was assessed according to one review author's judgement

(AH), with justifications. This was then checked by another review author to reach a consensus (AW).

4.1. Selection bias (random sequence generation and allocation concealment).

Four of the six studies were low risk in that a randomisation list was generated. Two of these four studies report the use of STATA (Bass et al., 2016 & Bolton, Lee et al., 2014), and the remaining two did not state which programme was used (Wang et al. 2016, & Weiss et al., 2015). The risk was unclear for one study (Esala & Taing, 2017) as they did not describe the method of randomisation.

Four of the studies were classed as low risk of bias for allocation concealment as mental health professionals in these trials were provided with pre-numbered consent forms or sealed envelopes (Bass et al., 2016; Bolton, Lee et al., 2014; Wang et al. 2016; Weiss et al., 2015). There was an unclear risk in Esala and Taing's (2017) study as the method of allocation was not described.

One study showed a high risk with regards to both randomisation and allocation (Puvimanasinghe & Price, 2016), as the researchers randomly allocated pairs of participants after matching them according to independent variables and demographics; this likely led to selection bias especially given that sample sizes were relatively low.

4.2. Blinding (performance bias and detection bias). Given the nature of the intervention and comparator arms, it was not possible to blind participants nor researchers/practitioners to allocations. Further, data on participants' expectations of treatment benefit were not collected at baseline. Therefore, all studies were at high risk of performance bias.

All but one study (Wang et al., 2016) described their methodology for collecting outcome data. The remaining five studies indicated that outcome assessments were blind in all, or over 80% of, the assessments. However outcomes were collected via interview in all, which would have likely led to unwitting unblinding through participants' comments. None of the studies commented on this, rendering risk unclear. One study found that outcomes of unblinded interviews differed significantly to those of blinded interviews, rendering a high risk of detection bias (Bass et al., 2016).

4.3. Incomplete outcome data (attrition bias). High risk of attrition bias was indicated in four studies where those lost to follow-up significantly differed to the initial sample at baseline (Bolton, Lee et al., 2014), over 26% of total participants either dropped out or had systematically missing data (Wang et al. 2014) or there was higher attrition in intervention arms than comparator arms (Esala & Taing, 2017; Weiss et al., 2015). Two studies showed a low risk of attrition bias as it was reported that over 90% of all participants completed treatment and follow-up (Bass et al., 2016; Puvimanasinghe & Price, 2016). All studies dealt with missing data. Intent-to-treat analyses were used in two studies (Puvimanasinghe & Price, 2016; Wang et al., 2014), multiple imputation methods were used in three (Bass et al., 2016; Bolton, Lee et al., 2014; Weiss et al., 2015) and a multilevel modelling approach was used in one (Esala & Taing, 2017).

4.4 Selective reporting (reporting bias). All six studies showed an unclear risk of reporting bias. Although all studies reported all outcomes, no protocols for reporting were provided.

4.5 Other potential sources of bias. While some studies contained relatively large sample sizes (Bass et al., 2016; Bolton, Lee et al., 2014; Weiss et al., 2015) with over 80% power based on prior calculations, others had small samples of between 13 to 45 in each arm (Esala & Taing, 2017; Puvimanasinghe & Price, 2016; Wang et al., 2014). Of these studies with smaller sample sizes, only Wang et al. (2015) commented on power and justified their sample size of 17 participants in each arm based on a prior study's findings for the detection in a shift in the HTQ with a power of 90%. All six studies used waitlist control for the comparator arm. However, waitlist control designs may artificially inflate intervention effect estimates. In contrast with studies using active control (such as placebo) designs, participants assigned to a waitlist control condition appear to improve very little, or not at all (Cunningham, Kypri & McCambridge, 2013).

4.6 Overall methodological quality. The methodological quality of all fifteen studies is shown below using the risk of bias categories.

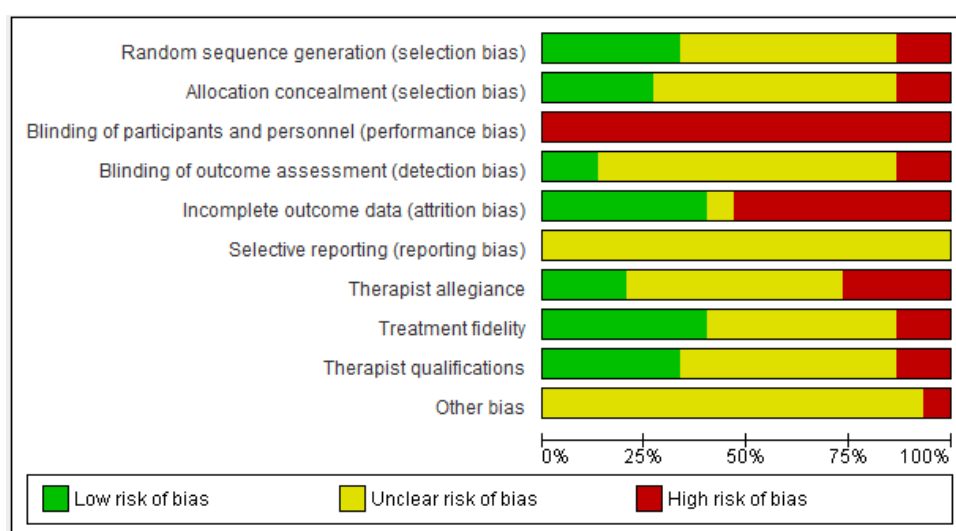


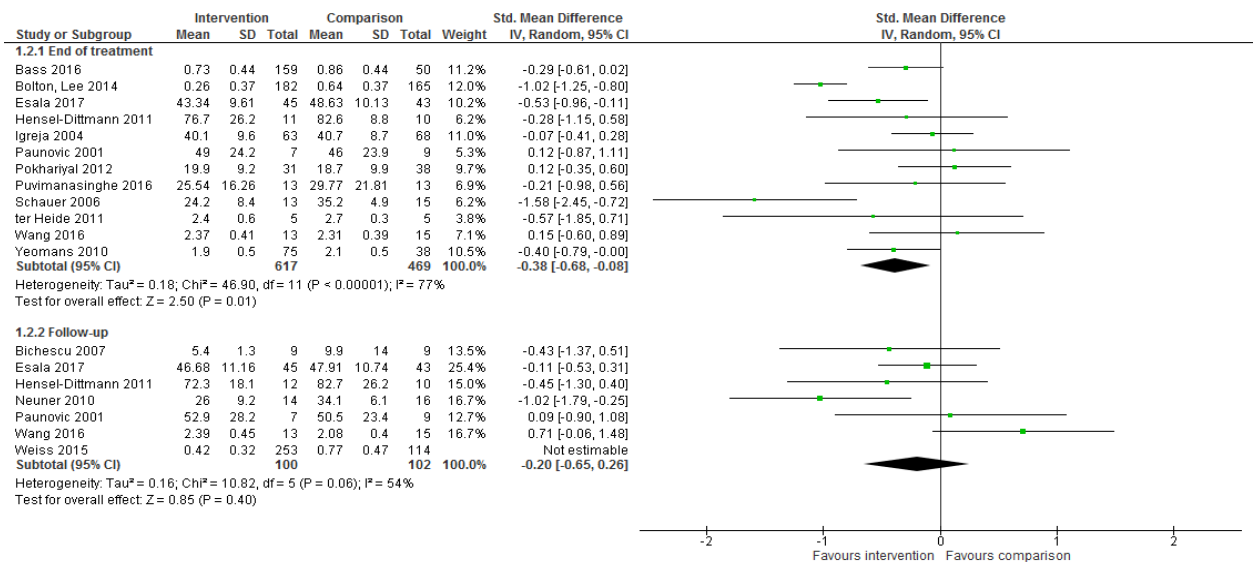
Figure 2: Risk of bias graph (taken from Revman)

5. Effects of interventions

5.1. PTSD symptoms

5.1.1. Intervention versus control at end of treatment. Five trials reported data for PTSD symptoms no more than three months after the end of treatment. These were combined with seven trials included in the previous review, all of which measured PTSD using several different scales but with a similar PTSD formulation (Hensel-Dittmann et al., 2011; Igreja et al., 2004; Paunovic & Öst, 2001; Pokhariyal et al., 2013; Schauer et al., 2006; ter Heide et al., 2011; Yeomans et al., 2010). They were analysed for the effect of psychological intervention on PTSD at end of treatment using standard mean differences (SMDs). In total, 12 studies contributed to this comparison, with 1086 people, see Table 1 below. This table and following tables indicating results are taken from Revman. There is a character limit for the studies in this programme, and so shortened versions of study names are used.

Table 1: Effect of Intervention on PTSD Symptoms at End of Treatment and Follow-up



There was a small to moderate reduction in PTSD symptomatology (SMD -0.38, 95% confidence interval (CI) -0.68 to -0.08, $z = 2.50$, $p = 0.01$). However, heterogeneity

was 77%. Following similar procedures in the previous review (Patel et al., 2014), the removal of Bolton, Lee et al. (2014) study reduced I^2 value to 40%, and reduced SMD to -0.28 (CI -0.50 to -0.06) but statistical significance was essentially unchanged ($z = 2.49$, $p = 0.01$). Bolton, Lee et al. (2014) produced a larger effect of intervention relative to other studies, with a large sample size leading to greater power in detecting changes. However, it was also evident that mean baseline scores for all outcomes were low, creating a higher likelihood of improvement at end of treatment. The confidence in these results is limited overall, as it was unclear whether unwitting unblinding may have contributed to detection bias in all studies but Yeomans et al. (2010).

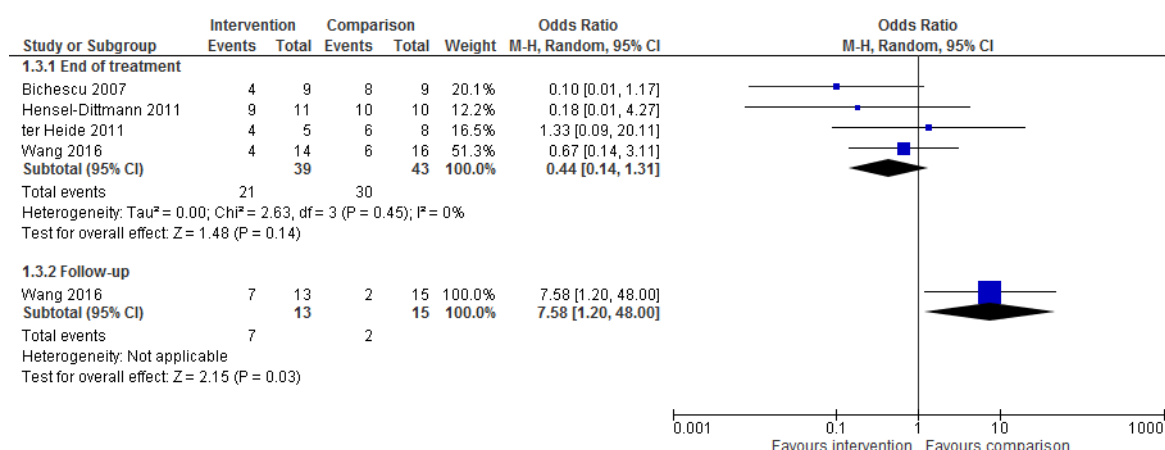
5.1.2. Intervention versus control at follow-up. Three trials reported data for PTSD symptoms more than three months after the end of treatment. All used the HTQ to measure symptoms with the exception of Esala and Taing (2017) who used the PCL-5. These studies were combined with four trials included in the previous review (Bichescu et al., 2007; Hensel-Dittmann et al., 2011; Neuner et al., 2010; Paunovic & Öst, 2001). They were analysed for the effect of psychological intervention on PTSD at follow-up using SMDs. In total, seven studies contributed to this comparison, with 569 people altogether, see Table 1.

There was no difference between the intervention group and the control group (SMD -0.34, 95% CI -0.83 to .014, $z = 1.38$, $p = 0.17$). Heterogeneity was again high at 78%. The removal of Weiss et al. (2015) reduced I^2 value to 54% but made no substantive difference to the outcome (SMD -0.20, CI -0.65 to 0.26, $z = 0.85$, $p = 0.40$). Given the large confidence interval, the precision of estimate was low and all studies but Weiss et al. (2015) appeared to be underpowered.

5.2. PTSD caseness

5.2.1. Intervention versus control at end of intervention. One trial classified participants using caseness as meeting criteria for PTSD no more than three months after the end of intervention (Wang et al., 2016). This was combined with three trials from the previous review (Bichescu et al., 2007; Hensel-Dittmann et al., 2011; ter Heide et al., 2011), making four studies with 82 participants in this comparison, see Table 2.

Table 2. Effect of Intervention on PTSD Caseness at End of Treatment and Follow-up



There was no overall benefit of treatment on PTSD caseness, with an odds ratio (OR) of 0.44 (95% CI 0.14 to 1.31, $z = 1.48$, $p = 0.14$). Low heterogeneity was noted for this comparison ($I^2 = 0\%$), but a number of sources of bias in methodology were observed.

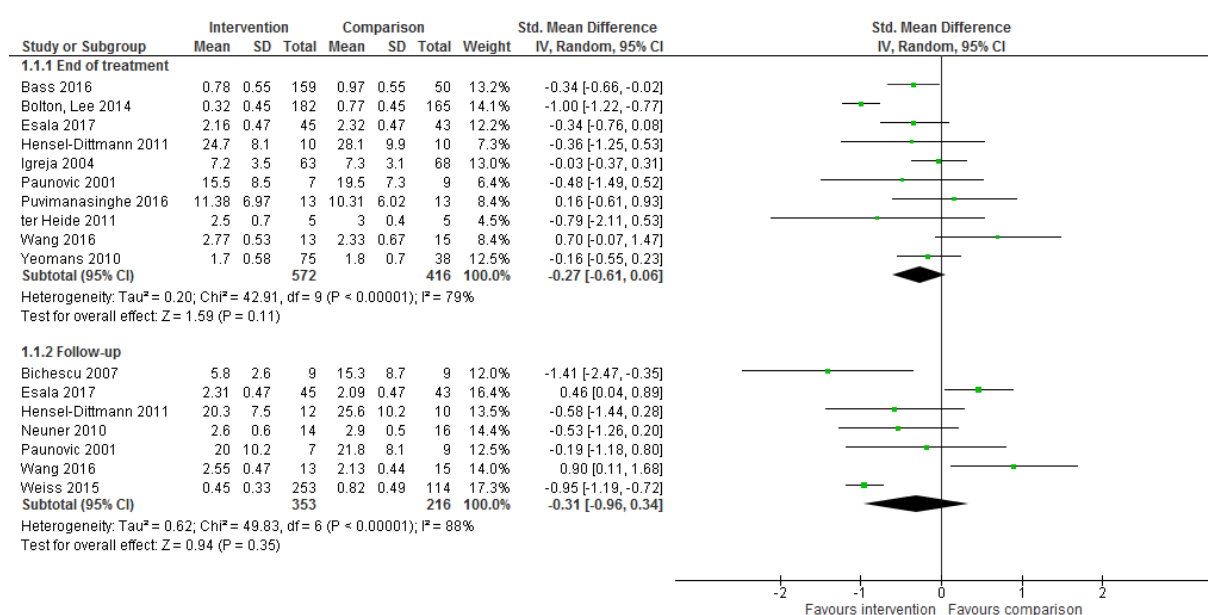
5.2.2. Intervention versus control at follow-up. Only one trial compared PTSD caseness in intervention and control groups at six month follow-up (Wang et al., 2016), with a total of 28 participants. Caseness was significantly higher at six month follow-up in the intervention group than in the control group, with an OR of 7.58 (95% CI 1.2

to 48, $z = 2.15$, $p = 0.03$). While this points to a potential harmful effect of intervention, this study's low precision of estimate and power may reduce confidence in the findings and the accuracy of this conclusion. Wang et al (2016) commented on this finding, but were not able to explain the reasons for the rebound effect of PTSD at follow-up.

5.3. Distress

5.3.1. Intervention versus control at end of treatment. Five trials reported data for distress, measured as depression, no more than three months after the end of treatment. All but one study (Puvimanasinghe & Price, 2016) used the HSCL-25 to measure depression. These studies were combined with five trials included in the previous review, four of which measured depression using two similar scales (Hensel-Dittmann et al. 2011; Paunovic & Öst, 2001; ter Heide et al., 2011 & Yeomans et al., 2010) and by a broader symptom scale in a fifth (Igreja et al., 2004). They were analysed for the effect of psychological intervention on distress using SMDs. In total, 10 studies contributed to this comparison, with 988 people altogether, see Table 3.

Table 3. Effect of Intervention on Distress at End of Treatment and Follow-up



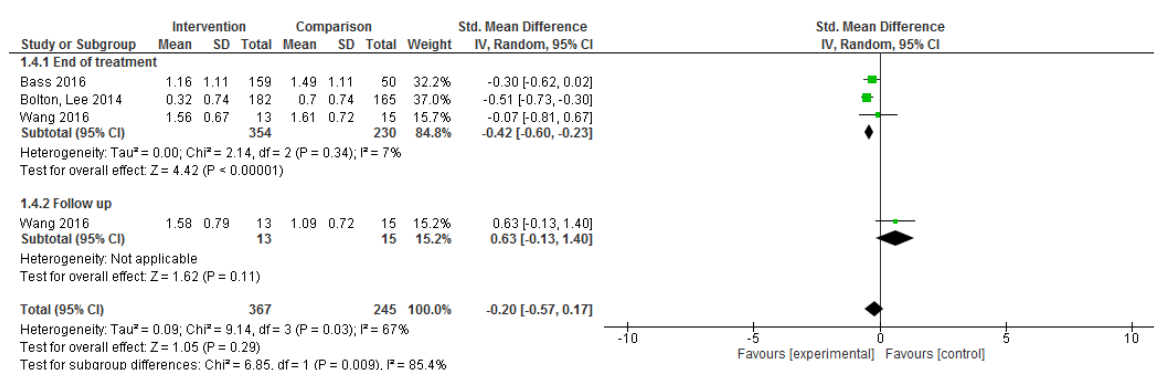
There was no benefit of treatment over control (SMD -0.27, 95% CI -0.61 to 0.06, $z = 1.59$, $p = 0.11$). However, heterogeneity was high ($I^2 = 79\%$). Following similar procedures as above, the removal of Bolton, Lee et al. (2014) study reduced I^2 value to 15%, but results were essentially unchanged, and the precision of estimate was relatively low.

5.3.2. Intervention versus treatment control at follow-up. Three trials reported data for distress, measured as depression using the HSCL-25, more than three months after the end of treatment. These were combined with four trials included in the previous review, all of which measured depression using three scales (Bichescu et al., 2007; Hensel-Dittmann et al., 2011; Neuner 2010 and Paunovic & Öst, 2001). They were analysed for the effect of psychological intervention on distress at follow-up using SMDs. In total, seven studies contributed to this comparison, with 569 people altogether, see Table 3.

There was no benefit of treatment over control for distress at follow-up (SMD -0.31, 95% CI -0.96 to 0.34, $z = 0.94$, $p = 0.35$) and heterogeneity was high ($I^2 = 88\%$).

5.4. Functioning

5.4.1. Intervention versus treatment control at end of treatment. Three trials reported data for functioning no more than three months after the end of treatment. Functioning was measured using a locally developed functioning scale described by Bolton, Bass et al. (2014; Bass et al., 2016 & Bolton, Lee et al., 2014) and one study measured functioning using the WHODAS 2.0 (Wang et al., 2016). No studies in the previous review measured functioning. The three trials included a total of 584 participants, see Table 4.

Table 4: *Effect of Intervention on Functioning at End of Treatment and Follow-up*

There was a moderate benefit of intervention over control for functioning (SMD -0.42, 95% CI -0.60 to -0.23, $z = 4.42$, $p < 0.001$). Heterogeneity was low ($I^2 = 7\%$).

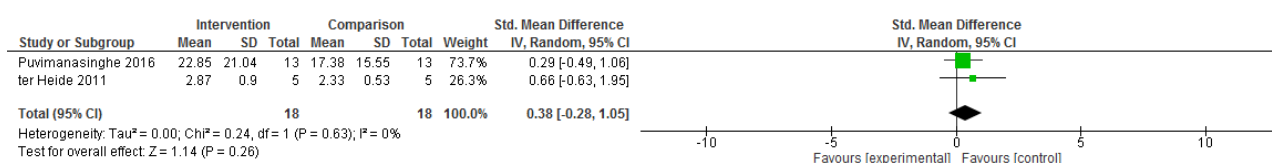
5.4.2. Intervention versus treatment control at follow-up. Wang et al. (2016) was the only study that compared intervention and control in terms of functioning at six month follow-up, and used WHODAS 2.0 with 28 participants, and did not show statistically significant changes for treatment over control (SMD 0.38, 95% CI -0.13 to 1.40, $z = 1.62$, $p = -0.29$) with a low precision of estimate.

5.5. Quality of life

5.5.1. Intervention versus treatment control at end of treatment. Only Puvimanasinghe and Price (2011) measured social quality of life using the P-scale. As described above, ter Heide's (2011) subscale for social quality of life from the WHOQOL was used here for congruence of constructs. The scores in Puvimanasinghe and Price (2011) were reversed for intervention and control given that higher scores on the P-scale corresponded to lower quality of life, contrary to ter Heide's (2011) study. The two studies contained 36 participants, see Table 5.

Table 5: *Effect of Intervention on Quality of Life at End of Treatment and Follow-up*

There was no effect of intervention over control on quality of life (SMD 0.38, 95% CI -0.28 to 1.05, $Z = 1.14$, $P = 0.26$) with a low precision of estimate.



5.5.2. Interventions versus treatment control at follow-up. No study assessed quality of life at follow-up.

5.6 Effects of different types of interventions offered

While not the main purpose of the review, given that there were was a diverse range of interventions, the effects of the different types of interventions were analysed.

There is a rationale to compare the effects of the eleven studies using active ‘trauma processing’ as a specific intervention such as those using NET, testimony therapy, CBT exposure and elements of EMDR (Bichescu et al., 2007; Esala & Taing, 2017; Hensel-Dittmann et al., 2011; Igreja et al., 2004; Neuner et al., 2010; Pokhariyal et al., 2013; Puvimanasinghe & Price 2016; Schauer et al., 2006; ter Heide et al., 2011; Wang et al., 2015 & Yeomans et al., 2010) with the effects of the five studies using non-trauma specific elements including CETA, CBT and supportive counselling (Bass et al., 2016; Bolton, Lee et al., 2014; Paunovic & Öst, 2001 & Weiss et al., 2015).

These were tested for PTSD and distress outcomes at end of treatment and follow-up, given that there was not enough data in the remaining outcomes for a comparison.

5.6.1. Trauma-specific interventions versus non-trauma specific interventions: PTSD outcomes

For the trials with a trauma-specific element, there was a small benefit of intervention over control for PTSD at end of treatment (SMD=-0.30, 95% CI -0.58 to -0.03, Z=2.16, P= 0.03). Heterogeneity was moderate (I² = 50%). This benefit was not maintained at

follow-up (SMD = 0.04, 95% CI -0.54 to 0.62, Z=0.13, P=0.9) and heterogeneity was also moderate ($I^2 = 57\%$).

For the trials with a non-trauma specific element, there was a moderate to large effect of intervention over control for distress at the end of treatment (SMD = -0.65, 95% CI -1.18 to -0.11, Z= 2.37, P=0.02). Heterogeneity was high ($I^2 = 82\%$). Only one non-trauma specific trial contained distress outcome at follow-up, and there was no effect of intervention over control (SMD = 0.09, 95% CI -0.9 to 1.08, Z=0.18, P=0.86).

5.6.2. Trauma-specific interventions versus non-specific interventions: distress outcomes

For trials with a trauma-specific element, there was no effect of intervention over control for distress at end of treatment (SMD=-0.10, 95% CI -0.33 to 0.14, Z=0.81, P=0.42) Heterogeneity was relatively low ($I^2 = 20\%$). There was no effect of intervention over control for distress at follow-up (SMD = 0.30, 95% CI -0.41 to 1.01, Z=0.83, P=0.41), and heterogeneity was high ($I^2 = 70\%$).

For the trials with a non-trauma specific element, there was a moderate to large effect of intervention over control for distress at the end of treatment (SMD = -0.65, 95% CI -1.18 to -0.11, Z= 2.37, P=0.02). This was also maintained at follow-up, and there was no effect of intervention over control (SMD = -0.73, 95% CI -1.41 to -0.04, Z=2.08, P=0.04).

6. SMD relative to clinical change

The SMD method assumes that the differences in standard deviations among studies reflect differences in measurement scales and not real differences in variability among study populations (Higgins & Green, 2011). Wang et al. (2015) was chosen to

calculate differences using the HTQ for PTSD symptom outcome and the HSCL-25 for distress (depression) outcome.

The meta-analysis indicated that there was a small to moderate effect size for intervention over control in reduction of PTSD symptoms. In looking at actual change, the HTQ uses a four-point severity response scale. Respondents endorse how much each symptom has bothered them in the past week: not at all (1), a little bit (2), quite a bit (3), or extremely (4). The HTQ total score is an average score, with 2.5 or above suggested as the clinical cut-off score which indicates that a respondent has a high likelihood of PTSD (see Mollica et al., 1992). The mean pre-treatment HTQ score was 2.49 and mean post-treatment score fell to 2.37. This suggests that, while participants fell slightly below clinical cut-off post-treatment, participants were also exhibiting low mean baseline scores to begin with, and therefore the clinical significance of this change is small.

The meta-analysis showed no benefit of treatment over control with regards to distress post-treatment or follow-up. Wang et al (2015) used the HSCL-25 to measure distress as depression, with 1.75 or above suggested as the clinical cut-off score indicated a high likelihood of depression. The mean pre-treatment HSCL-25 score was 3.02, and mean post-treatment score fell to 2.77, indicating that participants were still in the clinical range for depression at the end of treatment. The mean follow-up score, 2.55, indicated further improvement at six months, but that this still fell within the clinical range for depression.

Discussion

A systematic review and meta-analysis of interventions for torture survivors included 15 studies (six from current review, nine from previous review) and compared intervention arms with mostly inactive control arms.

Summary of main results

The primary objective of this review was to evaluate the effectiveness of interventions for torture survivors, adding to a previous literature review. This review used data from 15 RCTs representing 1373 participants from 10 different countries. There were no trials of social or welfare interventions identified and all 15 represented psychological interventions. Psychological interventions were overall predominantly based on principles based on CBT, NET or testimony therapy.

Meta-analysis demonstrated significant gains from psychological interventions compared to mostly inactive (waiting list) controls in reducing PTSD symptoms at the end of treatment, but this benefit was not maintained at follow-up. This reduction in PTSD symptoms represented a small clinical change, with average scores falling just below the cut-off point for PTSD at the end of treatment. No significant benefits were found for PTSD caseness at end of treatment, and a significant negative effect (i.e. worsening) was seen at follow-up, although this finding was from a single study and was not conclusive. No significant effects were found for reducing distress at end of treatment and follow-up. A significant improvement in functioning was found at end of treatment but not maintained at follow-up, although this was only from one study. No significant effect was found for improving quality of life at end of treatment and no data were available for follow-up.

Given the relatively small number of RCTs on interventions for torture survivors, and given the diverse types of intervention arms, control arms, locations and numbers of sessions, it is difficult to compare the effects of specific interventions, and this was not the main purpose of this review. However, when comparing interventions with trauma-specific elements vs non-trauma specific interventions, meta-analysis only demonstrated significant gains from trauma-specific psychological interventions compared to controls in reducing effects on PTSD outcomes, but this was not maintained at follow-up. However, only non-trauma specific psychological interventions demonstrated significant gains compared to controls in reducing distress, and this was also maintained at follow-up. This, taken together with the fact that the intervention resulting in a significant negative effect on PTSD caseness at follow-up was also a trauma-specific intervention, suggests that the current emphasis on exposure elements in trauma-specific interventions with this population should be questioned. Given the limited sample and study sizes and the heterogeneity both within and between the studies, it is not possible to draw firm conclusions beyond that non-specific therapy such as CBT and supportive counselling appear promising.

Quality of the evidence

The quality of evidence was acceptable. Although the risk of bias was unclear in many cases across the categories, a number of studies within the following categories showed a low risk of bias: selection bias (given that a number of studies used randomisation methods) and attrition bias (given that a number of studies using imputation methods for missing data). In more recent studies, there was a lower risk of bias related to therapist allegiance yet biases related to therapist fidelity and

qualifications have deteriorated despite showing an overall low risk of bias. This is as a result of a number of studies being recently included where CMHWs have been trained to carry out interventions in order to provide a culturally adapted intervention based on the resources available, leading to a reduced likelihood of CMHWs being aligned to a particular model. This may also compromise fidelity and adequate qualifications and experience. Over time, power also improved, with the six new eligible trials showing a mean of number of participants at beginning of treatment of 170, whereas the nine previous trials had a mean of 53 (to the nearest whole number). Detection bias was unclear overall and there was a very high risk of performance bias in all studies, giving that blinding is not deemed possible given the nature of the studies however there was no mention of unwitting unblinding in all studies.

A major challenge in assessing the effect of all interventions is the impact of intervening events or daily stressors before and during outcome measurements. As previously mentioned, daily stressors play a significant role in mediating the distressing effects of trauma and violence (Miller and Rasmussen, 2010, 2017; Fernando, Miller & Berger, 2010). Therapeutic effects can therefore be enhanced or diminished by events that occur prior to follow-up assessment (see Kazdin, 1992). While a number of studies acknowledge this, few directly measure the impact of social stressors, and even fewer aim to address these stressors. For example, Raghavan, Rasmussen, Rosenfeld and Keller (2012) found that torture survivors granted asylum during multidisciplinary treatment experienced a significantly greater reduction in PTSD symptoms than those who were not, and legal status was the most significant correlate of improvement in PTSD symptoms.

Limitations of review

The search could have been widened through the use of grey literature. However, the decision not to search the grey literature was guided by the previous review, in which around 1500 chapters, reports and other articles were searched yet yielded no eligible studies. Therefore it is possible, if unlikely, that eligible studies were missed given that RCTs are normally published in the peer-reviewed scientific literature. The assessment of risk of bias was done by one of the review authors (AH). A direct comparison of the risk of bias categories were made between the previous review findings and this review's findings, although the risk of bias being categorised by different review authors may have introduced rating bias. To minimise this, an author of both this review and the previous review (AW) did a final check of the categories and confirmed any potential uncertainties in ratings. It is recognised that ideally all risk of bias ratings and data extraction are done independently by two raters and then compared (Higgins and Green, 2011). However due to the scope and timeframe of the project, this was not feasible .

A trend within more recent studies is an emphasis on cultural adaptation and validation of measures and interventions. Using unadapted standardised assessment tools developed in one culture risks misinterpreting distress and functioning in another culture. Adaptation and validation is an important movement towards appropriate evaluation necessary to test the effects of healthcare provision. It should be noted that meta-analysis reduces each result in such studies to a variation of an effect size and variance attributed to cultural differences is subsumed under error variance. Consequently, the investigation of functioning and quality of life as valid predictors of success of treatment from the receivers' perspective is key.

Although all the studies selected in this review were RCTs of interventions for torture survivors, there was a high level of variability in many features of the studies: clinical heterogeneity in that the participants, interventions and outcomes studied differed; and methodological heterogeneity in that the trials had varied design and risks of bias. This led to generally high levels of between-study heterogeneity (represented by I^2) that makes it difficult to be certain that small statistically significant differences were true intervention effects. Caution should therefore be exercised when interpreting results.

Agreements and disagreements with the literature

A significant effect was seen for psychological intervention versus comparator only for PTSD and functioning symptoms at the end of treatment, whereas in the previous literature review (Patel et al., 2014), an effect was seen for PTSD only at follow-up. The confidence in studies in the previous review at follow-up was low, while the methodological rigour of this set of studies was somewhat higher providing greater confidence in the results. No significant effects were found for distress in this review, whereas the Patel et al. (2014) found an effect for distress at follow-up, although the studies were deemed as low quality.

When assessing RCTs for adult survivors of war, Morina et al. (2016) also found a small to medium effect size of active treatment on PTSD symptoms at posttreatment when compared to control conditions. Morina et al (2016) however found significant and larger effect sizes for PTSD symptoms at follow-up, as well as for depression at both pre-post and follow-up; which was not seen in this review. It is important to note, however, that findings cannot be comprehensively compared given that Morina

et al (2016) studied adult survivors of mass violence more generally, not exclusively torture survivors.

Clinical implications

The provision of integrated collaborative care is key given the contribution of social stressors. Torture survivors often have complex needs and social conditions. Meta-analyses within refugee populations have found that collaborative care is effective in reducing anxiety and depression and improves treatment satisfaction (see Esala, Vukovich, Hanbury, Kashyap, & Joscelyne, 2018). In settings where mental health services are well-resourced, individual or group therapy and medication should be provided within a multidisciplinary team and complemented with case management, helping clients to address any material, social and legal aspects of their daily lives, ensuring a holistic service. In settings where there is a scarcity of resources, communities should consider the development of 'task-shifting' methods, such as those seen in a number of recently included studies in the review, where trained (para)professionals within the community implement interventions. Regardless of setting, initiatives to connect survivors with each other in a safe and empathic settings would foster community support and enable mutual learning (see Goodkind, 2006; Goodkind et al., 2013).

Research implications

Research amongst torture survivors and those who are forcibly displaced as a result would benefit from a social ecological lens (Bronfenbrenner, 1977; Salo & Bray, 2016), where distress stems not only from the violent and traumatic experiences endured, but also the stressful daily social and material conditions following these experiences, or following their displacement (see Miller & Rassmussen, 2017). Risk

factors can be seen at multiple levels (individual, family, community, society) and therefore intervention can be placed at multiple levels. Using this theoretical framework allows for more comprehensive research reflecting the reality of survivors' experiences.

Measuring the quality of life and functioning in future studies is crucial. Given the long-standing debate concerning validity of measures pertaining to psychiatric constructs such as PTSD and depression, and the difficulty of incorporating cultural adaptation when using meta-analytic means, it is very useful and important to include more universal, participant-informed measures based on quality of life and functioning as indicators of the effectiveness of treatment. These measures should also take into consideration the fact that respondents may not have their basic safety and security needs met, such as food and a stable living situations, and therefore questions should incorporate this. Outcome measures be decided through collaborative discussion with participants to ascertain their priorities and definition of what it means to function or to have a higher quality of life, using a participatory action research approach (Lewin, 1946). Qualitative methods may be helpful in understanding specific definitions of wellbeing and quality of life within each community.

Future research

Although it should be interpreted with caution, the finding of potentially harmful long-term effect in Wang et al.'s (2015) study should alert researchers to the importance of studying long-term outcomes. The potentially harmful effects of re-traumatisation through therapy should be taken into consideration, particularly if participants' context is not. A minimum of 12 sessions are recommended for

individuals with PTSD and depression (NICE, 2005; 2010). However these guidelines do not draw directly on studies relevant to torture survivors, suggesting that more sessions should be offered given the likelihood of torture survivors' experience of repeated trauma leading to chronic and complex problems.

The new paradigm of 'task-shifting' as seen in the included studies is a sustainable method for the provision of mental health care for torture survivors in low-resource settings, and enables the reduction of language and cultural barriers. However, efficacy trials of task-shifting are often highly resourced and funded and therefore lack ecological validity. The study of such task shifting models under the natural conditions in which many local health centres and NGOs operate would be a helpful step.

More importantly, to the author's knowledge, the continued lack of any identified RCTs on social or welfare interventions for torture survivors is an important gap for research in this area to address, especially given that national guidelines for trauma-informed interventions (NICE, 2005) emphasise stability prior to treatment; and that guidelines on mental health in emergency settings emphasise the meeting of basic security and financial needs, and drawing on community and family support where possible, prior to assessing the provision of specialised psychological interventions (IASC, 2007).

Conclusions

A systematic review and meta-analysis of RCTs of interventions for torture survivors found six recent eligible studies since the Patel et al. (2014) review. All six studies were of psychological interventions. Small improvements for intervention over control were found for PTSD symptoms and functioning, but not at follow-up, nor was

any improvement evident for distress immediately after treatment or at follow-up, or for quality of life at the end of treatment. While the methodological rigour and cultural sensitivity of studies since Patel et al.'s (2014) review has improved overall, the confidence in these results and the precision of estimate is still less than satisfactory. More studies are required on social and welfare interventions, and future research should investigate longer term psychological interventions while taking the effect of daily social stressors into consideration.

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Part 2: Empirical Paper

Mental Health Care for Syrian Refugees: Shared Realities in the Context of Conflict and Forced Displacement

Abstract

Background. The ongoing Syrian conflict has led to increasing mental health needs, and the training of Syrian community mental health workers in mental health care provision is poorly understood.

Aims. Part A aimed to investigate Syrian mental health professionals' professional quality of life. Part B sought to examine characteristics that Syrian mental health professionals shared with their clients, the formers' use of self-disclosure and the personal impact of therapy on them.

Method. Part A used cross-sectional questionnaires with 61 participants and Part B employed semi-structured interviews with 16 participants using thematic analysis.

Results. Syrian mental health professionals showed higher levels of secondary traumatic stress relative other samples. Qualitative interviews showed that all participants experienced their shared realities as a helpful tool, and a smaller proportion of participants described it as a vulnerability. All participants described their work with Syrian clients as fulfilling while most described it as distressing, with some referring to personal therapy, most referring to supervision or peer support, and all referring to self-care as means to cope.

Conclusions. While Syrian mental health professionals experience elevated levels of secondary traumatic stress, a shared reality is also an asset. Emphasis should be placed on the availability of personal therapy and ongoing supervision, as well as Syrian-defined self-care training sessions.

Introduction

Background

Syria in conflict. For the first time since World War II, in 2013 more than 50 million were forcibly displaced from their homes, with millions more displaced since (Amnesty International, 2015). Half of the Syrian Arab Republic (from now on referred to as Syria for ease of reading) population has been displaced, and the international community's failure to resolve the conflict has led to an ongoing public health crisis.

At least 5.2 million Syrians are displaced to neighbouring countries and 6.1 million internally displaced. Over 13.1 million remain in need of humanitarian assistance (United Nations Office for the Coordination of Humanitarian Affairs, 2018). Turkey is the largest host of Syrian refugees worldwide and hosts over 3.5 million Syrian refugees (accurate as of June 2018; United Nations High Commissioner for Refugees [UNHCR], 2018) with around 1 million of those living along the South Turkish-Syrian borders.

Syrian mental health. Since 2011, Syrians experience problems with forcible displacement, conflict-related violence and loss and the adaptation to new settings, along with exacerbation of pre-existing mental health problems (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo & Kirmayer, 2016).

Prevalence of post-traumatic stress disorder (PTSD) amongst Syrians has been shown to be as high as 83.4% (Acarturk, Cetinkaya, Senay, Gulen, Aker, & Hinton, 2018) or 89% (Vukcevic, Dobric & Puri, 2014), whereas studies estimate rates of 30% (Chung, Shakra, AlQarni, AlMazrouei, Al Mazrouei, & Al Hashimi, 2018). This large inter-survey variability is a common occurrence within prevalence research on psychological disorder in humanitarian contexts. A global systematic review of 181

such surveys found prevalence rates of PTSD ranging from 0 to 99% (Steel, Chey, Silove, Marnane, Bryant & Van Ommeren, 2009). These studies are often carried out using tools that have not been validated for use in the local context, culture and languages and therefore lack scientific and conceptual validity (see Wells, Wells & Laws, 2015). Prevalence studies on Syrian refugees' mental health are often carried out in environments such as camps or asylum centres, and so these samples do not accurately represent the context of the majority of forcibly displaced Syrians. In addition, the daily stressors such as those related to basic needs, housing and finances have been shown to mediate the relationship between war exposure and experience of mental health problems, therefore further conflating symptoms (Miller & Rasmussen, 2010).

Literature on mental health interventions for Syrians affected by the conflict is relatively scarce. The majority of published studies relate to individual trauma-focussed work using eye movement desensitisation and reprocessing (EMDR) and tele-interventions (Acarturk et al., 2015; 2016; Jefee-Bahloul, Moustafa, Shebl, & Barkil-Oteo, 2014). EMDR is recommended by the UN and WHO as an evidence based therapy for use in trauma-related distress (World Health Organisation [WHO] & UNHCR, 2015).

Training community workers. Within ongoing and post-conflict settings across the globe, a Western model of diagnosis pertaining to individualised therapy may be culturally and resource inappropriate. This is not to say that Western evidence based therapies do not have their place; but their monopoly may be harmful in that they undervalue community-based coping incorporating cultural and spiritual contexts. Health pluralism is arguably a more helpful alternative perspective. This involves a

varied range of multi-layered explanatory health beliefs with a concomitant wide range of help-seeking behaviours and a diverse range of helpers and resources (see Tribe, 2007). Widely endorsed global mental health programmes such as WHO's mental health GAP action programme humanitarian intervention guide (mhGAP HIG; WHO & UNHCR, 2015) and international guidelines on working with humanitarian disasters (IASC, 2007) emphasise the importance of working with communities and influential community figures including religious healers, at multiple levels of support, from ensuring basic safety and security to specialised psychological support. Where specialised support, such as trauma-focused interventions, are required, recommendations involve the training of local community workers in evidence based trauma therapies such as EMDR and trauma-focussed cognitive behavioural therapy (WHO & UNHCR, 2013, 2015).

The historical shortage of mental health provision before and after the Syrian conflict has prompted initiatives by expatriate Syrian MHPs and various Syrian non-governmental organisations (NGOs) in neighbouring countries to deliver training sessions and supervision on interventions, such as Teaching Recovery Techniques (Smith, Dyregrov & Yule, 2002; see Almoshmosh, Mobayed & Aljendi, 2016 for more examples). International NGOs have also provided training and supervision for evidence-based therapies to displaced Syrian MHPs. One such example is Trauma Aid UK, which has provided qualifying EMDR training workshops and ongoing (online) supervision to displaced Syrian MHPs in Turkey and Jordan.

Impact on community workers. While this model of training mobilises resources, reduces language barriers and enhances cultural sensitivity, it may also come with its challenges. Given the increased need relative to available resources,

many community workers would likely be working in environments with high caseloads and reduced availability of supervision, leading to potential negative emotional consequences.

There is an emerging interest in the wellbeing of humanitarian workers in conflict settings as a result of recent conflicts and disasters, with an emphasis on the ethical duty to protect workers from emotional harm. A study of 44 international medical aid workers found that overworking, overwhelming emotional exposure combined with lack of self-care and poor personnel management led to burnout, which the majority of participants reported experiencing (Asgary & Lawrence, 2014). While research has focused on international humanitarian workers, less attention has been paid to workers from the same context as the people they help. The term 'shared traumatic reality' refers to situations where both professional and client have been exposed to the same communal disaster, and 'double exposure' refers to health professionals' exposure both as professionals providing a service and as members of the community (Baum, 2010; Nuttman-Shwartz, & Dekel, 2008).

This direct exposure may increase health professionals' vulnerability of experiencing PTSD. For example, of 424 nurses and doctors working in hospitals in the Gaza strip during Israeli offences, 89.8% participants scored higher than the threshold for PTSD (Abu-El-Noor, et al., 2016), with female healthcare providers shown to be at greater risk. Literature has also been published with reference to 'secondary traumatic stress' (Figley, 1995) referring to MHPs' experience of similar PTSD symptoms of the clients they see; and 'vicarious traumatising' referring to the personal transformations experienced by MHPs resulting from a cumulative and empathic

engagement with clients' traumatic experiences (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

Most of these studies are based on quantitative enquiry and should be interpreted with caution, based on the aforementioned issues of conducting such research within disaster and conflict settings. Cohen and Collens (2013) conducted a meta-synthesis of twenty studies, the majority conducted in North America and Israel, on the impact of trauma work on trauma workers. They found themes related to emotional and somatic reactions to trauma work such as sadness, helplessness, nausea and despair; changes to schemas and behaviours such as questioning themselves and their lives and perceiving the world as unsafe.

In parallel with much of PTSD literature surrounding the impact of war and conflict, particularly on refugees and asylum seekers, research investigating the quality of life of MHPs working in the context of trauma tends to pathologise and overshadow paradigms of growth and resilience. More recent counter-narratives have emphasised growth. Post-traumatic growth, defined as a significant positive psychological change following a major life crisis or trauma was coined by Tedeschi & Calhoun (1995), and the concept of vicarious post-traumatic growth arose from this, describing the positive sequelae experienced by therapists carrying out trauma-related work (Arnold, Calhoun, Tedeschi, & Cann, 2005).

Similarly, literature concerning the shared reality of MHP and client has typically focussed on the negative consequences. This is reflected in the terms such as shared traumatic reality (Nuttman-Shwartz & Dekel, 2008), shared tragedy (Eidelson, D'Alessio, & Eidelson, 2003), shared trauma (Saakvitne, 2002) and shared traumatic stress (Tosone, Nuttman-Shwartz & Stephens, 2012). More recently researchers are

acknowledging the potential for shared resilience in a traumatic reality (for a review see Nuttman-Schwartz, 2015).

To investigate the quality of life of professionals working in the context of mental health and conflict, one must take a broader perspective accepting a dynamic interaction between both positive and negative aspects at the individual, organisational and societal levels (Larsen & Stamm, 2008). The Professional Quality of Life scale (ProQOL) is a 30-item measure developed in the United States of America, that captures both the negative aspects including secondary traumatic stress and burnout as well as the positive aspects, encompassed by the concept of 'compassion satisfaction'. Burnout has been described as a "syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with people in some capacity" (p4; Maslach, Jackson & Leiter, 1996). Compassion satisfaction encapsulates the positive feelings experienced by workers from helping others through traumatic situations including satisfaction (Stamm, 2010). The ProQOL is one of the most frequently used and best validated instruments assessing professionals' quality of life. The complexity of multiple definitions and labels reflect the complexity of the terms themselves and will not be reviewed here in detail, but Elwood, Mott, Lohr and Galovski (2010) provide a good review of terminology.

Risk and protective factors for professional quality of life. As with any psychological phenomena, there are protective and risk factors for negative and positive aspects of professional quality of life. At the individual level, risk factors include therapist trauma history (Ghahramanlou & Brodbeck, 2000; Pearlman & Maclan, 1995) and both the low and high ends of the distribution of years of work

experience leading to higher risk for negative impact on professional quality of life (Ghahramanlou & Brodbeck, 2000; Moulden & Firestone, 2007). Risk factors at the organisational level include high caseload demand, non-supportive work environment, limited access to supervision, and poor work environment safety (Adams, Matto & Harrington, 2001; Meldrum, King & Spooner, 2002).

Protective factors at the individual level involve high work satisfaction (Ghahramanlou & Brodbeck, 2000; Stamm, 2002) and self-care, including engaging in a personally balanced lifestyle and physical self-care (Figley, 2002). Religious values and spirituality have also been found to be significantly associated with compassion satisfaction (Newmeyer et al., 2016). Protective factors at the organisational level include peer support, good quality supervision, specific trauma-focussed training (Cunningham, 1999; Pearlman, 1999; Pearlman & Maclan, 1995) and balanced caseload in the ratio of trauma cases to non-trauma (Cunningham, 1999; Ghahramanlou & Brodbeck, 2000; Pearlman & Maclan, 1995).

Most of this research has been developed and based on Western health professionals. The ProQOL, however, has been used and validated in at least 24 languages. To the researcher's knowledge, no published literature exists on the use of an Arabic version of the ProQOL. In addition, there have been no in-depth qualitative investigations on the professional quality of life and experiences of Syrian MHPs providing mental health care to fellow Syrians within the displaced community.

Syrian MHP-client dyad. Very little literature exists on Syrian MHPs warranting an in-depth exploration to further understand their context and experience. While there are intra- and inter-variations within Arab cultures, the influence of Syrian culture contributes to differential conceptualisations, processes and experiences of

both the MHP and client. Hassan et al. (2015) provides an overview of Syrian cultural frameworks and idioms. For example, in most Arab cultures, common same-sex greetings (including with strangers) consist of hugging and cheek-kissing, asking about family and offering food or drink. These reflect the importance of the deep-rooted values of family and hospitality in Arab cultures (Harb, 2016).

Given these Syrian-Arab cultural frameworks and the shared ongoing trauma reality of Syrian MHPs and clients, it is unclear what this reality looks like and how it differs (or not) from a context of Western mental health care. For example, there are clear rules around therapist-client behaviour that preclude kissing and hugging in Western cultures, and it is unclear how this is conceptualised within the Syrian mental health context. It is also unclear how or whether MHPs' self-disclosure, in any capacity, features within these therapeutic dyads. Therapist self-disclosure has been defined as a verbal act "therapist statements that reveal something about the therapist" (p255; Hill & Knox, 2001) in some research, while Constantine and Kwan (2003; p582) describe self-disclosure as "[behaviours], either verbal or nonverbal, that reveal personal information about therapists themselves to their clients". In Western therapies, self-disclosure is often used cautiously and governed by a number of rules regarding professionalism, an important value in Western therapy. A literature review of MHP self-disclosure found that it occurs infrequently, is more common in humanistic-experiential therapists than psychoanalytic therapists and more often relates to MHPs' professional background rather than personal details (Hill & Knox, 2001).

One may expect that a shared reality in the context of Syrian culture may increase likelihood of MHP self-disclosure and in therapy, as disasters often create

boundary ambiguity between the personal and professional. Baum (2016) proposes a conceptualisation of a shared traumatic reality in communal disasters and posits that blurred boundaries in the professional realm occur due to MHPs often acting both as a professional and as an individual member of the disaster-stricken community. This also occurs due to the penetration of demands from neighbours, friends and acquaintances. One may expect this to occur with Syrian MHPs given that the displaced Syrian community in Turkey are living within a small city, and that there are very few MHPs relative to residents. Baum (2016) argues that this may lead to burnout in MHPs. Baum (2016) propose that blurred boundaries also occur in the therapeutic dyad, such that clients' references to the disaster lead to strong countertransference arousal responses. This may also affect what Baum terms the "real relationship" beyond the professional, and drew on literature in the US after September 11 where many therapists phoned clients they believed may be directly involved in the crisis, hugged and were hugged by clients, expressed their own feelings about the attacks and shared information about the fate of their own family members and friends (Frawley-O'Dea, 2003).

A qualitative study of trainee social workers sharing the traumatic reality of the 9/11 disaster with their clients found that the feeling of universality led to their increased self-disclosure to clients (Tosone et al., 2003). Zerubavel and Wright (2012) wrote about the concept of the 'wounded healer'; the notion that "a healer's own wounds can carry curative power for clients". Appropriate self-disclosure allows the wounded healer's resourcefulness to instil hope in clients of healing and recovery (Kirmayer, 2003; Miller & Baldwin, 2000). At the same time, blurred boundaries

through increased self-disclosure within a shared reality can increase MHPs' vulnerability for distress (see Saakvitne, 2002; Tosone et al., 2012).

Many Syrian MHPs are themselves forcibly displaced, have witnessed and experienced traumatic events and, given the long-standing and ongoing nature of the conflict, have an ongoing sense of hopelessness and loss. The Syrian MHP-client dyad creates a shared reality that, to the researcher's knowledge, has not been explored in the literature. An exploration of this context is warranted, along with what allows Syrian MHPs to continue to function in their capacity as healers, and what coping consists of within a displaced Syrian context.

Dutton and Rubinstein (1995) presented a theoretical model for explaining secondary stress reactions among trauma workers. They hypothesise that both personal and environmental factors mediate trauma workers' reactions to indirect exposure to traumatic events through their clients. Syrian MHPs are likely to hold many of the mediating factors leading to higher levels of secondary traumatic stress. These include prior trauma, lack of adequate training, ongoing stressors in the MHP's life and counter-transference reactions, including identification with the client. Consequently one may expect higher levels of secondary traumatic stress within this context, adding to the importance of investigating this population of Syrian MHPs working with Syrian clients with trauma-related distress.

Conceptualising, assessing and treating mental health problems within low resource (post-)conflict settings brings a number of ethical dilemmas to the forefront. One stance derives from an etic approach, where research is conducted from the perspective across various cultures to learn about the universality of behaviours or symptoms. For example in this context this would be an assumption that because

symptoms such as flashbacks and nightmares are commonly seen in those who experience trauma-related distress across the globe, these symptoms are universal. In practice, this would take the form of the application of Western developed and evaluated evidence based therapies such as EMDR and TF-CBT, without particular emphasis on adapting to the cultural context. Another stance derives from the emic approach in which the focus is on one single culture and context and involves looking at behaviours or symptoms from the perspective of that particular group, without necessarily drawing on the available evidence base. Both extremes of this spectrum can bring potential harm. Extreme etic approaches may bring the notion of 'philanthrocapitalism' (Economist, 2006), placing revenue as a priority over the healing of communities, or 'medical imperialism' (Summerfield, 2013), taking Western knowledge as definitive. Extreme emic approaches may enable methods that are not effective or even harmful to become widespread, with no regulation of who is doing what, and no means to evaluate this. Both extremes have a platform in the global mental health field, not necessarily as a result of the evidence base aimed at better understanding and healing communities, but often as a result of geopolitical agendas and personal biases, rivalries between NGOs, competition for scarce resources and attempts to monopolise the field to create a strong presence of an intervention with the aim of generating attention and revenue.

This research steps outside of any extreme frames or approaches and aligns itself with a pragmatic middle ground, with emphasis on evaluation using culturally appropriate methods. Consequently, this research aims to generate knowledge carved directly from Syrian MHPs who have been trained in a Western-developed therapy through communicating with them in their own native Arabic language to understand

how their training is translated within a Syrian culture and displacement context, while acknowledging and seeking better understanding of the potential harmful impact given their own background and setting.

Aim

The aims of this study were two-fold and are reflected in the fact that this study was conducted in two parts:

Part A:

- a) to establish the levels of secondary traumatic stress, burnout and compassion satisfaction among Syrian mental health professionals using a widely used measure, the ProQOL, and to compare these levels across other samples
- b) to translate the ProQOL into Arabic and investigate its psychometric properties

Part B:

- a) to investigate the impact of the shared culture and experiences of forcibly displaced Syrian MHPs and their Syrian clients
- b) to investigate the incidence and impact of MHPs' disclosure of shared experiences
- c) to investigate the impact of providing therapy on Syrian MHPs

This research used a mixed methods design, with questionnaires used in Part A and an interview with additional questionnaire used in Part B.

Setting

The research took place across two cities in Turkey, Istanbul and Gaziantep, a city in the south of Turkey, 75km from the Syrian border. Turkey is home to the largest

number of Syrian refugees, and the majority live along the southern border, with around half a million Syrians living in Gaziantep (accurate at the beginning of 2018). This project was run in collaboration with Trauma Aid UK who have links with a large number of Syrian MHPs in Turkey as a result of EMDR training workshops Trauma Aid provided there.

This research was approved by UCL Research Ethics Committee (REC) - 0163/001 (see Appendix 11).

Researcher's perspective

The researcher has a similar experience and background to this study's participants in some ways, in that she is also Arab, Muslim with personal experience of war and displacement. She is also trained in mental health provision and works with refugees and asylum seekers with trauma-related distress. The researcher is also different to participants in that she is British, Iraqi, bilingual, living in the UK and has had a predominantly indirect experience of war. The researcher is also linked to Trauma Aid UK through both professional and personal ties with its consultants.

The researcher acknowledged her stance of being born in Iraq and living in the UK since the age of six at the beginning of every interview for transparency. The researcher also highlighted that her Baghdadi Iraqi dialect, which differs quite significantly from Syrian dialects, may lead to misunderstandings. She encouraged participants to explain if they thought she had misunderstood them and she encouraged them to ask her if questions did not make sense. She also emphasised that participants' (non-)involvement in the research had no bearing on their involvement with Trauma Aid UK and that all information was confidential and would be anonymised in all reports on the study.

The researcher's epistemology is aligned with pragmatism through a community psychology lens. Pragmatism has the potential to embrace both qualitative and quantitative methods of enquiry; not to seek an objective truth but a richer experience through multiple means and their combination (Yardley & Bishop, 2008). This influenced the choice of using a mixed methods approach. Pragmatism as an approach differs to critical realism in that it focuses on intersubjectivity, places emphasis on identifying practical solutions to answering research questions and emphasises shared meaning making rather than context (see Morgan 2007; Shannon-Baker, 2016). The researcher was also influenced by Barker and Pistrang's (2005) paper on methodological pluralism stemming from community psychology approaches. The ethos of this research fits with not only the criteria of using mixed methods approaches but also endeavoured to meet a number of criteria outlined in the paper including: sensitivity to people's contexts, respect for diversity, addressing competencies (as well as problems), promoting empowerment and social justice and giving voice to traditionally underrepresented populations.

Part A Method

Design and participants

Part A used a cross-sectional design with a questionnaire. Participants were recruited at an annual Syrian mental health conference held in Gaziantep over the course of two days. Eligible participants were Syrian mental health professionals who often work with Syrian clients.

Recruitment

Participants were invited to complete a questionnaire via two announcements during the aforementioned conference. One announcement was given by the

president of the association hosting the conference, and another by a Trauma Aid UK consultant during one of his workshops. The announcements were brief, introducing me, outlining the topic of the study and stating that a prize draw is involved.

Power analysis undertaken using “G-Power” (Faul, Erdfelder, Lang & Buchner, 2007) software indicated that in order for a medium effect size of $r = 0.3$ to be detected, as indicated in previous studies using ProQOL (see Turgoose, Glover, Barker & Maddox), a sample of 64 participants would be required, assuming an alpha of 0.05 (two-tailed) and power of 0.80.

Data collection

Multiple ‘packs’ containing an information sheet, consent forms and questionnaires (see Appendices 12, 13 and 14 respectively) were placed on all tables at the annual conference. The questionnaires did not request any identifying information. Contact forms were placed on the table for participants to complete, separate to the questionnaires to ensure anonymity. Participants were alerted to a box in the main hall of the conference where they were able to anonymously drop their completed questionnaires and contact forms. The questionnaire was also available online via a web-based questionnaire tool, Qualtrics. An electronic link to the questionnaire was circulated to members of the conference via a mailing list. This was also kept anonymous by ensuring that a new survey link requesting participants’ contact details appeared at the end of the questionnaire. In this way, participants were able to provide their contact details separately from the anonymous questionnaire.

Measures

The questionnaire used in this study included a set of demographic questions developed for the purpose of this study. The demographic questions asked about

MHPs' profession, nationality, years of experience, supervision amount and subjective satisfaction, displacement situation and identification with their culture and religion.

This questionnaire also included the ProQOL-5 scale (Stamm, 2009; Appendix 15), a 30-item self-report scale with questions related to three subscales; compassion satisfaction (e.g. "I have happy thoughts and feelings about those I help and how I could help them"), secondary traumatic stress (e.g. "I avoid certain activities or situations because they remind me of the frightening experiences of the people I help") and burnout (e.g. "I feel worn out because of my work as a helper"). Convergent and discriminant validity tests have shown that each of these three subscales measure different constructs (Stamm, 2010). Reliability ranges from .84 to .90 on the three subscales, and interscale correlations of $N = 1187$ show 5% shared variance ($r = -.23$) with secondary traumatic stress and 2% shared variance ($r = -.14$) with burnout. While there was 34% shared variance between burnout and secondary traumatic stress ($r = .58$), the two scales measure different constructs with the shared variance likely reflecting the distress that is common to both conditions.

The scale comprises 30 brief statements rated on a five point intensity scale, anchored by 1: Never, 2: Rarely, 3: Sometimes, 4: Often and 5: Very Often. The maximum within each subscale is 50, with high scores indicating high levels of STS, burnout or CS. Scoring instructions are provided in a comprehensive manual (Stamm, 2010).

The ProQOL was translated in to Arabic (see section below), and this version was used throughout, given that Arabic was the first language of all participants.

Translation

All questionnaire material was initially developed in English and was translated

into Arabic. Arabic versions of the information sheet, consent form and questionnaire (see Appendices 16, 17 and 18 respectively) were utilised throughout the study for all participants. The initial part of the questionnaire consisted of questions developed by the research team. This was forward translated by a bilingual Syrian Arabic speaker, and back translated by another bilingual Arabic speaker. The back-translated version was compared to the original and there two contested words were resolved following discussion. The process followed guidelines provided by the WHO on the process of translation of instruments (WHO, 2018.).

A secondary aim was to validate the ProQOL in Arabic. A stringent seven-step method of translation and validation of instrument scales as suggested by Sousa and Rojjansrirat (2010) was used to translate the ProQOL. All but one non-essential step was followed involving three bilingual (Arabic-English speaking) consultants with a range of professional backgrounds and an additional two monolingual (Syrian Arabic) consultants with a psychology background. The ProQOL was forward translated from English to Arabic by two independent bilingual consultants and any issues were resolved. This was then back-translated (Arabic to English) by two independent bilingual consultants and further discrepancies were resolved. A pre-final version was then piloted by two monolingual Arabic speakers, leading to a final version.

Planned analyses.

This study planned to explore the translated ProQOL's psychometric properties by investigating the correlation among the three subscales and the reliability of each subscale (Cronbach's alpha). Mean scores for subscales were also planned so that they could be compared with existing literature on ProQOL scores of MHPs.

On the basis of the existing literature outlined in the Introduction section, it

was predicted that years of experience (both the low and high ends of the distribution), high caseloads, being female and limited supervision would lead to higher scores on secondary traumatic stress and burnout, and that placing high importance on religion in everyday life would lead to higher scores on compassion satisfaction. Consequently, the following tests were planned:

- t-tests with gender as an independent variable (IV) and compassion satisfaction, burnout and secondary traumatic stress as dependent variables (DVs).
- analysis of variance (ANOVA) tests, with supervision amount, profession, importance of religion as IVs in turn with compassion satisfaction, burnout and secondary traumatic stress as DVs
- correlations to ascertain whether there is a significant relationship between number of cases per week or years of experience as IVs with compassion satisfaction, burnout and secondary traumatic stress as DVs.
- regression analyses with any IVs showing a significant relationships indicated by correlations using the same DVs of compassion satisfaction, burnout and secondary traumatic stress.

Data were analysed using SPSS V.22.0.

Part A Results

Demographics

Questionnaires were completed by 61 Syrian mental health professionals (32 females, 29 males); Table 1 below outlines the demographic characteristics of this sample.

Table 1. Demographic characteristics of sample (N = 61)

Variable	Raw count	%	Variable	Raw count	%
Profession			Supervision regularity		
Psychologist	46	75.4%	Weekly	7	11.5%
Psychiatrist	6	9.8%	Fortnightly	8	13.1%
Trainee Psychologist	5	8.2%	Monthly	22	36.1%
Other ^a	4	6.6%	Other	2	3.3%
			None	19	29.5%
			Missing	3	4.9%
Years of experience			Number of cases per week		
1 - 3	18	29.5%	0	9	14.8%
4 - 7	23	37.7%	1 - 5	16	26.2%
8 - 10	9	14.75%	6 - 10	12	19.7%
11 - 15	4	6.6%	11 - 15	7	11.5%
16+	5	8.2%	16 - 30	8	13.1%
Missing	2	3.3%	31+	9	14.8%
Forcibly displaced			Percentage of Syrian clients		
Yes	53	86.9%	N/a ^c	9	14.8%
No	8	13.1%	1-10	3	4.9%
			11-50	4	6.6%
			51-75	3	4.9%
			76 - 99	12	19.7%
			100	30	49.2%
Location			Percentage of clients with trauma		
Turkey	52	85.2%	N/a ^c	9	14.8%
Syria	2	3.3%	1-10	1	1.6%
Other ^b	7	11.5%	11-50	20	32.8%
			51-75	15	24.6%
			76-100	16	26.3%
Religion					
Muslim	60	98.4%			
Atheist	1	1.6%			

Note. ^a = psychosocial support worker, non-psychologist: EMDR trainee, project manager, architect

^b = Algeria, Germany, Kuwait, Malaysia, Saudi & UK

^c = not currently seeing clients

Missing data

A total of 67 participants took part in the questionnaire. However only 61 are included in Table 1 given that two cases were excluded from the analyses as more than half of the ProQOL data were missing in the questionnaire, and four cases were also excluded from the analyses given that they were not Syrian. The remaining cases

had 100% completion for the ProQOL. List-wise exclusion was applied where there were missing data within predictor variables.

Normality tests and outliers

The Shapiro-Wilks test was used as a preferred test for normality (see Ghasemi & Zahediasl, 2012), with an additional investigation of effect size, as advised by Field (2009). The Shapiro-Wilks test indicated that scores on all three subscales were significantly non-normal; for compassion satisfaction $W(61) = 0.868, p < 0.001$; for burnout $W(61) = 0.926, p = .001$ and for secondary traumatic stress $W(61) = 0.939, p = .005$. Consequently, data for all three subscales were log-transformed using LG10 function in SPSS.

After log transformation, both, burnout $W(61) = 0.981, p = 0.446$ and secondary traumatic stress $W(61) = 0.973, p = .194$, no longer deviated significantly from normal. However, compassion satisfaction remained significantly non-normal: $W(61) = 0.738, p < .001$. Inspection of Q-Q plot for compassion satisfaction confirmed this non-normal distribution, with a skewness indicating that most participants tended to score highly on compassion satisfaction, $-3.143 (SE = 0.306)$. The log transformed data were used for all the analyses unless otherwise noted, and results with the compassion satisfaction subscales should be interpreted with caution.

A boxplot flagged one significant outlier on all three subscales. Closer examination of this individual's data indicated that this individual scored very low on compassion satisfaction and very high on secondary traumatic stress and burnout. Upon closer examination it was concluded that this outlier was not due to error, therefore a decision was made to therefore keep it in all the analyses.

Psychometric properties of measure

Spearman's rho among factors were -.49 between compassion satisfaction and burnout ($p < 0.001$), -.32 between compassion satisfaction and secondary traumatic stress ($p = 0.012$); and .57 between secondary traumatic stress and burnout ($p < 0.001$). Internal consistency estimates of reliability were good for compassion satisfaction (Cronbach's $\alpha = .84$), and acceptable for secondary traumatic stress (Cronbach's $\alpha = .78$) and burnout (Cronbach's $\alpha = .73$).

Subscale means and predictors

Participants reported a mean compassion satisfaction score of 42.7 ($SD = 5.4$), mean secondary traumatic stress score of 20.9 ($SD = 5.5$) and mean burnout score of 21 ($SD = 5.1$). These means are of the untransformed data to ease comparison with the existing literature. In a study by McKim & Smith-Adcock (2014) investigating the ProQOL with 98 trauma counsellors in the US ($n = 90$ White, $n = 73$ female), similar compassion satisfaction scores were seen (40.9, $SD = 5.6$) yet Syrian MHPs seemed to score much higher for mean secondary traumatic stress (11, $SD = 6.1$). There were no data available for burnout in McKim & Smith-Adcock's (2014) study, but Stamm (2010) reports population norms for burnout as 20, similar to this study's sample. Using cut-off scores recommended by Stamm (2010) by way of t-scores, 26.2% of participants ($n = 16$) reported high levels of secondary traumatic stress in this sample. This is compared to 5% in a sample of 532 self-identified US trauma specialists (Craig & Sprang, 2009) and 0% in a sample of 506 Norwegian child protection personnel (Baugerud, Vangbæk, & Melinder, 2017).

Analysis of variance showed no main effects of gender, supervision amount, satisfaction with supervision amount, satisfaction with supervision quality, importance

of religion in everyday life and importance of religion in upbringing on any of the three subscales. See Appendix 19 for these non-significant test results.

Analysis of variance showed a main effect of profession on all three subscales; CS, $F(3, 57) = 3.186, p = .03$; burnout, $F(3, 57) = 3.519, p = .021$ and STS, $F(3, 57) = 3.5, p = .021$. A closer look at the data using means plots showed that the four participants who had not had specific training as MHPs but rather were either EMDR trainees, project managers or psychosocial support providers, had higher secondary traumatic stress and burnout, and lower compassion satisfaction relative to trainee and qualified psychologists and psychiatrists. Given that there were unequal sample sizes across the four different groups of profession, a non-parametric equivalent was run to determine whether this was an artefact. A Kruskal-Wallis test showed that there was a statistically significant difference between all three subscales by profession; compassion satisfaction, $p = .003$, burnout, $p = .021$ and secondary traumatic stress, $p = .043$.

A Pearson's r test was carried out to assess the relationship between number of cases per week and each of the three subscales. There was no correlation between any of the subscales; compassion satisfaction, $r = .03, N = 61, p = .81$; burnout, $r = .08, N = 61, p = .53$ and secondary traumatic stress, $r = .09, N = 61, p = .5$.

A curve estimation was carried out to clarify the relationship between years of experience and the three subscales; on the basis of the previous literature, a curvilinear relationship was hypothesised. However, a linear relationship was the most likely fit in all three subscales, although a weak relationship was observed between years of experience and both compassion satisfaction and secondary traumatic stress. A Pearson's r test confirmed that there was no correlation between years of experience and compassion satisfaction, $r = .25, n = 59, p = .06$, and secondary

traumatic stress, $r = 0$, $n = 59$, $p = .98$, and that there was a significant relationship with burnout, $r = -.3$, $n = 59$, $p = .02$.

A significant regression equation was found for burnout; $F(1,57) = 5.438$, $p = .023$, with an R^2 of 0.087, indicating that more years of experience predicted lower burnout scores.

Part B Method

Design and participants

Part B of this study used a semi-structured interview, as well as a questionnaire. Eligible participants were Syrian MHPs residing in Turkey who regularly work with Syrian clients and were forcibly displaced as a result of the 2011 conflict. Throughout recruitment, strong emphasis was placed on the optional nature of the study and participants' right to withdraw without consequences given that the risk of coercion was high because many of the participants were trained by Trauma Aid UK and were currently receiving supervision by its members.

Recruitment

Purposive sampling was used. Participants were approached by the researcher at the aforementioned annual conference, as well as at a Trauma Aid UK EMDR training session in Gaziantep. Participants were also approached through Trauma Aid UK's mailing list for all participants who had attended previous EMDR training sessions. A number of participants were additionally recruited by word of mouth.

Interviews were either held at a hired office in Istanbul or Gaziantep or via Skype where participants were not available in person. Prior to the interview, participants were asked to read an information sheet (Appendix 20) and complete a consent form (Appendix 21), which also asked for their consent to audio record the

interview. All interviews lasted between 40 and 70 minutes. Participants were informed that the researcher was independent of Trauma Aid UK, that all of their information would remain anonymous and confidential and encouraged to be open and honest.

The sample size was determined on the basis of when the researcher felt that the data became saturated. Saunders et al. (2018) identify different types of data saturation, the type of data saturation used in this study relates to the degree to which new data repeat what was expressed in previous data.

Data collection

The interview schedule was guided by the research questions, and the research questions were guided in part by the questionnaire used in Part A. Appendix 22 contains the full interview schedule. Table 2 contains the research's aims mapped onto the interview questions. Open-ended, exploratory questions were used given that little is known in the literature for this sample (Barker, Pistrang & Elliot, 2002). It was structured in a way that helped participants tell their stories using the three most basic narrative structures (see McLeod, 1997); a beginning in which the setting was described ("What brought you to Turkey?"), a middle which contains a series of actions or obstacles ("In what way do you experience similarities between you and your clients?" and "How do you think these affect the therapy?") and attempted solutions and an ending or resolution ("What resources do you draw on that help with the challenging aspects of doing therapy?"). When asking participants about both the positive and negative aspects of therapy, the researcher used externalising questions, derived from a narrative approach (see White & Epston, 1990), to open up dialogue and encourage participants to feel more comfortable to talk about them. It felt

ethically important, given that a large part of the interview asked participants to elaborate on the negative impact of therapy, to structure the interview such that the ending was chosen to thicken participants' stories around resources and contentment.

The semi-structured interview questions were based on the research questions and aimed to elicit responses relating to shared realities, self-disclosure and coping with providing therapy; the analysis was theory-driven or deductive (Braun & Clark, 2006). It also aimed to be grounded in examples (see Elliot, Fischer & Rennie, 1999) and therefore elicited examples where relevant.

All interviews were conducted in Arabic, and as such the information sheet, consent forms and interview schedule were also translated to Arabic (Appendices 23, 24 and 25 respectively)

Table 2. Research aims with subsequent interview questions

Aim	Interview Questions
a) investigate the impact of shared culture and experience	<ul style="list-style-type: none"> • In what way do you experience similarities between you and your clients? • How do you think these affect the therapy?
b) investigate the incidence and impact of MHPs' disclosure of shared experiences	<ul style="list-style-type: none"> • Do you talk with your clients about your own experiences? • Would you talk about your own experiences of displacement with your clients?

c) investigate the impact of providing therapy on Syrian MHPs	<ul style="list-style-type: none"> • Many professionals find that trauma therapy affects them in different ways. Can we talk about the impacts of trauma therapy with Syrian clients on you? • What resources do you draw on that help with the challenging aspects of doing therapy?
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Measures

The ProQOL and a short demographic information form were used to situate the sample (Elliot et al., 1999). The demographics information form was a shorter version of Part A questionnaire, with the omission of questions around supervision, identification with culture and religion given that these were not quantitatively required for the purposes of the aims of this section of the study. Consenting participants completed the questionnaire before the interview; in person, or an online version hosted by Qualtrics if the interview was conducted via Skype.

Planned analyses

A thematic analysis (TA) was used to analyse interviews on participants' experiences. TA is not confined within a particular epistemology and allows for guiding the discovery of data related to the research questions (Braun & Clark, 2006).

The following steps were taken to analyse the data, following the steps recommended by Braun & Clark (2006):

1. Interview audio tapes were transcribed from Arabic into English using NVivo (see below for translation process)
2. Familiarisation with the data: English transcripts were read at least twice by the researcher

3. Coding: the researcher systematically coded each transcript using NVivo, giving full and equal attention to each item, attempting to ensure that codes were generated directly from the data, rather than personal assumptions or theories, thus taking an inductive approach. Meanwhile, the researcher made a note of any significant and interesting points, as well as similarities and differences between and within participants
4. Code checking: a peer researcher independently coded a transcript using the same procedure outlined above, and any discrepancies were resolved through discussion
5. Creating themes: the researcher used mind maps to construct a thematic structure while being mindful of personal biases and influences
6. Refining themes: the researcher reviewed the themes with the research team (KS, AW) to discuss whether this was an accurate depiction; consequently some themes were renamed and reorganised

Translation and transcription

Excerpts from the first two transcripts were translated using the method described in Part A (minus the step of piloting). Given that the lengthy and complex process outlined above only identified two easily resolved translation issues, the remainder of the interviews were translated directly from Arabic audio to English transcript by myself and two hired bilingual British Syrian health professionals who were sent instructions (Appendix 26) and encouraged to communicate any queries or concerns with the author. Additionally, recommendations for translating a non-English language for the purpose of English publication and disseminations provided by Van Nes, Abma, Jonsson and Deeg (2010), were used. This included the initial use of fluid

English translations and descriptions of Arabic words, and then going back to the source language with the aid of professional Syrian translator. The researcher checked all transcripts back against the original audio recordings, as recommended by Braun and Clarke (2006).

After reading and re-reading transcripts, the entire dataset was coded in a data-driven way with equal attention given to each data item. Data were coded and analysed at the semantic level given the lack of previous literature on this topic. Initial codes were generated from the data (Appendix 27). The data were further re-read to check validity of codes and a number of thematic maps were created before reaching a final map.

Transcription was conducted using NVivo 11.

Credibility checks

To ensure credibility, a transcript was selected at random and underwent independent analysis by a colleague independent of the project, and differences in coding, themes and their relationships were resolved through discussion and amended. Consenting participants were contacted to review the final themes and to check whether the themes fitted well with their experiences.

Part B Results

While all data were coded, only data relevant to the three research aims were analysed in detail and are outlined in sections below. Prior to presenting this, data relevant to participants' background and experiences will be reported, followed by data that maps the context in which Syrian MHPs are currently living and working in.

Situating the sample

Sixteen Syrian MHPs residing in Turkey participated in interviews, with

fourteen participating in person and two via Skype. They were aged between 24 and 54 years ($M = 35$, $SD = 8.3$). There were eight females and eight males, and all were University graduates. Table 3 provides demographic information of the sample, along with which category each person scored on the three subscales, using cut-offs recommended by Stamm (2010).

Given the relatively small number of Syrian psychologists and psychiatrists residing in Turkey, information has been omitted where participants could be identified such as an uncommon psychological approach or title. Participants' ages are reported in decades to ensure anonymity throughout.

Table 3. Demographic characteristics of sample (N = 16)

ID	Gender	Age	Profession	Psychological approach(es)	CS	Burnout	STS
P1	F	20s	Psychologist	CBT, counselling and EMDR	Moderate	Moderate	Low
P2	F	40s	Psychologist	CAT, CBT and counselling	Moderate	Low	Moderate
P3	M	30s	Psychologist	CBT, counselling and EMDR	High	Low	Moderate
P4	F	20s	Psychologist	CBT, counselling and EMDR	High	Low	Low
P5	M	50s	Psychiatrist	CBT and medication	High	Low	Low
P6	M	30s	Psychologist	Counselling and EMDR	High	Low	Low
P7	M	30s	Psychiatrist	CBT, EMDR and medication	High	Low	Low
P8	M	40s	Psychologist	CBT and EMDR	High	Low	Low
P9	M	40s	Psychiatrist	Counselling, CBT and medication	Moderate	Low	Moderate
P10	F	20s	Psychologist	CBT, counselling and EMDR	High	Low	Low
P11	F	30s	Psychologist	CBT, counselling and EMDR	High	Low	Low
P12	F	30s	Psychologist	CBT, counselling and EMDR	High	Low	Low
P13	F	20s	Psychologist	Counselling and EMDR	High	Low	Low
P14	M	30s	Psychiatrist	CBT	Moderate	Low	Low
P15	M	20s	Psychologist	Counselling and EMDR	High	Moderate	Low
P16	F	20s	Psychologist	EMDR	High	Low	Low

Participants obtained a mean compassion satisfaction score of 44.5 ($SD = 5.1$), mean secondary traumatic stress score of 19.1 ($SD = 3.4$) and mean burnout score of 18.1 ($SD = 6.1$). These scores are similar to the larger group of Syrian MHPs as outlined in Part A Results.

An excerpt of a coded transcript is presented in Appendix 28. For ease of reading, any presented quotes containing non-words and repeated words have been deleted, connected words have been inserted in square brackets ([]), an ellipsis (...) replaces any superfluous segments and rounded brackets (()) represent non-verbal communication. Quotes belonging to participants are denoted by participant number, unless where anonymity may be compromised, in which case this is denoted by 'PA' (participant anonymous).

Situating the context

The following section contains data referring to the context in which the participants were working in, outlining the picture of provision of mental health care of Syrian MHPs to Syrian clients in Turkey. Appendix 29 contains a thematic map of this context, and the facilitators and barriers to mental health care provision are briefly outlined below.

Facilitators. All participants referred to a number of helpful specific psychological tools, including the training they received enable them to provide therapy. Given that most participants were recruited through Trauma Aid UK EMDR training sessions, most spoke about EMDR, and in particular the use of the 'safe or special place' visualisation. Many also spoke about CBT, breathing techniques and problem solving as useful techniques. A number of participants mentioned a preference for techniques showing faster results, as they explained that many clients

move around the country, and workloads are high, so MHPs are able to provide a limited number of sessions per client.

“psychology is not only about make the symptoms disappear”. However, during the current situation and the limited time, it is fine to only reduce the symptoms.” (P8)

Participants described a number of helpful non-specific tools such as openly adopting a non-judgmental and empathic stance, putting emphasis on confidentiality and taking the time to listen as a way to build a trusting relationship.

Some participants reported that it was helpful to incorporate spirituality in sessions. The majority of participants and clients are Muslim, so reference to spirituality in this context relates to the Islamic faith. Some participants reported the use of examples from the Quran, ideas of compassion and mercy and using comforting phrases for clients’ difficult predicaments such as “God has willed this”. All participants said that they would only use this if clients showed that spirituality is an important part of their life.

Participants said that flexible ways of working, including Skype/Whatsapp therapy/training and providing therapy in people’s homes, facilitated therapy.

Participants also spoke about the importance of psychosocial support including the use of psychological first aid and linking clients to activities and social centres.

“The main thing is to provide people with their main needs, not only the food and water but also their human rights. We tried to change the mentality of the psychologists and the psychological workers to be able to support the people affected by the crisis.” (P5)

Barriers. Half of the participants spoke about feeling under pressure due to high workloads and consequently only being able to provide a limited number of

sessions. Participants also stated that clients were reluctant to talk about their experience of mental health problems and traumatic experiences, especially sexual abuse.

“They always say: ‘Am I a crazy person?’ I face this word ‘crazy’ a lot.” (P1)

A number of participants also described a general stigma within the community accompanied by a lack of awareness of psychology amongst Syrians. Some participants expressed the need for more trained therapists, risk management staff and sensitive interpreters.

Some participants spoke about financial difficulties as a barrier to the provision of adequate mental health care and training. Financial difficulties were also described as a barrier to clients accessing services as a result of not having money to pay for transport to reach sessions.

Main Themes

Analysis led to two overarching themes of shared characteristics and personal impact, with six themes and ten sub-themes; Figure 1 on the next page illustrates these themes.

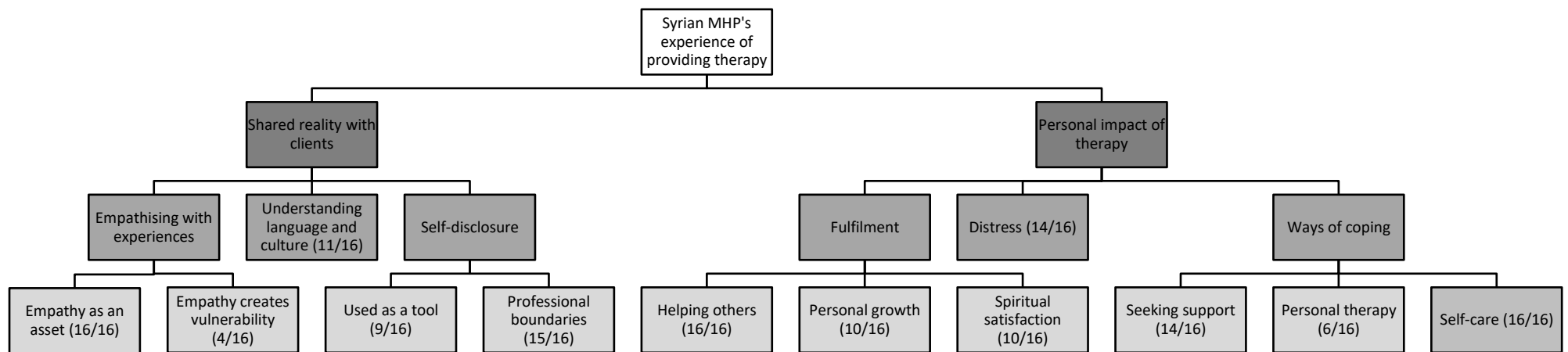


Figure 1. Thematic Map

Shared reality. Participants described a number of shared characteristics with their clients, namely being Syrian, having lived in Syria through war and being forcibly displaced in Turkey. Some also described sharing experiences with their clients; both in Syria, such as having family members kidnapped, tortured in prisons or killed and in Turkey, such as experiencing isolation and instability. Three sub-themes made up this main theme, all representing the impact of having a shared reality.

Empathising with experiences. All participants alluded to the fact that their shared reality of being Syrian and living through war and displacement enabled them to empathise with and understand their clients' experiences, such as traumatic experiences, migration and leaving everything behind.

Empathy as an asset. All participants referred to this as an asset, in that MHPs can understand and therefore help clients more as a result.

"I am a Syrian Arab Muslim, they are also Syrian, Arab and Muslims...I am also a woman and they are women, I am young and they are young. I lost a brother, he was a freedom fighter and he was put in prison and then he died, and they also lost people so I can feel what they feel when they lose people."(P1)

"...they have someone in their family who has been detained and I have someone in my family who is detained. Some people have family who they have not seen for a long time and I too have not seen my family for a long time, because of the war...it lets you be more empathic with him [or her], sometimes you be may be able to relieve him more...it makes you have more motivation, it makes you feel how much he is literally suffering." (P3)

Some participants also noted that their similarities benefitted the clients in that their clients felt understood, validated, were more trusting and their burden of suffering is reduced.

“Because of my clear participation in the Syrian revolution (it was not under the table), I was arrested because of a protest. Thus, the people who were suffering from Al-Assad’s pressure felt safe to come to me and talk.” (PA)

“The best social support comes from people who come from the same culture and same environment.” (P14)

Empathy creates vulnerability. Four participants spoke about how the shared traumatic reality with clients brought about unpleasant experiences by reminding participants of experiences they had undergone or had witnessed.

“...a male patient, he was in prison and was subject to a lot of torture...I always heard about these things but I never thought I will see it in reality. It was hard for me because afterwards I thought that my brother [who was imprisoned and possibly killed in Syria] might have gone through the same things” (P1)

“...some of the stories I hear would trigger some sensitive issues for me. Not necessarily as a flashback or trauma, but it could remind me of an experience I lived, or story I have heard.” (P14)

Two participants described not going into too much detail when clients discuss traumatic experiences to avoid over-identification with clients.

Referring to a client: “...I will help you with a lot of details and get you out of the problem without going into details...details that may bring back...be annoying for both of us which causes burnout as well for the therapist and causes him sad memories because he lived through the same experience as the patient.” (P3)

"I do not go into a lot of details with [the client] about the problem, so as not to empathise to the extent that I feel that our problem is one" (P16)

Understanding language and culture. Around two thirds of participants commented on how their shared characteristics allow them to better understand clients' language and culture. Participants commented on the nuances of the Syrian dialect, and how they are able to pick up on these and link these to their cultural, religious, linguistic and social contexts.

"Because I know enough about the groups and cities in Syria...I know that if he is from this city then he lived under Islamic State control or if he is from that city he lived under the government's control...I know to which sect this person belong based on where he is from and then I can understand the social context." (P4)

Participants also referred to understanding and working with cultural and religious norms and practices, such as understanding the relationship between males and females in therapy in relation to disclosing emotional experiences and physical touch, and offering words of comfort in a way that the client would find helpful.

"We tried in our work to have females treat males but it did not work. This is in our culture, it is hameful for males to talk about his problems with females and this is why males prefer to talk with male doctor. So we started to refer males to males and females to us [females]." (P1)

"So if he says my son became a martyr, you don't just say 'oh ok' and write it down and then what... you make them feel that you heard them...and say oh Allah rest his soul', and Allah willing he's now in heaven and may his martyrdom be a reason for your redemption" (P3)

Self-disclosure. Participants were asked about their experiences of self-disclosure in therapy. Nine participants described examples where disclosure was used as a tool, and almost all participants brought up the notion of professional boundaries.

Used as a tool. Nine participants gave examples and instances of self-disclosure, and all gave disclaimers, and this often depended on their values and beliefs as a therapist.

"... [a child client] told me he views himself [negatively due to social anxiety] so I tell him "ok look at me, do I have any hair?" OK, I am bald (laughter), so he says to me "no" and I say to him like "this thing is not embarrassing" and we both laugh (laughter), and that's the only personal example I have...I don't bring my personal details into my work....and this is personal" (P3)

"...we want to think about transference and countertransference, even if we give an example about ourselves we don't use ourselves, we would say I know someone who went through X" (P9)

Two participant spoke about self-disclosure as a way for clients to see them as an example of being able to cope after experiencing similar difficulties.

"I had a patient who lost her father...he was with the army and then he was arrested and they did not hear anything about him. I told her...I also had a brother who was arrested and I went through the same thing you are going through. She asked me how are you are able to laugh and talk now, I told her that at that time it was difficult but you have to believe that what you are going through will end." (P1)

Another participant spoke about the importance of sharing information for political purposes to maintain clients' trust.

“...[most of my clients] are originally from rural Aleppo and they speak in different accent to me as I come from Douma, rural Damascus...patients ask me where I am from. This question could come from the fear inside them that I have different political views or I might report them to the Syrian regime. In this case, I tell them that I am from Douma which they know that it has gone through the same experience as rural Aleppo.” (P14)

One participant spoke about sharing the fact that they are in a similar social situation so that clients do not see him as an alien, or very different to them.

“...when he comes to see a therapist or doctor, he thinks that the therapist/doctor comes from another planet and doesn't know the struggle that he goes through. So we talk about general issues like there's a lot of traffic, public transport is expensive., rent is going up for us as Syrians, living in Turkey is expensive ...he feels that you've experienced the same struggle...I also have a problem when I come with public transport in the morning I didn't come by plane...” (P3)

Interestingly, participants who did not share the experience of financial difficulties with their clients were less likely to disclose:

“In regards to the Syrian in Gaziantep, I am a refugee like them, we both managed to survive from what is happening in Syria. My financial situation more stable than then and I have many sources of protection. I have these resources and I try to use it to help the people with message of increasing their resilience and empower them... I do not share my experiences...I do not share not because I want to look stronger than them but because I want to build a therapeutic relationship.” (P5)

Professional boundaries. Fifteen participants brought up the notion of professional boundaries, and spoke about being consciously aware of maintaining these.

"I make sure the relationship is not too formal or strong, I always remind them that I am not their problem solver and a big part of the job relies on them. I often check on them on WhatsApp, and when I feel that the relationship starts becoming too strong I stop this." (P2)

"I try to keep it within the professional boundaries, sometimes the relationship becomes unprofessional when I start to use the phone to call them and see how they are doing. When [I feel this]... I reduce the number of sessions and give her the responsibility to make her...life choices." (P10)

Participants mentioned that professional boundaries acted as a way to protect them from being negatively affected by clients' stories.

"So this is what made a difference - listening to stories made me stronger and now I was able to override this feeling [of being affected by traumatic stories] and have immunity and I put a separation between me and the client so that I don't get affected." (P16)

Personal impact of therapy

Fulfilment. All participants spoke about the rewarding aspects of providing therapy, and these positive aspects took three sub-themes.

Helping others. All participants spoke about gaining satisfaction and pleasure from knowing that they have helped and relieved their clients.

"As any other human being, I play many roles in life, I am a doctor, a husband, a citizen, and a friend. My role as a doctor increases my self-appreciation given that I

am working according to roles that help others. My role as a citizen is to benefit society, to empower society and maintain its coherence.” (P5)

“I love it, I love my job, I studied this because it is what I want, I feel happy when I help someone sad to smile again and feel comfortable.” (P10)

“When I finish the sessions and the person starts to improve and offer ways to help themselves, for example she starts to talk about her brother as a husband rather than only as ill or a martyr, or tortured...I feel happy and comfortable for what I offered and helped to do.” (P11)

“...the thing that protects me is to complete therapy [with a client] and see the improvement and change that happened. The person who came completely destroyed and began to love life... when you see the change...this is the biggest thing that pushes me through difficulties” (P16)

Personal growth. A number of participants spoke about growing and changing for the better as a result of therapy, and referred to their clients teaching them things. Some participants spoke about how listening to difficult and traumatic stories a number of times over the years made them more “immune” to distress.

“I used to tell my teacher I do not think I can treat people in the future because I lost my brother... she told me you will be able to do it because you are Syrian and you know Arabic and you will be a role model for those people who you will meet. And now I think this true because now when I see Syrians who are struggling I can feel what they are going through. Jalaluddin Rumi said that the wound in your heart is the place where light enters you.” (P1)

“Something happened to me three times -maybe four times- during my work life. Some of my clients sometimes gives me an answer to a random question, and this

makes me change my perspective about something. This is something that happens rarely but has deep effect on you when it does.” (P14)

Spiritual satisfaction. Ten participants spoke about experiencing spiritual satisfaction from the services they are providing.

“I started to see God as a source for my power to help people, He brought me from the war to help those people.” (P1)

“I feel happy because I know that God will reward me because I am helping people to feel better” (P12)

“I feel happy because I am doing good things for my Muslim brothers and sisters” (P15)

Distress. Ten participants spoke about their experiences of being negatively affected by hearing traumatic stories of their clients. Participants described experiences of STS, burnout, shock and mental and emotional exhaustion.

“At the beginning of my experience I was by myself with a lot of trauma cases I felt that I was burnt out...and that I was trapped. I was not happy, I started having nightmares because I was exposed to very big issues such as incest, physical and sexual assaults, losing body parts and suicide” (P1)

“The other day I was working at the orphanage and I saw 11 people in one day so this is a big number and causes pressure, mental exhaustion and burnout. Sometimes you're tired and you need to take a day off holiday and your capacity becomes less...and this is...we all...this is burnout.” (P3)

“To be honest, sometimes at the end of the day I feel that I am unable to speak anymore, around 5.30 when we finish our work” (P4)

Four participants spoke specifically about being shocked by the reality of the

traumas that clients spoke about, particularly those including sexual abuse and children witnessing their parents' deaths.

"These were things I heard for the first time, or I only heard about it and I did not expect that it existed in reality and I will see it in real word." (P1)

"I was shocked by what [the children] went through..." (P10)

"The first period that I worked with EMDR it was very difficult for me...I used to think it's unbelievable all this pain happened to us, I can't believe to this extent; really is it possible that this shelling happens, these things happened inside prisons?" (P16)

Ways of coping. All participants spoke about different ways of coping with the impact of therapy.

Seeking support. All sixteen individuals spoke about seeking support from people or resources to allow them to gain more knowledge when dealing with difficult or upsetting cases. Most participants noted the usefulness of supervision.

"The most difficult case was when I worked with a woman my age who experienced gender based violence. I felt very emotional and I felt what she was feeling. I had to stop and step back to make sure that I can separate my feelings from her. I asked for advice from my supervisor and I managed to keep working and helping this case." (P13)

"The main thing that helps is using supervision to talk about the cases...if I had a question or if I was unable to provide a solution for someone...[T]he supervisor may be able to answer the question or provide the support and strength that really helps." (P16)

Other participants spoke about support from their colleagues or family at

home.

"Sometimes when I have problems in my life or with my son, it is hard to always listen to all people, sometimes it is a very simple thing but you feel you need someone to ask about you....you just need to talk to someone." (P4)

"Peer support is also important, your colleagues around you, it is not the same as supervision but it helps." (P8)

Four participants also spoke about gaining knowledge to further their understanding.

"...I started searching and learning about self-care techniques...I also use learning resources and attend trainings and lectures...I consider every case as a learning experience, and sometimes I go back and read what I learnt about it at university" (P1)

"I read a lot because we did not learn a lot at University. When you ask others, study and read more that helps." (P6)

"You need to work with the skills and the responsibilities that you have, rather than trying to do things you're not qualified for...[K]eeping up with literature, Cochrane reviews and so on...I try to keep up to date." (P9)

Personal therapy. Six participants spoke about using personal therapy to cope.

"I am using personal therapy to keep myself aware of these things and do not let it affect me or the treatment." (PA)

"Personal therapy is useful. First, it allows me to put myself in my patients' position, this makes me feel humble. Second, it gives me the chance to explore the perspectives of other therapists and how they see things. Third, when there is an issue that is overwhelming, personal therapy gives me the space to speak out about it". (PA)

As well stigma amongst Syrian clients, one participant mentioned that there was stigma amongst Syrian mental health professionals with regards to their accessing treatment, and that this was often unspoken.

“On the social level, people still have stigma about psychology...we don’t tell each other that we need help but we still go and seek the help. We still have the stigma about psychology treatment.” (PA)

Self-care. All participants brought up the notion of self-care as a means to cope, often by spending time with loved ones and relaxing without thinking about or speaking about work to create separation from home and life. Some participants also spoke about making sure their relationship with their family at home is good in order to enable them to better help others.

“I do not know how I will be able to help people fix their life if my own life is messed up!” (P2)

“Gaziantep has a lot of big and beautiful gardens where we go and spend time, sometimes we meet friends, but also sometimes you feel you just want to be on your own.” (P4)

“My wife has started to follow my cases and understand my work. She says to me ‘where is the self-care?! You train on self-care but we want you to do self-care with us!’ [laughter] she’s like let’s go to the ocean this year, so we will go with the kids.” (P9)

Relationships between themes

While the two overarching themes have been presented separately, it is important to acknowledge that participants’ descriptions of their shared characteristics, self-disclosure and personal impact of therapy were interconnected in multifaceted ways. Some of these are captured in the links created between different

elements. For example, the vulnerability created by way of shared characteristics would often be linked to participants' descriptions of difficulties in relation to the personal impact of therapy. Also, the use of professional boundaries was linked to self-care in that it acted as a 'protection' against distress for some clients.

Discussion

Summary of findings

This research sought to elucidate Syrian MHPs' self-reported professional quality of life in the context of a shared reality using both established quantitative methods and richer exploratory qualitative methods. Syrian MHPs had elevated secondary traumatic stress scores relative to other non-Syrian MHP samples. All Syrian MHPs endorsed the belief that their shared reality enabled them to better understand and empathise with their clients. All also stated that providing mental health care to Syrians was fulfilling, while the majority also reported that it was distressing. All participants referred to self-care as a means to cope, and some referred to personal therapy. In what follows, findings will be discussed in accordance with (dis)agreements with previous literature, followed by their implications. A summary of findings has been produced, both in English and in Arabic (see Appendices 30 and 31 respectively), to ensure that the results reach participants and other relevant stakeholders.

Quantitative findings

Compassion satisfaction and burnout scores in this sample were similar to other samples in the existing literature, yet secondary traumatic stress scores were much higher relative to other samples of trauma workers elsewhere (McKim & Smith-Adcock, 2014; Baugerud, Vangbæk, & Melinder, 2017; Craig & Sprang, 2009).

On the basis of the previous aforementioned theory of secondary traumatic

stress (Dutton and Rubinstein, 1995) this high level is expected in this sample, given the multiple mediating factors including such as the daily stressors experienced by participants given the ongoing nature of the Syrian conflict, past trauma and reduced opportunities for training and education in psychology. However, the specific pathways leading to a high secondary traumatic stress scores in this sample are unclear. Secondary traumatic stress may be heightened when MHPs have themselves experienced past trauma, although this link is unclear and inconclusive (See Baird & Kracen, 2006). Many studies showing a link between secondary traumatic stress and therapist trauma history used subjective dichotomous questions (e.g. Pearlman & Maclan, 1995). When using a more thorough measure of past trauma, no significant relationship and a low correlation was found between the two (Creamer & Liddle, 2005). There have also been suggestions that a shared traumatic reality increases risk of secondary traumatic stress, as indicated in studies with disaster mental health workers (Argentero and Setti 2011; Naturale 2007; Pulido 2007). Establishing a link raises concerns around the validity of secondary trauma as a separate and distinct construct to PTSD; an issue pertinent in the literature that has not yet been resolved. Elwood et al. (2010) provide a helpful critical review of the construct of secondary traumatic stress and its specificity.

Burnout was negatively related to years of experience, with MHPs with more experience showing lower scores of burnout. This finding was counter to expectations that burnout would be higher at both ends of the distribution of years of experience, as indicated in previous literature (Ghahramanlou & Brodbeck, 2000; Moulden & Firestone, 2007). This finding is however consistent with Boscarino, Figley and Adams' (2004) study with US social workers and Craig and Sprang's (2009) finding that younger

professionals reported higher levels of burnout. It may be that MHPs with a number of years of experience would leave the profession, given the choice, upon experiencing high levels of burnout, creating lower burnout levels in remaining MHPs with many years of experience.

Profession was the only significant predictor of all three subscales, with MHPs without an academic psychology background showing higher secondary traumatic stress and burnout scores and lower compassion scores, despite the very low number ($n = 4$) indicating reduced power to detect a result. This suggests that the MHPs are more likely to struggle because they lack the specific psychological tools and insight to carry out therapy, rather than lack the experience. These findings corroborate with Craig and Sprang's (2009) finding that special training significantly predicted higher burnout and lower compassion satisfaction.

No other factors such as gender, number of clients (with trauma-based distress) seen per week, supervision amount or satisfaction with supervision were found to be significant in predicting professional quality of life, against expectations on the basis of existing literature. There may have been complex interactions which were not hypothesised or explored in this study, creating an area for further research.

While the use of established measures is helpful in comparison with the existing literature and furthering understanding, comparing this sample of Syrian MHPs to other samples, all of whom were predominantly White American or European and living in relatively stable conditions, may introduce the notion of category fallacy (Kleinman, 1977). It may be that secondary traumatic stress does not arise from working with trauma per se, but rather is a consequence of the interaction of working with survivors of trauma within a post-modern Western culture (Satkunanayagam,

Tunariu & Tribe, 2010). There also seems to be a lack of conceptual clarity and methodological issues in the literature pertaining to professional quality of life (see Baird & Kracen, 2006), with different conceptualisations being used interchangeably creating a barrier to understanding and interpreting the vast literature surrounding this topic (see Najjar, Davis, Beck-Coon & Carney Doebbeling, 2009). A similar issue exists for literature pertaining to the notion of a shared traumatic reality, with different research teams using different terms despite overlapping concepts (see Bell & Robinson, 2013) also creating challenges for comprehensive enquiry. It was therefore deemed necessary from the outset to have a more in-depth exploration of Syrian MHP's experiences using their own words and examples, warranting qualitative enquiry.

Qualitative findings

Simultaneous impact of therapy. All participants who spoke about feeling distressed, experiencing nightmares and exhaustion as a result of therapy with their clients also simultaneously spoke about how supporting clients provided them with a strong sense of compassion satisfaction. As mentioned earlier, the literature often conceptualises positive and negative impacts as separate and mutually exclusive concepts; it is important instead to acknowledge their coexistence and interaction. This fits with findings of a qualitative exploration of MHPs' experience of working with survivors of trauma in Sri Lanka. MHPs experienced "an accumulated negative emotional impact but also to simultaneously contain positive, growth-promoting and personally satisfying aspects." (p43; Satkunanayagam, Tunariu & Tribe, 2010). Harrison and Westwood's (2009) qualitative study of trauma therapists also showed that positive changes co-occur alongside the negative emotional impact of trauma

work.

MHPs often reported the shock of the human rights abuses that they hear from clients, experiencing distressing emotions as a result, particularly early on in their experience. This fits with broader qualitative research that a sense of shock was captured as a theme by counsellors in Sydney working in child protection services (Hunter & Schofield, 2006) and child trauma therapists in America (Lonergan, O'Halloran, & Crane, 2004). In both studies, time and experience were key moderators of the negative emotional impact; more time and experience led to less distress and overwhelming emotions. This fits with these findings in that participants spoke about time, experience and supervision making them more equipped to deal with shock.

A main theme across all participants was the fact that MHPs' shared reality enabled them to better empathise. Previous research suggests that therapists' own difficult experiences may facilitate therapists to empathically connect with clients and use countertransference positively in therapy (Gelso & Hayes, 2007). The fact that Syrian MHPs are working with Syrians for a common cause is likely to enhance MHPs' sense of compassion satisfaction; MHPs are likely to experience heightened empathy and bonding in a shared reality given that they experience similar emotions, and allow therapists to feel more competent in helping their clients (Shamai, 2005; Tosone & Bialkin, 2004). As one participant stated, the shared reality *"lets you be more empathic with him, sometimes you be may be able to relieve him more...it makes you have more motivation because it makes you feel literally how much he is literally suffering"* (P3).

Most participants referred to their similarities allowing them to better understand the cultural nuances and language of their clients. This was important given participants' reference to the lack of available sensitively trained interpreters.

Research has shown that matching MHPs to clients based on their language similarities predicted better outcomes in therapy (Sue, Fujino, Hu, Takeuchi & Zane, 1991).

In some cases, having a shared reality also lead to negative consequences. Given that many of the Syrian therapist have themselves witnessed the traumatic effects of war on a personal level, a number of participants spoke about how their clients' traumatic experiences would remind them of their own. In two cases, participants spoke about dealing with this by not going into too much detail about the clients' traumatic experiences. It is unclear whether or how this may affect the process of therapy, particularly when processing or reliving trauma, as theoretical underpinnings of both EMDR and TF-CBT require clients to bring to mind and/or verbalise necessary detail in order to process traumatic events in an adaptive way. Furthermore, shared realities and characteristics are likely to lead to other challenges that were not captured in this data. Sue & Sue (2013) describe common challenges for therapists of an ethnic minority background working with clients of an ethnic minority background and these are likely to also exist in this sample of minority Syrians residing in a Turkish majority country. These challenges included over-identification with the client leading to assumptions and encountering clashes in cultural values and communication styles.

Self-disclosure. More than half of the participants reported that self-disclosure was used as a tool, and most added that they would use this with caution, such as not using themselves as a direct example, choosing participants for self-disclosure carefully on the basis of their demographics, and maintaining a sense of hope. Almost all participants also concurrently spoke about maintaining professional boundaries using contracts, fixed hours of contact and putting responsibility back onto clients.

These findings are very much in line with the literature available on disclosure in the Western literature (Knapp & VandeCreek, 2012). Some participants referred to these rules and boundaries coming about as a result of their training.

On the basis of Baum's (2010) conceptualisation of shared trauma in a traumatic reality, one may expect that self-disclosure and the blurring of boundaries would be much greater. The researcher is aware that her own position as an individual who is linked to the organisation who provided their training may have influenced participants' answers in a way that implicitly meant that sharing of blurring of professional boundaries was not encouraged. However, participants' scores on burnout were also expected to be higher due to a blurred boundary between the professional and personal on the basis of Baum's (2010) theory, yet quantitative scores of burnout in this sample were comparable to other samples. Therefore it is possible that participants' adherence to professional boundaries may have contributed to protecting participants from the experience of burnout.

Syrian MHPs who were more socially and financially privileged than their clients reported actively not disclosing their experiences, whereas MHPs who were in a similar social and financial situation described disclosing this as a way to gain common ground with clients. This is in line with previous findings looking at cross-racial dyads, where therapist self-disclosure was only perceived as helpful when used as an "effective strategy for bridging perceived social and power distance" (Chang & Berk, 2009).

Importance of self-care. Self-care was often located in the context of social support; participants would speak to friends, family and peers about their experiences or they would go to parks and fun places with family and friends. A longitudinal study

of international NGO workers showed that social support was associated with lower levels of depression, burnout, lack of personal accomplishment and greater life satisfaction (Cardozo et al., 2012).

An aspect linked to the sub-theme of self-care was the need for therapists to take care of themselves in order to be in a position to help others; this has also been found in previous literature on trauma professionals. Miller (1998) described that in order for MHPs to be effective, they need to have insight into their own feelings and the ability to differentiate between the needs of the self and of the patient. Personal therapy was described as a helpful means to do this, as well as a way to cope with emotional distress. However, it was noted that there was a stigma within Syrian MHPs around accessing personal therapy. Indeed, within the Western literature it appears that it is risky for MHPs to disclose that they are undertaking personal therapy, and negative consequences of disclosure have been described, such as being seen as incompetent (see Zerubavel & Wright, 2012). Syrian MHPs likely experience a double stigma of seeking professional support, given that mental health problems have been described in this sample as highly stigmatised generally within the Syrian community, as well as within Arab communities overall (see Scull, Khullar Al-Awadhi & Erheim, 2014; Aloud & Rathur, 2009).

Spirituality. Syrian MHPs collectively experience the ongoing Syrian conflict on a daily basis through media outlets, while hearing first-hand accounts from clients (and family and friends) about the ongoing human rights violations committed in the context of the failure of the international community and law. This may damage a sense of hope, connection and faith in humanity, and maintaining optimism and hopefulness are seen as essential aspects of being an effective trauma therapist

(McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). It was evident that many Syrian MHPs' strong sense of faith in God and in their purpose was away to make sense of often incomprehensive things, and to maintain hope; this is line with qualitative findings from Israeli social workers (Shamai & Ron, 2009).

Spirituality also brought a sense of satisfaction to a number of participants in that their work is a good deed towards a wider struggle and a wider cause. Spirituality was mentioned in other qualitative studies as both a buffer to reduce negative impact of trauma therapy (Bell, 2003) and as a coping mechanism (Harrison & Westwood, 2009).

Limitations

There were a number of limitations associated with the use of the ProQOL. The compassion satisfaction subscale remained significantly non-normal with a negative skew, despite transformation, and so the results and their implications concerning the compassion satisfaction subscale should be interpreted with caution. The ProQOL subcales and their related constructs are contentious and have led to debate. Contradicting results and methodological limitations have led to calls for additional conceptual and measurement clarity (see Boscarino et al. 2004; Sabin-Farrell & Turpin, 2003).

Furthermore the sample size is relatively small in order to draw conclusions about the validity and acceptability of this translated version of the ProQOL. Although 67 participants were recruited, due to exclusion from analyses only lead to 61 participants, despite power calculations requiring 64 participants. This may have contributed to the lack of significant findings in some of the analyses. Due to the limited scope of the study, it was not possible to test concurrent validity through the

use of alternative validated measures of the three subscales, nor was it possible to measure divergent validity of, for example, secondary traumatic stress using the ProQOL and PTSD for example, which would have been helpful given the aforementioned limitations of the construct validity of the subscales. It was also not possible to culturally adapt the measure in the given timeframe.

Potential confounders of ProQOL scores were not assessed. For example, openness and conscientiousness was positively associated with compassion satisfaction, while neuroticism was a negative predictor, accounting for 24.2% and 19.8% of the variance in compassion fatigue and burnout, respectively (Yu, Jaing & Shen, 2016). Resilience has also been shown to mediate the relationship between compassion fatigue and burnout (Burnett & Wahl, 2015). Therefore, conclusions in relation to years of experience significantly predicting burnout, for example, should be treated with caution as other factors may account for this. However, this research did not aim to look at predictors of professional quality of life, but rather to get a snapshot of Syrian MHPs and compare to other groups of professionals.

The method of recruitment may have influenced the demographic of Syrian MHPs who agreed to participate. There was a prize draw associated with participating in Parts A and/or B, involving EMDR equipment or its cash equivalent. This may have increased the likelihood of Syrians who were EMDR trained and/or in more difficult financial positions to participate given the incentive. Further, the announcement during a conference and the emails sent to participants inviting them to participate were conducted by a Trauma Aid consultant. This may have unintentionally pressured participants by sending an unspoken message that the nature of their involvement may be linked to Trauma Aid, despite emphasis on the voluntary nature of their

involvement and the separation of the project from Trauma Aid. The information sheet and content of the questionnaires and interviews may have led those who are struggling to (understandably) opt out, therefore creating a less representative sample and impression of coping.

This study relied exclusively on self-report methodology. This was an important feature given that an underlying aim of study is to gain access to phenomenological data given that concepts important to the research questions are related to participants' own views and experiences. However, given the emotive and exposing nature of the research questions and the context of the project being linked to some participants' training and ongoing supervision, participants may have found it difficult to give open and detailed information that fully represented their internal experience.

The researcher is aware that her own position has likely influenced all levels of this research cycle, from its inception, to creating and analysing the questionnaire and interviews all the way to its write-up. The researcher's interest in this topic and similarities with participants may have led her to over-identify with the findings. At the same time, the researcher's clinical experience and cultural background put her in a uniquely helpful position to carry out this research using experiential knowledge to enhance understanding beyond the abstract theoretical level.

This research is a result of the interaction of a small research team, including a bilingual interviewer, with a specific group of participants in a highly specific context, and this should be taken into consideration with regards to applicability of findings. However, the use of a transparent approach, credibility checks and emphasis on reflexivity throughout the process allows for replicability of the methodology with different groups and contexts.

Research implications

This Arabic version of the ProQOL showed acceptable psychometric properties and is suitable for use amongst Syrian mental health professionals. Further research may involve further dissemination of the measure to non-Syrian Arab mental health professionals to determine whether it is suitable for wider use. Focus groups may also be conducted as a step towards the cultural adaptation of the ProQOL. There is increasing need of trained Arab MHPs given the historical shortages and ongoing conflicts in the Middle East beyond Syria such as in Yemen and Palestine; as well as a recognition of the need for greater provision of mental health care in post-conflict settings such as in Iraq and Egypt (see Bruckner et al., 2011).

Researchers are urged to study both the positive and negative impact of the provision of mental health care simultaneously, without over-pathologising the work of MHPs within a shared context of trauma and conflict, while not romanticising the notion of Syrian MHPs as wounded healers. The quantitative findings offered a cross-sectional investigation of Syrian MHPs' professional quality of life and, based on the sample, it pointed to the acceptability of this model in relation to the impact on professionals. Future research should evaluate the impact of this model of working on the quality of the provision of mental health care from a clients' perspective using culturally appropriate and participant-defined outcomes.

Clinical implications

This snapshot of Syrian MHPs trained to provide therapy to Syrians within the community suggests that this model is helpful, as it promotes understanding of clients and empathy while reducing cultural and language barriers. This is also a sustainable model of provision of mental health care, in line with the UN's 2030 Agenda for

Sustainable Development and the Sustainable Development Goals (United Nations, 2015), which includes mental health within their vision (see Izutsu et al., 2015). It enables Syrian MHPs to gain enough experience to become supervisors and increases access to psychology within displaced, conflict-affected communities. Although small in sample, the finding that individuals without a formal psychology background showed significantly higher levels of secondary traumatic stress and burnout with reduced compassion satisfaction points to the importance of choosing appropriate community workers. This is an important finding for very poorly resourced settings, where 'barefoot' workers or 'paraprofessionals' carry out tasks without adequate training. This also points to the provision of sufficient educational training (and not just clinical training) where possible, and the close monitoring of workers who do not have an academic psychology background, acknowledging that they may be at higher risk for experiencing a negative emotional impact.

Training community workers to work in shared realities overall fosters growth and empathy in MHPs, while also creating potential for emotional vulnerability. It is important, then, to ensure adequate supervision where necessary, even if through online means, to enable clients to discuss difficult cases given that a number of participants referred to experiencing distress as a result of not enough supervision. A number of participants spoke about the helpfulness of peer support and this should be promoted in the workplace, as previous research has found that this helps to prevent and manage secondary traumatic stress (Rourke, 2007).

Personal therapy should also be made available within organisations, and employers should "adapt a tolerant attitude to suffering therapists" (Catherall, 1995). Given that there is somewhat of a stigma of accessing therapy within Syrian MHPs,

and given that the displaced Syrian MHP community in Turkey is relatively small and well-connected, it would be helpful to introduce an Arabic speaking therapist, who is not a displaced Syrian MHP within this circle (even if virtually), to ensure confidentiality. Increased emphasis and awareness of self-care is important, including promoting a work-life balance and separation and speaking to friends and family.

Conclusions

This study was the first of its kind and successfully reached the initial aims it set out to achieve. It has confirmed the acceptability of an Arabic version of the ProQOL, while quantitatively and qualitatively exploring the professional quality of life of forcibly displaced Syrian professionals in the context of the provision of mental health care within a shared reality.

The findings of this study illuminate the benefits of providing training and supervision in psychological and psychosocial approaches to professionals with a mental health background within conflict-affected areas with reduced mental health resources. The shared reality of the practitioner and client enhances empathy and understanding and overcomes language and cultural barriers often present in such settings where there is a gap in the demand and supply of mental health services. While this shared reality likely contributes to a strong sense of compassion satisfaction amongst practitioners, motivating them to help their community and be role models, it also likely contributes to practitioners' vulnerability of secondary stress and burnout, particularly in light of shared traumatic experiences. Taken together, these results suggest increasing training and supervision of community practitioners, while promoting participant informed self-care techniques and ensuring the availability of personal therapy.

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Part 3: Critical Appraisal

Introduction

This critical appraisal comprises of an exploration of what led me to this research and the main issues, assumptions and learning that I came across. I begin by discussing my background and experiences, followed by my assumptions and motivations relevant to this research. Next, I will discuss my reflections on the process. Finally, I will conclude with future work and dissemination of this research.

Researcher background

As a result of my own background, beliefs and experiences, I came to this research heavy with assumptions and expectations. While assumptions are widespread and cannot be eliminated, they can be explicitly acknowledged and brought to the forefront; both to allow for transparency and to enrich research outputs through the process of reflexivity. With this in mind, I outline a number of my own 'perspectives' below, on the basis of my background and experiences relevant to this research.

Psychological impact of war. I have always been drawn to the impact of war and conflict from a clinical and research perspective. From the age of 13 up until 21 I grew up closely following the news of my country, Iraq, at war leading to hundreds of thousands of casualties. To this day, family narratives often concern the loss of the beautiful family home we had, filled with memories and sentiments; and of a once beautiful country; an intellectual hub flowing with rivers and the smell of jasmine. My uncle, a psychiatrist, also became drawn to this field as a result of the war and has now devoted his professional life to working with those who have been affected by war-trauma. I myself worked as an assistant psychologist at a trauma clinic for

refugees before training and I've now returned to that clinic as a final year trainee working in that capacity.

Mental health and conflict research. While I was drawn to seeking knowledge about war and conflict from a psychological perspective through the evidence base, I often found myself frustrated, particularly with the trauma literature and its over-pathologisation and internal location of trauma or distress, seen as an individual phenomena; taking a very a "biopsychological" approach.

The missing 'social' element in trauma, for me, represents two domains. First, 'social' support within a community that is accepting and fitting with individuals' values. There is no shortage of literature emphasising the importance of social support, yet it lacks an integration within common theoretical models. From the snapshot I got through this research, it seemed that, given the large number of Syrians in Turkey, a sense of community has been re-created. The political and social outlook of Turkey as a host country, being geographically and culturally close to Syria, has largely led to an acceptance and integration of Syrian refugees. I compare this to my clinical work at my trauma placement with Syrians who have come to the UK through a governmental resettlement scheme and I see a very different snapshot of a much less well-adjusted group of Syrians. From speaking to these Syrian clients and clinicians, I got the sense that this was in large part due to their isolation due to a lack of community, and being very far from their culture left to navigate a complex UK system.

The second lacking social domain represents the role of socio-political levels of context in creating and contributing to distress. Surely, I thought, the distress of civilian survivors of war related trauma is a political issue in itself. I tried to bring this

into the research, drawing on the humanitarian ethics and global health literature as an attempt to create a bridge.

Language and culture. I came to the UK as a refugee at the age of six. One thing I really remembered was struggling with English and feeling rather paralysed with my Arabic mother tongue. I quickly learned English, as you do at that age, and held on to my Arabic language thanks to my family's efforts (or should I say adamancy) of speaking to me in Arabic...at the time it was very frustrating but I thank them for it now. As I continued to clumsily navigate between my dual British and Arab culture and identity, I really saw the importance of culture in shaping the way that one perceives the world. For a long time, I felt that I was constantly switching between these two hats. And with culture, comes language. Khaled Hosseini (2000) wrote *"if culture is a house, then language was the key to the front door; to all the rooms inside."*

Through my clinical and pre-clinical work, I have worked with a number of Arab clients. Often, Arab clients request that I speak to them in Arabic, even after I make multiple disclaimers that my Arabic therapeutic terminology is weak (and the fact that I have a very strong Iraqi dialect, which is difficult to understand unless Iraqi). I noticed that, with clients I did use Arabic with, it was a lot harder to maintain professional boundaries and my Arabic-speaking colleagues noticed the same thing. Interestingly, with bilingual clients I frequently found myself speaking English when I wanted to be more formal, for fear that it would otherwise come across as rather rude if said in Arabic.

Epistemology

I come from a family of mainly scientists of some form. My choice to pursue a career in psychology was a very unfamiliar and initially uncomfortable one for my

family, given that it is not strongly aligned to realism. I myself also love the sciences and a career linked to mathematics would have been my second choice. I initially found myself aligned with realism within psychology. However, I was soon after left with frustration mainly because of its potential to deflect attention from important cultural and socio-political influences on both the internal and external reality of an individual or community. At the same time, I also found myself frustrated with a radical relativist position's lack of means of the credible empirical investigation required for introducing changes within a wider system, which is itself often based on empirical investigation in order to influence change on higher socio-political levels (commissioning, academic curricula and so on). For these reasons, I found myself very much aligned to pragmatism within a community psychology approach as I outlined when disclosing my perspective in Part B.

Motivations and Assumptions

In my view there are two main things that have an unconscious impact research: one's motivations and one's assumptions, and they operate at all levels of the research cycle. Traditionally these are seldom transparent despite their importance and heavy influence in driving research. Below, I highlight my own assumptions and motivations that I noticed throughout the research process.

Motivations. One thing I really wanted from this project is to 'pass the microphone' to Syrian therapists themselves to get rich descriptions of how it is done out there given that they are the ones with first-hand knowledge and experience, and to disseminate this as an initiative. Upon reflecting on this, I believe this partly comes from a number of negative interactions both in my clinical and research work; at best these interactions come from ignorance and at worst, opportunism. Ignorance

through a failure of reflecting on one's own biases and privilege of Western psychology being the only gold standard, dismissing the importance of cultural and religious factors and opportunism with those wishing to monopolise the field as I alluded to in Part B.

Assumptions. I made the assumption that both culture and religion will feature very strongly in participants' narratives, and that relationships between MHPs and clients would differ very strongly to those typically seen in the Western world, in that boundaries would be much more open due to influence of Arab culture. These assumptions are a result of my own relationship to my language and culture, and my own clinical experiences.

Challenges to and confirmations of assumptions. Through this research to my surprise I found that there were a lot of similarities to professional boundaries and self-disclosure in the Western literature, and a lot of this was by way of Syrians being trained by Western-trained professionals who pass on this wisdom. Furthermore, I assumed that many more participants would describe more use of religion in therapy, however almost all spoke about not using it as they did not feel qualified to, and only a few spoke about using it sensitively such as using religious phrases when a client speaks about someone who passed away, taking more of a cultural rather than religious influence.

Fitting with assumptions. A lot of my assumptions about Western trained therapists coming to the field with a more opportunistic and less well-intentioned approach were confirmed. One participant brought up the fact that she got frustrated by a number of psychologists training the Syrian mental health professional community, who often live in high income countries and would come in and provide training on a

great therapy for a few days, while staying at their very expensive hotels and then going back home to their comfortable lives, never to be seen again. Another participant spoke about how trauma was over-emphasised so much so that simple psychosocial support in relation to security and safety were often overlooked; he reported that a number of children in a particular area of a camp in the South of Turkey were bedwetting regularly. This led to a number of (international) trauma therapists trying to 'heal' this through trauma processing, with the assumption that this was a symptom of PTSD in response to a nightmare, but to no avail. After a while, someone decided to speak to the children and soon after realised that the toilets were just too far away, and that the kids were too scared to go to the toilet in the middle of the night. This not only confirmed my assumptions, but it had a rather profound impact on me, and made me reflect on my own assumptions and biases given my interest and training in trauma-focussed therapy.

Reflections on the research process

Transcription and Translation. Transcription reveals the particular stance of the transcriber. It reveals their epistemological position and purposes. I initially put emphasis on capturing exact words that people uttered in order to convey their particular experiences. Consequently, there was an initial wish to verbatim transcribe every word in Arabic first, this proved difficult as the Syrian dialect is a 'spoken' dialect, rather than a written one. This coupled with the constraints of DClinPsy led me to only transcribe significant utterances.

Another alternative would have been to translate the Syrian spoken Arabic to the Modern Standard Arabic (MSA; fus'ha) version, however this would not have captured the essence of participants' words. Furthermore, some words belonging to

the Syrian dialect simply do not exist in MSA. The decision was therefore made to do a direct Arabic verbatim to English transcription so that the participants' words are captured inasmuch as possible. Given that I, an Iraqi Arabic speaker who has lived in the UK for the majority of her life, initially began the translation, I felt it important to instead hire native Syrian speakers to conduct this translation while checking the transcripts.

Interview experience. I found it interesting how the assumptions I held about Syrian MHPs interactions with their clients being influenced by Arab culture fit with my own experiences of interactions with participants. I found, particularly initially, that my own professional boundaries were naturally reduced. The experience was a much less formal one than I had anticipated; I was invited to a number of participants' houses, and often found myself speaking about participants' family lives and so on. I also found myself becoming quite emotional at some points, and it seemed harder for me to hear some of the content than in my own clinical work at the trauma clinic, despite regularly hearing and being responsible for processing equally horrific human rights abuses. I assumed that this was due to the fact that my own professional boundaries were reduced, and reflected on how my own assumptions about the research process were playing out in my own experiences.

I also found myself changing the interview schedule as I went along. It may have been due to the translation of words, or participants' expectations of the interview content, but I found that in most instances when I used the Arabic word for impact (yu2athir), almost all participants would make the assumption that I meant in a negative way. Consequently, I added to this question "both in helpful and unhelpful ways?". There were also changes from a political stance, I started off by using the

Arabic word for 'conflict' to indicate the war, but soon after changed this to 'revolution (thawra)' given that all participants used this word instead. It was very inspiring to see how Syrian MHPs were very motivated to help fellow Syrian clients. All participants were also very motivated to help participate in this research, always being very accessible and willing to give their time.

Qualitative analysis. I was completing the qualitative analysis at a time when I was seeing adult survivors of war trauma, trafficking and child abuse for trauma-related distress. I was at the early stages of providing trauma therapy involving reliving of traumatic events and I myself experienced some of the things that I was researching and analysing; secondary traumatic stress symptoms, compassion satisfaction, prioritising self-care and so on. Given that I was seeing two Syrian clients and an Iraqi client at this clinic, I was also thinking about and experiencing the impact of shared characteristics. I was very aware that this, as well as my overall investment and interest in the project had the potential to lead me to over-identify with the data, increasing the likelihood of my own ideas and experiences at a personal level and professional level affecting the analysis. As a result I aimed to continually maintain reflexivity and I kept a journal throughout to enhance my ability to reflect on such issues. I reflected that this personal and clinical position that I held was also a very helpful one, as it allowed me to understand these concepts not only at an abstract level but experientially, and heightened my understanding and ability to link theory to practice while being at an advantage to understand cultural nuances and contexts.

Future work

This project has contributed to my view that, while there is no doubt that the provision of specialised psychological support, particularly for trauma-related distress,

is important in contexts of war and conflict, the provision of basic security, safety and stability is equally as important. These two do not contradict each other, but are crucially carried out together, particularly given the phased model of care of post-traumatic stress-disorder (PTSD). However, in the case of global mental health, there is an overall lack of integration between the professionals providing the two types of support. It is important to encourage cross and inter-disciplinary working in this context to provide holistic care. Future studies can aim to evaluate the effectiveness of interventions targeting both basic safety and security as well as specialised care.

With regards to the cultural and contextual influence of the therapy-client dyad, it would be interesting to understand how Syrian clients see their therapists. It would also be helpful to understand how the similarities of the therapist impact the client in helpful and unhelpful ways.

Outputs

Teaching. The knowledge and experience that I have gained doing this project has allowed me to give four talks in March 2018, to medical students and engineering master's students working with conflict and disaster at King's College London, St George's University and UCL, as well as to all three cohorts of trainee clinical psychologists at an end of term conference that I organised. Preparing for the talks and the discussions and debates that followed allowed me to get a grasp of the literature and my ideas.

New collaborations. This project brought along a number of opportunities. I am very grateful to KS for introducing me to UCL's new Global Mental Health Working Group which I am now an active member of. A collaboration has also been made with Trauma Aid UK and Syrian Association for Mental Health.

Dissemination. The results of this study will be disseminated to participants, almost all of whom requested to be kept informed of the findings via email. I met with a Trustee of Trauma Aid, who was also one of the EMDR consultants who trained and supervised a number of participants in Turkey. She was keen for me to present the findings at a Trustee meeting so that new learnings and understandings can be taken forward given that Trauma Aid UK hope to continually expand their training in the Middle East, with projects hoped to take place in Lebanon, Amman, Cairo and Egypt. I was also given the opportunity to present the findings at the annual Syrian Association for Mental Health and I hope to do this next year. I hope to continue disseminating the findings of this research not only through meetings and conferences, but also through publication so that they can make a helpful contribution to the very scarce literature on this important topic.

Appendices

Appendices 1-9 below contain search terms for respective databases.

Appendix 1. OVID PsycINFO (January 2014 to January 2018)

A sensitive search was conducted using terms for population (only) plus an RCT filter:

1. torture/
2. torture\$.mp.
3. "prisoners of war"/
4. ((trauma* or psychotrauma* or violence) and (asylum\$ or refugee\$ or hostage\$)).mp.
5. ((organised or mass) adj3 violence).mp.
6. exp survivors/ and War/
7. ((surviv\$ or victim*) adj7 war).mp.
8. (polit\$ adj7 persecut\$).mp.
9. exp genocide/
10. genocide.mp.
11. or/1-10
12. clinical trials.sh.
13. mental health program evaluation.sh.
14. treatment effectiveness evaluation.sh.
15. placebo.sh.
16. placebo\$.ti,ab.
17. (wait* and list* and (control* or group)).ab.
18. ("treatment as usual" or TAU).ab.
19. randomly.ab.
20. randomised.ti,ab.
21. trial.ti,ab.
22. ((singl\$ or doubl\$ or trebl\$ or tripl\$) adj3 (blind\$ or mask\$ or dummy)).mp.
23. (control\$ adj3 (trial\$ or study or studies or group\$)).ti,ab.
24. factorial\$.ti,ab.
25. allocat\$.ti,ab.
26. assign\$.ti,ab.
27. (crossover\$ or cross over\$).ti,ab.

28. (quasi adj (experimental or random\$)).mp.

29. "2000".md.

30. or/12-29

31. 11 and 30

Appendix 2. OVID MEDLINE (January 2014 until January 2018)

1. torture/

2. torture\$.tw.

3. ((trauma* or psychotrauma* or violence) and (asylum\$ or refugee\$ or hostage\$)).mp.

4. ((organi#ed or mass) adj3 violence).tw.

5. exp survivors/ and war/

6. ((surviv\$ or victim*) adj7 war).tw.

7. (polit\$ adj7 persecut\$).tw.

8. genocide.tw.

9. or/1-8

10. randomized controlled trial.pt.

11. controlled clinical trial.pt.

12. randomi#ed.ti,ab.

13. randomly.ab.

14. placebo.ab.

15. (wait* and list* and (control* or group)).ab.

16. (treatment as usual or TAU).ab.

17. trial.ab.

18. groups.ab.

19. (control\$ adj3 (trial or study)).ab,ti.

20. ((singl\$ or doubl\$ or tripl\$ or trebl\$) adj3 (blind\$ or mask\$ or dummy)).mp.

21. or/10-20

22. 9 and 21

Appendix 3. OVID EMBASE (January 2013 until January 2018)

1. torture/

2. torture\$.tw.

3. torture survivor/

4. ((trauma* or psychotrauma* or violence) and (asylum\$ or refugee\$ or hostage\$)).mp.
5. ((organi#ed or mass) adj3 violence).tw.
6. survivor/ and war/
7. ((surviv\$ or victim*) adj7 war).tw.
8. (polit\$ adj7 persecut\$).tw.
9. genocide.mp.
10. or/1-9
11. randomized controlled trial.de.
12. randomization.de.
13. randomi#ed.ti,ab.
14. randomly.ab.
15. placebo.de.
16. placebo\$.ti,ab.
17. (wait* and list* and (control* or group)).ab.
18. (treatment as usual or TAU).ab.
19. ((singl\$ or doubl\$ or trebl\$ or tripl\$) adj3 (blind\$ or mask\$ or dummy)).mp.
20. factorial\$.ti,ab.
21. allocat\$.ti,ab.
22. assign\$.ti,ab.
23. volunteer\$.ti,ab.
24. crossover procedure.de.
25. (crossover\$ or cross over\$).ti,ab.
26. (quasi adj (experimental or random\$)).mp.
27. (control\$ adj3 (trial\$ or study or studies or group\$)).ti,ab.
28. or/11-27
29. 10 and 28

Appendix 4. Web of Science (all years to January 2018)

1. torture*
2. ((trauma* or psychotrauma* or violence) and (asylum* or refugee* or hostage*))
3. ((organized or organised or mass) NEAR/3 violence)
4. ((surviv* or victim*) NEAR/7 war)

5. (polit* NEAR/7 persecut*)
6. genocide
7. (#6 OR #5 OR #4 OR #3 OR #2 OR #1)
8. (randomized or randomised)
9. (random* NEAR/3 (allocat* or assign*))
10. placebo*
11. ((wait* and list*) SAME (control* or group))
12. ("treatment as usual" or TAU)
13. (control* NEAR/3 (trial or study))
14. ((singl* or doubl* or tripl* or trebl*) NEAR/3 (blind* OR mask* OR dummy))
15. (quasi NEAR/3 (experimental or random*))
16. (#15 OR #14 OR #13 OR #12 OR #11 OR #10 OR #9 OR #8)
17. (#7 and #16)

Appendix 5. CINAHL-EBSCO Host (January 2013 until January 2018)

- S1 (MH "Torture")
- S2 (MH "Torture Survivors")
- S3 (torture*)
- S4 ((trauma* or psychotrauma* or violence) and (asylum* or refugee* or hostage*))
- S5 ((organi#ed or mass) N3 violence)
- S6 (MH "Survivors") and (MH "War+")
- S7 ((surviv* or victim*) N7 war)
- S8 (polit* N7 persecut*)
- S9 (genocide)
- S10 (S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9)
- S11 (MH "Clinical Trials+")
- S12 (PT Clinical trial)
- S13 (TX clini* N1 trial*)
- S14 (TX ((singl* N1 blind*) or (singl* N1 mask*)) or TX ((doubl* N1 blind*) or (doubl* N1 mask*))
- or TX ((tripl* N1 blind*) or (tripl* N1 mask*)) or TX ((trebl* N1 blind*) or (trebl* N1 mask*))
- S15 (TX randomi* control* trial*)

S16 (MH "Random Assignment")
 S17 ((TX random* allocat*) or (TX allocat* random*))
 S18 (TX placebo*)
 S19 (TX (wait* and list* and (control* or group)))
 S20 ((TX "treatment as usual") or (TX TAU))
 S21 (TX (control* N3 (trial* or study or studies or group*)))
 S22 (MH "Quantitative Studies")
 S23 (S11 or S21 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20 or S21 or S22)
 S24 (S10 and S23)

Appendix 6. ClinicalTrials.gov and WHO ICTRP (January 2014 until January 2018)

Tortur*

Appendix 7. PILOTS-ProQuest Host (January 2014 to January 2018)

Randomised AND tortur*
 randomized AND tortur*
 randomly allocated AND tortur*
 randomly assigned AND tortur*
 quasi-random AND tortur*
 quasi-randomized AND tortur*
 quasi-randomised AND tortur*
 placebo AND tortur*
 controlled trial AND tortur*
 controlled study AND tortur*

Appendix 8: DIGNITY (Danish Institute against Torture; January 2014 to January 2018)

Randomised AND tortur*
 randomized AND tortur*
 randomly allocated AND tortur*
 randomly assigned AND tortur*
 quasi-random AND tortur*
 quasi-randomized AND tortur*
 quasi-randomised AND tortur*
 placebo AND tortur*
 controlled trial AND tortur*
 controlled study AND tortur*

Appendix 9. Description of types of interventions, taken from Patel, Kellezi & Williams (2014)

1. **Psychological interventions** are delivered to the individual, family, group or community with the aim of changing cognitive, emotional or behavioural outcomes. These interventions draw on a variety of theoretical and therapeutic schools but can be grouped into broad models, including behavioural, cognitive behavioural, systemic, humanistic, psychodynamic and integrative psychological interventions. These include psychodynamic and psychoanalytical therapies, behavioural and cognitive psychotherapies (including cognitive-behavioural therapy (CBT) and exposure therapy), interpersonal psychotherapy, narrative therapy, testimony therapy, cognitive analytic therapy, anxiety/stress management approaches, systemic psychotherapies, counselling, supportive and experiential psychotherapies, art therapy, drama therapy, dance therapy, eye movement desensitisation and reprocessing (EMDR) and hypnotherapy.
2. **Social interventions** may be delivered at individual, group and community levels with the aim of improving interpersonal relationships, social involvement and participation, social integration of individual survivors and their families, and social cohesion. Social interventions may include building communication skills, facilitating the formation and maintenance of relationships, facilitating empowerment and agency and building educational and vocational skills to support reintegration into society. Social interventions can also include community development and resources that can provide a supportive and trusting context for torture survivors and their families. These consist of involvement in community activities, reparation and judicial activities, educational initiatives (such as learning the host country language) and others.
3. **Welfare interventions** are delivered at the level of the individual, family and community with the aim of benefiting survivors' health and well-being by improving social conditions, addressing basic needs for food, clothing and adequate housing and meeting educational, employment or vocational needs. Among welfare interventions, legal interventions may be delivered to ensure legal protection (e.g. refugee status), to facilitate access to redress and justice (which can include access to appropriate healthcare) and to provide emotional support for torture survivors. These are exemplified by information about legal and welfare rights and entitlements, nursery and school places available for children, productive and creative activities including work initiatives and others.

Appendix 10. Table of Characteristics of studies

Bass et al. (2016)

Methods	Study design: randomised controlled trial
Participants	<p>209 adults who have experienced or witnessed physical torture</p> <p>Diagnosis: Depression</p> <p>Method of diagnosis: reporting at least 20 on Hopkins Symptom Checklist (HSCL-25) depression scale and meeting DSM-IV criteria for major depression.</p> <p>Age: mean age 40 years (range 18 to 82)</p> <p>Gender: 66% male, 34% female</p> <p>Location: Dohuk, Kurdistan, Iraq</p>
Interventions	<p>Participants were randomly assigned to:</p> <ol style="list-style-type: none"> 1. Experimental arm ($n=159$) <p>Duration: 6-12 sessions depending on client need</p> <p>Treatment protocol: supportive counselling</p> <p>Practitioners: trained community mental health workers (CMHWs) who were permanent employees of the Ministry of Health</p> 2. Comparator arm ($n=50$) <p>Duration: 3-5 months</p> <p>Treatment protocol: waitlist control: monthly telephone calls to participants for brief check-in</p>

	Practitioners: same as above
Outcomes	<p>Time points for assessment: baseline and 1 month post-completion for intervention participants or 3-5 months after baseline for waitlist participants</p> <p>Assessment language: Kurdish</p> <p>Primary outcome: : PTSD using the Harvard Trauma Questionnaire (HTQ)</p> <p>Secondary outcome: depressive symptoms and anxiety symptoms (HSCL-25), functional impairment (locally developed scales described in Bolton, Bass et al., 2014) and traumatic grief (Inventory of Traumatic Grief).</p>
Baseline Characteristics	20% self-reported disability, majority married, approximately 50% unemployed, and more than 40% reported no education. Demographic characteristics of the participants across the two arms were comparable, with no statistically significant differences.
Adherence and Completion	Of the 159 allocated to treatment, 5 never initiated counselling. Of the 154 who initiated counselling, 147 (95.5%) completed treatment. Mean number of sessions attended was 11.29 (range 6-12). 10 individuals in treatment arm were lost to follow up and 7 in control group were lost to follow-up. In total, 188 individuals (90% completed follow up).
Notes	The HSCL-25, HTQ and Inventory for Traumatic Grief were adapted and validated for the local context, detailed methods were described elsewhere.
<i>Risk of bias</i>	
Bias	Author's judgement and support for judgement
Random sequence generation (selection bias)	Low risk. "ID numbers were randomly allocated using STATA's randomisation function"
Allocation concealment (selection bias)	Low risk. "Study CMHWs were provided with a set of pre-numbered consent forms with the designation of intervention or waitlist control status on a piece of paper that was folded and stapled to the back."

Blinding of participants and personnel (performance bias)	High risk. Not possible to render participants nor practitioners blind to allocation.
Blinding of outcome assessment (detection bias)	High risk. “82% of the follow-up interviews were conducted by CMHWs who were blinded to the participant’s treatment status but no comment on unwitting blinding.18% if interviews were unblinded, affecting the significance of findings.
Incomplete outcome data (attrition bias)	High risk. Over 90% completed treatment and follow-up, multiple imputation methods were used for incomplete data.. The 10% of individuals lost to follow-up were significantly more likely to be female ($p= .04$), self-employed ($p = .007$), and unmarried ($p= .04$).
Selective reporting (reporting bias)	Unclear risk. All measures were used and reported, validity and reliability tests reported, the development and adaptation of scales were also reported, but no protocol reported
Therapist allegiance	Low risk. All CMHW from varying health backgrounds and received training in supportive counselling at same time
Treatment fidelity	High risk. Counselling was given according to need with no specific protocol followed.
Therapist qualifications	High risk. Community based providers without formal mental health training
Other bias	

Bolton, Lee et al. (2014)

Methods	Study design: randomised controlled trial
Participants	<p>347 displaced Burmese adults who have experienced or witnessed physical torture, imprisonment and “related traumas”</p> <p>Diagnosis: Moderate to severe depression or PTSD</p> <p>Method of diagnosis: reporting at least 20 on the HSCL-25 depression scale while meeting DSM-IV criteria for major depression, and the HTQ for depression and PTSD respectively</p> <p>Age: mean 35.6 years</p> <p>Gender: 63% female</p> <p>Location: Thailand</p>
Interventions	<p>Participants were randomly assigned to:</p> <ol style="list-style-type: none"> 1. Experimental arm ($n = 182$) <p>Duration: 7-13 weekly sessions, average number of sessions: 9.7</p> <p>Treatment protocol: common elements approach (CETA), a transdiagnostic treatment developed by the authors</p> <p>Practitioners: trained lay workers, all Burmese refugees who received regular supervision</p> 2. Comparator arm: ($n=165$) <p>Duration: 3-4 months</p> <p>Treatment protocol: waitlist control: monthly telephone calls</p>

	Practitioners: project coordinator (no further details given)
Outcomes	<p>Time points for assessment: baseline and post-completion</p> <p>Assessment language: Burmese</p> <p>Primary outcome: depression and anxiety symptoms (HSCL-25) and PTSD (HTQ)</p> <p>Secondary outcome: aggression behaviour (12 item Aggression Questionnaire, Buss & Warren, 2000), functional impairment (locally developed scales described in Bolton, Lee et al., 2014) and alcohol use (Alcohol Use Disorders Identification Test; AUDIT)</p>
Baseline Characteristics	“Baseline anxiety was identified as the only measured variable likely to be different between the two groups at baseline and was included in adjusted models”
Adherence and Completion	79% of all participants were followed-up. 5 were recruited in error in that they did not meet depression or PTSD criteria, 34 were lost to follow-up in the intervention arm with 18 withdrawing due to lack of time or return to Burma, 1 passed away and 15 could not be located. Of 39 controls lost to follow-up, 8 no longer had time to left the area and 31 could not be located.
Notes	The mean baseline for all participants for both depression and PTSD was low overall and so researchers are not investigating a highly affected sample. The paper did not include type of traumatic event as a descriptive variable but upon following up with the authors, it was confirmed that 54% of participants reported torture. All outcome measures were adapted to the local context and tested during a prior instrument validation study (described elsewhere).
<i>Risk of bias</i>	
Bias	Author’s judgement and support for judgement

Random sequence generation (selection bias)	Low risk. Project site director generated random ID numbers using STATA
Allocation concealment (selection bias)	Low risk. Counsellors opened a pre-sealed envelope (corresponding to the ID number) containing an assignment to treatment or waitlist.
Blinding of participants and personnel (performance bias)	High risk. Not possible to render participants nor practitioners blind to allocation.
Blinding of outcome assessment (detection bias)	Unclear risk. “Interviewers at baseline and follow-up did not know to which study arm the interviewees belonged” but no comment on unwitting blinding
Incomplete outcome data (attrition bias)	High risk. Those lost to follow-up had higher baseline alcohol use, reported more current problems and were more likely to be of an ethnicity other than Burman.
Selective reporting (reporting bias)	Unclear risk. All measures were used and reported, validity and reliability tests reported, the development and adaptation of scales were also reported but no protocol reported
Therapist allegiance	Low risk. All community based providers from varying health backgrounds and received training in CETA at same time
Treatment fidelity	Low risk. “Counsellors were able to implement CETA with fidelity, per local supervisor report” although no details of report were given.
Therapist qualifications	High risk. Community based providers, with only 2 of 11 having prior general counselling experience. One of the supervisors was a former political prisoner with no counselling experience or advanced degree
Other bias	

Esala & Taing (2017)

Methods	Study design: pilot randomised controlled trial
Participants	<p>88 Khmer Rouge torture survivors</p> <p>Diagnosis: Moderate to severe depression or PTSD</p> <p>Method of diagnosis: HSCL-25 for depression, Posttraumatic Stress Disorder Checklist (PCL-5) for PTSD.</p> <p>Age: mean age 60.4 years</p> <p>Gender: 74% female</p> <p>Location: Cambodia</p>
Interventions	<p>Participants were randomly assigned to:</p> <ol style="list-style-type: none"> 1. Experimental arm ($n = 45$) <ul style="list-style-type: none"> Duration: 5 days Treatment protocol: testimony therapy plus ceremony Practitioners: counsellors trained in testimony therapy plus ceremony from a German clinician, with biweekly supervision from psychologist in Cambodia. 2. Comparator arm($n = 43$) <ul style="list-style-type: none"> Duration: 5 days Treatment protocol: waitlist control: no information available Practitioners: no information available
Outcomes	<p>Time points for assessment: baseline, 3 months and 6 months</p> <p>Assessment language: Khmer</p>

	<p>Primary outcome: PTSD (PCL-5)</p> <p>Secondary outcome: depression and anxiety (HSCL-25).</p>
Baseline Characteristics	Over 60% in both groups were married, and the majority (at least 95%) in both groups were Buddhist. 73.3% and 72.1% of the treatment and control participants respectively are able to read.
Adherence and Completion	60 participants were randomised to each group. Of the individuals randomised to the treatment group, 15 chose not to complete baseline or participate in intervention and 9 did not complete at least one of the follow-up assessments. Of the individuals in the control group, 17 participants did not complete the baseline and 3 did not complete at least one of the follow-up assessments.
Notes	Testimony plus ceremony was culturally adapted for local context
<i>Risk of bias</i>	
Bias	Author's judgement and support for judgement
Random sequence generation (selection bias)	Unclear risk. Method of randomisation not described
Allocation concealment (selection bias)	Unclear risk. Method of allocation not described
Blinding of participants and personnel (performance bias)	High risk. Not possible to render participants nor practitioners blind to allocation.
Blinding of outcome assessment (detection bias)	Unclear risk. Measures were "administered by a blind assessor at baseline, 3 months and 6 months" but no comment on unwitting unblinding
Incomplete outcome data (attrition bias)	High risk. Of 45 intervention participants who completed baseline, 9 were lost to follow up. Out of 43 comparator participants who completed baseline, only 3 were lost to follow-up.
Selective reporting (reporting bias)	Unclear risk. All measures were used and reported but no protocol reported

Therapist allegiance	Unclear risk. Counsellors prior experience, training and qualifications not reported
Treatment fidelity	Low risk. Counsellors received training in testimony therapy plus ceremony. Prior to each supervision session, the counsellors completed a form to document deviations from the model and general challenges, with deviations prompting ongoing individual and group training by advisors and supervisors.
Therapist qualifications	Unclear risk. Counsellors' experience and qualifications not reported
Other bias	

Puvimanasinghe & Price (2016)

Methods	Study design: randomised controlled trial
Participants	<p>26 primary (69%) and secondary survivors of torture (30%)</p> <p>Diagnosis: none specified – distress measured instead</p> <p>Method of diagnosis: not applicable</p> <p>Age: mean 40.5 years</p> <p>Gender: 38.5% female</p> <p>Location: Sri Lanka</p>
Interventions	<p>Participants were randomly assigned to:</p> <ol style="list-style-type: none"> 1. Experimental arm ($n = 13$) <p>Duration: 5 sessions (60-90 minutes each)</p> <p>Treatment protocol testimony therapy plus ceremony</p>

	<p>Practitioners: counsellors trained in testimony therapy plus ceremony from a German clinician, with biweekly supervision from psychologist in Cambodia.</p> <p>2. Comparator arm: ($n = 13$)</p> <p>Duration: waitlist control: not described</p> <p>Treatment protocol: participants were informed that they would be contacted again and offered testimony therapy at a later date</p> <p>Practitioners: no information available</p>
Outcomes	<p>Time points for assessment: baseline and 2-3 months later</p> <p>Assessment language: Sinhalese</p> <p>Primary outcome: trauma-related distress (Sri Lanka Index of Psychosocial Status; SLIPSS-A), social participation (Participation scale)</p> <p>Secondary outcome: emotional well-being (World Health Organisation Five Well-being Index, WHO-5) to measure depression</p>
Baseline Characteristics	In both groups, 77% of participants experienced torture, 15.4% experienced ill-treatment and 7.7% experienced psychological abuse. Comparison of mean pre-test scores for the two groups found no significant differences for all outcomes, and no age or gender differences.
Adherence and Completion	Low risk – no participants were lost to follow-up
Notes	
<i>Risk of bias</i>	
Bias	Author's judgement and support for judgement

Random sequence generation (selection bias)	High risk. After matching pairs according to demographics and nature of violation, participants were then randomly assigned to either the treatment group or waiting list
Allocation concealment (selection bias)	High risk. Assignment to condition was decided by using the characteristics of gender, participant status, and nature of violation, to match pairs of participants as closely as possible.
Blinding of participants and personnel (performance bias)	High risk. Not possible to render participants nor practitioners blind to allocation.
Blinding of outcome assessment (detection bias)	Unclear risk. Method not described
Incomplete outcome data (attrition bias)	Low risk. Two outcome measures were unavailable for one individual at follow-up and “these points were substituted with pretest scores according to intent-to-treat analysis”.
Selective reporting (reporting bias)	Unclear risk. All measures were used and reported but no protocol reported
Therapist allegiance	Unclear risk. Counsellors prior experience, training and qualifications not reported
Treatment fidelity	Unclear risk. No information provided.
Therapist qualifications	Unclear risk. Counsellors’ experience and qualifications not reported
Other bias	

Wang et al. (2016)

Methods	Study design: pilot randomised controlled trial
Participants	34 torture and war victims with chronic pain and comorbid mental health diagnosis Diagnosis: chronic pain, PTSD, depression or anxiety Method of diagnosis: Wong-Baker FACES Pain Rating Scale and SF-MPQ to assess chronic pain, HTQ for PTSD, HSCL-25 for depression and anxiety symptoms.

	<p>Age: mean 47.7 years</p> <p>Gender: 45% female</p> <p>Location: Kosovo</p>
Interventions	<p>Participants were randomly assigned to:</p> <ol style="list-style-type: none"> 1. Experimental arm ($n = 17$) <p>Duration: 10 weekly individual sessions (90m duration) and 10 weekly group sessions (60-90m duration) over 3 months</p> <p>Treatment Protocol: CBT with adapted prolonged exposure and breathing exercises using biofeedback, group physiotherapy and daily multivitamin</p> <p>Practitioners: 3 therapists (1 doctor and 2 psychologists) and 3 physiotherapists</p> 2. Comparator arm ($n = 17$) <p>Duration: 3 months</p> <p>Treatment protocol: waitlist control: daily multivitamin</p> <p>Practitioners: same as above</p>
Outcomes	<p>Time points for assessment: baseline, 3 months, 6 months</p> <p>Assessment language: Albanian</p> <p>Primary outcome: PTSD symptoms (HTQ), anxiety and depression (HSCL-25)</p> <p>Secondary outcome: chronic pain (FACES and SF-MPQ), functioning and quality of life (WHODAS)</p>

Baseline Characteristics	Participants in the intervention arm had worse baseline symptoms of chronic pain and disability than participants in comparator arm, while participants with chronic pain or depression were equally distributed in both groups.
Adherence and Completion	2 participants did not begin the treatment, and 1 dropped out before the second session. Outcome data for 6 participants had systematically missing data at month 6. In total, 13 participants in the intervention group and 15 in the waiting list group were included in an intent-to-treat analysis. Attendance rates were 76% and 55% for individual sessions and group respectively, with no significance difference in attendance between both groups
<i>Risk of bias</i>	
Bias	Author's judgement and support for judgement
Random sequence generation (selection bias)	Low risk. A block randomisation procedure using a computerised random number generator created by staff member not involved in the trial.
Allocation concealment (selection bias)	Low risk. Each participant was given a unique number according to above method
Blinding of participants and personnel (performance bias)	High risk. Not possible render both participants and therapists blind to group allocation
Blinding of outcome assessment (detection bias)	Low risk. "At the baseline assessment, participants and therapists were blinded to the allocation. Therapists were also blinded to the outcomes during baseline and outcome assessments – the assessor was blinded to which group was which throughout the study"
Incomplete outcome data (attrition bias)	Low risk. Intent to treat analysis as 3 participants dropped out and 6 participants had systematically missing data
Selective reporting (reporting bias)	Unclear risk. All measures were used and reported but no protocol reported

Therapist allegiance	Unclear risk. No mention of types of therapy and qualifications of therapists and doctor who participated, aside from CBT training for the latter
Treatment fidelity	Unclear risk. “To check treatment integrity and compliance for quality assurance, at least 15 % of the CBT treatment sessions were randomly selected and recorded. An independent assessor reviewed these with the assistance of an experienced interpreter with medical background.” But no outcome given by authors. A physiotherapy manual was given to physiotherapists for the group, but the sessions were not monitored closely
Therapist qualifications	Unclear risk. “The therapists’ working clinical experience ranged from 1 to 15 years. The three physiotherapists also had university degrees and few years of working experience”
Other bias	

Weiss et al. (2015)

Methods	Study design: two-site, two-armed randomised controlled trial
Participants	<p>342 torture survivors</p> <p>Diagnosis: PTSD</p> <p>Method of diagnosis: HTQ to assess trauma symptoms, HSCL-25 to assess depression and anxiety symptoms</p> <p>Age: mean 41.9 years</p> <p>Gender: 33% female</p> <p>Location: Southern Iraq</p>

Interventions	<p>Participants were randomly assigned to:</p> <ol style="list-style-type: none"> 1. Experimental arm 1 ($n = 99$) Duration: 8-12 weekly sessions Treatment Protocol: CETA Practitioners: 12 non-specialised CMHWs working in South Iraq 2. Comparator arm for experimental arm 1 ($n = 50$) Duration: 12 weeks Treatment protocol: waitlist control: monthly telephone calls from CMHWs who enrolled them into the study to assess safety. Practitioners: same as above 3. Experimental arm 2 ($n = 129$) Duration: 12 weekly sessions Treatment protocol cognitive processing therapy (CPT) Practitioners: 17 non-specialised CMHWs working in South Iraq 4. Comparator arm for experimental arm 2 ($n = 64$) Duration: 12 weeks Treatment protocol: waitlist control: monthly telephone calls from CMHWs who enrolled them into the study to assess safety. Practitioners: same as above
Outcomes	<p>Time points for assessment: baseline, post-intervention. Mean time from end of treatment to follow-up interview is 3.5 months for CETA and 4.5 months for CPT.</p>

	<p>Assessment language: Arabic</p> <p>Primary outcome: PTSD symptoms (HTQ)</p> <p>Secondary outcome: functional impairment, assessed by a locally developed scale (see Weiss & Bolton, 2010). anxiety and depression assessed by HSCL-25</p>
Baseline Characteristics	For CETA arm, controls tended to be older (mean age 45.2 years versus 41.6 years), less likely to be single (4% versus 13%) and less likely to have a disability (2% versus 13%) than intervention group. The researchers did not identify any differences in trauma, anxiety, depression, dysfunction and other demographic variables. For CPT arm, there were no differences in characteristics between control and intervention clients.
Adherence and Completion	Of the 99 participants enrolled in the CETA arm, 97 (98%) completed therapy and all 97 were reassessed at follow-up. Of the 50 control participants, all completed a follow-up interview but interview forms for 2 participants were lost. Of the 129 participants enrolled in the CPT arm, 107 (82.9%) completed therapy, and all but 1 completed follow-up. 18 intervention drop outs also completed follow-up interviews. Of the 64 control participants, all completed follow-up.
Notes	CETA and CPT manual was translated and adapted for the Southern Iraq context.
<i>Risk of bias</i>	
Bias	Author's judgement and support for judgement
Random sequence generation (selection bias)	Low risk. "A randomisation list was generated for each CMHW by study investigator...the assignment was generating using a random number generator in excel...a piece of paper

	indicating treatment assignment was stapled directly to the back of [pre-numbered] study consent forms.”
Allocation concealment (selection bias)	Low risk. “The study investigators and supervisors maintained a master list for each CMHW that indicated the sequence and appropriate treatment status (intervention/waitlist control) for each participant to enable checking fidelity to the randomisation model”
Blinding of participants and personnel (performance bias)	High risk. Not possible to render participants nor practitioners blind to allocation – “the supervisors and study participants were not blind to the treatment condition”
Blinding of outcome assessment (detection bias)	Unclear risk. “Baseline assessments were conducted by CMHWs as part of the recruitment process prior to randomisation and who were therefore blind to assignment of study...follow-up interviews were done by a different CMHW than the one who recruited the participant so were unaware of the participant’s assignment” but no comment on unwitting unblinding
Incomplete outcome data (attrition bias)	High risk. Overall high adherence to therapy but greater attrition in intervention arms relative to comparator arms. 98% completed CETA follow-up and 100% controls completed follow-up although 2 forms for comparators were lost. However only 82% completed CPT follow-up while 100% of comparators completed follow-ups although forms for 1 intervention participant and 3 comparator participants were lost.
Selective reporting (reporting bias)	Unclear risk. All measures were used and reported, validity and reliability tests reported but no protocol reported.
Therapist allegiance	Low risk. All CMHW were non-specialised and all received the same training, albeit 3-4 years prior to study

Treatment fidelity	High risk. “Fidelity was tracked by CMHW self-report of elements delivered, supervisor review of notes and CMHW reports, and finally by trainer review”. However, for the CETA arm, number of treatment sessions varied across participants (8-12), as did its components “some participants received the additional components for comorbid symptoms: 26 received relaxation, 12 received behavioural activation, and one received In Vivo exposure”.
Therapist qualifications	Unclear risk. CMHW primarily medics or nurses who were trained in counselling methods “some years before by a partner international non-governmental organisation and continued to provide these services part-time.
Other bias	

Appendix 11. Notification of Ethical Approval

UCL RESEARCH ETHICS COMMITTEE
ACADEMIC SERVICES



28th April 2017

Dr Amanda Williams
Research Department of Clinical, Educational and Health Psychology
UCL

Dear Dr Williams

Notification of Ethical Approval

Re: Ethics Application 10163/001: Syrian mental health professionals trained in trauma focused therapy. Therapeutic procedures in the context of cultural norms and displacement

I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC for the duration of the project until **30th September 2018**.

Approval is subject to the following conditions:

Notification of Amendments to the Research

You must seek Carir'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 the '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 Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Chair or Vice-Chair 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 Chair or Vice-Chair 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.

With best wishes for the research.

Yours sincerely



Dr Lynn Ang
Interim Chair, UCL Research Ethics Committee

Cc: Aseel Hamid

Academic Services, 1-19 Torrington Place (9th Floor),
University College London
Tel: +44 (0)20 3108 8216
Email: ethics@ucl.ac.uk
<http://ethics.grad.ucl.ac.uk/>

Appendix 12. Part A Information Sheet

Syrian mental health professionals trained in trauma focused therapy: therapeutic procedures in the context of cultural norms and displacement

My name is Aseel Hamid. I am a Trainee Clinical Psychologist at University College London (UCL) and I would like to invite you to take part in a research study that I am conducting in collaboration with Trauma Aid UK. You will be given a copy of this information sheet.

What is the research about?

We are looking for Syrian mental health professionals who have worked with or are currently working with Syrian clients. We want to find out what Syrian mental health professionals views and experiences are of providing trauma therapy to their Syrian clients.

What will the research involve?

You are asked to complete online questions, which should only take ten to fifteen minutes. They are available in Arabic or English.

The questions ask about your experience of providing trauma-based therapy and how this affects you. It also asks about your professional training, experience and supervision, and relationship to different aspects of Syrian culture.

Where can I take part?

The questions are completed online so you can do this in your own private time.

What are the benefits?

When you complete the questions, you can choose to be entered into a prize draw to win an EMDR tapping device. Alternatively, if you are chosen for the prize draw, you may wish to receive its cash value instead (£99). We also hope that the knowledge gained from your responses will be of benefit to you, and to the wider international community of Syrian mental health professionals.

What happens to the information that I give?

All information you give will be treated as confidential and kept in accordance with the UK Data Protection Act (1998). This means that the information you give us will be well protected. For example, your information will be marked with a code

rather than your name, so that you cannot be recognised (data are kept anonymously). Additionally, your information will be stored securely, so that only the researcher working on the project can access it.

Will the results be written up and published?

The results of this project will be written up and published in a professional journal. However, these will contain general results only. They will not contain any personal information that would allow you to be identified. It is hoped that this research help to develop the field of psychological research within a Syrian context.

Further information and contact details

The project is being conducted at University College London (UCL), with the support of Trauma Aid UK. The project has been approved by the UCL Ethics committee (Project ID Number: 10163/001).

It is up to you to decide whether to take part or not; choosing not to take part will not disadvantage you in any way. If you do decide to take part you are still free to withdraw at any time and without giving a reason. In this case, any data you provide will be deleted from our online servers within seven days.

If you have any questions or would like further information, please feel free to contact me, Aseel Hamid by phone, email or post. My contact details are as follows:

Email: aseel.hamid@ucl.ac.uk

Post: Research Department of Clinical, Educational and Health Psychology

FREEPOST University College London

London WC1E 6BT

Thank you for taking the time to read this information sheet
Your help makes this research on an important cause possible

Appendix 13. Part A Consent Form

Syrian mental health professionals trained in trauma-focused therapy: therapeutic procedures in the context of cultural norms and displacement

This study has been approved by the UCL Research Ethics Committee (Project ID Number: 10163/001). Thank you for your interest in taking part in this research. If you have any questions arising from the Information Sheet, please ask the researcher before you decide whether to join in. You will be given a copy of this consent form to keep and refer to at any time.

Participant's Statement:

- I have read the notes written above and the Information Sheet, and understand what the study involves;
- I understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately;
- I consent to the processing of my personal information for the purposes of this research study;
- I understand that data I provide on the secure survey will be transferred outside of the European Economic area
- I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998;
- I agree that the research project named above has been explained to me to my satisfaction and I agree to take part in this study.

☐ I have read and agree with all of the above, and I wish to proceed to the study
(participants' checking of tick box required in order to proceed to actual study online)

Appendix 14. Part A Questionnaire

Professional questions

What is your job title?

How long have you been in this job for?

How many clients do you see per week?

Roughly what percentage of the clients you see are Syrian refugees?

Roughly what percentage of those Syrian clients show trauma related distress?

What main psychological approach do you use?

What other psychological approaches do you draw on?

What are your relevant qualifications or training that have prepared you for this work? (Tick all that apply)

Do you currently receive supervision?

Which therapeutic approach does this supervision use?

What format is the supervision in? (Group or Individual)

Who by (type of professional)?

How often?

How satisfied are you with the amount of supervision you are currently receiving? (Likert)

How satisfied are you with the quality of supervision you are currently receiving? (Likert)

Demographic questions

What is your gender?

How old are you?

What is your nationality?

Which country do you currently live in?

How long have you resided in this country for?

Were you in Syria when the conflict began in 2011?

Did you leave Syria as a result of the conflict?

In what year did you leave Syria?

Cultural/Religious questions

How much do you identify with Syrian culture?

How much did you identify with Syrian culture growing up?

What is your religion?

How important is religion in your current everyday life? (Likert)

How important was religion in your upbringing? (Likert)

How much does your religion influence your therapeutic practice? (Likert)

How much does your religion influence how you manage difficult circumstances? (Likert)

ProQOL

As in Appendix 15

Appendix 15. Part A ProQOL

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE

(PRO QOL) VERSION 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____	1.	I am happy.		
_____	2.	I am preoccupied with more than one person I [help].		
_____	3.	I get satisfaction from being able to [help] people.		
_____	4.	I feel connected to others.		
_____	5.	I jump or am startled by unexpected sounds.		
_____	6.	I feel invigorated after working with those I [help].		
_____	7.	I find it difficult to separate my personal life from my life as a [helper].		
_____	8.	I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].		
_____	9.	I think that I might have been affected by the traumatic stress of those I [help].		
_____	10.	I feel trapped by my job as a [helper].		
_____	11.	Because of my [helping], I have felt "on edge" about various things.		
_____	12.	I like my work as a [helper].		
_____	13.	I feel depressed because of the traumatic experiences of the people I [help].		
_____	14.	I feel as though I am experiencing the trauma of someone I have [helped].		
_____	15.	I have beliefs that sustain me.		
_____	16.	I am pleased with how I am able to keep up with [helping] techniques and protocols.		
_____	17.	I am the person I always wanted to be.		
_____	18.	My work makes me feel satisfied.		
_____	19.	I feel worn out because of my work as a [helper].		
_____	20.	I have happy thoughts and feelings about those I [help] and how I could help them.		
_____	21.	I feel overwhelmed because my case [work] load seems endless.		
_____	22.	I believe I can make a difference through my work.		
_____	23.	I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].		
_____	24.	I am proud of what I can do to [help].		
_____	25.	As a result of my [helping], I have intrusive, frightening thoughts.		
_____	26.	I feel "bogged down" by the system.		
_____	27.	I have thoughts that I am a "success" as a [helper].		
_____	28.	I can't recall important parts of my work with trauma victims.		
_____	29.	I am a very caring person.		
_____	30.	I am happy that I chose to do this work.		

© B. Hudnall Stamm, 2009-2012. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). www.proqol.org This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold. Those interested in using the test should visit www.proqol.org to verify that the copy they are using is the most current version of the test.

المعالجون النفسيون السوريون المدربون على علاج الصدمة: الإجراءات العلاجية ضمن نطاق الأعراف الثقافية للمهجرين السوريين

انا اسمي اسيل حميد و انا طالبة دكتوراه في علم النفس السريري في جامعة UCL في لندن و اود ان ادعوكم للمشاركة في البحث الذي أقوم به بالتعاون مع جمعية Trauma Aid UK.

موضوع البحث

نحن نبحث عن المعالجين النفسيين السوريين الذين عملوا او يعملون حاليا مع المرضى السوريين. نحن نريد ان نتعرف على وجهات نظر وخبرات هؤلاء المعالجين في توفير علاج الصدمة لمرضاهم السوريين.

ماذا سيضمن البحث؟

سوف يطلب منك الإجابة عن بعض الأسئلة عبر الانترنت والتي من المفروض الا تأخذ من وقتك أكثر من 10- 15 دقيقة. الأسئلة متوفرة باللغتين العربية والإنجليزية.

سوف تكون الأسئلة عن خبرتك في توفير العلاج للمرضى الذين يعانون من الصدمات النفسية وكيف يؤثر ذلك عليك. وبعض الأسئلة سوف تكون عن تدريبك المهني، خبرتك، الاشراف عليك والعلاقة مع مختلف الأوجه من الثقافة والتقاليد السورية.

أين يمكن ان أشارك؟

يمكن الإجابة عن الأسئلة عبر الانترنت، لذا يمكن الإجابة عليها في وقتك الخاص.

ما هي الفوائد من المشاركة في البحث؟

عندما تكمل الإجابة عن الأسئلة، يمكنك ان تختار المشاركة في قرعة للفوز بجائزة وهي جهاز النقر الخاص ب EMDR وان تم اختيارك للفوز بالجائزة، يمكنك بدلا من ذلك ان تختار قيمة الجهاز نقدا وهي 99 باوند إسترليني. ونحن أيضا نتمنى ان تكون المعرفة التي اكتسبتها من البحث مفيدة لك ولجميع المعالجين النفسيين السوريين حول العالم.

ماذا يحدث للمعلومات التي ازودكم بها؟

كل المعلومات التي تزودنا بها سوف تعامل بسرية تامة وتحفظ وفقا لقانون حفظ المعلومات في المملكة المتحدة لعام 1998. هذا يعني ان المعلومات سوف تكون محمية. على سبيل المثال، سوف تحفظ المعلومات تحت شفرة معينة وليس تحت اسمك لكيلا يتم التعرف عليك (المعلومات تحفظ تحت اسم مجهول). بالإضافة الى ذلك، معلوماتك سوف تخزن بشكل آمن بحيث تكون متاحة فقط للباحث الذي يقوم بالدراسة.

هل تتم كتابة ونشر نتائج البحث؟

نتائج البحث سوف تكتب وتنشر في مجلة علمية متخصصة، ولكن النتائج سوف تشمل المؤشرات العامة فقط ولن تتضمن اية معلومات شخصية تؤدي الى التعرف عليك. نتمنى ان تساعد هذه الدراسة في تطوير حقل البحوث النفسية ضمن النطاق السوري.

معلومات إضافية وبيانات الاتصال

هذا البحث يقام في جامعة UCL في لندن بالتعاون مع جمعية Trauma Aid UK. وقد وافقت عليه لجنة اخلاقيات البحوث في الجامعة (مشروع رقم 10163\001)

المشاركة في هذا البحث من عدمها تعود اليك، واختيارك لعدم المشاركة فيه سوف لن يؤثر عليك سلبا بأي شكل من الاشكال. إذا قررت المشاركة فيمكنك الانسحاب في أي وقت وبدون إعطاء الأسباب. في هذه الحالة، اية معلومات زودتنا بها سوف تمحى من سجلاتنا خلال سبعة أيام. ان كان لديك أية أسئلة او تحتاج الى المزيد من المعلومات، ارجو الا تتردد بالاتصال بي (اسيل حميد) بواسطة الهاتف او البريد الالكتروني او البريد العادي. وبيانات الاتصال هي:

البريد الالكتروني aseel.hamid@ucl.ac.uk

البريد العادي

Aseel Hamid

Research Department of Clinical, Educational and Health Psychology

Freepost

University College London

London WC1E 6BT

شكرا لكم لقراءة هذه المعلومات ومساعدتكم لنا تتيح لنا البحث في المواضيع المهمة

Appendix 17. Part A Consent Form Arabic

الموافقة على المشاركة في البحث

المعالجون النفسيون السوريون المدربون بعلاج الصدمة النفسية: الإجراءات العلاجية ضمن نطاق الأعراف الثقافية للمهجرين السوريين
هذه الدراسة حصلت على موافقة لجنة أخلاقيات البحوث في جامعة UCL في لندن (رقم المشروع 10163\001)

شكرا لاهتمامكم بالمشاركة في هذا البحث إذا كان لديكم أية أسئلة بخصوص صحيفة المعلومات" يرجى التوجه بالسؤال للباحثة قبل اتخاذ القرار بالمشاركة بالبحث او بعدمها. سوف نرودك بنسخة من هذا النموذج تحتفظ به وتعود اليه في أي وقت.

تعهد المشارك:

- لقد قمت بقراءة كل الملاحظات السابقة وصفحة المعلومات ولقد فهمت ما تتضمنه الدراسة
- لقد صار عندي علم بأنني ان قررت في أي وقت انني لا ارغب بالمشاركة في هذا البحث، يمكنني اعلام الباحثين ذوي العلاقة ويمكنني الانسحاب مباشرة
- ازودكم بموافقتي على طريقة التعامل مع المعلومات الخاصة بي من اجل إتمام البحث
- اتفهم ان هذه المعلومات سوف تعامل بسرية تامة وتعالج حسب قانون حماية المعلومات لعام 1998
- لقد تم شرح البحث لي بشكل مرضي وانا أوافق على المشاركة فيه
- لقد قمت بقراءة ما سبق ووافق على كل المعلومات التي وردت فيه، وانني أرغب في المشاركة في هذا البحث (المشاركون يجب ان يؤشروا على مربع صغير في الانترنت لكي يبدأوا بالبحث)

□ أقر أنني قرأت كل ما ذكر أعلاه و موافق عليه، و أود البدء بالدراسة

دراسة مسحية -: المعلومات سرية وبدون اسماء

أسئلة مهنية

- ما هو وصف مهنتك؟

- ما هي مدة ممارستك للمهنة؟

- كم مريض ترى في الأسبوع؟

- بشكل تقريبي ما هي نسبة اللاجئين السوريين بالنسبة الى كل مرضاك؟

- بشكل تقريبي ما هي نسبة المرضى الذين يعانون من مشاكل نفسية متعلقة بالصدمة ضمن المرضى السوريين؟

- ما هي أساليب العلاج النفسي التي تعتمد عليها (اختر كل الأجوبة الصحيحة رجاء)؟
☐ العلاج السلوكي المعرفي CBT ☐ الالامدر EMDR ☐ الارشاد النفسي ☐ التحليل النفسي
_____ : (يرجى ذكرها) اخرى ☐
- وهل تعتبر احداها اسلوبك الرئيسي في العلاج (ضع علامة x لاختيار جواب واحد فقط)؟
العلاج النفسي ☐ الاستشارة النفسية ☐ CBT ☐ EMDR ☐
ليس هناك أسلوب ☐ : (يرجى ذكرها) أخرى ☐
رئيسي
- ما هي مؤهلاتك او خبرتك في هذا المجال التي اعدتك للقيام بهذا العمل؟-

- هل تعمل تحت اشراف شخص آخر (ضع علامة x لاختيار جواب واحد فقط)؟
اشراف جماعي ☐ اشراف انفرادي ☐
لا اعمل تحت أي اشراف ☐
- أي أسلوب للعلاج يستعمل الشخص الذي يشرف عليك (ضع علامة x لاختيار جواب واحد فقط)؟
العلاج النفسي ☐ الاستشارة النفسية ☐ CBT ☐ EMDR ☐
- لا اعمل تحت اشراف احد - غير مشمول ☐ (يرجى ذكرها) _____
- ما هي مؤهلات الشخص الذي يشرف عليك؟

مرشد اجتماعي □ اخصائي نفسي سريري □ طبيب نفسي □
مستشار نفسي □

لا اعمل تحت اشراف احد □ أخرى □ (يرجى ذكرها) _____

• كم هي عدد المرات التي يتم فيها الاشراف عليك؟
مرة كل أسبوعين □ مرة في الاسبوع □

مرة في الشهر □

لا اعمل تحت اشراف احد □ أخرى □ (يرجى ذكرها) _____

• ما مدى رضاك عن كمية الاشراف التي تتلقاها؟

لا □ راض بشكل عام □ راض جدا □

راض ولا غير راض

غير راض جدا □ غير راض □

• ما مدى رضاك عن نوعية الاشراف التي تتلقاها؟

لا □ راض بشكل عام □ راض جدا □

راض ولا غير راض

غير راض جدا □ غير راض □

معلومات شخصية

• الجنس

انثى □ ذكر □

• العمر _____

• الجنسية _____

• في أي بلد تعمل حاليا؟ _____

• ما هي المدة التي قضيتها في هذا البلد _____

• هل كنت في سوريا عندما بدأ النزاع عام 2011؟

كلا □ نعم □

• هل غادرت سوريا بسبب النزاع او لأسباب أخرى؟

لأسباب أخرى □ بسبب النزاع □

• في أي عام غادرت سوريا؟

أسئلة ثقافية \ دينية

• الى أي مدى تتمسك بالعادات والتقاليد السورية؟

لا اتمسك كثيرا □ اتمسك الى حد ما □ اتمسك بشدة □

ابدا لا اتمسك □

• كم كنت متمسكا بالعادات والتقاليد السورية اثناء نشأتك؟

لم □ كنت متمسكا الى حد ما □ كنت متمسكا بشدة □

اكن متمسكا كثيرا

ابدا لم اكن متمسكا □

- ما هي ديانتك؟ ☐ مسلم ☐ مسيحي ☐ أخرى - يرجى ذكرها _____

- كم هو مهم تدينك في حياتك اليومية؟
☐ غير مهم ابدا ☐ غير مهم ☐ مهم ☐ مهم جدا
- كم كان التدين مهما خلال نشأتك؟
☐ غير مهم ابدا ☐ غير مهم ☐ مهم ☐ مهم جدا
- كم يؤثر مدى تدينك على ممارسة مهنتك؟
☐ غير مهم ☐ لا تأثيرا لا رأي ☐ مهم ☐ مهم جدا
- كم يؤثر تدينك على طريقة معالجتك للظروف الصعبة في حياتك؟
☐ غير مهم ☐ لا تأثيرا لا رأي ☐ مهم ☐ مهم جدا
- كم يؤثر تدينك على طريقة معالجتك للظروف الصعبة في حياتك؟
☐ غير مهم ابدا

رضا وتعب الرحمة (الاحترق المهني): الإصدار الخامس
 عند مساعدتك الناس يكون لديك اتصال مباشر مع حياتهم. وكما قد وجدت، فإن التعاطف الذي تبديه خلال تلك المساعدة يمكن أن يؤثر عليك بطرق إيجابية وسلبية. وفيما يلي بعض الأسئلة عن تجربتك، الإيجابية والسلبية على حد سواء، في كونك مساعدا للآخرين. نرجو منك النظر في الثلاثين عبارة التالية عنك وعن الوضع في عملك الحالي. حدد الرقم من 1-5 الذي يعكس بصدق درجة تكرار ما تواجهه من هذه الأمور في الثلاثين يوما الماضية وضعه فوق الخط على يمين العبارة رجاءا.

1 = لا أبدا 2 = نادرا 3 = أحيانا 4 = في كثير من الأحيان 5 = غالبا

1. أنا سعيد.
2. أنا مشغولة بمساعدة أكثر من شخص واحد.
3. أشعر بالرضا من أن أكون قادرا على مساعدة الناس.
4. أشعر بالتواصل مع الآخرين.
5. أنا أففز أو أجفل من الأصوات غير متوقعة.
6. أشعر بالنشاط والانتعاش بعد أن أعمل مع من أقدم لهم المساعدة.
7. أجد صعوبة في فصل حياتي الشخصية عن حياتي كمساعد.
8. أنا لست منتجا كما كنت في العمل بسبب صعوبة الذهاب للنوم بسبب التجارب الصادمة للشخص الذي أقدم له مساعدة.
9. أعتقد أنني قد تأثرت بصدمات من أقدم لهم المساعدة.
10. أشعر بأنني واقع في شرك مهنتي كمساعد.
11. بسبب عملي كمساعد شعرت بأنني "على حافة الهاوية" في مختلف الأمور.
12. أنا أحب عملي كمساعد.
13. أشعر بالاكئاب بسبب التجارب الصدمية للناس الذين أساعد.
14. أشعر كما لو أنني أواجه صدمة الشخص الذي ساعدت.
15. لدي الأيمان الذي يدعمني.
16. أنا مسرور بكيفية قدرتي على مواكبة تقنيات وبروتوكولات المساعدة.
17. أنا الشخص الذي دائما كنت أريد أن يكون.

- _____ 18. عملي يجعلني أشعر بالرضا.
- _____ 19. أشعر بالتعب والتهالك بسبب العمل بصفتي كمساعد.
- _____ 20. لدي أفكار ومشاعر سعيدة عن أولئك الذين أساعدتهم وكيف يمكنني مساعدتهم.
- _____ 21. أشعر بالإغراق لأن ضغط حالات العمل يبدو بأنه لا نهاية له.
- _____ 22. أعتقد بأنه يمكنني أن أحدث فرقا من خلال عملي.
- _____ 23. أتجنب بعض الأنشطة أو الحالات لأنها تذكرني بالتجارب المخيفة للناس الذين أساعدتهم.
- _____ 24. أنا فخور بما يمكنني القيام به للمساعدة.
- _____ 25. نتيجة المساعدة، لدي الأفكار اقتحاميه و مخيفة.
- _____ 26. أشعر بأني غصت في "مستنقع" نظام العمل.
- _____ 27. تأتيني أفكار بأني "ناجح" كمساعد.
- _____ 28. لا أستطيع تذكر أجزاء مهمة من عملي مع ضحايا الصدمات.
- _____ 29. أنا شخص عطوف جدا.
- _____ 30. أنا سعيد بأنني اخترت القيام بهذا العمل.

لكم منا جزيل الشكر لمشاركتكم في هذه الدراسة
يرجى التأكد من الإجابة عن جميع الأسئلة والا يكون اسمك موجودا على هذه
الاستمارة كي تبقى اجاباتك غير معرفة باسمك
ان كنت ترغب بالمشاركة في قرعة الجائزة يرجى ملء الورقة الخاصة لهذا
الغرض

Appendix 19. Part A ANOVA table for three ProQOL subscales

Variables	df	F	p
Gender			
CS	1, 59	0.967	.33
STS	1, 59	0.01	.91
Burnout	1, 59	0.56	.81
Supervision amount			
CS	5, 52	1.5	.21
STS	5, 52	1.27	.29
Burnout	5, 52	2.25	.06
Supervision amount satisfaction			
CS	6, 52	0.72	.64
STS	6, 52	2.17	.06
Burnout	6, 52	0.88	.52
Supervision quality satisfaction			
CS	4, 54	1.38	.25
STS	4, 54	1.53	.21
Burnout	4, 54	1.12	.36
Importance of religion in everyday life			
CS	3, 55	1.67	.18
STS	3, 55	1.26	.30
Burnout	3, 55	0.03	.99
Importance of religion in upbringing			
CS	3, 55	.59	.63
STS	3, 55	1.45	.24
Burnout	3, 55	0.56	.64

Appendix 20. Part B Information Sheet

Syrian mental health professionals trained in trauma-focused therapy: therapeutic procedures in the context of cultural norms and displacement

My name is Aseel Hamid. I am a Trainee Clinical Psychologist at University College London (UCL) and I would like to invite you to take part in a research study that I am conducting in collaboration with Trauma Aid UK. You will be given a copy of this information sheet.

What is the research about?

We are looking for Syrian mental health professionals who are currently working with Syrian clients who have experienced trauma and who have been displaced in Gaziantep. We want to hear about your experiences of providing trauma therapy to Syrian clients within this context of displacement.

What will the research involve?

The research consists of a one-off interview with me on your experiences of working with Syrian clients. Before the interview, there will be a short questionnaire about the impact of providing therapy to your clients. Throughout the interview, we will discuss the work that you do with your clients and the impact that working with Syrian clients has on you. Altogether, this meeting will last no longer than ninety minutes.

Will there be any risks?

Some topics we discuss may be sensitive and may cause some distress. If this occurs and you feel unable to continue, you are able to withdraw during any point of the interview with no consequences at all, or you may wish to continue the interview at a later date.

Where will it take place?

The interview will be conducted at a convenient location in an office in Gaziantep. We can do this either in Arabic or English, depending on what you prefer. You will be reimbursed 90 Turkish Liras for your time.

What happens to the information that I give?

All information you give will be treated as confidential and kept in accordance with the UK Data Protection Act (1998). This means that the information you give us will be well protected. For example, your information will be marked with a code rather than your name, so that you cannot be recognised (data is kept anonymously). Additionally, your information will be stored securely, so that only the researcher working on the project can access it.

Will the results be written up and published?

The results of this project will be written up and published in a professional journal. However, these will contain general results only. They will not contain any personal information that would allow you to be identified. It is hoped that this research help to develop the field of psychological research within a Syrian context. You will also receive a copy of a summary of the results if you wish.

Further information and contact details

The project is being conducted at University College London (UCL), with the support of Trauma Aid UK. The project has been approved by the UCL Ethics committee (Project ID Number: 10163/001).

It is up to you to decide whether to take part or not. Choosing not to take part will not disadvantage you in any way. If you do decide to take part you are still free to withdraw at any time and without giving a reason.

If you have any questions or would like further information, please feel free to contact me, Aseel Hamid by phone, email or post. My contact details are as follows:

Email: aseel.hamid@ucl.ac.uk

Phone: TBC (awaiting sim card)

Post: Research Department of Clinical, Educational and Health Psychology

FREEPOST University College London

London WC1E 6BT

Thank you for taking the time to read this information sheet
Your help makes this research on an important cause possible

Appendix 21. Part B Consent Form

Syrian mental health professionals trained in trauma-focused therapy: therapeutic procedures in the context of cultural norms and displacement

I: (please print name):

- agree that the interview will be recorded and a transcript removing any identifying information will be produced, after which the actual recording will be destroyed
- understand that the transcripts will be kept on a secure and password encrypted institutional computer
- understand that access to the interview transcript will be limited to Aseel Hamid and academic colleagues with whom she might collaborate as part of the research process
- understand that any summary interview content, or direct quotations from the interview, that are made through academic publication, will be anonymised so that I cannot be identified and care will be taken to ensure that other information interview that could identify me is not revealed.

Signed: _____ (participant) Date: _____ (participant)

Signed: _____ (researcher) Date: _____ (researcher)

Appendix 22. Part B Interview Schedule

Introduction

- Thank for agreeing to take part
- Interview focus recap. I will ask you about (1) your experiences of doing trauma therapy with Syrian clients given your shared characteristics (e.g. being Syrian and affected by the conflict) (2) the impact of trauma therapy on you
- Timing recap. The interview will last up to ninety minutes. Please feel free to ask for breaks
- Confidentiality recap. Your information will be unrecognisable, well-protected and anonymous
- Recording recap. I will use audio recording to enable transcribing. All recognisable info will be removed. After transcription, your audio will be deleted.
- Any questions?

Getting to know you

Opening question: before we talk about your experiences of working with your clients, can I get to know you a little bit?

- What brought you to [Istanbul or Gaziantep]?
- Can you tell me a bit about your background in psychology?
- How did you find out about Trauma Aid?

Experiences of trauma therapy with Syrians

Opening question: How would you describe the therapeutic work that you do with Syrians who have experienced trauma?

Subquestions (ask for examples throughout)

- What therapeutic tools do you draw on to help Syrians who have experienced trauma?
- Have you drawn on any other (non-therapy specific) resources to help Syrians who have experienced trauma? (enquire: Quran, general advice)

Main question: In what way do you experience similarities between you and your clients?

Subquestions (use flexibly to help fulfil the stated aim of main question / ask examples throughout)

- How do you think these affect the therapy?
- Do you talk with your clients about your own experiences?
- Would you talk about your own experiences of displacement with your clients?
- How do you think your clients view their relationship with you?
- How do you think that having similarities with your clients affects you?

Impact of therapy

Many professionals find that trauma therapy affects them in different ways. Can we talk about the impacts of trauma therapy with Syrian clients on you?

Subquestions (use flexible to help fulfil the stated aim of main question)

- What resources do you draw on that help with the challenging aspects of doing therapy?
- What keeps you going in spite of the difficulties?
- How is therapy fulfilling for you? (enquire: at the personal, community, spiritual levels)

Debriefing

- How did you find the interview?
- Do you have any questions on any of the things we talked about?
- Was there anything we said that has left you feeling concerned or unsettled in any way?
- Would you like more information about anything we talked about?
- Do you have any questions about the research project or what will happen to your information?

Appendix 23. Part B Information Sheet Arabic

الثقافة للمهجرين السوريين

انا اسمي اسيل حميد و انا طالبة دكتوراه في علم النفس السريري في جامعة UCL في لندن و اود ان ادعوكم للمشاركة في البحث الذي أقوم به بالتعاون مع جمعية Trauma Aid UK .

موضوع البحث

نحن نبحث عن المعالجين النفسيين السوريين الذين يعملون حاليا مع المرضى السوريين الذين تعرضوا للصدمة و الذين نزحوا الى تركيا. نحن نريد ان نتعرف على وجهات نظر وخبرات هؤلاء المعالجين في توفير علاج الصدمة لمرضاهم السوريين ضمن سياق النزوح.

ماذا سيضمن البحث؟

البحث هو عبارة عن مقابلة واحدة معي حول تجاربكم من خلال العمل مع مرضاكم من النازحين السوريين. وقبل اجراء المقابلة يرجى منكم ملء استطلاع بسيط على شبكة الانترنت عن تأثير تقديم العلاج لمرضاكم عليكم. و خلال هذه المقابلة سوف نقوم بمناقشة عملكم مع مرضاكم و مدى تأثير تعاملكم مع المرضى السوريين عليكم. بشكل اجمالي سوف لن تأخذ المقابلة اكثر من تسعين دقيقة.

هل ستكون هناك اية مخاطر من هذا البحث؟

بعض المواضيع التي سوف نناقشها سوف تكون حساسة و قد تسبب بعض الضيق. اذا حصل ذلك و شعرت بانك غير قادر على اكمال المقابلة فيمكنك ان تنسحب في اي وقت خلال المقابلة بدون اية تبعات او يمكنك ان تكمل المقابلة في وقت اخر لاحقا.

أين ستجرى المقابلة؟

سوف تجري المقابلة في مكان ملائم في مكتب اما في غازي عنتاب او في اسطنبول. و كذلك يمكننا ان نجري المقابلة اما باللغة العربية او الانجليزية حسب رغبتك.

ما هي الفوائد من المشاركة في البحث؟

نتمنى ان تكون المعرفة التي اكتسبتها من البحث مفيدة لك ولجميع المعالجين النفسيين السوريين حول العالم. سوف نقوم بمنحك تسعين ليرة تركية مقابل مشاركتكم

ماذا يحدث للمعلومات التي ازودكم بها؟

كل المعلومات التي تزودنا بها سوف تعامل بسرية تامة وتحفظ وفقا لقانون حفظ المعلومات في المملكة المتحدة لعام 1998. هذا يعني ان المعلومات سوف تكون محمية. على سبيل المثال، سوف تحفظ المعلومات تحت شفرة معينة وليس تحت اسمك لكيلا يتم التعرف عليك (المعلومات تحفظ تحت اسم مجهول). بالإضافة الى ذلك، معلوماتك سوف تخزن بشكل آمن بحيث تكون متاحة فقط للباحث الذي يقوم بالدراسة.

هل تتم كتابة ونشر نتائج البحث؟

نتائج البحث سوف تكتب وتنشر في مجلة علمية متخصصة، ولكن النتائج سوف تشمل المؤشرات العامة فقط ولن تتضمن اية معلومات شخصية تؤدي الى التعرف عليك. نتمنى ان تساعد هذه الدراسة في تطوير حقل البحوث النفسية ضمن النطاق السوري. و ان رغبت يمكننا تزويدك بنسخة من ملخص نتائج البحث.

معلومات إضافية وبيانات الاتصال

هذا البحث يقام في جامعة UCL في لندن بالتعاون مع جمعية Trauma Aid UK. وقد وافقت عليه

لجنة اخلاقيات البحوث في الجامعة (مشروع رقم 10163\001)

المشاركة في هذا البحث من عدمها تعود اليك، واختيارك لعدم المشاركة فيه سوف لن يؤثر عليك سلبا بأي شكل من الاشكال. إذا قررت المشاركة فيمكنك الانسحاب في أي وقت وبدون إعطاء الأسباب. في هذه الحالة، اية معلومات زودتنا بها سوف تمحى من سجلاتنا خلال سبعة أيام. ان كان لديك اية أسئلة او تحتاج الى المزيد من المعلومات، ارجو الا تتردد بالاتصال بي (اسيل حميد) بواسطة البريد الالكتروني او البريد العادي. وبيانات الاتصال هي:

البريد الالكتروني aseel.hamid@ucl.ac.uk

البريد العادي

Aseel Hamid

Research Department of Clinical, Educational and Health Psychology

Freepost

University College London

London WC1E 6BT

شكرا لكم لقراءة هذه المعلومات ومساعدتكم لنا تتيح لنا البحث في المواضيع المهمة

الموافقة على المشاركة في البحث

المعالجون النفسيون السوريون المتدربون بعلاج الصدمة النفسية:
الإجراءات العلاجية ضمن نطاق الأعراف الثقافية للمهجرين السوريين
هذه الدراسة حصلت على موافقة لجنة أخلاقيات البحوث في جامعة UCL في لندن (رقم المشروع 10163\001)

شكرا لاهتمامكم بالمشاركة في هذا البحث إذا كان لديكم أية أسئلة بخصوص صحيفة المعلومات يرجى التوجه بالسؤال للباحثة قبل اتخاذ القرار بالمشاركة بالبحث أو بعدمها. سوف نرودك بنسخة من هذا النموذج تحتفظ به وتعود اليه في أي وقت.

تعهد المشارك:

نرجو كتابة الاسم رجاء

- لقد قمت بقراءة كل الملاحظات السابقة وصفحة المعلومات ولقد فهمت ما تتضمنه الدراسة
- لقد صار عندي علم بأنني ان قررت في أي وقت انني لا ارغب بالمشاركة في هذا البحث، يمكنني اعلام الباحثين ذوي العلاقة ويمكنني الانسحاب مباشرة
- ازودكم بموافقتي على طريقة التعامل مع المعلومات الخاصة بي من اجل إتمام البحث
- اتفهم ان هذه المعلومات سوف تعامل بسرية تامة وتعالج حسب قانون حماية المعلومات لعام 1998
- لقد تم شرح البحث لي بشكل مرضي وانا أوافق على المشاركة فيه
- لقد قمت بقراءة ما سبق ووافق على كل المعلومات التي وردت فيه، واني أرغب في المشاركة في هذا البحث (المشاركون يجب ان يؤثروا على مربع صغير في الانترنت لكي يداوا بالبحث)
- ازودكم بموافقتي على تسجيل المقابلة وان نص المقابلة سوف تزال منه أية معلومات تدل على صاحبها و بعد ذلك سوف يتم التخلص من التسجيل.
- اتفهم ان نص المقابلة سوف يحفظ في حاسبة الجامعة بشكل آمن و بالاستعمال كلمة سر مشفرة.
- اتفهم انه لا احد لديه حق الاطلاع على نص المقابلة غير الباحثة اسيل حميد و زملائها الاكاديميين الذين يشكلون جزء من عملية البحث.
- اتفهم ان أية خلاصة لمضمون المقابلة او اي اقتباس مباشر من المقابلة تنشر ضمن البحث سوف تكون مجهولة المصدر بحيث لا يظهر اسمي فيها و سوف نأخذ كل الحيلة لكي لا يمكن التعرف على صاحب المقالة من خلال أية معلومات اخرى في المقابلة.

توقيع المشارك التاريخ

توقيع الباحثة التاريخ

Appendix 25. Part B Interview Schedule Arabic

شكرا لموافقتك على المشاركة في هذه المقابلة

بخصوص ما ستركز عليه هذه المقابلة، سوف أقوم بسؤالك عن (١) خبرتك و تجاربك في تقديم علاج الصدمات النفسية مع المرضى السوريين بحكم وجود خصائص مشتركة بينك و بين المرضى

(٢) تأثير تقديم علاج الصدمات النفسية عليك

بخصوص الوقت، ستستغرق هذه المقابلة ما لا يزيد عن ٩٠ دقيقة. إذا ما احتجت إلى اي استراحات، لا تتردد بطلب

بخصوص السرية، المعلومات التي تقدمها ستكون مجهولة المصدر، اي أنه لن يتم البوح بقائل المعلومة. ستكون المعلومات في الحفظ والصون ولن يتم التعرف عليها بخصوص التسجيل، سأقوم بتسجيل الصوت لأتمكن لاحقا من تفريغه كتابيا. كل المعلومات التي توشي بهوية المتكلم سيتم حذفها. بعد تفريغ النص، سيتم حذف التسجيل.

هل لديكم أي أسئلة ؟

التعرف عليكم

قبل أن نتحدث عن خبراتك في التعامل مع المرضى، هل لي أن أتعرف عليك قليلا؟
ما الذي أتى بك إلى غازي عنتاب؟

هل يمكنكم إخباري عن خلفيتك في علم النفس؟

كيف سمعت عن منظمة Trauma Aid ؟

خبرتك في تقديم علاج الصدمات النفسية للسوريين

كيف تصف عملك في تقديم العلاج للسوريين الذين تعرضوا لصدمات نفسية.

ما هي أدوات العلاج النفسية التي تستخدمها لمساعدة السوريين الذين تعرضوا لصدمات نفسية؟

هل قمتم باستخدام أدوات أو مصادر أخرى (غير أكاديمية أو سيكولوجية) لعلاج السوريين الذين تعرضوا لصدمات نفسية مثل القرآن الكريم أو النصائح العامة؟

هل هناك قواسم مشتركة بينك و بين المرضى؟

إن وجد ما هي؟

كيف تعتقد أن ذلك يؤثر على العلاج؟

هل تتحدث مع المرضى عن تجاربك الشخصية؟

هل تتحدثون مع المرضى عن تجاربك في الزواج؟

باعتقادكم، كيف يرى المرضى العلاقة بينك و بينهم؟

هل تعتقد أن الأمور المشتركة بينك و بين المرضى تؤثر عليك؟

التأثير على العلاج

الكثير من يعملون في مجال علاج الصدمات النفسية يجدون أن عملهم يؤثر عليهم بطرق

مختلفة. هل من الممكن أن نتحدث عن تأثير علاج الصدمات النفسية عليك عند العمل مع

المرضى السوريين؟

ما هي المصادر التي تستعين بها في التعامل مع التحديات الشخصية و العاطفية لديك عند

القيام بتقديم العلاج؟

ما هو الدافع لك للاستمرار في ظل هذه الصعوبات ؟

كيف يعطيك تقديم العلاج الشعور بالرضى؟

(على المستوى الشخصي، على المستوى الإجتماعي، على المستوى الديني)

الخلاصة

كيف وجدت المقابلة؟

هل لديك أي أسئلة بخصوص ما تحدثنا عنه

هل أيا مما تحدثنا عنه سبب لك قلقا أو عدم ارتياح

هل ترغبون في الحصول على أي معلومات إضافية عن اي شيء تحدثنا عنه؟

هل لديك أي أسئلة عن البحث أو ما سيحدث للمعلومات التي قمتم بتقديمها؟

Appendix 26. Part B Transcriber Instructions

Project: Syrian mental health professionals' interviews – Translation and Transcription, UCL

Confidentiality

For ethical purposes regarding confidentiality and anonymity, I've deleted identifying information so don't be surprised if it sounds like the tape has jumped at certain parts. In the unlikely event that you spot any remaining identifying information, please help me to maintain participants' confidentiality by not sharing any identifying info etc.

Software

Please download Nvivo, you can download it here

<http://www.qsrinternational.com/nvivo/support-overview/downloads>. Sometimes nvivo can be quite fiddly initially but overall smooth once it gets going. I've uploaded all of the interviews on the Dropbox link here (<link>) you'll see an NVivo document named 'Syrians'. The idea is to transcribe according to the time stamp. So NVivo will create a 'time section' once you press play, and then as you press stop it will go on to another section. Don't worry too much about how to divide the sections, you can divide it according to whether it's me talking or the participants talking. I've left one that I am working on there to give an example (named 3G Aseel).

You'll see that the audio files are named – please work on the ones with your names on it. If you can also regularly save it on the Dropbox as you're working on it. That way we have a backup and also it makes it easier for me to check out any things you're unsure of etc.

Translation

The idea is to convey the message that the interviewees are putting across as accurately as possible – and sometimes that doesn't necessarily require a direct translation. Also there's no need to transcribe pauses or 'uhm' etc. unless they seem significant, e.g. they signify a lot of hesitation or distress and so on.

If there are words that you can't hear properly or are unsure about, especially as there are quite a few psychological terms etc., then please just write it in Arabic as you hear it, in brackets so for e.g. *"I completed a masters in (irshad nafsi)"* or if you have Arabic on your computer then put the Arabic word in.

If there are words that have multiple meanings and you're not sure which to use, you can put more than one meaning in brackets e.g. *"There are (similar/mutual) characteristics between us"*

Process

There may or may not be some things that can be upsetting to hear, given that they are all Syrian professionals who work regularly with trauma and some have experienced difficulties themselves. If you need to chat about something you've heard or have some questions please don't hesitate to talk to me at all. Of course talk to your close ones too if you need (I only ask that you maintain participants' anonymity). I found it an emotional process to do the interviews, and overall I was very inspired by their courage and determination to help fellow Syrians.

Appendix 27. Part B Initial Codes

Below is a screenshot of all initial NVivo codes, with their sources (number of participants endorsed) and references (number of times code was endorsed overall)

Nodes			
	Name	Sources	References
	Being an example for others	2	5
	Context	1	4
	Disclosing	13	18
	Disclosure as a helpful tool	8	15
	Displacement experience	10	14
	Experience	13	33
	Feeling (dis)connected with clients	5	10
	Financial difficulties	7	10
	Helpful process tools	11	43
	Helpful psychology tools	15	56
	Lack of awareness or faith in psychology	6	16
	Lack of enough MH resources	4	10
	Need for novel methods of working	5	8
	Not doing things not trained for	10	16
	Organisational pressure	8	16
	Personal therapy	8	13
	Political context	7	10
	Professional boundaries	14	38
	Psychosocial support	3	7
	Reaching out by reading	4	6
	Reaching out for professional support	12	26
	Reaching out to others about self-help	6	9
	Resilience & growth	12	28
	Satisfaction of helping	16	49
	Secondary traumatic stress and burnout	13	31
	Self-care	15	33
	Shock of reality of trauma	4	5
	Similarities - social situation	4	11
	Similarities - trauma	6	9
	Similarities - triggering	3	6
	Similarities helping MHPs empathise with clients	16	47
	Social roles of psychologists	1	5
	Spiritual satisfaction	10	21
	Stigma	8	18
	Syria experiences of trauma	5	8
	Syrian client needs	13	28
	Syrian culture or religion featuring in therapy	6	19
	Syrian MHP needs	6	14
	Using client-generated resources	7	11
	Using spirituality in sessions	7	12
	Western or other culture clash	8	10
	Work life balance	3	4
	Work life separation	6	14
	Working with non-Syrian war trauma	5	9

Appendix 28. Part B Coded Transcript Excerpt

I3: So you said that, when your client trusts you a lot he will talk to you. What are the things that you use so that your clients trust you and talk to you?

helpful process tools { P3: In most cases we work on building a relationship with the client, for example, so that he feels comfort, because he's in front of a stranger. As you know, any person does not like to feel exposed in front of a stranger, he feels weak, when he tells you his ideas he gives you a picture of himself as if he is exposed in front of you, so when you make him feel settled, then (pauses to think). In the first session, I try as much as possible not to take too much information and just to have a normal discussion; very routine information you know general questions...

I3: Aha, like what?

P3: Like what do you work as, how are you living here, how is your situation, how many kids do you have? You know details that are to do with general information. Like how do you see Turkey, it's expensive, how's public transport?

financial difficulties { helpful process tools {

I3: Mmhmm...

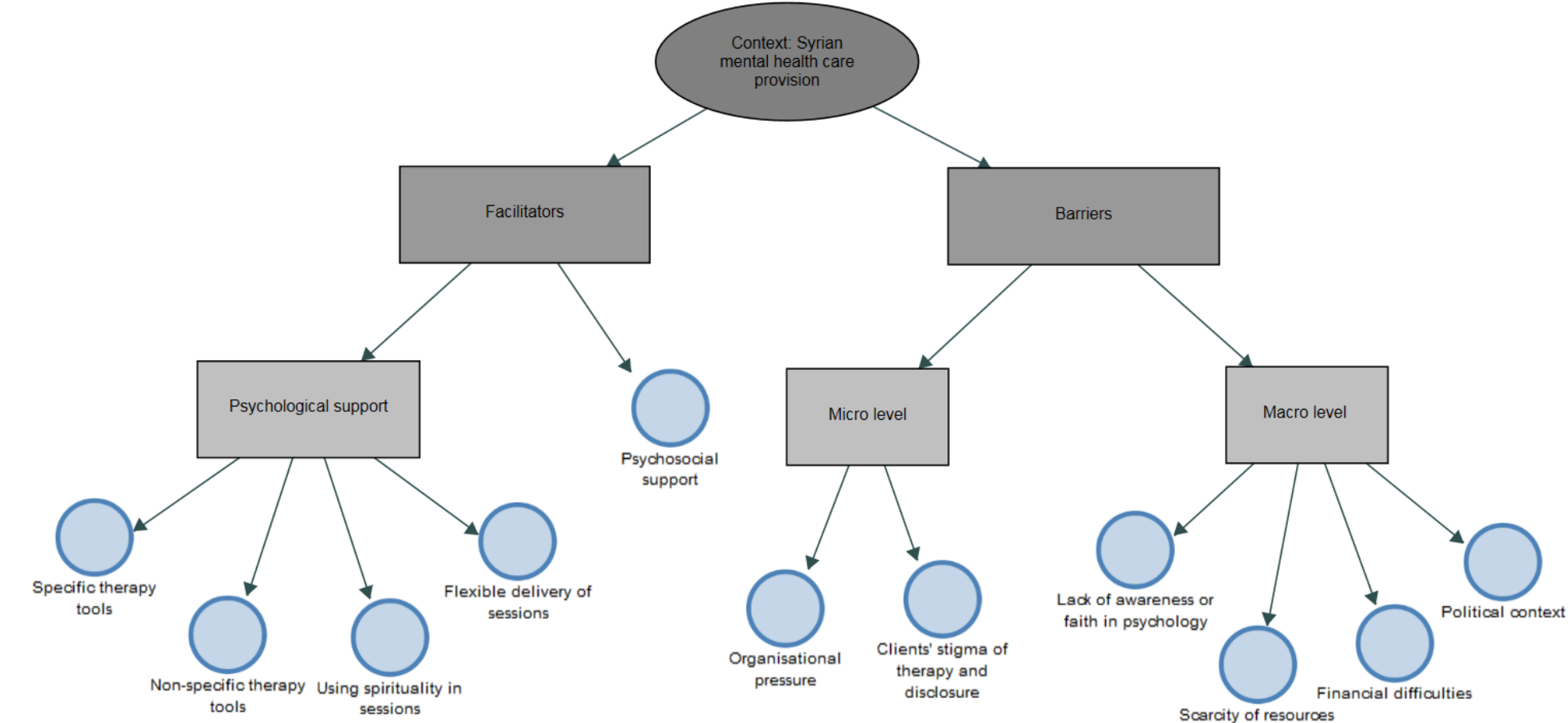
helpful process tools { Syrian client needs { P3: So you try to open any topic up with him because (pause). He comes to see a therapist or doctor, he thinks that the therapist comes from another planet and doesn't know the struggle that he goes through. So when we talk about general issues like there's a lot of traffic, public transport is expensive, rent is going up for us as Syrians, living in Turkey is expensive so we speak general information, ok so little by little, and like this it makes him speak little by little...

financial difficulties { helpful process tools {

noted boundaries here, more of a friendly chat / small-talk; opens up room for therapist disclosure
participant disclosure of 'expensive' as a way to let client know that he understands his struggle
↓
self-disclosure as a way to reduce "social" distance?

Note. While data were analysed in NVivo, a handwritten version of the process is provided here, where the codes are displayed on the left hand side, and ideas and reflections written on the right hand side.

Appendix 29. Part B Thematic Map of Context



Appendix 30: Summary of Findings

Aims. This research looked at Syrian mental health professionals' professional quality of life in the context of a shared reality.

Methods. It used both questionnaires and interviews to explore this topic, which has not been examined before in the literature. Questionnaires were completed by 61 Syrian mental health professionals, and interviews were conducted with sixteen forcibly displaced Syrian mental health professionals living in Turkey.

Findings. Questionnaires showed that Syrian mental health professionals had higher secondary traumatic stress scores relative to other samples in the literature. Professionals who did not have a psychology academic background had significantly elevated secondary traumatic stress and burnout scores, and lower compassion satisfaction scores. Interviews indicated that while the majority of participants expressed that mental health provision with Syrian clients was sometimes distressing, all spoke about how providing support was very fulfilling, especially when witnessing positive changes in clients. Some professionals spoke about how their clients' similarities were sometimes distressing to hear, especially if they shared similar distressing experiences. However, all professionals spoke about how their similarities enabled them to strongly empathise with their clients and understand their language and culture. All participants referred to self-care as a means to cope, most referred to supervision and peer support and some referred to personal therapy, although it was acknowledged that there was often stigma surrounding this.

Implications. The findings of this study illuminate the benefits of providing training and supervision in psychological and psychosocial approaches to professionals with a mental health background within conflict-affected areas with reduced mental health resources. Sufficient educational training (and not just clinical training) and close monitoring of professionals who do not have an academic psychology background is key given that they are at greater risk for experiencing a negative emotional impact. The shared reality of the practitioner and client enhances empathy and understanding and overcomes language and cultural barriers often present in such settings where there is a gap in the demand and supply of mental health services. While this shared reality likely contributes to a strong sense of compassion satisfaction amongst practitioners, motivating them to help their community and be role models, it also likely contributes to practitioners' vulnerability of secondary stress and burnout, particularly in light of shared traumatic experiences. Taken together, these results suggest increasing training and supervision of community practitioners, while promoting participant informed self-care techniques and ensuring the availability of personal therapy.

Appendix 31: Summary of Findings Arabic

الهدف: نظر هذا البحث إلى جودة الحياة المهنية للعاملين السوريين في مجال الصحة النفسية المقدمة للعملاء للسوريين في سياق الواقع المشترك بينهم.

الأساليب: استخدمت كل من الاستبيانات والمقابلات لاستكشاف هذا الموضوع الذي لم يتم التطرق له من قبل في البحوث. تم ملئ الاستبيانات من قبل ٦١ شخص من أخصائيي الصحة النفسية السوريين ، وأجريت مقابلات مع ستة عشر من المهنيين السوريين المهجرين قسراً العاملين في مجال الصحة النفسية و الذين يعيشون في تركيا.

النتائج: أظهرت الاستبيانات أن أخصائيي الصحة النفسية السوريين لديهم درجات عالية من الصدمات الثانوية مقارنة بالعينات في الأبحاث الأخرى. وكان المهنيون الذين لم يكن لديهم خلفية علمية أكاديمية يعانون بشكل أكبر من الصدمات الثانوية وحالات الإرهاق وانخفاض في درجات التعاطف. أشارت المقابلات إلى أنه في حين أن غالبية المشاركين عبروا عن أن توفير الصحة النفسية للعملاء السوريين كان في بعض الأحيان محزناً ، فقد تحدثوا جميعاً عن مدى كون تقديم الدعم أمراً مُرضياً للغاية ، خاصة عند مشاهدة التغييرات الإيجابية عند العملاء. تحدث بعض العاملين عن أوجه التشابه بينهم وبين عملائهم حيث يصعب عليهم أحياناً الإستماع إليهم خاصة إذا كانوا قد عانوا من تجارب مؤلمة مماثلة. ومع ذلك ، تحدث جميع العاملين عن أن أوجه التشابه تمكنهم من التعاطف بقوة مع عملائهم وفهم لغتهم وثقافتهم. أشار جميع المشاركين إلى الرعاية الذاتية كوسيلة لهم للتأقلم ، وأشار معظمهم إلى أن وجود الإشراف و دعم الأقران و العلاج الشخصي يساعدهم أيضاً، على الرغم من الاعتراف بأن هناك غالباً وصمة عار تحيط بهذا النوع من الدعم.

الآثار: توضح نتائج هذه الدراسة فوائد توفير التدريب والإشراف للعاملين من من يملكون خلفية في علم النفس داخل المناطق المتأثرة بالصراع التي تعاني من انخفاض في موارد الصحة النفسية. إن التدريب التعليمي (وليس فقط التدريب السريري) والمراقبة الدقيقة للعاملين الذين ليس لديهم خلفية علم نفس أكاديمية هو أمر أساسي لأنهم معرضون لخطر أكبر في مواجهة التأثير العاطفي السلبي. يعزز الواقع المشترك للعاملين والعملاء التعاطف والفهم ويتغلب على العوائق اللغوية والثقافية التي غالباً ما تكون موجودة في مثل هذه الظروف حيث توجد فجوة في الطلب والعرض لخدمات الصحة النفسية. وبينما من المرجح أن يساهم هذا الواقع المشترك في إحساس قوي بالرضا بين الممارسين ، مما يحفزهم على مساعدة مجتمعهم وأن يكونوا قدوة يحتذى بها، فمن المرجح أن يساهم أيضاً في تعرض العاملين للإجهاد الثانوي و الإرهاق ، خاصة عندما يتعلق الأمر بالتجارب الصادمة المشتركة. وإذا أخذنا هذه النتائج مجتمعة ، فإن هذه النتائج تدل على أهمية زيادة التدريب والإشراف على الممارسين المجتمعيين ، مع تعزيز تقنيات الرعاية الذاتية وضمان توافر العلاج الشخصي لهم.