Portfolio for Professional Doctorate in Counselling Psychology (DPsych)

War-related trauma: Forced migrants' experiences of Trauma therapy in the Treatment of Post-Traumatic Stress Disorder

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CITY, UNIVERSITY OF LONDON DECLARATION

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PREFACE

The theme permeating through this portfolio is the psychological treatment of forced migrants presenting with war trauma and post-traumatic stress disorder (PTSD). PTSD became a special interest of mine following my first PTSD training case as a therapist, during which time I faced the challenges of working with chronic PTSD. Since then, I have worked therapeutically within specialist trauma services, both in the NHS and voluntary sector as a trauma therapist. More recently within my psychology training, I have treated a range of trauma presentations including working with forced migrants, victims of childhood sexual abuse, birth traumas, traumatic grief, childhood and developmental trauma, single and multiple PTSD presentations. I learned about the need to have a varied tool box and the importance of taking a relationship-based approach to working through trauma. Courtois and Ford (2013) encapsulate this by highlighting that "The treatment relationship is at once technique, relational bond, and container" (p. 287).

I trained in a range of trauma therapies including Trauma-focused CBT (TF-CBT), Eye Movement Desensitisation and Reprocessing (EMDR), and Narrative Exposure Therapy (NET). Whilst working in a specialist PTSD service in the NHS, I noted the use of NET as a treatment of choice, at least by psychologists treating complex and war-related trauma. Using NET for survivors of multiple traumas including war, I became curious about how forced migrants experience this type of trauma-processing therapy, an exposure-informed therapy that does not prescribe a stabilisation phase, and whose originators maintain that it is optional for those who find it difficult to disclose their trauma (Neuner, Schauer & Elbert, 2014). It encompasses a story-telling narrative component at the heart of the therapy, placing the trauma and other significant life events of the survivor within the context of their entire biography to date (Neuner, Schauer & Elbert, 2005). NET is currently accumulating a substantial evidence base in the treatment of PTSD for this population.

Part 1 – The research

The research component of this portfolio focuses on forced migrant phenomenological experiences of NET in the treatment of PTSD using the analytic method of Interpretative Phenomenological Analysis (IPA, Smith & Osborn, 2008). The research aims to give voice to their experience of this type of trauma therapy and to capture their

lived experiences of it. The existing evidence base for the use of NET for this population is entirely quantitative. Although this group reports significant symptom reduction, there are no studies reporting how this group experiences a narrative approach such as NET in the treatment of their PTSD. A defining principle of counselling psychology is its concern to engage with people's unique phenomenological and subjective experiences. Thus, as well as randomised controlled trials, expert opinions including that of service-users is also part of the hierarchy of evidence (Glasby & Beresford, 2005). The Institute of Medicine (2001) define evidence-base practice as "…the integration of best research evidence with clinical expertise and patient values" (p. 147).

My experience as a practitioner, psychologist and qualitative researcher has informed my critical epistemological standpoint and my understanding of how people subjectively make sense of their lived experiences. IPA as a methodological approach is about accessing phenomenological experience and meaning-making. In relation to this thesis, IPA and NET both share the essential requisite of bearing witness to an experience. I take the position of the model of a person as being 'vulnerable' and as having a psyche impacted on by events, which they seek to make sense of, interpret and synthesise into a narrative structure. Brison (2002) conceptualises the self as 'relational', vulnerable to be undone with human-inflicted trauma, and yet resilient enough to be reconstructed with the help of others. To remain transparent in the research, reflexivity sections beginning in the methodology are written in the first person to connect with the reader and reflect the subjective nature of the analysis.

Part 2 – The journal article

The journal article is intended for the *Journal of Traumatic Stress*. Aside from formatting, which has been kept consistent with the rest of the thesis, the double-blind review requirement, and the running head, which will be 'A life more than just trauma – something to navigate from', it adheres to the guidelines for contributors to this journal. The journal article gives a brief overview of three super-ordinate themes: 'The struggle with therapy, fear, ambivalence and exposure'; 'Living with loss, pain, grief and uncertainty'; and 'Trusting someone else to be your voice'. However, it focuses on three themes: A life more than just trauma – 'remembering the good and the bad'; Reconstructing a sense of self, identity and attachment; and From trauma and despair to

understanding the big things in life – ‘something to navigate from’, argued to be novel findings in relation to the existing trauma-focused literature for this population, unique to NET. A sub-theme that emerged unanimously from accounts was that of NET as ‘shaking up symptoms’ and this is discussed in relation to existing trauma-focused literature. Despite not being able to generalise the findings, the article argues that the findings represent the real-world outcomes that existing studies on the efficacy of NET have not been able to capture.

Part 3 – Professional practice: Combined case study and process report

The combined case study features the use of trauma-focused cognitive behavioural therapy (TF-CBT) to treat multiple war trauma in a forced migrant woman now residing in the UK. Using TF-CBT provided the opportunity to reflect on its use to treat multiple war traumas. TF-CBT is interested in the subjective experience of the trauma and trauma hotspots. In this paper, I reflect on my experience of using TF-CBT and its sole focus on the trauma memories, in contrast to NET. The centrality of the therapeutic relationship and the importance of providing a secure base from which to explore and work through this woman’s trauma emerge as common factors in both trauma approaches. Both approaches require a relational approach to treating trauma, in bearing witness, containing and ensuing trust, to facilitate the working through of the trauma narrative into a narrative memory (Brison, 2002). This is consistent with the humanistic principles in counselling psychology. The case study presents the phenomenological and subjective experiences and interpretation of the multiple war traumas endured by my client. Clinically, it demonstrates the need to work integratively within the umbrella of cognitive behavioural therapies and includes compassion-focused approaches and re-scripting approaches to work through traumas, whilst putting the person of the client before the models. It also provides a reflexive account of my self-awareness, the challenges in working with shame and disgust as dominant peri-traumatic emotions, and the challenges of using TF-CBT in a time-limited setting with multiple war traumas. Using a critical realist approach, I take the position that the lived trauma experiences in this population are real ones, and I adopt the position of there being multiple meanings and perspectives about the reality of having had trauma therapy, whether through developing a narrative or through the multiple ways used to update and reappraise a trauma hotspot.

This portfolio presents the current trauma-focused literature in relation to the forced migrant population. The professional practice section features the real-world process of therapy and complexity in working with multiple trauma in this population. The research gives voice to this group and highlights the real-world subjective outcomes that existing studies on the use of NET for this population have not been able to capture. Reflexivity sections are written in the first person to reflect the subjective nature of the research and connect with the reader.

TERMINOLOGY

The following acronyms are used in this Portfolio:

PTSD: Post-traumatic stress disorder

TF-CBT: Trauma-focused cognitive behavioural therapy

NET: Narrative exposure therapy

CBT: Cognitive behavioural therapy

PE: Prolonged exposure

NICE: National Institute of Clinical Excellence

IPA: Interpretative phenomenological analysis

RCT: Randomised controlled trials

REC: Regional Ethics Committee

For the transcription and analysis, participants were given pseudonyms and all identifying information was removed. In the theme tables, the first letter of their pseudonyms followed by the comment number was used to reference quotes (e.g. G36) indicates a quote from Gizlan, comment number 36.

Trauma and PTSD (Post-traumatic stress disorder) are used interchangeably to indicate the mental state that follows an event that is experienced as 'traumatic'.

Part 1 – Doctoral research

An Interpretative Phenomenological Analysis of Forced Migrant Experiences of Narrative Exposure Therapy in the Treatment of Post-Traumatic Stress Disorder

Supervised by Dr Jacqui Farrants

Abstract

The world's biggest forced migration is currently taking place. This population now makes up a considerable proportion of those accessing trauma services in the UK. Narrative exposure therapy (NET) is increasingly used with this population in services across the NHS. However, there are no studies reporting on its acceptability or how this group experiences this narrative and exposure-informed approach. Although the evidence base for the use of NET is promising, it remains symptom-reduction focused. This study sought to capture the accounts of seven forced migrants who had had NET for their PTSD through Interpretative Phenomenological Analysis. Six super-ordinate themes emerged from the data: (1) The struggle with therapy, fear, ambivalence and exposure; (2) Living with loss, pain, grief and uncertainty; (3) Trusting someone else to be your voice; (4) A life more than just trauma – 'remembering the good and the bad'; (5) From trauma and despair to understanding the big things in life – 'something to navigate from'; and (6) Reconstructing a sense of self, identity and attachment. The latter three themes reflect new findings in relation to the existing trauma-focused literature for this population, unique to NET. A sub-theme that emerged unanimously from the accounts was NET as 'shaking up symptoms'. The tangible and experiential aspects of the therapy contributed to participants being able to 'see the bigger picture' at a flashback and gestalt level, seeing the 'self' as a survivor and as having 'a life more than just trauma'. Developing a future orientation, reinvesting in the 'self', developing a balanced perspective of life and of a 'self' that endured more than just trauma, were some of the outcomes. The findings represent real-world subjective outcomes that existing studies on NET for this population have not been able to capture. Implications, limitations, and suggestions for future research are discussed.

1. INTRODUCTION AND LITERATURE REVIEW

1.1 Chapter overview

This chapter provides an overview of the rationale for the research and examines the wide-ranging theory and research relating to trauma as applied to the forced migrant population. The theories and studies discussed were chosen as they relate to the research focus and help to contextualise the topic of investigation. The researcher acknowledges the risks in incorporating such theory and evidence base within the introduction as it may be deemed to impact on the analytic process. However, IPA already acknowledges the challenges of setting aside knowledge, and takes steps to limit this impact through reflexive practice. There were no links made between the data and theory discussed until the final analysis chapter was complete, to ensure that the themes emerged from the data.

This section firstly outlines the definition of forced migrants and PTSD. A deconstruction of the construct of PTSD and trauma is detailed, followed by an outline of theories of PTSD, and dominant trauma therapy models. Secondly, it discusses the epidemiology of PTSD in forced migrants and the impact of torture on forced migrants, followed by a deconstruction of PTSD, and a critical discussion of how the 'trauma' paradigm has been applied to the forced migrant population. Thirdly, NET is detailed and discussed in relation to other cognitive and exposure-informed models. Narrative structures in human psychology and the difference between trauma memory and narrative memory are also outlined. Finally, the evidence base on the use of NET for this population is critically appraised, followed by an examination of patient-focused research in therapy treatments, together with the study rationale and implications.

1.2 Definition of forced migrant

The International Association for the Study of Forced Migration (IASFM) defines forced migration as the forced movement of people, displaced within their own countries or across borders, whether forced to migrate due to persecution, war, famine, or major development projects, they face a need for assistance and protection (International Association for the Study of Forced Migration, 2010). There are three types of displacement; conflict induced, disaster induced, and development induced.

Types of forced migrants include refugees and asylum-seekers. This research focuses on those displaced by conflict, war and persecution.

A refugee is defined by the Refugee Convention (1951), article 1, as an individual who "owing to a well-founded fear of persecution due to race, religion, nationality, membership of a particular social group or political opinion" has lost the protection of their state or origin or nationality (Office of the United Nations High Commissioner for Refugees, 2015. Under the 1951 refugee convention, an asylum-seeker is defined as a person who has moved across an international boundary in search of protection and has applied for asylum but whose application has not yet been granted or concluded.

The Office of the United Nations High Commissioner for Refugees (UNHCR, 2017) reports that in 2017 the number of people forcibly displaced worldwide had reached 68.5 million. By the end of 2017, about 3.1 million people were awaiting a decision on their application for asylum, about half in developing region. More than two-thirds (68 per cent) of all refugees worldwide came from just five countries: Syria, Afghanistan, South Sudan, Myanmar, and Somalia (UNHCR, 2017). In 2016, there were 39,000 applications for asylum in the UK (Full Fact, 2017). One of the consequences has been the growth in the number of forced migrants seeking safety through dangerous sea journeys which is likely to compound their experience of trauma.

1.3 Definition of the construct of PTSD and diagnostic labelling of PTSD

PTSD as a diagnostic construct has been a contentious subject, with decades of criticism that rather than being a biomedical construction of distress, it is in fact a socially and politically constructed idiom (Summerfield, 2001).

PTSD is defined as an event-related disorder that can result from the experience or witnessing of a life-threatening event. Under the DSM-5 (American Psychiatric Association, 2013) it is currently classified as a trauma and stress-related disorder. Examples of traumatic events include violent assaults, combat, natural and unnatural disasters, and accidents.

In 2013, the DSM-5 (American Psychiatric Association) was revised and includes changes to the diagnostic criteria for PTSD. PTSD is no longer categorised as a fear-based anxiety disorder as in the DSM-3 and DSM-4, and is now under a new category, 'trauma and stress-related disorders'. The rationale for this was based on the clinical

recognition of the range of expressions of distress, such as shame and guilt, which are now seen as important emotional reactions in trauma experiences.

Under the DSM-5, PTSD consists of four symptom clusters in response a person who has been involved in the following: witnessing or having direct exposure to a trauma; learning from a person exposed to a trauma; and having indirect exposure to aversive details of the trauma)

- Persistent re-experiencing of the traumatic event via intrusive memory, nightmares, flashbacks, emotional distress or physical reactivity after exposure – one required)
- Avoidance of trauma-related stimuli after the trauma (trauma-related reminders or thoughts and feelings – one required)
- Negative mood and cognition (inability to recall features of the trauma, overly negative thoughts and assumptions about the self or the world, exaggerated self-blame, negative affect, decreased activity, feeling isolated, difficulty experiencing positive affect – two required)
- Arousal and reactivity (irritability or aggression, risky behaviour, hypervigilance, heightened startle reaction, difficulty sleeping, difficulty concentrating – two required).

The symptoms must last for one month and create functional impairment, and must not be attributable to medication, substance misuse or other illness.

The majority of those exposed to traumatic events recover from transient psychological symptoms. However, certain risk factors include the nature of the traumatic event, the intensity and duration of the threat, and a personal history of trauma. The NICE Guidelines for PTSD (2005) indicate watchful waiting if symptoms are mild and have been present for 4 weeks after the trauma. Where symptoms have been present for 3 months, the use of trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing is recommended.

1.4 Deconstruction of the construct of PTSD

Although the cross-cultural validity of PTSD has been documented worldwide (Hinton & Lewis-Fernandez, 2011), the wide clinical use of PTSD as a diagnostic construct and

marker of trauma has been dogged by controversy ever since its appearance in the DSM-3 (American Psychiatric Association, 1980). Historically, PTSD as a diagnosis arose during the Vietnam war.

Trauma is used widely to denote an induced psychological condition following the effects of war. Whilst there is yet no consistent working definition, trauma is defined as a situation where the individual experiences a subjective threat to life, bodily integrity or sanity (Pearlman & Saakvitne, 1995, p. 60).

The debate on the use of PTSD and trauma centres around PTSD as a real clinical entity, as opposed to the medicalisation of social problems into narrowly defined Western notions of trauma (Rosen, 2004). It has been criticised as being a socially constructed artefact and pseudo-condition, which reframes the effects of war as a technical problem within the individual, used as a means of legitimising compensation and disability claims due to precipitant events such as exposure to war (Summerfield, 1999).

Criticisms of the symptom-based categorisation of PTSD have focused on conceptual problems arising from the diagnostic category, which are argued to be reductionist and pathologising, whereby distress is positioned as being caused by biological and psychological aetiology. Rosen (2004) highlights the question of what qualifies as ‘traumatic’, as how one interprets the event is relative and influenced by historical and cultural factors. Questions about context have been avoided, and conceptualisations of the response to traumatic events have focused on the impact on the self, and psychological and neurological processes, in isolation from the political and cultural context in which the traumatic event is situated (Bracken, Giller & Summerfield, 1995).

Burstow (2005) argues that labelling distress following traumatic events enables the normalisation of the use of the notion of trauma, legitimises it under diagnostic systems, and minimises the aftermath of violence as a preceeding event. Further, Gojer and Ellis (2014) assert its reductionist nature, given the over-focus on death and serious injury as a criterion. This overlooks major losses, repeated violence, victimisation and humiliation, and fails to consider the ethno-cultural context of trauma.

Further, the ‘re-experiencing’ criterion is the lynchpin on which the disorder rests. Rosen (2004) asserts that there is little data on the ‘re-experiencing’ cluster and that retrospective accounts of re-experiencing symptoms can be misleading. For a PTSD diagnosis, the DSM-5 requires that symptoms be present for at least one month and

produce distress and impairment. However, this criterion has been argued to represent an oblique attempt at distinguishing disordered stress reactions from normal ones. Overlapping criteria such as depressive cognitions and emotions, and the inability to experience positive emotions, highlight the problem of subsuming other difficulties such as adjustment reactions (Rosen, 2004).

Alongside the two parallel arguments that PTSD is a natural discovery versus a socially constructed one, Rosen (2004) maintains that there is a third possibility – PTSD is an ‘interactive kind’, a real entity and one affected by the process of classification, e.g., flashbacks are now an integral part of the cultural lore of trauma, which affects how people experience their trauma, as photographic snippets.

On the other hand, Rosen (2004) contends that there is a competing argument that the scepticism that revolves around the syndromic validity of PTSD only serves to silence the voice of those who continue to suffer from trauma-related difficulties.

In light of the criticisms of the concept of PTSD in general, and as applied to forced migrants in particular, PTSD remains the dominant construct from which to understand traumatic reactions for war-related populations. PTSD as a construct is used for the entire research section of this portfolio to refer to those who have been diagnosed with PTSD, a core element of the inclusion criteria (enhancing homogeneity of the research sample). Terms such as ‘having PTSD’ and ‘with PTSD’ are used as shorthand for participants who have been diagnosed with PTSD.

*Various theories have been proposed to explain the development and maintenance of PTSD. The four main psychological theories are outlined here to provide an overview of the psychological processes implicated in PTSD. The most prominent current theories are conditioning theories, emotional-processing theory, dual-processing theory (under cognitive theories of PTSD), and psychodynamic theory. The biological theory of PTSD is also outlined.

1.5 Theories of PTSD

1.5.1 Conditioning theories

Mowrer’s (1960) two-factor learning theory of fear and anxiety has been used to explain the clinical symptoms of PTSD. According to this model, stimuli during the trauma (e.g. odours, sounds) become conditioned to elicit intense anxiety through classical

conditioning, which explains aversive emotional reactions to cues associated with trauma (e.g. sounds of gunshots), while operant conditioning explains the avoidance of these cues. Individuals learn that they can minimise the distress by avoiding internal and external cues associated with the trauma (e.g. suppressing trauma memories). The reward of minimising distress maintains the avoidance and avoidance behaviours, and when expanded to further stimuli associated with the trauma(s), these symptoms become chronic. However, learning theories do not account for the startle response, a characteristic of PTSD, unless this is acquired during the original trauma, nor do they explain the characteristic symptoms of re-experiencing the traumatic event(s), (Friedman, Keane & Resick, 2010).

1.5.2 Emotional processing theory

Foa and Kozak (1986) propose that anxiety disorders indicate the presence of pathological fear-structures in memory. Fear-structures comprise inter-related representations of feared stimuli, feared responses and information about verbal, behavioural and physiological responses to the stimulus, and the associated meanings. These are activated when a cue in the environment matches some of the information represented in the fear-structure and leads to associated, cognitive, physiological, and behavioural anxiety reactions. This theory posits that the fear-structure, characterised in PTSD by many harmless stimulus representations that are associated with the meaning of danger, in addition to representations of physiological arousal and behavioural reactions, results in PTSD symptoms. The fear-structure consists of several modalities (visual, physical, sound, cognitive and emotional) and is usually activated by many associated stimuli. It becomes prone to misfiring, leading to the perception of threat and the world as dangerous. Many of the symptoms in PTSD can be explained by the activation of the fear-structure. Subsequent traumas can strengthen existing fear-structures, meanings and associations. Recent developments of the theory have focused on the nature of the trauma memory, pre-morbid information about the self, and how the world influences how trauma experience is interpreted (Foa & Jaycox, 1999).

The disorganisation and fragmentation in trauma survivors’ narratives has been proposed to be a result of various mechanisms that interfere with the encoding of the memory under distressing circumstances. Prolonged exposure (Foa & Meadows, 1997), consisting of the activation of the fear-structure and the updating of the structure with

new information that is incompatible with the erroneous information, is associated with increased coherence, reduced fragmentation of the trauma memory, and reduced anxiety and depression (Foa, Molnar & Cashman, 1995). Friedman et al. (2010) maintain that the theory is better able to model the phenomenology of PTSD and complements learning theorist accounts. However, the theory primarily focuses on fear and danger, despite PTSD being no longer categorised as a fear-based anxiety disorder under the DSM-5. Power and Dalgleish (1997) report that other emotions such as bereavement and disgust may also be associated with PTSD disorders. Friedman, Keane and Resick (2015) assert that a complete theory needs to account for complex post-traumatic reactions.

1.5.3 Cognitive theory

Within the cognitive model (Ehlers & Clark, 2000), PTSD is conceptualised to be the result of negative appraisals related to impending threat of the trauma and its consequences, and negative appraisals about the nature of the memory and its link to autobiographical memories. Individuals with PTSD process the trauma and its consequences in a way that gives rise to a current sense of threat. The individual's appraisals of the trauma and its consequences, the nature of the traumatic memory (incoherent and fragmented), and how integrated it is to episodic memories and autobiographical memories are hypothesised to cause a sense of present threat in PTSD. The perceived threat is maintained by intrusions and behavioural and cognitive responses intended to reduce threat, preventing elaboration and cognitive change of trauma memories.

Ehlers and Clark's (2000) model is influenced by Beck's (1979) cognitive model and Foa and Kozak's (1986) emotional processing model. It posits that when individuals with chronic PTSD recall the trauma memory, their recall is biased by their appraisals and the selective retrieval of information that is consistent with these appraisals, thereby preventing changes in the appraisals. Avoidance is posited to be the result of a current sense of threat maintained by negative appraisals and the nature of the trauma memory. This model incorporates and shares the strengths of Beck's cognitive model and associative network theories, suggesting that the presence of strong stimulus-stimulus and stimulus-response associations make the memory more easily activated by numerous triggers (Friedman et al., 2015). However, Friedman et al. (2010) argue that

this model does not explain why the addition of cognitive therapy to exposure does not enhance treatment efficacy, except for one study (Bryant et al., 2008).

The dual representation theory (Brewin, Dalgeish & Joseph, 1996) assumes two separate memory systems that operate in parallel during the trauma, as well as subsequently: the verbally accessible memory (VAM), and situationally accessible memory (SAM). The VAM contains information from before, during and after the trauma and which has received sufficient conscious processing to be transferred to the long-term memory store, or autobiographical memory. This system is responsible for the individual giving a narrative account of the trauma which becomes contextualised and elaborated, including information about peri-traumatic emotions they experienced at the time of the trauma. In contrast, the SAM representation contains lower-level perceptual processing of the trauma scene and the person's bodily reactions at the time. SAM representations are too briefly understood to receive any conscious processing. These SAM representations are triggered involuntarily by internal and external stimuli associated with the trauma event, postulated to be responsible for flashbacks and cued physiological arousal. SAMs cannot be deliberately accessed as they are not verbally coded and thus more difficult to integrate into memory.

Brewin et al. (1996) conceptualise emotional processing as "a largely conscious process in which representation of the past, present and the future events, and awareness of associated bodily states, repeatedly enter into and are actively manipulated within working memory" (p. 677). In contrast, Foa and Kozak (1986) define emotional processing as changes in the fear-structure, promoting recovery. Brewin et al. maintain that recovery consists of integration, altering negative emotions both peri-traumatic and post-traumatic resulting from unhelpful appraisals, and preventing the automatic activation of SAMs. The model implicates the use of exposure therapy and cognitive restructuring. Exposure to information stored in the SAM is hypothesised to further restructure information stored in the VAM that is incomplete, and in addition results in a new SAM representation that is activated in the presence of new information, and without intense physiological arousal which competes with the old SAM. Brewin et al. (1996) postulate that in premature inhibition of processing, trauma survivors develop avoidance strategies that limit the activation of the trauma-related SAM and VAM representations, leading to no changes in the trauma memory, such as in chronic PTSD.

The theories provide an explanation for the mechanisms involved in cognitive behavioural therapy for PTSD. However, research demonstrates the effectiveness of

exposure as a key treatment component. The addition of exposure therapy enhances the efficacy of cognitive therapy (Foa & Cahill, 2001). In summary, these models provide an explanation for the mechanisms that trauma-focused CBT potentially uses to treat PTSD. Emotional processing theory and conditioning theories underscore the role of exposure in modifying maladaptive appraisal and associations in trauma memories.

1.5.4 Psychodynamic theory of trauma

Freud and Breuer (1895) hypothesised that hysterical patients repress their awareness of traumatic memories in order to defend against them, and thus a PTSD symptom is an adaptive attempt to manage the trauma. They later conceptualised trauma symptoms such as reliving as a repetition compulsion of the event carried out in the hope of remastering the trauma (Friedman, Keane & Resick, 2015). Contemporary psychoanalysts such as Krystal (1988) developed an information-processing model of trauma involving the idea of trauma events as disabling the psyche's ability to use anxiety to mobilise defences, rendering the ego defenceless, and leading to a disconnection with words and feelings, known as alexithymia. Chertoff (1998) defines trauma as external events that overwhelm ego-defences, leading to a regression to earlier modes of functioning. A manual for psychodynamic therapy for PTSD has not yet been developed, and the therapy has not yet been subjected to rigorous empirical tests. The relational and process-focused nature of psychodynamic therapy makes it difficult to hold the range of theories under this therapy to rigorous analysis. Complex trauma involves complex processes such as re-enactments of defensive roles and maladaptive defences and is usually targeted in therapy via the use of defence analysis and interpreting warded-off wishes and fears. This combination of wishes, fear and defences is referred to as the triangle of conflict (Friederickson, as cited in Schottenbauer, Glass, Arnkoff, & Gray, 2008). However, research has shown that completion of psychodynamic therapy is associated with more adaptive defences which correlate with a reduction of symptoms (Schottenbauer et al.).

1.5.5 Neurobiological theories of PTSD

Features of trauma have been found to account for a small proportion of variance in PTSD symptoms (Halligan & Yehuda, 2000). Studies into risk factors have investigated cognitive, biological, environmental, demographic, personality, and genetic factors. In a

review of the literature investigating the biological risk factors for PTSD, Halligan and Yehuda maintain that studies have highlighted neurobiological abnormalities in those with PTSD that are not observed in similarly exposed individuals without PTSD, which could represent at least in theory a pre-existing vulnerability to the effects of trauma.

Pitman (cited in Halligan & Yehuda, 2000) postulates that elevated noradrenaline during trauma may result in the over-consolidation of memory and development of intrusive symptoms. There is evidence that a hormonal system known as the hypothalamic-pituitary-adrenal (HPA) axis, which is involved in normal stress reactions, becomes disrupted in people with PTSD, and some have linked this HPA dysfunction to hippocampal damage (Cohen, 2017).

Neuro-hormonal research indicates low levels of cortisol (glucocorticoid secreted by the hypothalamic-pituitary-adrenal, HPA axis), and alterations in the HPA axis in both civilian and combat-related PTSD. Yehuda, Teicher, Trestman, Levengood and Siever (1996) reported that alternations in the HPA axis were mediated by increased glucocorticoid receptor activity, acting to keep cortisol levels low. Further support for the premise that HPA axis abnormalities act as a risk factor for PTSD comes from Resnick, Yehuda, Pitman and Foy (1995), who report that lower levels of cortisol were observed in women with prior exposure to rape and assault, suggesting a link between prior exposure and increased vulnerability to PTSD. Further, children of Holocaust survivors had lower cortisol levels relative to children of non-trauma-exposed parents, although this does not directly implicate genetic factors and could be attributed to environmental factors (Halligan & Yehuda, 2000)

Brain imaging studies emphasise two brain structures in people with PTSD: the hippocampus and the amygdala. The latter is involved in how we learn about fear and some evidence suggests that this structure is more active in people with PTSD. There is also some evidence that there is a loss of volume of the hippocampus, a structure which is involved in the formation of memory. This could be indicative of memory deficits and other PTSD symptoms (Cohen, 2017).

The next section outlines five treatment models of PTSD predominantly employed for multiple and chronic trauma presentations: Psychodynamic, Eye-movement Desensitisation and Reprocessing, Phase-based approaches, Sensorimotor, and Trauma-

focused CBT. In the NICE (2013) PTSD evidence update, the appraisal of further RCTs did not result in changes in treatment guidance for PTSD for this group. However, NICE (2013) recommends the need for further research into the delivery of trauma-based therapy within forced migrant communities in the UK. NET is detailed in section 1.11.

1.6 Treatment models for PTSD

1.6.1 Psychodynamic treatment models

The origins of psychodynamic approaches to trauma have been attributed to Freud's theory of unconscious conflict and defences and over the years have evolved into approaches exploring interpersonal, developmental and relational approaches. Therapy focuses on the therapeutic relationship, the client's developmental history, and on developing awareness of defensive dynamics, wishes and fears, termed "the triangle of conflict" (Friederickson, as cited in Schottenbauer, 2008).

The goal of the therapy is to get the patient to recall the trauma and integrate it through therapeutic re-experiencing in a safe place (Horowitz, 1974). Garland (1998) maintains that trauma survivors need a witness to their unbearable feelings in relation to their traumas, to incorporate the trauma experiences into the rest of their lives in a meaningful way. Working through the trauma is thought to facilitate the ego part of the mind responsible for decision making to discriminate the symptoms and understand cause and effect (American Psychoanalytic Association, 2009). Garland asserts the importance of sustaining a balance between taking in the survivor's state in a real way and offering containment involving

> a reworking of the traumatic experience with all its emotional impact, released by the original event, with someone who can…provide for the survivor something of what the mother (or primary care taker) offered her very young baby when it was overwhelmed with anxieties (p. 30).

Attention is given to the transference which enters a working relationship with the therapist, defined as attitudes toward the therapist that repeat important past relationships. Working with clients with complex trauma usually involves intense counter-transferential dynamics (the therapist's use of awareness of their own emotional

reactions to the patient during therapy), informing therapists about re-enactments of defensive roles as victim, perpetrator, rescuer in the therapeutic relationship (Spermon, Darlington & Gibney, 2010).

However, Spermon et al. (2010) maintain that psychodynamic approaches to trauma have seen controversy, as therapists have been pressured to choose between understanding aetiology as being due to intrapsychic theory of defences or primarily generated from external factors including the objective nature of the trauma. Research into trauma approaches has broadly been by way of randomised controlled trials. Traditional psychodynamic approaches employing qualitative methods have been seen as having limitations in generalising their findings due to non-random assignment of patients, single or small number of subjects, lack of the use of a control group, and allegiance effects (Spermon et al., 2010).

1.6.2 Eye-movement desensitisation and reprocessing (EMDR)

EMDR (Shapiro, 1995) is an information-processing model, proposed to resolve trauma memories. The model proposes that trauma interferes with biological and psychological processes that promote the healthy adaptation to these memories, which then become dissociated from the broader-semantic affective network, leading to distortions in affect, response and perception encoded during the trauma (Foa, Keane & Friedman, 2004). A self-healing mechanism is proposed to exist to facilitate the reintegration of trauma memories, and this is activated by bilateral eye movements, stimulation via auditory tone, or tapping movements, whilst the patient focuses on the trauma memory to be desensitised. The procedure requires the patient to hold in mind the disturbing image, and identify the negative self-representation encoded during the trauma, alongside affective and physiological components, and the identification of a desired positive self-representation or cognition. Foa et al. (2004) maintain that the evidence for EMDR is more robust for single trauma than for multiple trauma.

Although a considerable evidence base exists for the use of EMDR for PTSD, thereby establishing that alongside TF-CBT, it is one of the most effective treatments for adults with PTSD (Bisson et al., 2007), a crucial question has been whether bilateral stimulation is necessary for EMDR to work (Logie, 2014). Lee and Cuijpers (2013) conducted two groups of studies: the first comprised 15 clinical trials comparing the effects of EMDR with and without bilateral stimulation, and reported a moderate and

significant effect size for the additive effect of eye movements; the second group comprised 11 laboratory trials investigating the effects of eye movements whilst participants thought of a distressing memory, and the same procedure without eye movements in a non-clinical setting. This reported a strong effect size for the eye movement condition.

In an RCT comparing EMDR with stabilisation in 20 traumatised forced migrants and asylum-seekers, Ter Heide, Mooren, Kleijn, Jongh, and Kleber (2011) reported a high dropout rate for both groups, and only small improvements for EMDR. They concluded that EMDR was not less efficacious than stabilisation. However, there remains limited evidence for EMDR in forced migrant samples (Acarturk et al., 2015; Ter Heide, Mooren, Knipscheer, & Kleber, 2014).

1.6.3 Phase-based approaches

Pierre Janet (1919/1925) was the first psychologist to acknowledge the importance of the role of narrative in the resolution of a trauma memory. Janet developed a systematic phased-based approach to treating PTSD (Janet, as cited in Van Der Hart, Brown, & Van Der Kolk, 1989). This consisted of the following stages:

1. Stabilisation
2. Identification and modification of traumatic memories
3. Personality reintegration and rehabilitation.

A phased-based model has been recommended to treat forced migrants (Nickerson, Bryant, Silove, & Steel, 2011). Herman (1992) also advocates a phase-based model which mirrors Janet’s (1919/1925) model. The three phases of the model include: Stabilisation and symptoms management; trauma processing; and reintegration. Alternation between the stages can occur depending on need. The stabilisation phase ensures that the person has sufficient internal and external resources to tolerate the trauma-processing phase, and focuses on the establishment of trust and safety, emotional regulation, sufficient help with legal, financial and housing issues, and symptom management of nightmares, dissociation, and flashbacks through grounding and techniques for coping with difficult emotions. Phase two involves using exposure-based treatments like CBT, EMDR and NET. The final phase involves helping trauma survivors integrate into the community through building relationships, as well as facilitating access to language skills, education and employment. However, there is a

need to evaluate phased-treatment models for this group. Phase-based treatment has often been recommended for forced migrants who experience PTSD, as it has been suggested that stand-alone trauma treatments may overwhelm this group (Nickerson et al., 2001). This has clinically led to long phases of stabilisation work prior to trauma-focused processing (Ter Heide, Mooren & Kleber, 2016). However, there have been no RCTs of phase-based treatments on the forced migrant population.

1.6.4 Sensorimotor psychotherapy

Ogden, Pain and Fisher (2006) propose a more bottom-up approach to working with trauma awareness and integration of the cognitive emotional aspects and bodily symptoms of traumatic stress. The therapy works with the encoding of the event and its effects on the mind and body, attending to the memory with mindful curiosity whilst narrating the memory, and focusing on thoughts, emotions, sensations that arise when recalling whilst maintaining a dual awareness of the narration of the event and the associated sensorimotor responses. It uses the body as the primary entry point in processing trauma rather than emotion or cognition, in turn facilitating emotional and cognitive processing. Whilst noticing these patterns, the therapist directs the client to be attentive and become curious (mindful awareness), and then explore how a physical intervention such as lengthening the spine brings new kinds of sensory stimulation to the brain. The therapy makes use of somatic resources to increase regulation in the context of attunement and physical experience, analogous to the process observed in secure attachment relationships, and is proposed to be beneficial when working with dissociation in trauma.

1.6.5 Trauma-focused CBT

Trauma-focused CBT involves combining imaginal-exposure with cognitive techniques referred to as reliving. Grey, Young and Holmes (2002), in the case of multiple trauma, recommended the reliving of each troubling trauma memory, focusing on peak distress moments and emotional hotspots. This requires the use of cognitive restructuring, and leads to the updating and contextualisation of the memory. Treatment involves developing coping techniques to manage PTSD symptoms, psycho-education and stabilisation, emotional processing of distress hotspots for key intrusive trauma

memories, reclaiming life work, and engaging in discrimination exercises to manage matching triggers (Ehlers & Clark, 2000).

Ehlers and Clark's cognitive model provides the most detailed account for maintenance and treatment of PTSD and the most comprehensive implications for cognitive behavioural treatment. In a review of trauma-focused approaches, Brewin and Holmes (2003) note that aspects of the model have been consistently supported by empirical research and expanded understanding of a range of negative appraisals and cognitive coping factors that impact on the course of the disorder. However, the model places more emphasis on the way stimulus is processed during trauma rather than how these processes are represented in memory. The dual representation account is clinically informative rather than offering specific treatment guidelines. The emotional processing theory focuses on the habituation of fear in treatment; emotions other than fear implicated in PTSD may not respond to exposure. For an exhaustive evaluation of recent cognitive theories of PTSD and treatment implications (emotional processing theory, dual representation theory, and Ehlers and Clark's cognitive model), see Brewin and Holmes's (2003) review.

CBT with a trauma focus has been shown to provide moderate benefits in reducing PTSD symptoms in the medium term. However, PTSD in the forced migrant population presents with specific challenges (Patel, Kellezi, & Williams, 2014). Trauma experienced by forced migrants is different in duration, character, and severity as compared to other populations (Schick et al., 2016). Research into CBT for this group has highlighted that forced migrants with PTSD have not responded optimally to conventional interventions such as CBT or prolonged exposure (Cloitre et al. , 2009).

Moreover, Kar (2011) maintains that the effectiveness of CBT has not yet been tested for the complex reactions forced migrants often exhibit. In a 2007 study, d'Ardenne, Ruaro, Cestari, Fakhoury, and Priebe reported greater improvements in forced migrant groups receiving TF-CBT using an interpreter than without, albeit most did not make clinically significant improvements. There is evidence that TF-CBT is being used for the forced migrant population using an adapted testimony approach (Grey & Young, 2007), whereby a testimony of the traumas is written, and hotspots identified and worked through. However, Basoglu, Kilic, Salcioglu, and Livanou (2004) reported that participants did not report that TF-CBT had alleviated their nightmares, shame and anger, which are central features of more complex PTSD presentations.

Among cognitive behavioural therapies with a trauma focus, NET is the most recent of approaches (1.11). It has been designed and used for the forced migrant population. NET is a short-term psychological therapy designed to meet the needs of individuals from this population with PTSD following multiple traumatic events over long periods. NET is a new treatment developed for survivors of organised violence and war atrocities (Schauer, Neuner & Elbert, 2005). It incorporates exposure elements from existing models such as prolonged exposure (Foa & Kozak, 1986) and trauma-focused CBT (Ehlers & Clark, 2000), with an additional component of testimony therapy, a therapy that places the trauma within the socio-political context in which it occurred (Cienfuegos & Monelli, 1983). It is methodically a different treatment by comparison. The NET model argues that the hot memory (the trauma) is involuntarily retrieved without links to cold memories (autobiographical memory), and aims to contextualise the traumas, allowing the patient to see the event in the socio-political context of war and political persecution (Schauer et al., 2005).

1.7 The epidemiology of PTSD in forced migrants

Despite the lack of validated measures for PTSD in the forced migrant population, studies on the epidemiology of PTSD in this group have identified prevalence rates as ranging from 4% to 86% for PTSD, and 5% to 31% for depression (Hollifield et al., 2002). In a meta-analysis, Porter and Haslam (2005) reported that displaced forced migrants were significantly more disturbed than non-displaced controls, even when the controls had experienced significant war stress, indicating that living in institutional forced migrant camps was more disruptive than living temporarily with family and friends. Lindert, Ehrenstein, Priebe, Mielck, and Brahler (2009) report that forced migrants have been shown to present with higher rates of PTSD, anxiety and depression compared to the general population, with prevalence rates among migrants across studies approximating 30.6% for PTSD and 30.8% for depression, indicating that PTSD amongst forced migrants is as common as depression in this population. In the largest review undertaken, Steel, Chey, Silove et al. (2009) showed that prevalence rates of PTSD and depression were similar, approximately 30%, although there was significant heterogeneity in rates across studies. In a recent review of forced migrants in the European region, larger controlled studies yielded a prevalence of 15% as presenting with PTSD (Priebe, Giacco, & Elnagib (2016).

Research nevertheless indicates that the prevalence of torture and potentially post-traumatic events vary between groups of forced migrants (Sigvardsdotter, Vaez, Hedman, & Saboonchi, 2016). These authors suggest that both the heterogeneity of data and the methodological challenges of defining and measuring traumatic experiences in this population inhibit the generalisation of trauma across such a group.

1.8 The impact of torture on forced migrants

Gorman (2001) highlights that many studies on forced migrants and those who have had torture experiences report that the insidious aim of torture in war and political persecution has not been to uncover intelligence but to "break bodies and mind", destroying the individual's personality, and terrorising the population, ending any resistance to a regime (Bustos, as cited in Gorman). Torture has for many years been an instrument of social and political control intended to deny and rob individuals of a voice, and an inhumane means of subordination to silence and disable (Gorman). Forced migrants who have endured torture may acquire a sense of blame and shame for the persecution they have experienced, which may leave them distrustful of services and persons in authority (Gorman).

Further, human-inflicted torture can shatter fundamental assumptions about one's world and one's self. Brison (2002), in her book 'Aftermath: Violence and the remaking of the Self', asserts that those who have torture intentionally inflicted upon them are reduced to objects, and their subjectivity is viewed as worthless. She maintains that our lived sense of time and identity is usually one of coherence, and that "Trauma undoes the self by breaking the ongoing narrative, severing the connections among remembered past, lived present, and anticipated future" (p. 41).

An obstacle to trauma survivors reconstructing coherent narratives of the self is the difficulty in regaining one's subjective voice, after one has been reduced to the status of an object, and one's body has been used as someone else's speech (Brison, 2002). Trauma forces the survivor to relive earlier struggles of competence, autonomy, intimacy and identity (Brison). Brison details common emotional responses in trauma, such as shame (usually as a result of violation of bodily integrity and as a response to helplessness), pervasive doubt (another common emotional response to trauma, as survivors usually doubt themselves and others in the aftermath of trauma) and guilt or survivor guilt as a common reaction in those surviving wars and rape. Herman (1992)

conceptualises that guilt in trauma may be understood as a way of regaining some sense of control and power, which may be more tolerable than the reality of total helplessness. She asserts that trauma “destroys the belief that one can be oneself in relation to others” (p. 53), while Brison states that without this one can no longer be one’s self to oneself, since the self exists in relation to others. Thus shame, guilt and inferiority lead to withdrawal from relationships, maintaining a chronic cycle of pervasive distrust (Brison), a common response within the forced migrant population.

Despite epidemiological research indicating that a significant proportion of forced migrants suffer from PTSD, PTSD has been criticised as a European-American culture-bound syndrome that cannot be applied to other cultures (Friedman et al., 2015). The following section presents a deconstruction of the notion of the ‘trauma’ paradigm, and a discussion of the cultural transferability of this construct as applied to forced migrants.

1.9 Critique of the construct of trauma and its application to forced migrants

The diagnostic labelling of PTSD in forced migrants has been criticised for focusing on the individual rather than recognising the social and political context of people’s lives (Fernando, 2014; Lane & Tribe, 2014). The word ‘trauma’ has become pervasive when thinking about forced migrants and war. Within the literature, there is an inherent assumption that this population readily subscribe to this construct called ‘trauma’ or the diagnostic label of ‘PTSD’ from the outset, and tacit assumptions are readily applied about the experience of war leading to trauma within this population. Within the trauma paradigm, PTSD is central to the concept of trauma, and has become the gold standard for understanding the effects of displacement and war. Trauma and PTSD are now synonymously used and applied to all populations who have been displaced and affected by war and mass conflict.

Trauma has been criticised as being a product of the globalisation of PTSD and Western concepts, assumed and applied to war-related populations. Even where the phenomenon can be identified across social settings, Boyden and Gibbs (1997) assert that it is a mistake to assume that it means the same thing across such settings, where people have different diagnostic systems and understandings (spiritual, political and cultural rather than medical and psychological).

Further, applying ‘disorder’ to those who have experienced genocide and persecution presents with ethical problems. The terminology of ‘post’ and ‘disorder’ raises questions about who determines the beginning and the end in the context of continuing exposure to war and displacement and can be seen to justify acts of violence. Lira, Becker and Catillo (1988) assert that the notions of ‘post’ and ‘disorder’ are inadequate in understanding and treating those who experience human rights violations. Summerfield (1999) maintains that war is a collective experience, rather than a private one, involving the destruction of a social world, and that human response to war cannot be the same as to a physical injury.

According to Breslau et al. (1998), experiencing trauma does not have a causal relationship with the development of PTSD. Newman, Riggs and Roth (1996) report that the concepts of traumatisation and trauma are broader than the concept of PTSD, and that a multitude of other problems can arise as a consequence of ‘traumatisation’. PTSD does not occur in isolation to other comorbid conditions, such as complex grief, adjustment and persistent physical pain following injury (Spinazzola, Blaustein & van der Kolk, 2005). These conditions are frequently excluded in efficacy research, giving rise to an artificial homogeneity, threatening external validity, and under-representing the typical presentation of PTSD in this population in clinical practice. Depression and anxiety are frequently observed amongst those who are displaced and war-affected (Friedman & Marsella, as cited in Marsella, Friedman, Gerrity, & Scurfield, 1996). Panic, substance abuse and major depression are also common in traumatised populations (Halligan & Yehuda, 2000). In addition to this, there is a debate that practitioners should focus on the traumatisation of whole communities rather than the individual, where the effects have been documented to lead to an increase in interpersonal conflict, substance use, and domestic violence (Weiseth & Eitinger, 1991).

In circumstances where forced migrants are given a diagnostic label of PTSD, it remains questionable whether the full degree of traumatisation is being captured. In a study of 33 forced migrant trauma survivors, Teegen and Vogt (2002) reported that two-thirds exhibited the full syndrome of complex PTSD (CPTSD). CPTSD is characterised by repeated and or sustained multiple traumatic incidents, occurring in circumstances where escape is difficult. Individuals experiencing this kind of trauma often exhibit other additional difficulties, including dissociation, somatisation, emotional regulation difficulties, and difficulties in relational areas (Cloitre et al., 2011). However, in a systematic review, Ter Heide et al. (2016) showed that forced migrants are more likely

to meet a PTSD than a CPTSD diagnosis, and that the prevalence of CPTSD is more common amongst survivors of childhood trauma. In fact, only a minority of refugees present with CPTSD.

Whilst PTSD is used as a measure of the validity of trauma, this poses challenges for the forced migrant who tries to contextualise their trauma narrative into one which is narrowly defined by Western notions of trauma and PTSD (Gojer & Ellis, 2014).

1.10 The socio-political context of war-related trauma

For aid agencies and socio-political programmes in war-torn countries, trauma has been the ‘flavour of the month’ (Forced Migration Online, no date). With this emphasis, there are concerns that economic needs as well as socio-political issues are negated by aid agencies who have received funding for psychosocial projects, reflecting a Eurocentric agenda and grandising Western agencies rather than providing an attempt to address the actual needs of the war-affected populations (Summerfield, 1999). Thus, according to Summerfield, PTSD reflects “the globalisation of western cultural trends” (p. 1449), to medicalise and position pathology intra-psychically, rather than as distress mediated by socio-political structures.

The experience of forced migrants is diverse and they are often exposed to unique stressors. Desjarlais, Eisenberg and Kleinman (1995) developed a model which broke down the forced migrant experience and journey into stages. The first stage, pre-flight, is when forced migrants can experience a multiplicity of stressors involving being subjected to or witnessing political violence, political and social upheaval, loss of loved ones and property, and emotional and physical abuse. During the subsequent flight stage, forced migrants often experience challenging and life-threatening journeys to escape, and possible separation from family. The reception phase is characterised by long periods of uncertainty and worry over the future, poor living situations and difficult living conditions, with possible re-exposure to violence. The resettlement phase involves adjustment to the host country, culture shock, and re-exposure to discrimination and prejudice.

Forced migrants present with a multitude of losses and traumatic events, and both war and non-war-related traumas relating to their contextual and political circumstances. They often experience and witness atrocities and extreme losses in addition to their

experience of equally extreme losses linked to their self-identity, culture and language, as well as huge uncertainties relating to acculturation stresses and adjustment (Tribe, 2002). Thus, Tribe maintains that this group is often given the diagnostic label of PTSD, and that within the context of their losses, their response has been asserted to be a normal adjustment reaction. Referring to this population as 'traumatised' positions them as 'passive victims', and Bracken & Petty (1998) assert that in reality, only a small proportion require specialist help.

Within the literature, there appears to be an over-focus on what psychological professionals see as deficits rather than resilience in the phenomenological experiences of forced migrants (Summerfield, 2001).

Parallel to the trauma debate, and how this term has been used with the displaced and war-affected population, has been the debate on whether forced migrants perceive themselves as being 'victims' or 'survivors', 'resilient' or 'vulnerable', and whether this heterogeneous group may have different notions of the effects of war-related traumas (Forced Migration Online, no date). While the psychological well-being of forced migrants remains on the international agenda, the consequence has been the positioning of this heterogeneous group as 'victims'. This implies helplessness and disempowerment, rather than seeing their difficulties as an inevitable part of war-related events. For example, human rights activists in countries of war might not perceive themselves as 'victims' . Summerfield (2001) maintains the need to emphasise resilience within this group, taking the vantage point of acknowledging people's capacity to deal with events such as war, and highlighting the importance of the international community providing assistance that they need and want, which may be economic rather than therapeutic quick fixes.

Whilst individuals from such a heterogeneous group may not subscribe to the trauma paradigm or indeed perceive themselves as 'victims', Silove, Steel, Bauman, Chey and McFarlane (2007) maintain that the stakes are high if the critique of PTSD as applied to this population is mistaken, and if their real mental health needs are not addressed, given that this population is already a disadvantaged and vulnerable group.

1.11 Narrative exposure therapy (NET)

1.11.1 Mechanisms of NET in PTSD

NET has been informed by theoretical understandings of memory and PTSD conceptualisations (Brewin et al., 1996), autobiographical memory (Conway, 2001), the emotional processing of fear model (Foa & Kozak, 1986), and the Cognitive Model of PTSD (Ehlers & Clark, 2000). In a review by Brewin and Holmes (2003), these theories were identified as having the most explanatory power for current clinical findings and empirical findings in PTSD.

Neuner et al. (2014) assert that PTSD is maintained by excessive sensory-perceptual memory representations of the trauma, accompanied by fragmented, verbal autobiographical, and contextual information. Analogous to Brewin et al. (1996), Schauer et al. (2005) make the distinction between the contextual representation in contextual memory as cold memory (similar to C-reps in contextual memory, in Brewin's revised dual representation theory – Brewin, Gregory, Lipton & Burgess, 2010), and sensory representation as hot memory (Metcalfe & Jacobs, 1996) or situationally accessible memory – S-rep in Brewin et al.'s model. A cold memory or verbally accessible memory is comprised of contextualised information about one's life that is organised autobiographically, comprising lifetime periods, information about general events which can be single or generalised experiences, and event-specific contextual knowledge such as a memory of a life event. A hot memory is conceptualised to include detailed sensory information; cognitive, emotional, physiological and motor responses. Sensory-perceptual representations of traumatic events are also known as fear-structures, which cover many nodes; sight, smells, sound, physiological reactions and different emotions (Lang, as cited in Brewin & Holmes, 2003). These are later activated when the individual encounters an internal or external stimulus within the fear-structure, resulting in the full activation of the entire structure and leading to intrusive PTSD flashbacks (Schauer, Neuner & Elbert, 2011).

PTSD patients learn to avoid cues in order to prevent the painful activation of the fear-structure, making it difficult to appropriately place the fear and sensory recollections in time and context. As such, the avoidance makes it difficult for them to narrate their traumatic experiences (Schauer et al., 2011).

PTSD is also conceptualised as a consequence of physiological changes, the noradrenergic response to stress, which impairs the hippocampus, and leads to an over-activation in the amygdala, resulting in stronger sensory associations. In response to a traumatic event, the hippocampus along with the medial-frontal cortex is unable to mediate the distress and arousal occurring in the amygdala (Nutt & Malizia, 2004). The

impaired activation of the hippocampus means that the spatial-temporal information of a time and context tag is not incorporated in the memory, maintaining a current sense of threat (Ehlers & Clark, 2000), and an inability to narrate the story chronologically, thus disrupting autobiographical memory.

Adenauer et al. (2011) reported that after therapy, patients who received NET showed an increase in parietal activity (associated with episodic memory retrieval and attentional processes) towards aversive pictures compared to the wait-list control group. They reported that this "…represents voluntary top-down episodic memory search that was trained through the procedure of NET, which requires the detailed access to previously avoided episodic memory content" (p. 5). Adenauer et al. reported that NET contributed to an increase of activity associated with cortical top-down regulation of attention towards aversive stimuli. The authors concluded that "the increase of attention allocation to potential threat cues might allow patients to re-appraise the actual danger of current situations, thereby reducing PTSD symptoms" (p. 1). These findings are consistent with current theories on emotional processing theory which maintain that exposure therapy increases the ability to disentangle past experiences from current threat, in order to identify aversive stimuli as reminders of past trauma events rather than current threat. Further, in PTSD, trauma memory retrieval is associated with the activation of the right hemisphere, which is consistent with the non-verbal nature of intrusions and incoherent trauma narratives. Increased left hemisphere activation following therapy may be associated with higher-order verbally mediated activity, which in turn decreases the experience of intrusions, consistent with VAM representations as proposed in the dual representation model (Brewin et al., 1996).

The testimony component in NET combines the goals of PTSD treatment: elaboration, contextualisation and habituation of trauma memories, by facilitating emotional processing of survivor's traumatic events. The biography of the survivor's human rights violations is documented and can be used as a document for human rights purposes. Testimony therapy originated as a specialist approach for those presenting with trauma reactions and was used with the political goal of accusing the Pinochet dictatorship (Cienfuegos & Monelli, 1983).

1.11.2 The components of NET

Traditional exposure therapy focuses on the worst memory that the person has experienced. However, most forced migrants and survivors of organised violence are likely to have experienced a multitude of traumas. NET combines exposure therapy with testimony therapy, and focuses on constructing a consistent autobiographical representation of traumatic events within the context of a chronological narration of the entire life of the patient (Robjant & Fazel, 2010). The originators of NET propose that the approach is "grounded in a deep humanitarian respect for the biography of the survivor" (Neuner et al., 2014, p. 273). NET aims to enhance the encoding of autobiographical memory, when hot memories are activated, and reweave the events back into a "cool-system framework" (Schauer et al., 2011). This is conceptualised to reduce the fear-structure, simultaneously constructing an autobiographical representation of traumatic events within the context of a narrative of the whole life of the survivor (Schauer et al.).

At the start of treatment, patients narrate all traumatic life events in chronological order from birth to the present day, as well as their hopes for the future. Foa et al. (1995) reported that those who most benefited from exposure were also those who could construct a meaningful and consistent narrative, a principal factor in the recovery of PTSD.

NET is a manualised treatment. Following psychoeducation about PTSD, a lifeline is constructed to get an overview of trauma events, but also significant cold memories that will later appear in the narrative. A rope is used as a physical representation of their lifeline, and the patient briefly goes through their life, placing a flower to represent a positive or neutral life event, and stones to represent traumatic events in chronological order (the stones and flowers are of varied sizes). In subsequent sessions, a detailed narration of the cold memories is explored and used as contextual information, to support the hot memories. The process begins with a gentle probing of what life was like, what the person was doing, and what a typical day might have been, before narrowing this down to what exactly happened on the day of the trauma event, during which time further probing is used to activate all aspects of the hot memory structure. As patients narrate their life story and memories, associated fear networks are triggered.

NET facilitates the activation of all sensory modalities, in addition to thoughts during the trauma. It connects the hot memories with the corresponding cold contextual information, leading to a verbally accessible narrative. The therapist accesses current physical, emotional and cognitive reactions and guides the patient between 'then' and

‘now’ reactions, using the present tense for what is happening for them at the time of the narration, and the past tense for the time of the event. Examples of the questions used to target the fear-trauma structures across different levels of processing are; Past-tense questions: ‘what did the bodies look like’, ‘could you smell them’, ‘could you hear the gun fire’, ‘could you feel the pain in your legs’, ‘did you think you would die?’, ‘did you feel horror?’, did your heart beat fast then?’; and present-tense questions, ‘can you see the bodies in your mind now like it was then?’, ‘can you smell the dead bodies now like it was then?’, ‘what do you think then and now?’, ‘can you feel your heart beating fast now like it was then?’. The therapist uses observation of bodily reactions, behaviours and expressions during the activation of the hot memories, whilst elements from the hot memory are activated to facilitate greater awareness in the patient of their reactions both at the time of the trauma and currently. Moreover, the present tense is used more to help activate the fear/trauma network when the patient under-engages or is below the window of tolerance, referred to as the hypo-aroused state. Equally, with over-engaged, hyper-aroused patients, the past tense is used more, to help lower the level of autonomous sympathetic activation.

Emotional exposure to the memory is required for sufficient habituation. Each session ends at a safe point once the patient’s emotional arousal has diminished, and events following the trauma events are then narrated back to the patient to help place the episode in a context. All traumatic events are addressed. The narrative is written up between sessions and read at the beginning of each session to ensure coherence and possible further exploration. Exposing the patient to the memories once again promotes further integration of the hot and cold memories (Schauer et al., 2011). The patient is expected to notice a reduction in physiological responses compared to their first exposure to the memory, although several sessions may be necessary for habituation to occur for severely traumatic events. At the end of the re-reading of the narrative from the previous session, the period following the former trauma and the next trauma is briefly narrated, before the patient is exposed to the next traumatic event. The process continues until all identified traumatic events have been narrated, and a reduced affective response is observed. At the end of therapy, the narration also represents a testimony of the person’s life with a detailed narration of traumatic events, and the narration ends with hopes and aspirations for the future (Schauer et al.). The testimony is signed by the therapist, patient and interpreter if present and the patient receives a copy. Schauer et al. (2005) report that it is common for patients to share their testimony with human rights organisations and lawyers.

The authors of NET state that the narrative procedure creates an explicit and semantic representation of events, and a deactivation of the fear network, leading to an inhibition of fear and helplessness, and habituation. Working through the lifeline (biography) highlights the meaning of inter-related emotional networks from various traumatic events and facilitates the understanding of behavioural patterns and schemas through implicit meaning-making during processing (Neuner et al., 2014). In relation to post-traumatic growth, there is limited evidence as to whether in NET the individual experiences a sense of post-traumatic growth as part of their own history of survival, resistance and past and future resilience (Schauer et al., 2011). Kaminer (2006) maintains that NET aids with emotional catharsis, by developing an explanation of the traumatic incidences and facilitating the identification of the causes of and responsibilities for the horror and atrocities. Similarly, Neuner et al. (2014) maintain that NET allows reflection on the person's entire life experiences and in this way fosters a sense of personal identity.

Whilst the production of a coherent narrative is proposed to be a mechanism of change in NET, Mundt, Wunsche, Heinz and Pross (2014) maintain that non-Western cultures may not share similar conceptions of chronology and claim that this varies as a function of age and culture. Mørkved et al. (2014) suggest that a component analysis of NET could investigate the effects of producing a written narrative at the end of treatment or the use of past and present tense in narratives. They suggest that if the narrative provides an independent significant effect to changes in anxiety through mechanisms other than habituation as the mechanism of exposure, this can further conceptualisations of PTSD or complex PTSD.

Whilst NET is recognised broadly as a narrative therapy, it is important to stress the difference between NET and other types of narrative therapy such as White and Epston's (1990) Narrative therapy, and narrative therapies used in rehabilitation programmes such as Chow's (2015) train metaphor narrative therapy.

1.11.3 The differences between NET and Narrative therapy

Narrative therapy, developed by White and Epston in the 1980s, is a form of psychotherapy that seeks to re-author a new narrative through challenging the dominant social discourses that it proposes shape people's lives. It involves externalising the problem by situating it into a context, and deconstructing existing problem narratives

whilst deconstructing beliefs and ideas which maintain the dominant problem narrative. Chow (2015) developed a variation of narrative therapy intervention for stroke survivors and care-givers which uses a train metaphor. However, this intervention is significantly different from NET as it involves conversations about problem-saturated stories informed by dominant biomedical discourse. The therapist externalises these, whilst co-constructing new train stations through meaning reconstructions and re-authoring conversations.

In contrast, NET develops a narrative by contextualising the associative elements of the fear network to process uncontextualised and unelaborated aspects of the trauma memories, whilst further contextualising these within the course of the person's lifeline. This enables reflection on the survivor's life, the meaning of emotional networks from events, and an understanding of schemas and behavioural patterns (Schauer et al., 2011). Thus, with NET, the aim is to build a narrative which links events in time with social context, including socio-political context, rather than exploring dominant stories of problems and developing alternative problem-unsaturated stories.

1.11.4 Comparisons and differences between NET and other cognitive and exposure-based treatment models

Prolonged exposure (PE) and NET share many features. PE uses the theoretical foundations of emotional processing theory (Foa & Kozak, 1986). According to this theory, fear is present as a cognitive structure in our memory which also contains information about the feared stimuli, our subsequent fear response, as well as the meaning we assign to the stimuli. PE activates the fear-structure and is hypothesised to alter it by providing new information during and following imaginal exposure to a trauma memory.

Similarly, in NET, the fear-structure is also activated based on the same premise as PE, and, analogous to PE, the theory assumes that PTSD is a consequence of how trauma memories are stored and the changes to the memory following trauma (Schauer et al., 2011). PE is usually employed for a small number of traumas by targeting the most distressing trauma memory and associated hotspots within that memory. It assumes that exposure to one trauma memory has generalised effects to other trauma memories, and chooses the worst and in some cases the first trauma memory, using present tense to activate the fear-structure. PE does not specify chronology and targets memories based

on identifying the one that causes most distress as a measure for intervention. NET is proposed to process all associated hotspots for all significant distressing memories. Mørkved et al. (2014) state that PE also has a narrative component but that the focus of this narrative is based on one or two trauma memories rather than on multiple memories and the development of an autobiography. In both NET and PE, the nature of cognitive change is not explicitly described, and both allow the therapist to probe into how the traumas may have impacted on beliefs about safety and control. In PE, discussion of maladaptive thoughts and cognitive restructuring happens after the fear-structure is activated, and corrective information is inserted into the memory during a subsequent imaginal exposure. In NET, the therapist may explore maladaptive cognitions after a narration, or in between sessions before the next narration as changes in cognition may occur spontaneously. The therapist may use Socratic questioning or the narrative to facilitate cognitive change, although this process is less explicit compared to PE or enhanced reliving in TF-CBT.

Palic and Elklit (2011) maintain that PE, which is usually aimed at a single trauma, is likely to be problematic for treating PTSD in forced migrants, and suggest that the effects from PE are less likely to generalise to survivors of multiple traumatisation. Mørkved et al. (2014) compared 32 PE studies and 15 NET studies, and concluded that NET has advantages over PE for complex trauma in forced migrants, despite NET and PE having several commonalities.

1.12 The importance of narrative structures in human psychology

Creating a coherent story about traumatic events is central to trauma recovery and is at the heart of the core theories of trauma (Janet, 1919/1925; Brewin et al., 1996; Brewin & Holmes, 2003; Herman, 1992; Brison, 2002; Mengel & Borzaga, 2012). As humans, we seek to impose structure on the flow of experience and to the sequence of events that are deemed important. Hunt (2010) maintains that autobiographical memory is organised around narrative structures, and that trauma impacts on narrative development, inevitably influencing autobiographical memory. We use story components to order life experiences and this provides structure and a continuation, giving meaning to life events. We are in a constant process of constructing our personal narrative, through the evaluation of the experiences in our life, and, as such, the desired outcome is a coherent personal narrative comprising subjective truths, emotional evaluations and

interpretations, integration, and meaning being made more explicit (Burnell, Coleman & Hunt, 2009).

Humans tell stories in making sense of themselves and others, and according to Ricoeur (1991), the self only comes into being via the process of telling a life story. We organise our personal memories to build and establish a coherent sense of self (Gergen & Gergen, 1988). The study of trauma provides evidence for a view of the self as 'relational', vulnerable to be undone with trauma, and yet resilient enough to be reconstructed with the help of others (Brison, 2002).

It is imperative to understand some of the processes happening in trauma therapy in order to appreciate the experience of this group undergoing a narrative therapy like NET. In the following section, the distinction between trauma narrative and narrative memory is discussed, and the significance of narrative structures is explored in relation to developing an order of meaning.

1.13 Trauma narrative and narrative memory

Pierre Janet (1919/1925) was one of the first psychologists to discuss the idea that the resolution of a traumatic experience was about transferring a traumatic memory into a narrative memory, thus integrating it into the life story. According to Brison (2002), working through the trauma or 'remastering traumatic memory' involves a shift from being the object of someone else's speech, usually the perpetrator's, to being the human subject of one's own speech, through telling one's narrative to empathic others. She maintains that to work through trauma and reconstruct self-narratives, we need an audience able to hear the trauma narrative, and that the act of bearing witness to trauma facilitates this shift, by re-establishing connections to selfhood, as well as transforming traumatic memory into a coherent narrative memory. Psychoanalysts Feldman and Laub (cited in Brison, 2002) argue that bearing witness to a trauma is a process that actively involves an empathic listener. This involves the survivor articulating and transmitting the story to another person, or persons outside of themselves, and then taking it back inside, defined as 're-externalising'.

Narrative memory is defined by Mengel and Borzaga (2012) as the relating of the traumatic events into a story that has a beginning, middle, and an end. They maintain that the construction of the story gives shape to an 'unclaimed experience', and that the

narrative claims and contains it. The construction of a narrative memory is argued to be an active process, involving speech, and temporal order. Brison (2002, p. 4) states that

> narrative memory is not passively endured; rather, it is an act of a part of the narrator, a speech act that defuses traumatic memory, giving shape and a temporal order to the events recalled, establishing more control over their recalling, and helping the survivor to remake a self.

Thus, narratives can rebuild the individual's sense of identity and meaning when incoherence prevails (Crossley, 2000).

Evidence supports the idea that narrative structures are cross-cultural, and active in helping one understand events and connections. According to Crossley (2000), the function of narratives such as autobiographical narratives is to reveal structures or meanings that otherwise remain implicit or unrecognised. Polkinghorne (1988) maintains that an 'order of meaning' constitutes human consciousness. A unique feature of this is time and temporality, and the use of 'relationships' and 'connections', as we interpret the events around us. When we ask, 'what does this mean?' we are asking 'how is this connected to someone else?', and looking for connections among events that comprise their meaning. We are imprinted from an early age to see connections between events and people in the world, through the narrative and stories told within our families (Crossley).

Meichenbaum (2006) proposes a constructivist narrative model of PTSD reactions, in which:

1. Human beings are story-tellers following trauma experiences;

2. The type of stories determines the level of distress versus resilience;

3. Moving forward from resilience to post-traumatic growth requires activities such as constructing meaning, finding a future orientation, and retelling stories as artistic and commemorative activities.

Research on narratives and the use of testimony report that testimonies enhance general functioning. Weine, Kulenovic, Pavkovic and Gibbons (1998) reported that by documenting and communicating the experienced atrocities, Bosnian survivors of ethnic cleansing showed increased general functioning and a reduction in PTSD symptom severity and depression. The narrative creates a testimony which not only serves as a historical record, but gives meaning to the individual's experience, allowing for the re-

evaluation of emotions like shame and guilt whilst highlighting courage and resilience (Lustig, Weine, Suxe, & Beardslee, 2004). Mørkved et al. (2014), in a review of NET and prolonged exposure, indicated that research highlights the importance of constructing a written narrative in the cognitive reappraising of the trauma, and that this component may be more effective than exposure alone. The primary aim of NET is to create a coherent narrative rather than to challenge negative cognitions as in TF-CBT reliving, although the therapist may explore maladaptive cognitions after a narration as changes in cognition may occur spontaneously.

1.14 A review of the evidence base on the use of NET for forced migrants presenting with PTSD

In an uncontrolled study focusing solely on the outcome of testimony therapy, Weine et al. (1998) reported that Bosnian survivors of state-sponsored violence showed improvements in measures of PTSD, depression and general functioning.

Neuner et al. (2004) conducted the first RCT treatment trial to compare NET with psychoeducation alone or supportive counselling (SC), with (N=43) Sudanese forced migrants in a Ugandan forced migrant camp. Participants were randomised to receive 4 sessions of NET, 4 sessions of SC, or 1 session of psychoeducation. In the two treatment conditions, therapists provided both types of treatment to reduce therapist effects, and adherence to the NET protocol was monitored. At post-treatment and 4 months follow-up, there was an increase in PTSD symptoms in all groups. The authors attributed this to poor conditions and lack of food rations. However, at 1-year follow-up, the NET group showed significantly lower scores in PTSD compared to the comparison groups – 71% of those in the NET group no longer met the diagnostic criteria for PTSD.

In a study by Neuner et al. (2008), NET was delivered by lay counsellors in Uganda with Rwandan and Somali forced migrants. In this larger-scale study, 277 forced migrants diagnosed with PTSD were randomised into one of three groups: the first group of 111 forced migrants received 6 sessions of NET, the second group of 55 forced migrants were monitored but received no treatment as a control group, and the third group of 111 forced migrants received 6 sessions of trauma counselling (TC). The TC condition was deliberately designed as a model of therapy which may occur if individuals who are trained in NET do not adhere to a standardised manual of treatment. The remission rates were significantly higher in both treatment arms – 65% in the TC

group and 70% in the NET group. Attrition rates were low in the NET group (4%) compared to the TC group (21%).

Moving away from investigating the efficacy of NET in forced migrant camps and studying the effects of NET on pain (a typical presentation in this population as a consequence of torture), Neuner et al. (2010) conducted the first study of the use of NET for forced migrants with PTSD in high-income countries. The authors reported NET (9 sessions, N=16) to be effective for asylum-seekers in Germany compared to a treatment as usual (TAU) group (9 sessions, N=16). All but one participant showed significant reductions in PTSD and pain symptoms. Participants were randomly assigned to the two groups. In the TAU group focusing on stabilisation techniques, none received trauma-focused treatments. NET was delivered by psychologists with NET training, and the TAU by community therapists, with translators used in both conditions. Random NET sessions were observed by originators of NET to ensure NET protocol adherence. Whilst this was the first study to use NET with forced migrants in a clinical setting, there were a number of uncontrolled variables: difficulties in ruling out a dosage effect of unspecified treatment factors; a number of patients in the NET condition took anti-depressants which can increase the dosage effect; assessor bias effects may have impacted on the results, as blindness of conditions could not be maintained; and participants were a heterogeneous group, with the majority from Turkey and other small subgroups.

The authors concluded that NET was well tolerated, although it is unclear how this was measured. An increase in a PTSD measure for two participants was observed, although this was lower in the NET group than in the TAU group. NET participants showed statistical improvements, however, this does not necessarily equate to clinically significant improvements. The authors explain this by stating that participants in this study, compared to non-forced migrant populations in other studies, started off with a higher symptom level, which they explain was likely to be due to post-migration stressors. They concluded that in line with their hypothesis, NET is also effective for forced migrants living with uncertain conditions, such as the threat of deportation, as it is for forced migrants living in camps. Like most other NET studies, this study is not a true RCT, as there is no control group effectively receiving no treatment. Both groups are effectively receiving treatment, the true effect size of which was 1.04, lower than the average. The effect size in NET studies in non-clinical settings remains unknown.

Halvorsen and Stenmark (2010) investigated the efficacy of NET using 16 torture survivors receiving 10 sessions of NET in clinics in Norway. Whilst studies have usually failed to report on the number of traumas experienced, this study was one of the first to report on the typical number of traumatic events experienced by the forced migrants partaking in this study, reporting a minimum of between 4 and 17 traumatic life events. All participants had been imprisoned and subjected to abuse and torture methods for a minimum of 3 days, leading to a rigorous definition of torture experiences. The authors reported effect sizes of 1.16 and .84 from treatment to 6 months follow-up. However, the lack of a control group limits definite conclusions about effectiveness in this study, since comparisons cannot be made. Participants were asked to keep their medications at a constant dose throughout the study in order to reduce inflated treatment-dose effects. This study was more robust compared to others in how it defined clinically significant change, namely as two standard deviations in PTSD symptom scores. It used the CAPS (Clinician-administered PTSD scale), the gold-standard measure for diagnosis of PTSD, which has a high construct validity and high inter-rater reliability.

However, the CAPs, which was translated into Norwegian, was not validated and not translated into Arabic, despite more than half the participants being from Iraq. Treatment adherence was rigorously monitored compared to other studies, and included individual regular supervision and two-day workshops following NET training at 6 months to maintain skills. The authors account for the moderate effect size as being due to possible low treatment integrity, less imaginal exposure, and forced migrants having a higher baseline of trauma severity. Less than 20% achieved total remission, with most experiencing moderate to threshold PTSD at follow-up, and 3 not responding to treatment, in line with proportions in other studies with individuals who do not respond to other trauma-focused therapies. The effect size was moderate in this study compared to studies of TF-CBT in forced migrant populations (Schulz et al., 2006; Paunovic & Ost, 2001), and the authors account for this difference by saying that those studies used a higher number and longer duration of sessions.

The following two studies of NET with forced migrants were not conducted by the originators of NET. Hensel-Dittman et al. (2011) randomised 28 patients, most of whom were asylum-seekers, who received 10 sessions of NET or 10 sessions of stress inoculation training. The NET group showed significant decreases in PTSD compared to the comparison group at 6 months and 1-year follow-up, although NET did not have

an effect on depression and comorbid conditions. Adenauer et al. (2011) randomised 34 forced migrants into a NET and wait-list control group. Participants in the NET condition demonstrated significant reduction in PTSD symptoms as well as depression at 4 months follow-up compared to the wait-list control group. The main criticism of these two trials is the potential for allegiance effects, given that both trials included originators of NET.

Ertl, Pfeiffer, Schauer, Elbert, and Neuner (2011) conducted an RCT for PTSD in former child soldiers in three areas of Northern Uganda. In contrast to the majority of RCTs, suicidal ideation, substance misuse and depression were not excluded, thereby the range of complex reactions and comorbidity within this group were represented. A positive PTSD diagnosis was confirmed by the CAPS. Participants were randomly allocated to one of three conditions: NET (N=29), supportive counselling (N=28), and a waiting-list control (N=28), with treatment adherence monitored by video recordings. PTSD symptom severity improved significantly with NET. However, a small sample size and a lack of objective measures of functioning limited this study.

In a review of RCTs of treatment for PTSD amongst forced migrants and asylum-seekers, Crumlish and O'Rourke (2010) reported that there was evidence for the efficacy of NET and CBT. One trial included exposure therapy, four included trauma-focused CBT or general CBT, and five were NET. However, trials were small and there was inadequate concealment of condition or blinding in trials.

In a larger-scale review, Palic and Elklit (2011) reviewed 25 studies of different forms of CBT for PTSD treatment in adult forced migrants. They reported large effect sizes in some of the CBT studies, indicating good suitability of CBT for the core symptoms of PTSD in forced migrants. However, they argue that traumatic reactions in forced migrants can manifest as more complex reactions than those specified in the diagnostic category of PTSD, and that the effectiveness of CBT has not yet been tested on the full range of symptoms. Most of the evidence is centred on two variants of CBT: culturally adapted CBT and NET. The authors note that many of the studies report that very few forced migrants are symptom free at the end of treatment, and studies have focused on the limited core range of PTSD symptoms and neglected comorbid conditions like somatisation, depression and anxiety. Further, there is no consensus on what comprise meaningful therapeutic shifts in chronically traumatised forced migrants.

The above reviews examined the efficacy of both CBT and NET as a variant of CBT. In a more specific study of NET alone with survivors of organised violence, Robjant and Fazel (2010) conducted a review from 16 published and unpublished treatment trials with forced migrant resettlements in low-, middle- and high-income countries. All treatment trials indicated the superiority of NET over other therapeutic approaches. In low- and middle-income countries, NET was found to be an effective treatment in reducing PTSD symptoms, and in some cases comorbid disorders. However, sample sizes ranged from 18 to 277, thereby reducing the capacity to demonstrate efficacy. Studies demonstrated the effectiveness of NET in poorly equipped conditions, and how lay counsellors from forced migrant camps, frequently forced migrants themselves, could deliver NET with only 6 weeks of training.

Further, in a more recent review investigating the effects of NET alone, Gwozdziewycz and Mehl-Madrona (2013) conducted a meta-analysis to review the effectiveness of NET. NET was promising on all intervention measures, despite low pre-post effect sizes on physical symptom scores, indicating somatisation but also the real physical difficulties suffered in this population. This review was the first to highlight that there was no difference in the effectiveness of NET between trained and lay counsellors, with an average effect size of 1.02, indicating that NET is a cost-effective treatment and highlighting the importance of the narrative as a component, rather than the expert challenging of cognitions in trauma memories. This meta-analysis also underlined the range of difficulties suffered in NET studies including: difficulties in obtaining follow-up measures due to migration issues; difficulties in controlling for variables between pre-treatment and follow-up; variability in use of a control group, with two studies having no control or TAU group and two studies not reporting if a control group was included; and finally, failure to report whether treatment adherence was monitored.

Lambert and Alhassoon (2015), in a meta-analytic review, investigated the effects of culturally adapted CBT and NET in studies with forced migrants in unstable settings (Neuner et al., 2004, 2008); in two NET studies (Neuner et al., 2010; Stenmark, Catani, Neuner, Elbert & Holen, 2013); and in one EMDR study (Ter Heide et al., 2011) versus control groups. They reported a large effect size for trauma-focused treatment, chiefly based on NET and culturally adapted CBT, in forced migrants for PTSD and for depression.

Building on the Neuner et al. (2010) study which monitored the effect of NET on pain symptoms, Morina et al. (2012) conducted a pilot study with 15 forced migrants

presenting with PTSD and persistent pain and used biofeedback (10 sessions of pain-focused treatment) followed by NET as an integrated intervention. To assess pain severity and disability, structured interviews were used as well as the CAPs, and a quality of life measure. The authors reported significant reductions in outcomes following the combined intervention, with an effect size of 1.45, consistent with other studies, and improvements were sustained at 3 months follow-up. This was the first study to measure motivation to engage in NET following a pain intervention. The authors reported an increase in motivation for trauma-focused treatment, a moderate reduction in pain intensity, and a small reduction in pain disability following NET. The follow-up indicated marked improvements in pain and quality of life, however, not in pain intensity, which the authors theoretically linked to PTSD as maintaining pain symptoms.

Morina et al. (2012) conclude that the pain intervention benefits may have only been realised after NET. This study excluded neuropathic pain as an extraneous variable, as well as severe dissociative symptoms. The study yields important findings for this population, where somatisation is high and chronic pain symptoms comorbid. It highlights the importance of treating and validating pain symptoms which may help tolerance of NET and epitomises the ongoing conceptual debate in PTSD about having separate diagnoses of PTSD and pain. CPTSD already acknowledged somatisation as a main symptom, with 76% of PTSD sufferers in this population also presenting with persistent pain. This study has high face validity and brings to the fore one of the main clinical difficulties that trauma clinical services grapple with – chronic pain with PTSD, contributing to treatment resistance.

In summary, Neuner et al. (2014) report that NET produces more than short-term effects, asserting that the narrative reprocessing in NET continues to have cumulative curative effects for months and years, even in complex trauma survivors. Neuner et al. report that in all trials the number of symptom deteriorations has been lower in the NET condition compared to the control condition, and the attrition in NET is lower than in most other psychotherapeutic approaches. Nosè et al. (2017) recently conducted a systemic review of the effectiveness of psychosocial interventions in refugees and asylum-seekers with PTSD resettled in high-income countries. They included 12 studies in their meta-analysis and concluded that NET was the best supported intervention. However, the methodological quality in these studies was limited and the number of studies was small.

A critique of NET studies

Research into NET for forced migrants has been symptom-reduction focused and has suffered from methodological and empirical limitations. In a critique of the evidence base of NET, Fernando (2014) identified issues with clinical efficacy, allegiance effects and ecological validity. RCTs are only of use when studying narrowly defined groups in controlled conditions, contrary to those involved in migration and settlement (Slobodin & de Jong, 2015). Whilst RCT studies investigating the efficacy of NET have been promising, many of the studies have been undertaken by originators of NET. Independent NET studies have been conducted in China (Zang, Hunt & Cox, 2013), and in low- to medium-income countries (Gwozdziewycz & Mehl-Madrona, 2013).

Mundt et al. (2014) reported that the superiority of NET compared to control conditions cannot be concluded due to baseline differences between the groups. In response to this, Neuner et al. (2014) reported that in five of the six NET trials, there was no baseline group difference in ethnic composition or other measures. Further, Mundt et al. maintained that treatment for multiple traumatic events requires long-term therapy and a stabilisation phase rather than NET as a stand-alone intervention. However, Neuner et al. (2014) responded to this criticism by arguing that the NICE guidelines do not prescribe a stabilisation phase, and rather that professionals should consider providing ‘some sessions’ to facilitate rapport and enable participants to disclose their trauma events prior to exposure sessions.

Studies have not distinguished between asylum-seekers and refugees, despite the two groups coping with different challenges such as migration, acculturation, social support and ongoing threat (Slobodin & de Jong, 2015). However, Stenmark et al. (2013) reported no outcome difference between refugees and asylum-seekers with NET, and showed that the latter can still benefit, suggesting that together they can be argued to be a homogeneous sample.

Finally, not all RCT studies have included complex reactions and comorbidity, thereby reducing ecological validity. Neuner et al. (2014) argue that current NET studies have included suicidal and self-injuring patients (Van Minnen, Harned, Zoellner, & Mills, 2012; Pabst et al., 2014). In an evaluation of a specialist trauma service, Lab, Santos and De Zulueta (2008) highlighted a range of problems patients present with in addition to PTSD, such as dissociation, self-harm, severe depression, extreme somatisation and substance misuse, as well as the threat of deportation. Comparison with the evaluation

studies used in NICE revealed how the severity of PTSD and depression was higher in patients in this specialist service at assessment in all but two of those studies used in NICE. In a systematic review, Tribe, Sendt and Tracey (2017) reported limited evidence to support the use of standard CBT and EMDR for those with PTSD in the forced migrant population, and medium- to high-quality evidence supporting the use of NET, which produced positive outcomes in a range of backgrounds and trauma types. They highlighted a need for further research which models 'real-world' interventions and clinical practice.

1.15 Research into patient-focused experiences of therapy

In a qualitative study on patient experiences of mindfulness-based cognitive therapy (MBCT) for depression, Mason and Hargreaves (2001) interviewed seven participants and using grounded theory and identified preconceptions and expectations of therapy as important influences on later experiences of MBCT. Important areas of therapeutic change such as 'coming to terms', development of mindfulness skills, an attitude of acceptance, and 'living in the moment' were identified, and the development of mindfulness skills was seen to hold a key role in the process of change.

McDonald, Mead and Bower (2007) explored patient attitudes by examining patient expectancies of psychological therapy and their experiences with a 'minimal intervention', otherwise known as guided self-help. They reported that patients were often seeking insight into the 'cause' of their current difficulties, whereas the minimal intervention was largely focused on symptom resolution.

A handful of studies have looked at forced migrant experiences and have focused on: difficulties during migration and resettlement (Khawaja, White, Schwetzer, & Greenslade, 2008); the family consequences of forced migrant trauma (Weine et al., 2004); and forced migrant experiences of general practice (O'Donnell, Higgins, Chauhan, & Mullen, 2008).

In a doctoral thesis exploring refugee experiences of psychological therapy using Interpretative Phenomenological Analysis (IPA), Gilkinson (2009) reported six master themes emerging from the analysis: 'Therapy as a light in a dark place'; 'Rebuilding a shattered sense of self'; 'A changing relationship with the world and others'; 'Escaping the past to pursue a future'; 'A journey from sceptic to convert'; and 'From an unknown mystery to a known mystery'. The narrative accounts identified the need for a thorough

explanation of therapy, the need to pre-empt obstacles, allow time to build a therapeutic relationship, and the importance of non-specific therapy factors in addition to a symptom management approach.

Vincent, Jenkins, Larkin and Clohessy (2012) explored the acceptability of TF-CBT for asylum-seekers with PTSD, and using IPA reported six interlinking master themes: ‘Staying where you are versus engaging in therapy’; ‘Experiences encouraging engagement in therapy’; ‘Experiences impeding engagement in therapy’; ‘Importance of the therapeutic relationship’; ‘Losing oneself’; and ‘Regaining life’. However, the treatment was experienced as exceedingly difficult and the asylum-seekers were ambivalent about engaging in TF-CBT.

Research in this area has failed to investigate patient-reported experiences of NET. There is no formal qualitative research on how forced migrants experience NET, other than what can be inferred from the limited attrition rates compared to other exposure treatments, and which can be indicative of an acceptability of NET in this population (d’Ardenne & Heke, 2014). NET is markedly and methodically different from prolonged exposure and TF-CBT, despite the common exposure element. Qualitative research can be argued to add a further dimension to studies demonstrating the efficacy of NET, given that RCTs only capture narrowly defined groups, due to having to fulfil conditions of RCTs.

1.16 Summary

In summary, forced migrants offered TF-CBT in the UK report greater improvements in PTSD symptoms compared with treatment as usual, though not as much as treated non-refugees (d’Ardenne et al., 2007). Lab et al. (2008) assert that the therapy models advocated in NICE (2005) for treating PTSD are not sufficient for forced migrants presenting with PTSD. Forced migrant mental health needs have not been investigated beyond the recommendation for screening for PTSD. The special considerations section in the NICE (2005) guidelines for PTSD indicate the use of Trauma-focused CBT (TF-CBT), referring to single incident PTSD, and make no mention of war or torture, thus advocating a one-size-fits-all model.

In the Cochrane review for the Psychological Health and Well-Being of Torture Survivors, Patel et al. (2014) highlight that NET and CBT have moderate effects in reducing PTSD symptoms in the medium term. They maintain, however, that the

effectiveness of CBT and NET has not been tested on a range of complex-trauma reactions in forced migrants.

Research has focused on the effectiveness of NET in reducing PTSD symptoms compared with other therapeutic approaches, in both low- and high-income countries. The treatment involves emotional exposure to the memories of traumatic events, and the reorganisation of these events into a coherent chronological narrative. However, as things exist, there is a dearth of research on how forced migrants experience this narrative and exposure-informed treatment. Given the complex trauma reactions forced migrants present with, qualitative methods can address questions that cannot be examined by RCTs. Evidence from NET and other narrative approaches like EMDR and creative arts demonstrate that patients may prefer to tell their story in a graded and guided way which places the trauma within the context of their lifeline (d'Ardenne & Heke, 2014). Shertel and Sill (cited in Ertl et al., 2011) advocate that NET links healthcare and cultural boundaries, using the power of the story as the main mode of treatment. They maintain that the oral tradition of story-telling as a mode of treatment can disguise it as a psychological treatment, and so help to reduce the stigma associated with psychological therapy.

Although most therapies aim to develop a narrative, NET explicitly aims to develop a narrative using the testimony component, whereby the patient is exposed to their traumas, and encouraged to relate their experiences to an empathic listener, in a secure environment. In a survey by the International Society for Traumatic Stress Studies (ISTSS), Cloitre et al. (2011) report consensus between clinicians in the narration of trauma memory as being a first-line treatment for multiple trauma, however, narrating trauma memory did not rate as first-line for being safe and acceptable. Further, given that the leading trauma-focused therapy, TF-CBT, was experienced by asylum-seekers as 'exceedingly difficult', 'untrustworthy' and 'time-consuming' (Vincent et al., 2012), it is imperative to identify how forced migrants experience this new emerging therapy, designed specifically for this group.

1.17 Study rationale

A review of the current literature indicates a need to explore forced migrant treatment experiences of NET beyond treatment efficacy outcomes. Qualitative studies are better placed to help us gain a rich understanding of how this group experiences this type of

trauma therapy, in their words, and to ‘decentre’ clinicians, enabling them to look at the process of therapy though the eyes of this group (McLeod, 2001). This is consistent with counselling psychology’s philosophy of prioritisation of the client’s subjective and intersubjective experiencing and the NHS’s emphasis on patient-reported outcomes.

Clay (2010) asserts that RCTs should no longer be the ‘gold standard’ of research, as they only provide a narrow view of evidence. Qualitative research and patient-reported outcomes are important in conjunction with RCT studies in informing clinicians about efficacy. d’Ardenne and Heke (2014) advocate that understanding patient views can help increase success in trauma-focused therapy, particularly where participants doubt the validity of therapy, see it as culturally inappropriate, or are fearful of revisiting the past.

Implications of research study

It can be argued that the forced migrant population is usually a ‘done to’ group, stripped of their voice before they arrive in their host country and subjected to further adjustment and acculturation difficulties once they arrive. Thus, as psychologists, we need to be inclusive and provide acceptable trauma therapy beyond what we can infer about the acceptability of RCTs on NET for this group.

Forced migrants make up a significant proportion of those presenting to NHS clinics and specialist trauma services with trauma reactions (Lab et al., 2008). NET is increasingly used across services to treat forced migrants in the NHS, and specialist voluntary sector services.

Considering this, there is an absence of research on how patients experience NET. Recently there has been an emphasis on considering patient-reported experiences of treatment, as part of the general efficacy of therapy in the NICE guidelines. Patients have much to report on their treatment of PTSD, and now tell us how they see the clinician’s competence, the therapeutic relationship, and their hopes for recovery (d’Ardenne & Heke, 2014). Investigating patient experiences of NET and the acceptability of the process and components of NET as a treatment for this group is therefore now timely.

The clinical implications of this research study are threefold:

- to capture how forced migrants experience NET as a treatment for PTSD;

- to inform clinicians about the experiences of forced migrants who have undergone NET and be available for service-users to assist them in identifying how this group have experienced NET in the treatment of their PTSD;
- to inform the NICE guidelines with regard to patient-reported experiences of NET as another dimension of efficacy.

Conceptually, this study can illuminate our understanding of how the process of NET, the gradual chronological disclosure of traumas grounded in life-time context, is experienced by this group.

Counselling Psychologists (CPs) increasingly work in specialist PTSD services and there is a need for CPs to appraise NET as a treatment for multiple trauma presentations, and an emerging default treatment for forced migrants.

CPs are well positioned to:

- address the research-practice gap;
- appraise effective treatments for multiple trauma given the recent emphasis in evidence-based practice;
- identify patient experiences as part of the efficacy of treatment.

This study aims to help service-users to have a voice in their treatment by exploring their lived experience of this therapy, developed primarily for this group. This is consistent with the philosophy of CP in empowering service-users and prioritising the client's subjective and intersubjective experiencing (Kasket, 2012).

2. METHODOLOGY

2.1 Research aims and research question

The research study aims to investigate and capture experiential accounts of **'How forced migrants experience narrative exposure therapy (NET) for the treatment of post-traumatic stress disorder'**.

The research targets individuals in NHS trauma services as they come to the final session of their narrative exposure therapy, after completing their trauma processing. At this point they have reached the end of the narration of their lifeline and have listened back to their autobiographical testimony or narration.

This study asks a first-tier question which aims to elicit this group's experience of receiving NET and their general acceptability and tolerance of NET. The study also asks open exploratory, secondary, theoretically informed questions in relation to the components of NET, examples of which are: what is their experience of narrating and processing their traumas and have the therapist witness this?; what is their experience of revisiting their traumas, in a chronological order?; have they experienced shifts in self-narratives during NET?; and how have they experienced NET in relation to emotions such as shame and guilt, as a result of their traumas?

A semi-structured interview schedule was developed as a prompt, to tap into patient experiences of NET in relation to: their experience of the lifeline narration component of NET; the 'Then' and 'Now' questioning style in NET; their challenges in NET; shifts in self-narratives during NET; and their experience of NET with regard to emotions such as shame and guilt in relation to their traumas (Appendix F– interview schedule). A purposive sample of seven patients coming to the end of their NET treatment were recruited from East London Foundation NHS Trust trauma service, The Institute of Psychotrauma; Barnet, Enfield and Haringey Mental Health Trust Complex care team; and Central and Northwest London, Forced Migration Service.

2.2 Overview of research design

Willig (2012) maintains that the criteria for assessing research are informed by the epistemological position, the type of knowledge the researcher aims to generate, and the research question. The researcher aligned herself with a qualitative perspective using

Interpretative Phenomenological Analysis (IPA), a qualitative analytic method (Smith & Osborn, 2008).

2.3 Rejection of positivism

Positivism has been the dominant paradigm in psychology. It assumes that there is a single truth of reality of the phenomenon under investigation and of the world and people in it. In this case, this would be a single truth about NET for this population as inferred from trials that is independent of human perception – a straightforward relationship between this group and NET. Critiques of positivism argue that there are no fixed meanings of reality, as this is a product of time and context, and therefore there are no fixed meanings to be captured, but rather constructions over time and context (Denzin & Lincoln, 1994a).

2.4 Acceptance of qualitative methodology

The focus of this research was to capture forced migrants' lived experience of NET as a trauma therapy for their trauma difficulties rather than attempting to determine the truth about NET. The qualitative paradigm offers the ideal methodology from which to explore, gain understanding of, and interpret how individuals from this group experience this type of trauma therapy. The research question lends itself to a commitment to a phenomenological and interpretative stance in exploring, describing and interpreting forced migrants' lived experiences of NET within the context of their therapeutic NET journey, and the therapeutic relationship. It employed the use of semi-structured interviews as a method of data collection and uses interpretative phenomenological analysis (IPA) (Smith, 1996) as a method of analysis.

2.5 Ontological stance

In relation to the researcher's assumptions about the nature of being and experience (ontology), the researcher is of the view that each individual and their experience is unique, and that there are "as many experiential worlds as there are individuals" (Willig, 2012). As such, the same event can be experienced in many different ways, as there are "knowledges rather than knowledge" (Willig, 2013), consistent with a

phenomenological stance. However, the researcher takes the view that all understanding requires interpretation. This is consistent with an interpretative phenomenological ontological stance.

Phenomenology is the philosophical study of ‘being’ (existence and experience). It has had two historical phases, the transcendental and the hermeneutic (Larkin & Thompson, 2012). Transcendental phenomenology, founded by Husserl, focused on the core structures of a given experience. For Husserl, phenomenology was about identifying and suspending (bracketing off context, culture, history) and our experience, and knowledge (epoche), thus transcending our assumptions and prior knowledge to reveal the phenomenon as it appears (Langridge, 2007). Only then could we understand the essence of a given experience. However, IPA does not aim for transcendental knowledge; instead it draws on Husserl’s successors, Heidegger, Merleau-Ponty and Gadamer (1975), and their readings of phenomenology.

Heidegger’s phenomenology views the person as permanently intertwined in the world (a dasein), as ‘being-in-the-world’. Heidegger questioned the notion of knowledge devoid of interpretation, since individuals in his view are constantly meaning-making from experience in the context of time, relationships, language, and culture. For Heidegger, interpretation is seen as critical to understanding, and every encounter with phenomena involves an interpretation. Merleau-Ponty emphasised the embodied nature of being, which shapes our perception of the world (Larkin & Thompson, 2012). Gadamer (1975) contended that language and understanding are inseparable aspects of being in the world, and that not only is language a medium in which understanding occurs, but it is a universal platform for hermeneutic experience (interpretation). This phase of phenomenology is referred to as hermeneutic or interpretative phenomenology, which is consistent with the author’s phenomenological stance.

IPA does not access experience directly; rather it accesses this via intersubjective meaning-making. Influenced by hermeneutics, it acknowledges the researcher’s own stance, seeing this as a precondition for meaning-making. In doing so, it encourages reflection on our role in producing these interpretations (reflexivity), and ensures these interpretations are grounded in the actual accounts and words of the participants (Larkin & Thompson, 2012).

2.6 Epistemological stance

Epistemology is concerned with 'the theory of knowledge', 'how this can be demonstrated' and 'what we can know about it' (Willig, 2013). There are different types of epistemological positions, which make different claims about knowledge, and the type of knowledge they aim to produce, ranging from an extreme realist position at the one end, to an extreme relativist position at the other (Willig, 2012). The researcher distinguished critical-realism as the epistemological position most befitting this research.

Whilst the participants' accounts of NET are understood to be mediated through culture and language, the research provides us with access to their experience of an actual reality (their experience of NET), and not one merely constructed by language. The researcher concedes that although their experience of NET is a product of interpretation, it is 'real' to the person experiencing the phenomenon, and that the data can tell us something about how this group experiences this trauma treatment. Each participant will develop their version of their experience of NET through the processes of language and perception. Further, whilst their experiences are unique and subjective they can only be accessed by the researcher making sense of the participants making sense of their experience, referred to as double hermeneutics (Giddens, 1984), and a process of intersubjective meaning-making (Larkin & Thompson, 2012). To understand these experiences, the researcher elicits rich accounts of participants' experiences, moving beyond the data, and drawing from existing knowledge and theories as interpretative structures, to provide access to underlying structures or mechanisms (Willig, 2012). Their experiences/interpretations of NET are deemed to represent possibilities about this group's experience of NET rather than certainties (Frosh & Saville-Young, 2008).

Overall, the researcher takes a relativist position with regard to the status of the data (taking an interest in how meaning is created by each participant rather than embarking on a quest for absolute truths). Data analysis and interpretation is therefore tentative and intersubjective (Willig, 2012).

2.6.1 Epistemological reflexivity

Willig (2013) defines epistemological reflexivity as the role played by the researcher's values and assumptions, informed by their professional and academic background. Epistemological reflexivity in this research reflects the angle I decided to take on this occasion – an interpretative phenomenological method, super-imposed with a critical-realist approach to the data and a phenomenological approach to the data gathering, in

order to shed light and 'give voice' to this group's experiences of a treatment primarily designed for them and their trauma. This position requires reflexivity in terms of my own subjective involvement and assumptions in relation to NET.

IPA values pluralism in acknowledging multiple subjectivities, ways of being, ways of knowing, and theories. It engages with the difference and diversity of experiences and prioritises the other person or 'otherness' (Cooper & McLeod, 2007). It ethically positions the 'other', in this case the forced migrant, as first and different, whilst never assuming certainty about their reality. Essentially, this means being driven by an unending curiosity and tolerating uncertainty about the mind of the other and being open to alternative interpretations of what may be going on in the mind of the other in relation to their experiences of a particular therapy, thereby taking a mentalising stance (Fonagy, 2002). I take the stance that one can never really know the participant's experience of NET for the treatment of their PTSD in an absolute sense, but one can get as close as possible to the essence of their experience, while never being certain about it.

2.6.2 Personal reflexivity

Willig (2013) defines personal reflexivity as the acknowledgement that one's own interests, experiences, and beliefs have the potential to influence the research process. I present my reflexivity here, prior to the analysis chapter, in order that my experiences, assumptions and potential to affect the research are illuminated for the reader.

I trained in TF-CBT, NET, and EMDR, which I feel gives me insight into the trauma treatment models available. I have first-hand clinical experience of using these treatment models as a trauma therapist with this group. My practice in all three approaches is equally personally valued, and I believe all three are robust models of processing trauma.

The real questions that need to be addressed in the research field are: how is NET as a trauma therapy experienced by forced migrants; and how do they experience the components of NET such as the development of the lifeline and having someone bear witness to their testimony?

During my practice, I became curious about how NET was experienced by this population, given that it is now the emergent 'default' therapy for this group in many trauma services, making the timing of this research critically important.

Practising largely within a quantitative paradigm in my previous trainings, within an outcomes-driven NHS context over the years, my position is that qualitative research is just as valuable and complements RCTs in widening the snapshot of the evaluation of 'efficacy' in treatment outcomes. It can inform us as clinicians and researchers of the process of therapy from the eye of the patient, and can give this group a voice, which chimes with the service-user empowerment agenda in treatment choices. In my former role in executing the Delivering Race Equality in Mental Health Care programme (1995), I evaluated the mental health needs of British minority ethnics in mental health services, including forced migrants. Representing their voice remains a pertinent issue, given the mass forced migration over the years, and there is a need to understand more about trauma therapy provision for this group. I approach this work with the view that NET is experienced as a useful therapy for this group, as its narrative focus allows it to speak to all cultures. However, my position remains one of curiosity: if NET is experienced as a useful therapy for this group, why and how is it so, and if it is not experienced as a helpful therapy, why not and how not?

Whilst subjectivity is inevitable within the analytic and interpretation process, I endeavoured to 'bracket' my own preconceptions and knowledge about NET and PTSD. This was done via self-reflection, using a diary during and after each interview to record initial impressions and assumptions, as well as during the analytic stage in IPA. This allowed me to recognise my own subjectivities about NET for this group as separate from the participants' experiences of NET.

IPA comprises the co-construction of meaning between the participant and the researcher via the double hermeneutic. There may have been times when I may have imposed meaning due to my theoretical and practical familiarity with NET, perhaps overstepping the co-construction, particularly in my pilot interview which I learned from for subsequent interviews. Willig (2012) maintains that subjectivity is inevitable in qualitative research, stating that "every interpretation is underpinned by assumptions the interpreter makes about what is important and what is worth paying attention to as well as what can be known about and through a text" (p. 10). Further, Willig (2012) asserts that being involved and invested in the research, and being affected and changed by the research, is part of researching ethically.

2.7 Method: IPA and philosophical underpinnings

IPA adopts a flexible epistemological position, theoretically drawing on phenomenological traditions (Husserl, 1913; Heidegger, 1962) combining hermeneutics (Gadamer, 1975) with phenomenology, as well as in-depth single case analysis and idiography (Smith & Osborn, 2008) to explore the essences of the lived experience (Smith & Osborn).

IPA draws upon the hermeneutic phenomenology of Heidegger (1962) and Merleau-Ponty (1962) who posit that as persons we are permanently intertwined and embodied with the world – 'being-in-the-world' – and in relationships with others. Larkin et al. (2006) maintain that IPA has its roots in 'minimal hermeneutic realism', which posits that certain phenomena exist and that this reality is dependent on context. This is consistent with the position taken with regard to the status and analysis of the data in this research, i.e., contextual and critical. With regard to forced migrants' accounts of their experience of NET, they are persons who are 'always-already' immersed in a relational world with others, a linguistic and relational world with their therapist, and a cultural and physical old and new geographic world.

IPA aims to give rise to a second-order account (interpretative) which provides a critical and conceptual summary in contextualising this group's stories, grounded in their narratives from their verbatim interview commentaries (Larkin et al., 2006). The analysis's engagement with the data moves forwards and backwards, giving rise to the hermeneutics cycle (Smith, Flowers & Larkin, 2009). The researcher employed semi-structured interviews as a method of data collection, which is the most widely used method in qualitative research, compatible with obtaining phenomenological knowledge (Willig, 2013). Finlay (2009) underscores the importance of the phenomenological attitude, the researcher exploring embodied experience as a requirement of ascertaining phenomenological knowledge, to gain 'pre-reflective' experience, that is, something that has not yet been reflected on (Finlay, 2009).

IPA was chosen as an analytic method, as it allowed the researcher to explore the individual's personal perceptions and interpret the meanings they assigned to their treatment experiences of NET, leading to a detailed analysis of each participant's experience.

IPA has been identified as useful in: identifying experiences of the 'self' and changes in this during therapy; and giving voice to under-represented groups (Smith, 2004). It allows for creativity in studying under-represented groups, such as forced migrants,

considered homogeneous in nature (Smith, 2004), and is recognised as a useful analytic method in providing valuable contributions in healthcare research (Pringle, Drummond, McLafferty & Hendry, 2011).

2.7.1 Criticisms of IPA as a method

Common criticisms of IPA often focus on the importance of developing an interpretative focus beyond a descriptive account. Pringle et al. (2011) maintain that an insider's perspective of an experience can be difficult to decipher if the analysis does not develop an interpretative focus. The researcher needs to go beyond the immediately apparent content to collect the voices and represent these beyond a first-order analysis. Further, IPA is challenged in needing to balance representation, contextualisation, and interpretation (Larkin et al., 2006), i.e., representing this group's experiences of NET as well as providing a contextual account of these experiences.

IPA depends on the skills of the participant to fully articulate and transmit the richness and complexities of their 'experience' to the researcher, and to focus on a specific time course (the duration of the NET treatment). As such, it may miss other factors associated with the experience of this group which in turn or collectively impact on the overall experience of NET. This issue of IPA's reliance on language is further considered in the discussion chapter in Section 4.12 'Limitations'.

Whilst IPA does not theorise reflexivity, it does recognise the importance of the researcher's perspectives in enhancing or hindering the interpretation of another's lived experience (Willig, 2013). This issue of reflexivity in IPA is considered in the discussion chapter in Section 4.12 'Limitations'.

Given that IPA is dependent on the researcher's own conceptions, whereby the researcher is required to make sense of the other's personal world through interpretative activity, it has been criticised for a lack of rigour (Giorgi, 2010). However, in response to this, Smith (as cited in Pringle et al., 2011) has discussed using Yardley's (2000) criteria to ensure validity and rigour in qualitative research. These criteria – sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance – guided the current research. Sensitivity to context was demonstrated by seeking ethical approval to access such a vulnerable group, recruiting from appropriate channels (those considered clinically robust to partake in this research via their therapist), showing sensitivity during the semi-structured interview as guided by each

participant’s account, and prioritising their voice during the analysis presented in verbatim, whilst highlighting the researcher’s interpretations. Commitment and rigour was demonstrated by extensive immersion in the research topic, and methodological competence in IPA gained through attending specific IPA lectures and groups. A detailed account of the analytic process, highlighting rigour and the methodological flexibility of IPA, is presented under ‘Analytic strategy and procedure’, later in this chapter. In relation to transparency and coherence, this research and all documents were reviewed in the supervision process, and reflexivity in the research process and analysis is addressed under epistemological reflexivity (2.6.1), ethical considerations (2.15), and within the discussion chapter (4.2; 4.11; 4.12). Finally, it is hoped that the findings can inform clinicians about how this group have experienced NET as an exposure and narrative-informed trauma therapy, inform service-users, and provide insight into the lived experience of forced migrants and asylum-seekers who have had NET for their PTSD.

In spite of the common criticisms of IPA, the methodology was chosen for its analytic emphasis which can lead to insights that can have wider implications (Reid, Flowers & Larkin, 2005) for trauma services utilising NET for this group. Its emphasis on meaning-making and its exploratory phenomenological stance are helpful in addressing complexity and novelty. Its phenomenological and interpretative emphasis makes it an ideal method to access the NET treatment experiences of this hard-to-reach group, often stripped of expressing themselves and of having a ‘voice’.

In summary, the aim of this research has been to produce debate and accounts in relation to this group’s experience of NET, rather than produce claims about validity or truth value. The accounts are deemed to be credible accounts of this group’s experience of NET, and not the only credible account (Forshaw, 2007).

2.7.2 Possible alternative method

Thematic analysis (TA) was considered as an alternative analytic method for this study. TA is a method for organising patterns in content and meaning across entire data sets in qualitative research (Braun & Clarke, 2006). It aims to produce knowledge taking the form of themes, built up from descriptive codes to make sense of the meanings that capture the phenomenon under investigation (Willig, 2012).

However, TA was not chosen for this study. The research question and ontological and epistemological standpoint taken is rooted in a phenomenological interpretive perspective which espouses the use of IPA as a methodology and method to best address the research question.

The researcher in this study is wedded to a commitment to an interpretative phenomenological orientation, taking a critical-realist approach to the data analysis. TA is characterised by theoretical freedom and although it can be used to address realist and phenomenological questions, it has been regarded as a method rather than a methodology. TA has had a less coherent developmental history, has been variably used, and has been employed to address a range of qualitative data not tied to a particular epistemological commitment (Braun & Clarke, 2006).

Whilst in IPA and phenomenologically-informed TA, the end result or aim of theme development might represent a common ground between approaches, they are procedurally different in how they code and analyse themes. Coding themes in TA begins after a process of data familiarisation across the whole of the data, and thus focuses on patterning meaning across the entire data set. IPA focuses on patterning each individual's data set before moving on to the next data set, rather than coding across data sets from the outset. In this way, IPA's procedures of data analysis facilitate staying close to the participant's voice and each data item, and grounding interpretations back to the words of the participant and their unique experience and characteristics (Larkin et al., 2006).

In contrast, TA allows the researcher to expand the range of study past individual experience. In doing so, it does not place an idiographic emphasis on accessing the individual's lived experiences and individual characteristics, unlike IPA, which aims to capture the quality and texture of individual experience. IPA thus gives experience primary importance, and focuses on producing knowledge of what and how people think about phenomena, looking at those phenomena from the point of view of those who experience them (Willig, 2012).

PROCEDURE

2.8 Participant criteria and sampling

Purposive sampling was used for this research, the usual sampling method in IPA studies. Smith and Osborn (2003) suggest five to six participants as a suitable number for an IPA study. The aim for this study was to recruit a minimum of six participants. Potential participants were identified by their therapists from the following trusts which were identified and approved as recruitment sites for the research: East London Foundation Trust, The Institute of Psychotrauma; Central and Northwest London, Forced Migration Service; and Barnet, Enfield and Haringey Mental Health Trust Complex care services.

The therapists were asked to briefly explain the nature of the research and to provide potential participants with information sheets. This was a particularly hard-to-reach group, primarily due to pervasive concerns about confidentiality, given their experiences of political persecution. Additionally, therapists often struggled to find clients who were nearing the end of their NET treatment within the time frame of this research, or to identify participants who had NET as the main trauma therapy, as some services used multiple trauma therapies to manage the complex reactions this population clinically presented with in the services. Ten participants were initially identified, however, one started with NET and changed to imagery-rescripting therapy, as he found NET too unbearable, and the other wanted to take a break from NET and was referred to another service for further work. One potential participant was stopping and starting therapy and had not progressed very far in NET largely due to his asylum claim during the therapy. That left a total of seven participants recruited, each having had NET as the main mode of trauma-processing therapy, having got to the end of their lifeline and having had a reading of their testimony. To maintain confidentiality, participants are referred to by pseudonyms in the analysis, discussion, and conclusion.

Participants were from different countries of origin (see Figure 1: Table of participants). This may have impacted on the homogeneity of the data as the different socio-cultural contexts meant that it could not be assumed that participants applied the same meanings to the impact of war-related stressors, shared the same definition of a 'traumatic' experience, or had the same ways of coping. It is likely that they had different systems of meanings and understandings of trauma and its effects (culturally, spiritually, and politically), which challenged the assumption of a homogeneous sample. This may have compromised a focus on convergence and divergence within this group's experiences of NET, as the analysis naturally required comparisons at the individual level. However,

the author reflects that refugees and asylum-seekers (collectively referred to as forced migrants in this research) are both groups displaced by war, and although they may be from different countries of origin, they have all been affected by their experiences of war-related traumas. Having all had NET as a trauma therapy, and all residing in the UK in terms of current socio-cultural context, the author maintained that there was sufficient homogeneity amongst the group to explore their therapy experience of NET.

2.9 Interview schedule

Data was gathered through one semi-structured, face-to-face, audio-recorded interview with each of the participants within the service. A semi-structured interview schedule is considered an 'exemplary method' of collecting focused and flexible data in IPA (Smith & Osborn, 2008). A list of questions was designed with the intention of facilitating and tapping into the participants' experiences of NET (Appendix F). These questions were driven by a curiosity about understanding participant experiences of the different facets of this therapy, such as the chronological nature, the hot and cold interweaving of past experiences, their experience of the lifeline as an aspect of the therapy, and the interweaving of grounding questions in relation to the 'then' and 'now' style. These were tested on a non-participant, as suggested by Smith and Osborn (2003). However, the researcher only used these questions as a prompt and was primarily guided by the participants' responses, although an effort was made to explore these areas within the framework of their overall experience of NET. Each interview lasted around 50–60 minutes, ensuring sufficient time for the participants to pause and reflect, before providing accounts of their experiences of NET, and for discussing informed consent, briefing and debriefing. The researcher's role was neutral and facilitative in providing the patient with a semi-structured framework to elicit their subjective experiences of NET.

2.10 Recruitment strategy and service context

After consideration of various recruitment options, it was decided that suitable participants for the research would be identified through their therapists and handed a participant information sheet (Appendix C). It was suggested that the researcher attend service meetings to brief the service about the research and recruitment strategy. The researcher attended Trust-wide service meetings and corresponded with clinical service

leads to introduce the research and recruitment strategy and ensure all clinicians had access to the recruitment posters (Appendix A). During the service meetings, therapists were briefed about the research and inclusion/exclusion criteria, and potential participants were identified. Further, frequent periodic emails were sent to service leads to forward to the team in each respective Trust to ensure the research and recruitment strategy was kept in mind.

The therapist information sheet (Appendix D) stated clearly that only patients deemed suitable and clinically stable for the study should be given an information sheet and invited to contact the researcher. The therapists were instructed to only give the information sheet to patients they deemed sufficiently clinically robust to take part, and then have no further involvement in the study. It was highlighted to participants by their therapist (and via by the participant information sheet, and by the researcher during the pre-screening call and the interview) that if they decided to participate then subsequently withdraw from the study post-interview, this would not affect their treatment or access to services. It was further highlighted that the study and researcher were independent of the service and of their treatment sessions. Thus, the therapists were instructed not to ask potential participants if they planned to take part in the study, to reduce any risk of perceived coercion.

2.11 Inclusion criteria

Refugees and asylum-seekers were recruited for this study, despite claims that these two groups are different and that this may compromise homogeneity. Stenmark et al. (2013) reported no differences in NET treatment outcomes between refugees and asylum-seekers. The study endeavoured to include males and females aged 18 and over who had been given a diagnosis of PTSD at the start of treatment and referred for therapy for PTSD, where they would have received NET as the main trauma-processing approach. Participants had to be currently in treatment and coming to the end of their treatment (defined as having had a reading of their narrative by their therapist but not yet having terminated treatment). Participants would have normally been in treatment for 3 months to 1 year or more and would have received a range of between 10 and 25+ sessions of NET.

2.12 Exclusion criteria

The benefits and constraints of using participants requiring interpreters was considered, and a decision was made to include in this study only participants who were conversant in spoken English. Participants were not required to write English. Excluding participants requiring an interpreter ensured a high degree of internal consistency in the data, given that IPA endeavours to make sense of how the participant makes sense of their lived experience, which involves a 'double hermeneutic'. The use of an interpreter in the interview could be argued to add another layer of hermeneutics or interpretation, i.e., the researcher trying to make sense of how the interpreter is making sense of the participant making sense of their experience of NET, thus posing a challenge to the internal consistency and validity of the research. Moreover, even though in designing this research the aim was to be as inclusive as possible, to capture the real range of complexity and comorbidity of those presenting to NHS trauma services, patients with active psychosis, active risk of self-harming or those in a current crisis were not considered for this study.

2.13 Data collection

Once the participant contacted the researcher, the researcher undertook an initial screening by telephone, which involved asking for general demographic information (Appendix G), and a provisional interview date was arranged. The interview would take place at the service site from which the participant had been recruited. The follow-up contact served as a reminder and allowed for a cooling-off period, should the participant change their mind about their participation in the research.

Pre-interview telephone screening: Descriptive information was obtained pre-interview by the researcher from the participant regarding their demographic details: gender, age, country of origin, whether they were an asylum-seeker or refugee at referral, how long they had been in the UK, and the average number of NET sessions they had had in that treatment episode. This screening provided the opportunity to explain more about the study and answer any questions participants may have had prior to their research interview, as it had been the clinicians who had referred potential participants.

Informed consent: During the interview, the participants were given verbal and written information, at the beginning of the interview as well as during the pre-screening call.

The consent form was read to each participant at the start of the interview to obtain informed consent (Appendix B).

Participants were informed about their right to withdraw at any stage during the research interview, during the briefing and debriefing (Appendix E) at the interview, and informed that the data gathered would be kept confidential and anonymity would be maintained. They were again given the opportunity to ask questions.

Limits of confidentiality: Participants were made aware that no demographic information would be taken off-site, that only initials would be used in audio-recordings and interview notes, and that transcription would have pseudonyms to preserve anonymity. Participants were informed that the researcher had no knowledge of their mental health histories. Participants were also made aware that in addition to the researcher, only the research supervisor (academic) would have access to anonymised transcriptions. Participants were also informed that the researcher was not intending to access their trauma histories specifically.

Affiliation of researcher: Despite the researcher being an experienced CBT psychotherapist with trauma expertise, their role in this study was strictly as researcher. The researcher had not treated any of the patients from any of the services and maintained a strictly exclusive researcher position. A pertinent ethical concern to address was that on being asked by their therapist whether they wanted to partake in the research, participants may have felt that further contact with their therapist or service could be affected by their decision to participate. Therefore, during the pre-interview screening and at the beginning of the interview, the researcher identified herself as independent of the service and as solely interested in their experience of this type of therapy. It was highlighted that their participation would have no bearing on their further or future treatment or contact with the service or therapist.

Despite this, the researcher was aware that at times the participants might have seen her as part of the service, or as part of an evaluation of therapy check, possibly because the research interviews had taken place in the service grounds. The researcher noted that participants had made references to their aftercare, and spoke about members of the service, perhaps alluding to the need to praise their therapist. At times when participants perceived the researcher to be an outsider to the service, they may have been more comfortable to critique aspects of their therapy journey and service experience.

Potential distress: It was considered inevitable that distress might be activated during the interview, and likely to be associated with participants' reflections on their experience of how NET had impacted on their feelings and beliefs about their traumatic experiences, and their lived experience of this therapy.

Van de Veer (1998) maintains that there is a risk of re-traumatisation when memories from the past are triggered by a subsequent event that is perceived to be a repetition of previous trauma(s) in the present, e.g., an intrusive and interrogative style of relating and questioning. The research interview was exploratory and person-centred, which involved a warm, empathic, accepting, and non-judgemental stance. In the event of a participant becoming emotionally overwhelmed during the interview, the researcher, experienced in trauma-focused therapy, would use grounding techniques. As a contingency plan, at least one other clinician was present in the service whilst the interview was taking place, and it was intended that their help would be elicited if required. It was considered that these risks were no greater than what would be expected in the normal course of therapy with this group of patients. In fact, these patients would have already addressed their distress relative to their traumatic experiences in the therapy, as the research interview was timed for the end phase of their NET treatment.

Risk management: Further, participants were made aware through the information sheet as well as verbally that should current risk issues be disclosed during the interview, these would be shared with the lead psychologist in the service at the time of the interview, or with an allocated mental health clinician, and that Trust safeguarding and risk management policy would be actioned.

Potential for benefit for participants: Engaging in reflective and process-type research, such as an IPA study, is likely to be viewed by participants as potentially both a consolidating and therapeutic experience (Birch & Miller, 2000). Despite the risk of emotional distress given the marginalised nature of this group, the researcher hypothesised that it would be likely that this group would appreciate the opportunity to voice their experience of NET as way of helping other forced migrants make treatment decisions.

2.14 Ethics and permissions

NHS ethical approval was obtained from the Research Ethics Committee (REC) (Appendix H) and local Trust Research and Development Office (NOCLOR). The REC approval process involved an NHS peer review to assess the ethics and feasibility of the research prior to the proposal and documentation going to the REC (Appendix J). The initial REC approval provisionally sought to recruit participants from one NHS Trust, East London Foundation Trust, Institute of Psychotrauma; and Luton and Newham Increasing Access to Psychological Therapies primary care services. However, to facilitate recruitment further, given that English-speaking forced migrants have been a hard-to-reach group, it was decided to extend NHS ethics to two other Trusts in London: Central and Northwest London, Forced Migration Service; and Barnet, Enfield and Haringey Mental Health Trust Complex Care services. A research passport was obtained from NOCLOR, to permit the research to be extended across the two other NHS trusts in London (Appendix K). Following approval from NOCLOR and the REC, City, University of London ethics department granted ethics approval and insurance for this study, and an ethics code was provided (Appendix I).

2.15 Ethical considerations during analysis

Teo (2010) raises concerns about making interpretations, emphasising the need for self-reflexivity. The more analytic stages of IPA inevitably involve more researcher subjectivity. Subjectivity was inevitable in the analytic process, in terms of what the researcher ‘chose to select’ in the text and interpret descriptively and critically. Both the researcher and the participant are making sense of their experiences of NET, referred to as the double hermeneutic, resulting in inter-subjectivity. However, Finlay (2009) views subjectivity and inter-subjectivity as an opportunity and not a problem. Willig (2012) maintains that interpretations mean that something is added to the original data and this means that the interpreter has the privilege to shape what is known, which raises ethical questions. However, this was managed by grounding all interpretations back to the text whilst monitoring my own subjectivities and use of language. Thus, in line with Willig’s recommendations for upholding ethical considerations in research, the research question was kept in mind, maintaining a stance of privileging the participant’s voice by staying as close to the text as possible, consistent with Levinas’s (1969) considerations on relational ethics in analysis.

2.16 First and subsequent interviews

The first participant interviewed was Ali (pseudonym). This interview was also used as a pilot interview. Briefly, Ali is a 30-year-old male of Somali origin. His interview lasted one hour. The researcher began the interview process by asking what his thoughts were about engaging in the research and about psychological therapy, to develop rapport and acclimatise him to the interview process. This initial interview developed self-awareness of the tendencies the researcher had during the interview and enabled the researcher to address these in subsequent interviews (see methodological considerations in the discussion chapter (Section 4.11) for reflections on the interview style and analytic process).

2.17 Table of participants

Seven participants were recruited. Five were male and two female. Two were originally from Iraq, one from Iran, one from Somalia, one from Sudan, one from Jordan, and one from Eritrea. To maintain confidentiality pseudonyms were used.

Figure 1: **Table of participants**

Name	**Gender**	**Country of Origin**	**No. of Sessions** **NET**
ALI	**Male**	**Somalia**	**15-20**
AYMAN	**Male**	**Sudan**	**20-25**
KESHI	**Male**	**Jordan**	**25**
AHMED	**Male**	**Iraq**	**15**
EMANI	**Female**	**Iran**	**20-25**
ASHRAF	**Male**	**Iraq**	**15**
GIZLAN	**Female**	**Eritrea**	**20**

2.18 Analytic strategy and procedure

Smith et al.'s (2009) version of IPA is used to analyse the data. The authors state that there is no prescriptive way of conducting IPA and define the following six stages of analysis.

Step 1: Reading and re-reading

Step 2: Initial coding

Step 3: Developing emergent themes

Step 4: Clustering: searching for connections across emergent themes

Step 5: Developing a table of themes

Step 6: Moving to the next case and searching for connections across cases

Prior to the reading of each transcript, initial reflection notes were taken immediately following the interview, as recommended by Smith et al. (2009), and followed by a careful transcription of the data.

1. Reading and re-reading

The audio-recordings were listened to carefully and transcribed verbatim. Each transcript was checked again against the recording and anonymised. Listening to the recording carefully helped immerse the researcher in the experience of each participant, paying attention to tone and linguistic meanings, and ensuring a grounding back to the participant's experience. Smith et al. (2009) advise noting initial impressions during the listening and transcription stage, and bracketing these to ensure the participant's experience of NET remains the focus rather than the researcher's knowledge base and preconceptions about NET. This was done using a diary, to ensure these impressions and preconceptions about the data did not interfere with the analysis of participants' experience. Giorgi (1994) maintains that bracketing our initial thoughts and feelings after an interview is an essential part of IPA, "one simply refrains from positing altogether; one looks at the data with an attitude of relative openness" (p. 212). The interview schedule provided an overall structure for investigating participants' experience of NET and was employed flexibly during the interviews. Repeated reading of the text facilitated a more active engagement with the data. Each interview was transcribed and analysed separately to avoid any cross-analysis and to allow full immersion in the data set.

2. Initial coding

The initial coding stage allowed empathic engagement with the text by attempting to get as close as possible to each participant's experience of NET. In making empathic interpretations, the aim was to illuminate what presented itself in the text, paying attention to patterns, features and qualities as well as moving between a focus on parts and the whole of the text. Finlay (2009) underscores the importance of the researcher taking a phenomenological attitude – exploring the participants' embodied experience whilst striving to suspend presuppositions and go beyond the taken-for-granted understandings. Each recording was listened to again following transcription, before any exploratory comments were made. Linguistic and descriptive ideas were noted in the left-hand margin.

A more conceptual reading of the data involved using theory and experiential practice to go beyond the text. Connections and preliminary conceptual interpretations were also noted in the left-hand margin of the transcript, forming the exploratory comments. IPA takes a hermeneutics mode of empathy and mode of suspicion (Ricoeur, 1991). The empathy mode comes first, followed by the more critical and speculative reading of the data (Smith, 2004).

3. Developing emergent themes

Each interview was read again, and using the information from the left-hand margin, the right-hand margin was used to record emerging themes. This involved a more interpretative reading of the text and codes. For an example of the coding refer to Appendix N. Many of the emergent themes were drawn from the conceptual codes due to the dominance or recurrence of these themes. Others were further interpreted and were more psychologically defined, e.g. 'coherence', 'developed understanding of trauma', 'an updating experience'. Emergent themes were then chronologically ordered for each participant; for an example refer to Appendix P.

4. Clustering: searching for connections across emergent themes

The next stage involved making sense of the connections between the emergent themes, and is more analytical, as the themes are listed and clustered together. An Excel spreadsheet was used to facilitate deletion of emergent themes and shifting emergent themes according to their connections with other related themes. This proved invaluable with the clustering process and with the deletion of stand-alone emergent themes. Smith

et al. (2009) suggest that this level of analysis is not prescriptive, and encourage the analyst to be innovative in terms of how the data is clustered. In line with Smith (2008), I decided to discard emergent themes that were repeating and had already been captured as a theme, as well as those that did not fit well into the emerging structure or were not sufficiently in evidence in the transcript. Pietkiewicz and Smith (2014) maintain that some of the themes may be dropped at this stage because they have a weak evidential base. Smith et al. (2009) identify six different ways of clustering emergent themes.

- Numeration. This involves looking at how often a theme is referenced. This helped me draw conclusions as to how relevant the theme may have been to a participant's experience. Themes that only occurred once in the text were discarded and the number of emergent themes condensed in a re-cluster.
- Like-with-like themes. These were clustered together. An example might be 'feelings at the beginning of therapy'.
- Assigning super-ordinate status to prominent emergent themes. Examples might be: 'a life more than just trauma', 'ambivalence'.
- Constellations. Emergent themes that were found to be dispersed across the text were clustered together. Examples might be: 'contextualisation', 'shifts in emotions', 'map/frame of reference'.
- Polarisation. This involves grouping opposite themes together. Examples might be: 'ambivalence and fear about the lifeline', 'lifeline giving a sense of perspective'.
- Contextualisation. Grouping themes across narrative events, for example, 'beginning of therapy', 'experience of the lifeline and chronology', 'experience of the use of the flowers in NET', 'experience of the testimony'.

The number of sub-ordinate themes that emerged from each participant ranged between 8 and 10.

5. Developing a table of themes

A table of super-ordinate themes was developed for each participant consisting of sub-ordinate themes, and clusters of themes ordered meaningfully and coherently. Each these was grounded in the voice of the participant, quoted the participant's voice and had a comment number for cross-reference purposes. An example of this is found in Appendix L. The same process was followed for each of the remaining six participants and in the spirit of IPA, care was taken to ensure each of the seven participants' voices

was represented. Data was added to an Excel spreadsheet in the same way as for the first participant's process of analysis.

6. Moving to the next case and searching for connections across cases

Once each of the seven transcripts had been analysed through the interpretative process, a final table of super-ordinate themes was constructed. These were meaningfully selected on the basis of the richness of the passages, number of times they appeared in the text, and how the theme illuminated various dimensions of the account and higher-level convergences between the themes, whilst respecting the idiosyncrasy and how the convergence manifested. The number of sub-ordinate themes ranged from 8 to 10 for each participant. I had around 66 sub-ordinate themes colour-coded to represent each participant, allowing me to track how many participants were linked to each emerging super-ordinate theme. Six sub-ordinate themes were discarded on the basis that the passages in the two participants' accounts were not rich enough. The remaining 60 were organised into super-ordinate clusters. Six super-ordinate themes emerged, containing between 5 and 14 sub-ordinate themes. For example, six of the seven participants' narratives reflected a sense of 'trusting someone else to be their voice' in the therapy, which became a super-ordinate theme. Five of the seven participants reflected a sense of therapy being a journey from trauma and despair to understanding the big things in life, and the therapy as offering 'something to navigate from'. All seven participants related their 'struggle with therapy, fear, ambivalence and exposure'.

3. ANALYSIS

3.1 Chapter overview

This chapter presents the results of an interpretative phenomenological analysis of seven forced migrants' experiences of narrative exposure therapy for PTSD. Six key themes emerged and formed the basis of the analysis:

- Trusting someone else to be your voice
- The struggle with therapy, fear, ambivalence and exposure
- Living with loss, pain, grief and uncertainty
- A life more than just trauma – 'remembering the good and the bad'
- Reconstructing a sense of self, identity and attachment
- From trauma and despair to understanding the big things in life – 'something to navigate from'

The participants' experience of NET was subsumed into six super-ordinate themes which attempted to capture the essence of this group's experience of NET. Each of these comprised several sub-ordinate themes highlighting the different dimensions of each theme, and these were further clustered into sub-themes to facilitate the analysis. The analysis presented here provides a phenomenological account of participants' experience of NET, and an inter-subjective construction of meaning, whereby the researcher aims to make sense of the participants making sense of their experience of NET. All themes are grounded in the data and every effort was made to prioritise the voice of the participants. See Appendix O for a complete table of sub-themes and super-ordinate themes across cases, grounded in quotes from participants' accounts as referred to by initial and quote location. Theory and research is reserved for the discussion chapter. This chapter offers one possible account of how forced migrants experience narrative exposure therapy. Flowers represent the positive memories in the lifeline (Schauer et al., 2005). Flowers and positive memories are used interchangeably throughout the analysis.

Figure 2: **Table of super-ordinate themes**

Super-ordinate themes	Sub-themes
Trusting someone else to be your voice	Trust in the therapeutic relationship
	Balance of voices
The struggle with therapy ambivalence, fear and exposure	Pessimism and anxiety
	Ambivalence
	NET as shaking up symptoms
Living with loss, pain, grief and uncertainty	Defectiveness
	Living with uncertainty and loss
A life more than just trauma… "remembering the good and the bad"	A life more than just trauma
	"Remembering the good and the bad"
Reconstructing a sense of self, identify and attachment	Challenging self…sense of achievement
	Reconstructing a new self
From trauma and despair to understanding the big things in life – "something to navigate from"	From trauma to hope
	"Powerful stuff"
	"Understanding the big things" in life
	"Something to navigate from"

3.2 Super-ordinate theme 1: Trusting someone else to be your voice

The therapeutic relationship was considered not only as a vehicle whereby trust is gained in the therapist but as simultaneously helping to break a lack of trust. Having someone who they could trust to listen to their trauma narrative was deemed to be essential for all participants. Believing in the therapist gave rise to hope and belief in the therapy.

Sub-theme 1: Trust in the therapeutic relationship

All but one participant described trust in the therapeutic relationship and trusting the therapist to be their voice as key in helping them to work through their therapy. Participants felt they needed to trust the therapist to be their voice before they could take ownership of their narrative and thus their voice.

Keshi described the importance of the relational aspect of therapy and "connection" in his therapy, and referred to this as the "human factor". Connection with the therapist was synonymous with facilitating hope in the therapy.

> *"I think important is human factor…In my opinion, it is not medical treatment it is psychological treatment so it is very important to make good connection"* (Keshi, 105)

> *"At the beginning, it was the same. Inside my mind, I realise she was going to help"* (Keshi, 112)

Like Keshi, Ayman's belief in his therapist fosters hope and trust in the therapy. Although he finds his therapist's persistence as unrelenting and ruthless, he attributes his experience of change in the therapy to the therapist's stance of persistence and determination to work through his trauma narrative. His connection in the therapy is considered to be the lynchpin of his subsequent changes and re-ownership of the self.

> *"I always thought she was ruthless, ok, but I said that to her, but then I thought maybe she is the only person that makes this experience work. I believe in her more than any other thing…: I was just saying about X. Seriously I wasn't happy to see her, but you know I believe if there is anything that might work, it's that*

tense encounter pushed me to make change, helps, maybe the only thing that I feel is useful something I can take with me" (Ayman, 74; 76)

Gizlan alludes to her therapist's demonstration of authenticity in her use of self in the therapy as fuelling her motivation to continue returning each week. For Gizlan, the instillation of hope through containment of her worry and fears can be interpreted as being an essential aspect of the change that she sees as having taken place for her. Though it is difficult to separate the therapeutic relationship from the therapy, her use of the words "changing my life" represents that a change is taking place. This leads her to develop a confidence both in the therapist and the therapy, again a demonstration of connection, which is central to engagement with the trauma narrative

> *"…when we talking I tell her I love her because she is changing my life, she is doing this for me, she is changing my life…And then she give me a promise to be like her. I am with you don't worry, I am here, so that morale she gave me I'm really impressed with her"* (Gizlan, 48)

Both Gizlan and Ayman's accounts of the therapeutic relationship are explicitly of the therapist demonstrating a staying power to work through whatever appears in their trauma narrative.

Emani's account tells us that at times shame was an obstacle to expressing her trauma narrative. She uses the word "listen", perhaps indicating that she has been silenced over the years. Her use of the word "knowing" can be interpreted as an attunement to her sadness, which in turn facilitated trust. Her assumption that "trust" and "Dr" are synonymous indicates a pervasive tendency to distrust others who are perhaps not in a helping profession. For Emani, 'sharing' her trauma narrative leaves her with a stillness, a peace which can only be achieved by sharing with someone she perceives as trustworthy.

> *"Sometimes, I get shy but it was helpful somebody listen to me after all these years, somebody knows about what was my problem, what was my sadness…I feel in my inside I feel more peace because I share with someone who I can trust because I knew she is Dr, she will not use my story, maybe if I tell friend or someone I don't know, maybe they use that but when I say to someone who is a Dr and wants to help me that was very helpful"* (Emani, 110)

Sub-theme 2: Balance of voices

The therapist's voice became a guiding one through the participants' narrative, grounding them, yet reflecting their own voice. Both Ashraf and Ahmed's accounts of their therapy make reference to the therapist's voice as something they both internalised during the therapy; however, they experience this voice in different ways.

Ashraf refers to his therapist's voice as being a binding force, grounding him back to the present and to safety amid his despair and helplessness during his exposure to his trauma narrative. The image that came to mind for me was one of multiple loud voices representing chaos and helplessness, misery and pain, and in parallel a soft stable voice running through his narrative which he finds containing, analogous to the resonating bell sound in meditation practice.

> *"…the treatment for me is connection, even though I was there, there was a voice coming through you know my past which is telling me, are you here are you there, are you listening to me…it was all shouting and helpless, and voices seeking help, so big voices, which is all connected with balance, misery, pain, the soft voice which is hearing you saying you are safe"* (Ashraf, 54; 58)

In contrast, Ahmed identifies his therapist's voice as being a transmission of his own voice resonating back to him. He finds it almost unbearable for someone else to be his voice and to relate his traumas back to him. Being the subject of his own speech after it had been stripped as a result of his political persecution was not experienced as desirable, almost indicating a disassociation from his trauma narrative.

> *"So, she is a voice of me, she is telling me exactly what happened to me…Hard very hard, someone else be my voice, someone else knows my story saying to me what happened to me. Reminding me, or telling me, or reading from me, she saying exactly what I said to her, so she is reading exactly what I was going through in my life, and that is hard. Hard because I never said this to myself, now X is telling me this"* (Ahmed, 115; 117)

All accounts allude to the prerequisite of connection and trust needed by the participants before they are able to transmit their trauma narratives and let someone else be their voice. The therapist's voice was experienced as containing and guiding during the therapy whilst simultaneously reflecting what then emerges as their voice in their narrative, something they can take ownership of, after their voice has been used as someone else's speech.

3.3 Super-ordinate theme 2: The struggle with therapy ambivalence, fear and exposure

All seven participants described their struggle with the therapy. Their accounts refer to the different manifestations of their struggle, from their ambivalence, fears, scepticism and hopelessness during their therapy, to describing the therapy as causing tremors in their trauma memories, and as 'shaking' up their PTSD symptoms, leading to a sense of deterioration and a fear of remembering and listening to their trauma narrative. All described a sense of having to wrestle with the therapy, their struggle to keep returning to the therapy, and their symptoms as being an inescapable experience during the therapy.

Sub-theme 1: Pessimism and anxiety

All accounts of participants' experience of NET were riddled with a sense of anxiety, ambivalence and pessimism at various points of the therapy. For some this continued throughout therapy and exposure to their trauma narrative.

Keshi and Ali described a sense of dread and anxiety about being exposed to and having to talk about their trauma narrative, both implicitly referring to a felt-sense of ambivalence due to the myriad of strong emotions that were being triggered in the therapy.

Keshi described bracing himself upon the approach to each stone in his lifeline. He felt that each stone was a new storm to overcome and survive.

> *"I was preparing myself for next stone. But it did not help. But when we start all, coming all again. It was the same"* (Keshi, 8; 48)

Similarly, Ali described the therapy as anxiety provoking to the point of triggering panic attacks during the sessions. He refers to the lifeline at the beginning of therapy as compounding his feelings of anxiety, and fuelling his ambivalence about therapy, so much so that he felt he needed to leave the room. He felt that he still had not fully come to terms with his emotions in relation to some of his traumas.

> *"At the beginning, I remember when I first came to my sessions and we talked about the lifeline, I was scared talking about some of it, and even you know my*

> *therapist saying it, I was getting fear, I wanted to leave the room you know. Sitting there as she was reading some of the traumas I was alright. Some of them was a bit different, I still haven't got over them."* (Ali, 213)

Sub-theme 2: Ambivalence

All participant accounts reflect ambivalence in engaging with NET and in continuing to return to each session.

Keshi compared psychological therapy to medicine. There is a sense of initial hopelessness about how therapy can produce change.

> *"I was very pessimist about it…Ah yes, because it is a little bit strange. If some strong medicines cannot help, how can help…"* (Keshi, 4, 8)

Keshi described feeling overwhelmed with anxiety when his narrative from the previous session's exposure work was read out by the therapist. At times, he felt cut off from his repertoire of emotions during his therapy. However, his ambivalence fizzled out after he spontaneously began to feel less anxious during therapy. His use of the word "magic" indicates his fascination at the immediate effects of NET on his anxiety, something he did not expect or even attribute to the therapy, but some other force perhaps.

> *"She told me about the stones and the flowers. She explained about everything and she told me we will start from recover the difficulties I had. I have the same feelings that happened before. It was very stressful, sometimes I can't feel, sometimes very anxious. Some events more than one session. In the next session, we start from the same event to remember. I felt more anxious and I was more, I was less worried, it's like magic, because I was not very, very optimistic but against my mind it had very, very good result"* (Keshi, 14)

Ahmed's sense of ambivalence ran through his entire therapy. He referred to the therapy as having changed him for the worse, bringing him to a state of deterioration. Ahmed continues to struggle with his grief, guilt and uncertainty about the possibility of having lost his family and this continues to fuel his PTSD symptoms. His use of the metaphor "a drop of water in a glass" can be interpreted as his experience of the flowers as being like a drop of water in his ocean of hopelessness, rendering him unable to anchor himself to these memories as internal resources – deemed to be negligible – and

experiencing himself through the therapy as being completely engulfed in the deep waters, i.e., his trauma memories.

> *"Right, right…it was painful. It did not do good with me, it did not change me, it changed me for the worst then for the better, cos it brought more bad memories for me. I always tried to hold on to the flowers like you said, but no matter how strong enough I try to hold them, I am not strong enough to hold on to them, because I feel the stones are a lot stronger. Exactly like I said, it was like a drop of water in this glass it was nothing"* (Ahmed, 104)

Like most of the other participants, Ashraf refers to his ambivalence about the therapy as being synonymous with a struggle to maintain his motivation to keep returning to therapy, whilst contending with his feelings of hopelessness. For Ashraf, the pain and ambivalence became an integral part of his therapy, each time feeling just as ambivalent as the previous session. He describes his return to therapy every week as being like an "addiction" to his ambivalence, pain, and sensory re-experiencing. His use of the analogy of "addiction" suggests that he felt like a passive agent being drawn back to the therapy. It is not clear which aspect of the therapy he is craving, the flowers or the stones? His use of the word "torture" may signify the therapy as being a persecutory experience.

> *"I think I need to try it I say, I can't leave it, the more I leave it, the more my symptoms get worse…then I was always remembering, look I need that treatment, it's like a minimum 20% it will improve my case…You know you go through the sessions, then you feel all the pain, then you come out and you say it OK, I'm here in the UK, it happened so it's something like I am talking to myself and I try to change it, it's like there is a part fine it's happened but not anymore, I was talking to myself to challenge it. After the session, I was staying for two days at home like a failure, I don't have energies, everything I was mentioning it, I was feeling it, the pain in my heart, the torture, everywhere in my body I was feeling it, I mean everything was there, for two days there was the pain there I mentioned, and then I get my voice back for the next week, and be able to come again, it's like magnetic or addictions, I will go, and then after the time I was leaving I say this is the last session, I'm not going to go anymore"* (Ashraf, 68)

Sub-theme 3: NET as shaking up symptoms

All participant accounts highlighted that the therapy was experienced as triggering their flashbacks, nightmares and trauma-laden emotions. However, Ahmed, Emani and Gizlan's accounts were more conspicuous in referring to the therapy as agitating their symptoms, representing a simplistic yet powerful account of their experience of NET.

Ahmed described the reading of his trauma narrative as triggering his symptoms – a sense of threat and despair to the point of exhaustion. He uses the analogy of his therapist holding a microphone, illustrating that the exposure and narrating of accounts by his therapist were experienced as loud, and as assaulting his mind and body, amplifying his symptoms. This resonates with the earlier theme of trusting someone else to be your voice. Ahmed's voice in his trauma narrative is loud and is internalised as a deprecating and annihilating voice. For Ahmed, the chronological narration of his traumas was far from therapeutic.

> *"Going through everything she was reading for me, in the end, coming pictures in my head, in my eyes, picture from here, picture from here, I worried from here I worried from there, that's what made them stuck in my head…I remember the events that happened to me, everything that happened, it's painful (94)… Yes. Yes and painful. Honestly, I wanted to say to her, don't say anything to me anymore, because I am tired to think about it anymore. I am tired to think about it. But my respect for her it just made me quiet and I don't know how… She was talking very slowly. But also I felt like she had a microphone in her hand and it was going through my ears, through my head" (96)* (Ahmed, 94; 96)

Similarly, Gizlan describes the therapy as "shaking up her mind", which can be interpreted as causing tremors in her trauma memories. Despite having finished her therapy a short time before the interview, she still felt the reverberations from her trauma memories during and following her therapy. When she described her 'mind shaking', the metaphor that came to mind was one of a psychic earthquake, energy release resulting from the rapid movement in her trauma networks during the reciting of her narrative, and aftershock waves as continuing during and after the therapy, eliciting emotional pain and discomfort. Another metaphor that came to mind was that of a snow globe – the cognitive, emotional, sensory and visual fragments of each memory floating around before each fragment settled.

"The day before the therapy I couldn't sleep. Even when I finish the therapy, it's shaking my mind. It's very hard, even the day and the week, it comes up everything comes up" (Gizlan, 14)

Ashraf compared his therapy to "hell", a place of perpetual torment where he had to endure suffering. His pain of waiting compounded by the pain of his suffering in the therapy indicates the hardship in his journey, and instead of feeling the relief he expected, he instead feels punished.

"For a year I was waiting for 1-1 sessions, and then 1-1 I said I wish I never waited for it, this is wait for hell it's like, do I need to talk about everything which I don't want to remember" (Ashraf, 91)

Emani also questions why she went to therapy. Emani described a deterioration in her PTSD difficulties during her therapy which perpetuated her ambivalence and fears of engaging with the therapy. "Pushing" herself to attend therapy indicated a real struggle to continue with the therapy, and perhaps reveals a juxtaposition of feelings of reluctance with a determination to see the therapy through. Her previous experience of struggling in therapy (counselling) and remaining engaged is drawn upon in staying engaged with NET.

"…and you see at night bad things, and feelings and things coming to your head you cannot sleep in the night, in the day you don't want to do nothing, I think, oh why I go to therapy, I feel more bad I didn't want to go, sometimes I feel like that but I push myself to come, because I had experience in that, so I pushed myself to" (Emani, 92)

All accounts reported pessimism and ambivalence from the outset about engaging in NET. For some, this dominated the initial stages of NET, and for others it extended through to the end of the therapy. Hope for change and the therapist's stance of persistence and staying power mitigated this. All accounts showed that NET agitated their traumas and trauma-laden emotions, causing tremors in these both during and following NET, analogous to aftershocks in an earthquake. 'Shaking the mind' and 'hell' were terms used to describe NET, which had the reciprocal effect of fuelling their ambivalence and fears about the therapy. This indicates the need for building a therapeutic relationship that contains and buffers participants' ambivalence and offers a degree of motivational interviewing prior to commencing the exposure and narration of their trauma narrative.

3.4 Super-ordinate theme 3: Living with loss, pain, grief and uncertainty

For four participants, loss, pain (whether physical or emotional), grief (whether grieving for their family or for the self that had been undone by their traumas), and uncertainty (whether about the future or the whereabouts and status of their family) featured within their accounts.

Sub-theme 1: Defective self

All struggled with a self they deemed to be defective, undone by their traumas. For one participant, his self was perceived to be permanently damaged by the choice he made to escape his persecution and leave his family, a self he deemed to be not worthy of existence.

Ali gave the account of himself as being "cursed" and attributed the trauma events that happened to him as due to bad luck. This implies that Ali is experiencing himself as a passive victim of something larger and outside of his control or as being persecuted by something greater than him.

"…I had you know sad emotions, like I was feeling sad, down. I was feeling like I had bad luck, I was feeling like I was cursed or something" (Ali, 111)

Ahmed's account of his journey in the therapy was grief-laden and melancholic. He refers to his guilt and self-hatred at having left his family behind, despite his family pleading with him to leave Iraq at the time. His guilt and self-flagellation shroud his narration of his trauma narrative. His narration of his lifeline, and exposure to his stones/traumas and flowers/positive memories in his life only served to perpetuate his feelings of loss, uncertainty and self-blame, and he is fixed on believing that he is unworthy, which his feelings of ambiguous loss of his family serve to exacerbate.

> *"When I say I feel worthless, I feel bad, I hate myself, I hate my life. X (therapist), I know she tried her best or tried to find corners from here from here from there just to point to me I am not, or I am doing good, or I did good. But, I tried to believe her, I cannot, because…where is my family? It's just, where are they? I must have to say the word, is it worthless, scared, coward, I don't know. When I left them over there, alone, I don't feel I'm worth to live, because I left*

them alone. I should have just stayed together, whatever happened to them happened to me. But I didn't. Of course, that is the worst thing I did" (Ahmed, 86).

Ashraf reported feeling like a "failure" as he continued to be exposed to his stones.

"I had to expose myself, I expose all my stories, to me it was like a failure" (Ashraf, 77)

Sub-theme 2: Living with uncertainty and loss

Continued uncertainty about their future, and the end of their therapy, signified the loss of an empathic, containing and guiding other, and this contributed to participants' juxtaposed feelings of anxiety and achievement in coming to the end of therapy, and reflected a dependency of the self on the therapist.

As well as his grief at the loss of his family, Ahmed also refers to the ending of his therapy as signifying having to endure the loss of yet another attachment figure, his therapist. He describes this as the loss of someone whom he trusted exclusively, whom he feels he can now only experience as a flashback, possibly another trauma memory depicting yet another loss in his life. His words "lift me up and push me forward" evoke an image of his experience of his therapist as holding and containing his horrors and him as a person, like holding on to a limp body, and trying to move him forward, against all resistance. He remains immobile both geographically and in body and mind.

"Worse actually, a lot more worse when I found out session is going to end me and X (therapist), as I said, trust it's the main thing. I trusted the lady. And I know she was trying to help with everything. I trusted her with things that I could not even talk to myself about it. Then when she told me she was coming to the end, then that's when everything came back to me (40)… That's what makes it worse, that's what makes my pain worse, because I trusted X so much and now it's gonna end and now I have to leave one more person in my life I have to say good bye to. And that makes it a lot worse to be here. I already lost persons out there and now another person over here (75)… I don't know because I can't see her and I can't talk to her all the time, and that is hard. So, I have to live with it memory or flashbacks of her voice, how she tried to encourage me, how she tried to lift me up and push me forward" (125) (Ahmed, 40; 75; 125).

Ahmed expresses his uncertainty and feelings of guilt about the ambiguous loss of his family, and his constant despair about their circumstances and living conditions if they are still alive, whilst referring to himself as having his basic living conditions met.

> *"I am just living for the hope, one in a million or one in one hundred million maybe one day I will hear something about them" (49)*

> *"I don't know where they are. I have clothes, I am warm, I can eat, I can drink whenever I want, what about them" (86)*

Uncertainty about the effects of his therapy, sadness about coming to the end of his narrative and thus therapy, and both the unpredictability and risks of reading his testimony encapsulate Ashraf's account. He refers to the lived tension between his addiction to keep returning to therapy, to be exposed to his pain, and his desperate desire to hasten the end of his therapy.

> *"I don't know really, I don't know what is next, and then she said yesterday, in 2–3 months it will show. Yesterday I was really sad, because it ended, and this is the addiction which I told you I'm used to it, in the same time I was waiting for the last session, which is the last part of my life, the last stone was there I just wanted to reach there and finish it (81)… Now it's like why should I read it and I don't know what's gonna happen. It's scary, still scary to be honest. After all this treatment, what will happen" (83)* (Ashraf, 81; 83)

Keshi was still waiting for a decision on his asylum status at the end of his therapy, leaving him with uncertainty about his future. However, he refers to events from his past as more disturbing compared to his distress about asylum.

> *"…And some worries still remain in my mind it is because my status is unclear, I am still waiting. I was refused and events they were in the past, they more stressful"* (Keshi, 81)

In all accounts, loss, pain, uncertainty and grief featured as ongoing struggles of a self that has been undone by something greater than it. Various accounts of a self that is stuck, uncertain, in pain, and as lacking control, as well as a dependency of the self on the therapist, resonated in their accounts. The end of therapy for the majority was experienced as an uncertain and uncontaining period with most still experiencing the

aftershocks of the narration and exposure to their trauma narrative, being torn between the desire to hasten the end of therapy and afraid of contending with another loss, the loss of a trusted and containing other.

3.5 Super-ordinate theme 4: A life more than just trauma – 'remembering the good and the bad'

Five of the participants described NET as giving them perspective about their trauma experiences, a chance to ground their traumas within the context and circumstances of their life. NET helped them to access affiliative and positive memories during the narration of their life, going beyond exposing them to their trauma memories, while offering them the parallel opportunity of self-discovery. Processing their flowers or positive memories gave them momentum to process their trauma, an anchor to which to return, to cope with their trauma memories and accompanied overwhelming emotions, awakening them to the realisation that their life was a life more than just trauma.

Sub-theme 1: A life more than just trauma

This sub-theme captures the realisation of a change in participants' perception of their life as being a life of just trauma per se to a life deemed to be of more than just trauma. This change in their perception, as well as grounding them into a future orientation, enabled them to see their trauma as being in the past, alluding to a self that is fluid and continuous, rather than a self that is fixed in trauma.

Ashraf describes his lifeline and his sequence of stones and flowers as reminding him of an actual memory of being in the mountains. During his lifeline, his stones seemed to blend into the background, and the flowers became a more conspicuous representation of his life. He comes to the realisation that his life isn't solely about his traumas; rather, it is also about beautiful moments. His life is not monochrome – he uses the phrase "there is still…some colours".

> *"…it just gives me the hope, like, I have a memory, I used to go with my family to the mountains, and in the mountains always dirty stones and big stones, but few purple and pink flowers between, so you don't look at the stones and things, mostly you look at the flowers and colours, it just looked like, doesn't matter how many*

stones there but there is still, some rose and some purple colours and pink" (Ashraf, 42).

Gizlan describes the narrating of her flowers during the therapy as being enjoyable, and as helping her process her stones. Her account conveys feelings of hope for her future, and a sense of coming to terms with life being comprised of good and bad experiences.

"If she, if she talk to me about the best one and future, I really like it that one, so I can pass hard time now but in future it's a better one, yea I will do, because life isn't fair" (Gizlan, 26)

Gizlan finds the 'here' and 'now' questioning style as grounding her in the present, and in a future, facilitating the continued awakening of time and context.

"…but when she tells me what do you think then what do you think now, I wake up, I see where I am. I remember I left it that one, I am here now" (Gizlan, 44)

For Ali, listening to his narrative helped to ground him in the here and now, and to see his traumas as in the past, placing them within a time and spatial-geographical perspective, allowing him to regain a sense of self as continuous rather than fixed in his past traumas. This in turn leads to the realisation that he needs to move on with his life into his future.

"It made me think some of my traumas were a bit early in my life and I was always listening to my life, you know it started with the good then it started with trauma, to the end when we came to the present I realised…these traumas happened to me a long time ago you know. One of the worst traumas that I got, it happened to me when I was young. Listening to my lifeline, it's like, a lot of good things have happened to me, a lot of very good things you know. And I thought, after my testimony, I thought I was in the present, Ok, now that I am here, that happened when I was young, I need to get on with my life" (Ali, 229)

Ali realises his life has been more than just about his traumas.

"I've been through so much other than my trauma" (Ali, 223)

Sub-theme 2: 'Remembering the good and the bad'

This sub-theme represents the process functions that remembering the good and the bad served in therapy. Narrating the positive and negative memories in their life was

experienced by participants as providing a vehicle to access key positive autobiographical memories which had been subsumed by trauma memories. This also provided momentum and a motivational function in the therapy, facilitating emotional shifts, giving perspective, and enabling them to value their lifeline and experiences.

Five of the seven participants made specific reference to NET as providing an exposure experience to remember not just their traumas per se but also the good memories in their life. They experienced this interweaving element of key declarative autobiographical memories as refreshing, and at times giving them the strength and resources to return to therapy and to continue with the challenge of being exposed to their trauma memories.

Gizlan describes the lifeline as helping her to remember her entire life. Before this, she had struggled to remember most of her life, learning about it vicariously through her family. Her testimony served as an aide-memoire, something she could use to remember her life, the good and the bad memories.

> *"When I see my lifeline, I'm going to be back. Bad and good life situations I see in my lifeline. I remember everything. Almost all of my life, I don't know about, I don't know, just I hear from my mum or my brothers and sisters…so when she asked me I'm going to see the book I am writing for my life, so it really helped me remember my life"* (Gizlan, 10)

Keshi comes to the conclusion that if the therapy had solely consisted of exposure to his trauma memories, he would have found the experience unmanageable. He sees the accessing of the positive memories as an essential and integral aspect of the therapy, enabling emotional regulation during trauma narration. His use of the word "light" may indicate being able to access his positive memories and personal resources as a contrast to his dark memories. It can also be interpreted as shedding light on his life or on the darkness, or meaning structures.

> *"And when we worked with flowers, of course it was more relaxing because it ah, because the stones brought negative reactions against flowers, we are bringing more relaxing. It was the same, I was taken back and I was not seeing good experience and I was seeing the light, nice memories. Probably one of the segments of treatment because if it makes calm person then if they just bought the stones it would be very very hard to cope. Then with flowers it brings more hope, hope"* (Keshi, 59)

For Ali, there is a sense of being completely consumed by his traumas, feeling a constant sense of threat, a loss of the range of his human sensibilities of feeling "love" and "happiness". His experience of talking about his positive memories inspired hope and helped him to access feelings of happiness, a recurrent theme throughout Ali's interview. Narrating his positive memories or flowers also made him understand and contextualise his traumas. There is a shift in his perspective from seeing his whole life as being "bad" and hopeless, to accessing feelings of hope, and a realisation of having choices and a future. He experiences the intermittent focus on his flowers during his narrative as taking him away from his negative emotions, enabling a change in perspective, from a life deemed to be full of bad memories to a life that also comprised significantly positive memories, facilitating a shift from an unrelenting threat-focused mind, albeit only fleetingly.

> *"Because of the flowers, just looking at the flowers it gives me hope…it gives me…Because before I came to see my therapist, I felt like I had nothing to offer, I felt like that my whole life had been bad, bad after bad (67)… Talking about the flowers, my emotions were different, I felt loved, I felt I have love around me, I felt I had a family around me, I was happy. But just at the moment I was speaking about the flower. After the flower finishes, I was going back to the stones, my emotions changed (111)… As well as learning about the stones, the flowers made me understand the stones as well, because the stones represented something bad, a trauma, and at the beginning, before I came to the sessions everything was about the traumas, watching TV traumas would come to my head. I've lost all my love, you know my happiness, I didn't think anything, I was scared, constantly scared (179)" (*Ali, 67; 111; 179)

The following excerpts from Ahmed allude to his experience of narrating his positive memories as giving him a moment of relief and calm after the storm. He values having to remember his good memories and alludes to a shift from his traumas being the sole focus of attention to the "good things".

> *"At least there is something that put a smile on your face, or how you say, a fresh air in your heart or in your head, something, at least something, better than nothing"* (Ahmed, 130).

> *"And this is a good way to remember the good things it's not just the bad things. Because, if, when I started with X (therapist) I was always thinking about the*

bad things, and then when we go stone by stone and with the flowers, so there is good things" (Ahmed, 127)

Ahmed uses his positive memories as a means to cope with having to listen to his trauma narrative, something he can anchor himself back to during his re-exposure to his traumas. However, for Ahmed, the pull back towards his traumas seemed to be a greater force, the number and weight of his trauma memories made his positive memories almost negligible in effect. He was unable to use his flowers as internal resources, and experienced them as a limited resource, a 'drop in the glass'.

"So she mentioned the flowers, and I tried to think about that and not to think about the other things she was talking about, and I tried to leave the flowers in my head and not listen to her and what she was saying" (Ahmed, 96)

"I always tried to hold on to the flowers like you said, but no matter how strong enough I try to hold them, I am not strong enough to hold on to them, because I feel the stones are a lot stronger. Exactly like I said, it was like a drop of water in this glass it was nothing" (Ahmed, 104)

Amid the pain and emotional turbulence during the therapy, for five of the participants, NET was experienced as a contextualising experience, facilitating the perspective of a life more than just trauma. In parallel to this, the intertwining of the positive memories into their narrative was experienced as affording the opportunity to access fundamental life memories, unearthing the self which had been subsumed by their traumas. NET facilitated participants' access to affiliative memories and realisations which promoted choice and hope in their future and enabled them to access the full range of their emotions beyond their trauma-laden ones.

Emani's account reflects the difficulty in looking at her lifeline and seeing more stones than flowers, however, she uses the term "respect", which indicates her coming to a position of honouring the value of the lifeline element in her therapy.

"*That wasn't upsetting me too much after that, and maybe look like, I respect that. But before I was very upset looking at that"* (Emani, 40)

3.6 Super-ordinate theme 5: Reconstructing a sense of self, identity and attachment

Five participants reflected on how the therapy facilitated changes in their emotions, bringing a capacity to start feeling again, and the inception of a new relationship with the self.

Sub-theme 1: Challenging self…sense of achievement

For all participants, challenging themselves through returning to their sessions and continuing with exposing themselves to their traumas, along with the associated pain and emotion, became perceived as being their achievement.

Ali's account conveys a shift towards thinking about his connections, his family and affiliations during his narrative. For Ali, his positive memories comprised feelings of social connectedness – of being loved and connected – which in turn triggered affiliative emotions, in contrast to the feelings of isolation which he endured daily. This helped Ali to oscillate between negative and positive emotions during his therapy. He described a self that could make choices again and a self endeavouring to move forward autonomously, using the word "started", which indicated the beginnings of a shift in his feelings and an investment in his self and future, finding his voice.

> *"I think about what I have, I think about all my family, I think about all my family, my little nephews, my little cousins, and…my feelings started to change, I started to go out. I've got a voluntary job now, just started this week"* (Ali, 147)

> *"Before, I was, I isolating myself from people around me, I didn't talk to anybody"* (Ali, 129)

> *"I think about all my family, I started to go out"* (Ali, 147)

> *"I've challenged myself to speak*" (Ali, 203)

Having persevered with his therapy, Ashraf then turns to his testimony as being an incredible achievement. His account evokes an image of a light being switched on, as he shifts from the depths of despair and feelings of failure to having more positive emotions, accessing his capacity to laugh and imagine once again, following time spent thinking about the nicer moments in his life. His repetition of the word "stone" indicates a perception of his life and self as being subsumed and absorbed by his trauma, and that

the visual representation of his flowers on the floor is the first time he has thought about this shift in perception.

> *"This is my life story which is I never believed could be on paper, I never dreamed of this happening. Once I was going through my treatment I remember I was crying and emotional and then click, it makes me change and love things again, that is what I never expected or never experienced it before. To see the funny things which happened in the moment. I never saw these flowers on the floor. In my mind, I was thinking that everything was stone, stone, stone. I never thought about it, yes, there are nice moments in my life, so if I bring them it's nice"* (Ashraf, 95)

Sub-theme 2: Reconstructing a new self

Four participant accounts reflected an externalising of feelings of anger, originally directed at the self, and a decision to reinvest in the self by persevering with the therapy.

Emani describes accessing and realising a new self-narrative – a resilient self – during the narration of her trauma narrative. During her narrative, she began to see herself as a strong woman who has survived numerous dangers, indicating her becoming the subject of her own speech rather than her perpetrator's speech.

> *"But after, I think 4 or 5 times I come, I saw some change in myself, because I thinking bad things about myself, but other way, I thinking good things about myself as well…I saw I was too much strong, because I passed lots of dangerous things and you know I am alive now. I don't think I am too much weak"* (Emani, 16).

She refers to feeling a shift in the locus of responsibility, externalising her anger towards her abusers, whilst beginning to reframe beliefs about herself.

> *"But now I saw the abuser was responsible now for every problem in my life, that I have now, and that has helped me now not feel sorry for them, feel sorry for myself"* (Emani, 28)

Keshi described changes in his emotions during the therapy which he realised in a more understated way compared to Ashraf. As he worked through his lifeline, Keshi noticed less intense feelings of anger and perhaps rage in his use of the words “not hitting someone”, a shift from these strong emotions which he refers to realising in an implicit and subtle way.

> *“I thought my feelings were not changed but in fact they changed. They better and I wasn’t more anxious I was I had very strong emotions, probably we took it event by event and we finished one event out of this and it was of course my feeling was more calm and my feelings were less aggressive, aggressive in a good meaning, not hitting someone…In next session it was less but it got less and less”* (Keshi, 67).

He uses the phrase “head burning”, which perhaps describes the broiling intensity of his emotions during the processing of the stones. The phrase has connotations of torture, and the therapy as perhaps being analogous to torture, and may also be interpreted as his trauma networks being ignited all at once, leading to pain and suffering, or even intense feelings of anger. Ashraf noticed that this “head burning” had dampened down in his subsequent session and re-reading of his narrative.

> *“It was key for me when it was reducing my feelings in the next session. And even when it was a stone and I came next time and she asked me how I was feeling and it was of course low, it was not like this, my head burning, I was not anxious more relaxed. My feeling was better”* (Keshi, 116)

Using the metaphor of a device that cannot be erased, Ayman alludes to his wish for his trauma memories to be deleted. This is a form of wishful thinking, but also takes away any responsibility he has in managing and owning his trauma memories, either emotionally and cognitively. However, Ayman realises that he is not able to engage in the therapy and narrate his trauma memories without being an active and cooperative participant in it. His account refers to a choice to reinvest in himself again, and he sees the pain and challenge in therapy as being an integral part of choosing to reinvest in his self.

> *"I wanted this to be erased like devices like that, but you know one thing, as you come closer to facing you know those problems, you know that this cannot happen without you being part of it, involving and helping yourself, and this experience made it very real. It takes two to tango"* (Ayman, 35)

> *"And again, you do this because you are challenged and you allow yourself to be challenged" (35)*

> *"A few days ago, I was considering to take a role, volunteering and that" (39)*

> *"I came to the conclusion that I justified it to myself to be exposed" (53)*

> *"I was investing in me" (80)*

Ashraf speaks of his struggle with ruminations about self-blame and beliefs about himself being a "failure". However, he is not quite at the point of being able to replace this with more positive reconstructions of himself and his self-concept. His reference to the lifeline can be interpreted as the lifeline being a structure that helped him to challenge his 'if' ruminations, and his reference to "always controlled and forced" shows him beginning to see that he was stripped of having a choice.

> *"I always call myself a failure; I was always controlled and forced. I don't know, how can I say, I'm not going to say forgive myself but like less blaming myself… Before, I was always talking if, if, if, but if I review it now with my lifeline, what is the if, something was stopping me and crushing me, this is the questions I have, I don't have a solution for it…if I blame myself I have questions, is there anything I could have done… I'm feeling I am not the person 15-20 years ago, I'm feeling myself not weak, maybe fragile"* (Ashraf, 87)

These accounts allude to the return of the participants' capacity to feel the range of human emotions, and the emergence of what appears to be a move towards positive utterances and perceptions of the self. Participants seem to be less fixed in their negative global self-evaluation, and are moving towards making the decision to reinvest in the self, a self that is situated within a future orientation. Feeling less intense emotions took participants by surprise during the course of the therapy. Coming to the end of their

lifeline or testimony was perceived as a graduating and challenging experience amid the turbulent journey through their trauma narrative.

3.7 Super-ordinate theme 6: From trauma and despair to understanding the big things in life… 'Something to navigate from'

Five of the seven participants explicitly referred to the therapy as shifting them from a position of despair to one of understanding the bigger struggles and wider context in their life circumstances, and as inspiring feelings of hope for their future and symptoms. The therapy was not only experienced as something they had to vigorously wrestle with, but also as a powerful agent of change, giving rise to a tangible and vivid experience, illuminating fundamental meanings of structure and giving order to their life experiences.

Sub-theme 1: From trauma to hope

Three participants conveyed shifting from trauma to a sense of hope, light, and a sense of feeling graduated. They attribute this shift to the impact of narrating their positive memories during the chronological exposure to their traumas, during which time they were able to develop a bigger understanding of the context of their traumas and life experiences.

NET was both active and experiential for Ayman, who felt the effects of the therapy immediately. Like other participants, he refers to a self that is moving on from the trauma, alluding to having hopes for his future and to being more realistic. His use of the word "graduated" evokes a long and taxing journey of challenging work and commitment, where he is moving on to focus on his future. This suggests a coming of age or that he has reached a point where he is drawing a line in the sand, and re-orientating towards what lies ahead.

> *"It was practical, and you feel it immediately when you get started, and if you have enough patience to continue, you can reap some significant rewards. So, whatever I said about other things, I have hopes, I am very realistic, as a result of coming to this place, I am thinking about volunteering… I used to be a board member, I am a member of an international conference…and I'm thinking now*

> *to start things you know, like I've been graduated. So, I respect this service seriously"* (Ayman, 86)

Ayman refers to his sense of achievement in completing his therapy, despite not feeling significant shifts at the end of treatment.

> *"I cannot say those things have changed dramatically, no, but maybe I feel a little bit prouder that I went through this"* (Ayman, 53);

Like all participants, Emani found the therapy demanding and challenging, yet she comes to realise the utility and value of it during the end phase, and explicitly refers to developing structures of meaning about her life of which she was previously not cognisant.

> *"…maybe at the end you think it is helpful, maybe at the end, now I think it's very helpful. Maybe I had bad, difficult time during treatment, but now I understand lots of things about my life"* (Emani, 94)

Sub-theme 2: 'Powerful stuff'

Whilst five of the participant accounts describe the profound impact of the therapy as enabling shifts from a position of despair to facilitating access to a bigger picture of the context of their traumas, two specifically referred to the therapy as being "revealing" and "powerful". Participant accounts reflected both communicating their experience of their struggles to persevere with the therapy and describing the therapy as revealing a structure of underlying meaning.

Ayman identifies himself as a journalist prior to his political persecution, with an eye for identifying the common thread in a story. Perhaps the lifeline enabled him to see the common thread in his narrative? He alludes to being able to see this common thread and equates it with coherence. His use of the word "thread" perhaps indicates fine structures holding together elements of meaning to give rise to a coherent narrative.

He reflects on how the therapy facilitated finding structures of meaning in his narrative, inviting him to revisit his developmental history and how this may have left him more vulnerable to his difficulties. Ayman refers to his experience as a revealing one.

"…you don't know I'm a writer or that was my job anyway, and so when you write a story or an article there is a common thread, there from the start to the end. If you miss that then you are not coherent… I knew why this was important because you identify those areas. And I wasn't even thinking about those very stages of my life, but the experience was revealing. I thought, maybe I had problems with my family even, maybe I was susceptible to feeling that way. So that was a good thing, yea" (Ayman, 20)

Moreover, he describes the therapy as being fundamentally different from his previous therapies, as "tangible", which indicates that it gives him something to hold on to, a real and grounding entity, an anchor to come back to. He refers to the lifeline specifically as giving him a genuine experience of the events in his life, perceptible by touch and sight, and as affording an immediate understanding of his difficulties. For Ayman, the tangible nature of the therapy prepared him for what was yet to come and this may connote a sense of control in his therapy. At the same time, he describes therapy as a burden and tribulation, an effortful and grinding activity.

"…well I met so many psychologists, it's all about talking but here it seems like there is something very tangible about this. This is the line. That makes it easier for me to understand the spots, the focal points, the problems. So, it prepared me very well at least to know. I didn't share it with X (therapist), but I knew that she was taking me, enticing me gradually to that area, because I know, I'm not dumb, ok. And when I feel we are getting to this point, somehow, I feel I am not interested, I try to avoid it, because I know we are coming to the day which is going to shake things, it was like a chore, this is what you are going to do" (Ayman, 26)

Like many, he experiences the therapy as something he had to 'push' himself to complete, using the analogy of push ups. He refers to the therapy as being like the last few push-ups, the more painful and strenuous ones, which he needed to put himself through to achieve mental gains. This analogy can also be interpreted as him pushing against his avoidance and fears in narrating and exposing himself to his traumas, whilst having to endure the pain of being exposed to his overwhelming negative trauma-laden emotions.

"…sometimes when you undertake physical things you know the pain and you know the feeling, I never enjoyed doing the push ups, the last ones, and it feels

like that all the time, you know you don't enjoy it at all you just want this to end quickly. I hope I made a valid comparison, but, you know you can't measure feelings you know" (Ayman, 30)

Ayman praises the techniques and the entire method of NET. He uses the word "tangible", suggesting the importance of a therapy that feels real and that he can connect with, not only on an emotional and cognitive level but on a practical and graphic level too.

"…the techniques, the methods, that's it, that's what I'm talking about. I believe it is the best thing, really tangible thing that makes sense" (Ayman, 78)

Similarly, Keshi described his astonishment at a talking therapy that encompassed such tangible features such as the stones and flowers, contrary to his ideas about psychotherapy.

"I was not expecting bricks, stones and flowers, it was all a surprise" (Keshi, 12)

He describes this initial experience of his lifeline as being almost playful. He uses the analogy of being in a nursery, playing with the stones, perhaps denying the magnitude of their importance, until they became real events, and a rude awakening of his life experiences.

"I told you from new because never seen like this before, it looked like I came into nursery, like children coming playing with stones and cups, and she explained what are they about and how they can help and you know after this, at the beginning there were stones and flowers. But when we started they stopped just being stones and just flowers and they started being more important. For me they meant not just stones for me they meant events" (Keshi, 22)

He was amazed by how the intensity of the affect associated with his trauma memories had decreased, describing this as "magic". His use of the word "magic" could be interpreted as meaning that the changes he comes to experience in the therapy go beyond his understanding, and perhaps emerged spontaneously.

"It was less. I thought it was like magic" (Keshi, 71)

Sub-theme 3: Understanding the big things in life

Five of the seven participants experienced NET as facilitating an understanding of the context in which their traumas happened, a developmental and socio-political perspective through the course of their life. There was a sense of developing an understanding of the bigger struggles in their life, rather than being caught up in their flashbacks and individual hotspots per se, and of developing a story of their life.

Ashraf describes the visual, exposure-related, and tangible nature of NET as being more of a central feature of the therapy than the speech aspects. Being able to see and touch each representation of his life became a new way of relating to his life experiences. His reference to "I could see theory and practical all mixed together" could be interpreted as his being able to see the coming together of his system of ideas and how he reached certain assumptions and conclusions, perhaps relating to his beliefs about himself, the world and others during his life, thus 'understanding the big things in life'.

> *"…things was visual you know more than talk, I saw theory and practical all mixed together…I could just see it really, I could touch it the places, which is I never believed that this could happen"* (Ashraf, 91)

Keshi described his therapy as a story with different segments. This evokes an image of him writing and narrating a book about his life in his mind. It could also be interpreted as him being an active participant in writing his story or narration, and the owning of such. His reference to both stones and flowers implies that these components elicited different emotions. Similarly, with reading there is the analogy of 'turning over a new leaf', with earlier pages becoming more in the past, and new pages representing new feelings and hopes in his life.

> *"If you compare it to a book, same story, and each story contains different segments not like the other. If you take stones and flowers into pieces of paper and put into note book and then you opening one page, and then next one different and coming different feelings"* (Keshi, 52)

Ali's account is one of the therapy helping him to put his flashbacks together, and elaborating on them. He refers to a new insight about his trauma which is that it was "out of his control". His acceptance of his trauma narrative was experienced as painful but his use of the word "accept" indicates a coming to terms with or acknowledging aspects of his life he has not previously wanted to acknowledge. His reference to the ages at which his traumas occurred may indicate feelings of grief for the kind of life he should have had when he was growing up.

"It helped me put my flashbacks together; it helped me put the little bits in the flashbacks together, the sounds, the smells…" (Ali, 102)

"It made me sometimes feel bad when I accepted it. Some of these traumas were out of my control you know. Some of them I was 6 years old, some of them I was 8 years old" (Ali, 187)

Similarly, Emani describes a fundamental awakening during her therapy. She may be referring to being able to conceptualise her feelings of guilt and understand the origins of these feelings, as well as to her patterns of subjugating her needs and emotions. Using the phrase "big things that I understand" also implies pervasive and significant structures of meaning.

"…this is the big things that I understand. And I think the big things in my life was feeling guilty about the abuse" (Emani, 66)

"…maybe I can understand I have rights in a relationship and to respect my rights, and respect other ones rights, but I only respected other ones not myself" (Emani, 104)

Ayman alludes to the therapy ameliorating and as adding components to his understanding and awareness.

"I knew I was just going it felt like I was upgrading things" (Ayman, 43)

Sub-theme 4: 'Something to navigate from'

Three of the participants conveyed explicit accounts of the lifeline and chronological aspect of NET as giving them a sense of control during their therapy, allowing them a frame of reference and something to navigate from and anchor themselves back to visually.

Ali uses the word "order" twice in the following excerpts. In his first reference to this word, he pauses and uses the phrase "if it makes sense", suggesting a pre-reflective realisation of order to his experiences. He refers to the lifeline as giving him that sense of coherence and order to his experience, which is further strengthened by talking through each event in his lifeline. He describes being able to see the "whole picture", indicative of seeing connections and context among events – a gestalt or organised whole comes to mind.

> "*It did make me understand my life, because I was getting flashbacks…I didn't know where they came from…and a lot of feelings that I had that I didn't understand. Following my stones from a young age, I had an order (pause)…if it makes sense. Everything that I had done it came back to me, all the good the bad and everything came back to me, and I understood a lot of my flashback memories that I didn't understand what they was"* (Ali, 35)

> *"I didn't have an order, it's just that I wanted to get the treatment fully, and when I did that first session, the lifeline, I wasn't confused a lot, because the more I talked about each event it made me see the whole picture"* (Ali, 37)

His use of the metaphor of a "puzzle" epitomises the idea of different structures, which were once puzzling, incomprehensible and confusing, but were now coming together as a whole and having meaning, coherence and elaboration.

> *"The traumas, I already know my traumas but I didn't know what particular times they happened. But with the lifeline, it helped me because it helped me put the pieces into the puzzle you know"* (Ali, 89)

Similarly, Keshi refers to having more of a handle on and sense of control in his therapy after knowing what was in his lifeline. This helped to prepare him for the rest of his therapy, giving him a frame of reference for what was yet to come.

> *"And then I knew what was in the lifeline, and I knew what about next stone, so I knew, I was a little bit ready for treatment"* (Keshi, 26)

Ayman also identifies the lifeline phase of the therapy as being the reason behind his motivation to engage in the therapy.

> *"I believe the day we started laying this, everything seems realistic and that is the day when I started believing in it"* (Ayman, 43)

He refers to the importance of having something tangible through which to relate his experience, making reference to how traumatised people find it difficult to relate their experience as thoughts per se. His traumatic history led him to question his existence, and while he refers to his existential dilemma, the focus in his therapy towards his hopes and future direction enabled him to navigate through his ongoing narrative, and to extend his self-narrative into the future. The chronology and time frame illustrated in the lifeline provided a map from which Ayman could navigate, a visual framework for

him to understand his trauma symptoms, which he felt was compatible with how his brain worked, using the power of images.

> *"Yea, seemed realistic because you know for people like us those, we don't deal with abstractions, because it seemed like I was witnessing my life you know the line, not only that, there was remembering that sometimes we are sceptical and you feel like, do I really exist, this is a philosophical problem, but you see now not only the line seems like you have the thing you still haven't spoken about the distance, you have this one and you have seemingly this future thing, what you want to be. So, that made it believable, realistic, and it gave me something like a map, something to navigate through, a mind map if you like. Converting those abstractions into things that are tangible. In my world, maybe in my brain it's better, it operates this way, I can understand and relate to the experience"* (Ayman, 45).

His account gives us a sense that he felt more in control in his therapy, amid the noise of his flashbacks and amplified sensory experiences. He attributes this to the tangibility of the lifeline and the chronological nature of the therapy, giving him an immediate "frame of reference", clearly laid out and therefore difficult to misinterpret, "not clouded by any illusion".

> *"…the mind has a great ability to trick you, it goes this way and it tricks you, but now I feel I am in control, ok, not clouded by any illusion, just knowing this is a map, a frame of reference"* (Ayman, 64).

> *"…a frame of reference. It's like I have something now building on that"* (Ayman, 41).

> *"It was practical, and you feel it immediately when you get started, and if you have enough patience to continue, you can reap some significant rewards"* (Ayman, 86).

Five of the seven participants emphasise the practical, tangible and experiential aspects of the therapy as having contributed to being their able to see the bigger picture through providing a frame of reference. With that came new insights and an order of meaning, which had been previously shrouded by their trauma history.

3.8 Analytic summary

Six super-ordinate themes emerged from the narratives of this group's experience of NET. Noteworthy is the coherence between all seven participants' accounts, as many similar themes emerged. This chapter illuminates the participants' journeys, from their ongoing struggle and ambivalence in engaging with NET to developing trust to allow someone else to be their voice, affording them a medium through which to speak during their trauma narrative, and subsequently to take ownership of their own voice, after having been the subject of someone else's speech. The therapeutic relationship emerged as overarching in containing their ambivalence towards and fears of exposure to their traumas, whilst facilitating hope and allowing them to access their voice. Primarily, this was experienced as trusting the therapist, feeling an authenticity in the therapist, and by way of an unwavering persistence to continue narrating and being exposed to their memories and associated hotspots – what Courtois and Ford (2013) term "staying power" (p. 278).

All accounts indicated NET as being challenging, anxiety provoking, and overwhelming. One went as far as describing it as "hell". It highlighted their ongoing struggle with their loss of time, self and family, and their grief and uncertainty, bringing to the surface various accounts of the self as being stuck, uncertain, lacking control and with a dependency on the therapist to remake the self and instil hope. Hope for change and the therapist's stance of persistence mitigated their ongoing ambivalence during therapy. All accounts conveyed that NET agitated trauma-laden emotions and difficulties, and for some this continued after the therapy came to an end, analogous to the aftershocks in an earthquake.

Against this backdrop, whilst NET was experienced as causing tremors in their trauma network during exposure to their trauma and life narrative, the interweaving of positive declarative memories, and the chronological and gestalt nature of NET, enabled a shift in perspective from a life of just trauma to a life of more than just trauma. This offered a frame of reference from which to make new judgements about their trauma experiences and selfhood. Together, these aspects of therapy facilitated access to a pre-trauma self, as participants recovered autobiographical memory, fostered reconnections with affiliative memories and emotions, and reconnected with selfhood. Many began to foster the ability to reconnect with their self and their capacity to feel and make choices, thereby commencing a move towards an autonomous self. Six participants referred to the narrating of their positive memories as: providing access to moments of positive affect and enabling them to once again experience a range of positive and affiliative

emotions; affording them with a perspective of “good and bad” happening in their life; providing an opportunity to access lost autobiographical memories subsumed by their trauma; and helping them develop an order of meaning as well as promote self-discovery. For one participant, however, his positive memories triggered affiliative memories of his family, which in turn amplified his grief and self-blame.

4. DISCUSSION

4.1 Chapter overview

The current research aimed to explore the lived experience of forced migrants who presented with PTSD and have completed a course of NET for their PTSD. Despite extensive RCTs investigating the efficacy of NET for this group around the world, no research has examined how individuals in this group experience this therapy – a therapy that has been designed specifically for those who have suffered mass persecution and war trauma. Giving this group a voice in how they experience this therapy was considered timely given the increased use of NET in PTSD services for this group across the NHS. Six super-ordinate themes characterising their experience of NET emerged: Trusting someone else to be your voice; The struggle with therapy ambivalence, fear and exposure; Living with loss, pain, grief and uncertainty; A life more than just trauma – 'remembering the good and the bad'; Reconstructing a sense of self, identity and attachment; From trauma and despair to understanding the big things in life – 'something to navigate from'. The experience of this group that has undergone NET can be encapsulated in a journey beginning and continuing with feelings of ambivalence and fear, as they struggle with narrating and being exposed to their trauma narratives. For most, these feelings continued throughout their therapy, held by the therapist's staying power and persistence, which carried them through the therapy. For all participants NET felt overwhelming, and for many it had the effect of shaking up their PTSD symptoms and trauma-associated emotions during the course of their therapy, and which persisted post-therapy. However, this was mitigated by the therapist's persistence and attunement, acting as a container, holding their voice, and this enabled them to become the subject of their own voice during the narration of their trauma narrative. Whilst their journey was characterised by a struggle with uncertainty, loss, grief and a dependency on the therapist to facilitate hope and guide them through, the majority described regaining their capacity to feel the range of human emotions. They were able to develop a future orientation, choosing to reinvest in themselves through volunteering opportunities, engaging with society, and developing a more balanced perspective of their life as one that consisted of fundamental memories comprising the self – a life and self that endured more than just trauma. These are the real-world outcomes that empirical studies on the efficacy of NET have not been able to capture. The study's major findings are discussed in terms of theory, research and

practice, alongside consideration of practice implications, research limitations, and suggestions for future research.

These results find some reflections in the existing literature, particularly the findings of ambivalence in engaging in exposure-based therapy, having to grapple with their experience of loss and grief, and the necessity of the therapeutic relationship in trauma therapy. The study contributes new findings to the NET literature: 1) participants' experience of an exacerbation in their PTSD symptoms during the therapy and at the end of therapy; and 2) the real-world subjective outcomes that RCTs have failed to capture. These outcomes include:

- a shift from trauma-associated emotions;
- experiencing a range of emotions;
- accessing a new self or resilient self;
- a shift from feelings of shame and anger directed inwards to self-compassion;
- a reduction in the intensity of emotions associated with their traumas;
- having a sense of new-found agency in allowing the self to be challenged whilst regaining a responsibility for the self;
- regaining access to faculties of imagination in relation to the self.

Although IPA offers the co-construction of meaning between participant and researcher, every effort was made to ensure that the analysis reflected the participants' voices and journeys through NET. This chapter begins with a reflexive overview of the author's assumptions about NET before starting the research and how this may have impacted on the interpretation of the data. The chapter then focuses on the researcher's interpretations beyond the data and explores the participants' journeys through NET.

4.2 Personal reflexive overview

Although IPA acknowledges the co-construction of meaning and double hermeneutic when attempting to develop an understanding of phenomena, one of the concerns I had about doing this research was that my assumptions about NET as a clinician were not imposed on the interpretations of the participants' unique accounts of NET. Before commencing the research, and in practising NET as a trauma therapy within a specialist trauma service, I focused on delivering the therapy in a manualised and methodical manner. With the patients with whom I used NET, I noted their struggle in processing

their stones, and the utility of processing as providing a contextualising experience. At the end of therapy, all reported residual symptoms, however, all found the narration of their life story to be a profound experience. Having come from the position of believing in the clinical utility of NET, and also having previously worked in one of the services delivering NET to this population, my conviction and interest in NET may well have impacted on the way I asked questions, such as having a leading style in the first interview, and as having held positive preconceptions of NET as a trauma therapy which I learned to bracket. However, my knowledge of NET was also a huge advantage in enabling me to probe and gain deeper access into participants' lived experience of NET. With this in mind, I wanted to remain open and curious about how forced migrants experience this therapy, which can be described as being challenging for both clinicians and patients, given that there is no formal stabilisation phase that precedes the delivery of NET. From a data analysis perspective, my clinical experience served to help me shed light on their experiences. However, this also obscured interpreting the data as I had a tendency at the beginning to interpret the data from a more therapeutic and psychological perspective. I was motivated and committed to serving this group of participants in representing as closely as I could their accounts of NET.

The results fascinated me, providing me with insight into how the components of NET are experienced, and the phenomenology of NET as experienced by this group. I have learned to appreciate the subjective outcomes of NET, beyond than just the symptom reduction. I learned that NET was experienced as facilitating access to autobiographical memories, emotional range, personal resources, and reconnections with concepts of self and relationships. As a clinician, prior to doing this research I do not believe I fully appreciated the significance of the chronological aspect of NET, and how this could be experienced as being central to accessing the fluid nature of the self over time and context, or how the experiential aspects of NET (the lifeline and exposure/processing) enabled participants to focus on the whole of their lives rather than being fixed on the aspects of the traumatised self.

Reconstructing meaning is not a primary endeavour in NET. Rather, it is the processing of stones linked to trauma-related symptoms, the interweaving of cold declarative memories, and the development of a testimony. The research study has developed in me a new-found understanding of NET as facilitating identity reconstruction, in a group whose self has been undone by trauma after trauma. It has also allowed me to appreciate the array of subjective outcomes possible and to be sensitive to the diversity of

experience, namely, how not all patients may experience the narrating of their narrative and testimony as a positive or empowering experience, and that, rather, their narration may serve to amplify their voices of self-flagellation and intensity of grief.

4.3 **The journey through ambivalence, fear and exposure**

All participants reported experiencing states of ambivalence and for some, pessimism, in therapy from the outset and these were feelings which dominated the initial stages of NET. For others, ambivalence extended through the therapy. Participants described opposing emotional states of wanting to try NET as a trauma therapy while holding a fervent desire to hasten the end of therapy. Similar experiences of ambivalence are reflected in the IPA study of patient experiences of ambivalence in Shearing, Lee and Clohessy (2011) (in the theme 'Overcoming ambivalence about reliving'), and in Vincent et al.'s (2012) study on the experience of asylum-seekers receiving TF-CBT for PTSD (in the theme 'Staying where you are versus engaging in therapy'). However, in the latter study, the ambivalence and fear continued throughout their exposure to each stone in their trauma narrative, with exposure activating their fear networks (Foa & Kozak, 1986) comprising emotions, sensations and thoughts associated with each trauma. Exposure to each stone brought further trauma-associated emotions and cognitions to the surface, compounding their ambivalence about NET. Consistent with Vincent et al.'s study, participants in this study also experienced this exposure-informed therapy as anxiety provoking, difficult, overwhelming, painful and exhausting, which contributed to their ambivalence.

However, alongside their narrative of ambivalence, fears and pain in their continued engagement with NET through to the end was their opposing narrative about motivation and the desire for change. Holding on to the hope that the therapy would one day yield some symptom relief mitigated their ambivalence. Ashraf described his return to therapy every week as being like an addiction to his ambivalence, pain, and sensory re-experiencing; the pain and ambivalence became an integral part of his therapy. Like all other participants, his choice to expose himself to his traumas can be conceptualised as an attempt to consciously master his traumatic experience (Herman, 1992).

Whilst participants struggled with their fear and ambivalence about narrating and exposing themselves to their trauma narratives, contrary to Vincent et al.'s (2012) study, they remained hopeful in the therapy despite the emotional pain and intrusive re-

experiencing this triggered for them. The construction of the lifeline at the beginning was experienced by most as overwhelming and an ambivalent experience, triggering a myriad of emotions associated with their traumas. However, the lifeline was also experienced as grounding and contextualising, providing for the majority a map of where the therapy was heading, reflecting the aims of NET as weaving hot trauma memories into cold declarative memories and allowing an integration of the trauma network into autobiographical memory (Schauer et al., 2011).

4.4 **NET as overwhelming… 'Shaking the mind'**

Although not a separate super-ordinate theme, noteworthy to detail is that all accounts showed that NET agitated their trauma memory network and associated trauma emotions, causing tremors in their trauma network both during and following NET, analogous to aftershocks in an earthquake. 'Shaking the mind' and 'hell' were used to describe the process of NET, which had the reciprocal effect of fuelling participants' ambivalence and fears about the therapy. Whilst studies on the efficacy of NET report significant reductions in PTSD symptoms following NET, all participants in this study described NET as exacerbating their symptoms or, to use their term, 'shaking' up their trauma networks. Their experience of NET as feeling difficult and at times overwhelming is reflected in the following sub-ordinate themes from each of the seven participants, clustered to form the super-ordinate theme of 'ambivalence, fear and exposure': a sense of deterioration, therapy as a difficult struggle and as shaking up symptoms, therapy as causing tremors to trauma network, therapy as annoying and inescapable, a fear of exposure to traumas, and a fear of listening to narration. These findings are consistent with Vincent et al.'s (2012) study which reported that participants continued to experience nightmares, intrusive re-experiencing, anger and other emotions associated with their cumulative traumas post-NET.

The findings from this study are in contrast to Speckens, Ehlers, Hackmann and Clark's (2006) and Hackmann, Ehlers, Speckens and Clark's (2004) studies, which both reported that for most participants imaginal reliving did not lead to exacerbations in intrusion frequency. However, both studies incorporated discrete adult traumas rather than multiple or cumulative trauma, and it is likely that initial symptom severity would have been lower in comparison. The authors focused on change of intrusive memories per se, to the exclusion of all other complex reactions observed in those who have

experienced multiple traumas. Individuals with complex and multiple trauma in addition to intrusions also suffer from additional symptoms such as emotional dysregulations, anger, dissociation, somatisation and problems in relational areas (Herman, 1992) which can affect the maintenance and characteristics of intrusions. These studies used cognitive therapy for PTSD which relied less on exposure and more on cognitive restructuring, in contrast to NET which does not mandate or guide cognitive restructuring. Participants in this study reported anger, mixed emotions of loss and grief, and physical pain as characterising their journey, which may respond less well to exposure per se. Moreover, participants in this study also reported a ‘nowness’ to their intrusions which, according to Speckens et al. (2006), predicted a poor response to reliving alone.

There is a debate in the literature as to whether treatment success in exposure therapy is due to the level of fear initially experienced in therapy. Jaycox, Foa and Morral (1998) reported that treatment success in exposure therapy was positively associated with the level of fear initially experienced in the treatment. On the other hand, the phased-based approach to working with complex trauma recommends that during trauma memory processing, treatment should include continued application of intervention to strengthen emotional regulation, self-efficacy and relationship skills. This approach advocates that if symptoms become overwhelming then therapy should return to phase 1, to facilitate stabilisation of symptoms before engaging in further trauma processing (Cloitre et al., 2011; Nickerson et al., 2011). One of the reasons NET does not promote a phase-based approach is due to the context in which it was developed, and because there is still mixed evidence in the literature as to whether a stabilisation phase is of real benefit. The current evidence points to the immediate implementation of trauma-focused therapy for PTSD symptoms rather than delaying this with the use of prolonged periods of the use of a stabilisation phase or multi-modal treatments (Ter Heide et al., 2016; Nickerson et al., 2011). It is noteworthy that in a low-resource setting where NET was initially applied and developed, it may not make sense to waste resources on stabilisation.

However, even though NET has an in-built stabilisation function (the use of the ‘then’ and now’ questioning style which facilitates a grounding and contextualising function), without a formally applied stabilisation phase there is the risk of patients finding the therapy overwhelming, as was the case here. Ter Heide et al. (2016) assert that recommendations for phased-based treatment in the refugee population are experience-based rather than the result of randomised research on the efficacy of phase-based

treatment for this group. They maintain that there is no evidence that complex PTSD symptoms predict dropout or non-response, and no evidence that having a stabilisation phase predicts greater acceptability compared to the use of primarily exposure-based trauma-focused interventions such as NET.

As a feature of the therapeutic relationship, participants valued honesty from their therapists that the therapy would agitate and exacerbate their PTSD symptoms, which in turn helped them to manage their ambivalence though not overcome it. This indicates the need for building a trusting and honest therapeutic relationship during NET with this group, a relationship that contains and buffers their ambivalence, and offers a degree of motivational interviewing prior to commencing the narration of their trauma narrative. Although this group did not report struggling with change they did report their struggle with exposure to their traumas. Slagle and Gray (2007) highlight the use of motivational interviewing as an adjunct to exposure-informed therapies. This is discussed further in implications for research and practice in Sections 4.13 and 4.14.

4.5 **The struggle with loss, uncertainty and pain**

For all participants, loss, physical and emotional pain, grief and uncertainty about their prognosis and future were dominant features of their journey through their lifeline. All experienced immense losses in relation to career aspirations, family, and identity. Tribe (2002) maintains that one of the most significant losses is that of a belief in an imagined future. Ambiguous loss defined as uncertainty about the fate of a loved one was another dimension of loss, creating tension and difficulties about whether to move on (Lane & Tribe, 2014), especially for Ahmed whose feelings of uncertainty and guilt had left him feeling stuck following his therapy. Grieving the end of the therapy, the end of the therapeutic relationship, and the end of a dependency on the therapist was experienced as an uncontaining and uncertain period, too final and anxiety provoking. For all participants, the therapist was the first person to bear witness to their trauma narrative. This is consistent with literature reflecting that faculties including basic capacities for autonomy, trust, competence, identity and intimacy are damaged by traumatic experience and are reformed within relationships (Herman, 1992). Herman maintains that telling the trauma story plunges individuals into profound grief, given that many of their losses are unrecognised. Reclaiming the full range of emotions, which includes grief, needs to be understood as resistance rather than submission to perpetrators.

4.6 **The therapeutic relationship… trusting someone else to be your voice**

All participants valued their therapist bringing their compassionate best to the therapy, their authentic self as therapist, and prized their relenting persistence to guide and contain them through their trauma narrative and lifeline. Participants valued the human and humble stance of the therapist, and their empathic attunement, which enabled participants to reciprocally trust in the therapist to hold and to bear witness to the horrors of their cumulative traumatic experiences. Courtois and Ford define empathic attunement as “extending one’s personal perspective to understand that of the client, even when she or he interacts in ways that are challenging, confusing, erratic or emotionally shut down” (2013, p. 280). Displaying empathy, building trust and systematically addressing concerns about exposure have previously been recommended to help clients overcome a fear of reliving (Mueller, Hackmann & Croft, 2004). Analogous to Shearing et al.’s (2011) IPA study on the experience of TF-CBT, which showed that trust and safety in the therapeutic relationship facilitated engagement experiences, participants in this study also reported the significance of trust and connection to the therapist as buffering and overcoming their sustained ambivalence towards NET.

However, this study illuminated that therapist authenticity, ability to contain and hold the patient during the course of the narration of their traumas, the guiding voice, and unwavering staying power with the patient were essential requisites or conditions in enabling participants to trust the therapist to be their voice, before they were able to hear or internalise it as their narration or story. Courtois and Ford (2013) in their book *Treatment of complex trauma* argue that therapists must be willing to have an active stance and intentionality in what is often a fearful and mistrustful client. They use the term “staying power” (p. 278) which they assert the therapist must have when the client shifts back and forth between being connected and disconnected, or when the client is flooding the therapist with information or withholding. Aside from the trauma maintaining a sense of threat, relationship closeness can also become the trigger for such a sense of threat.

Brison (2002) maintains that to work through trauma and reconstruct self-narratives, we need an audience able to hear the trauma narrative, and that the act of bearing witness to trauma facilitates this shift, by re-establishing connections to selfhood, as well as

transforming traumatic memory into a coherent narrative memory. The findings are consistent with Feldman and Laub (as cited in Brison, 2002) who emphasise the need for an empathic listener and the individual transmitting their story to a person outside of themselves before taking it back inside. Therapist attunement and demonstration of empathic listening and containment facilitated the articulation and transmission of participant trauma narratives and enabled participants to hear, identify and own their voice and their narrative. For most participants, the therapist's voice became internalised as their voice, giving them ownership over their trauma narrative. Brison (2002) argues that the transmission of the trauma narrative to the therapist is a speech act or performance, and that the same utterance can be two kinds of speech act: one of bearing witness, and one of working through (albeit one speech act may succeed even if the other does not).

4.7 **Reconstructing a sense of self, identity and attachment**

Most of the participants were able to explain processes of change during their therapeutic journey, however, there was a struggle to explain the whole process of change, which is multifaceted and at times difficult to decipher amid the experiences of the difficulty of NET. Contrary to Shearing et al.'s (2011) study reporting positive change following TF-CBT, forced migrants in this study presented with a magnitude of traumas extending through poignant times of their life. The degree of subsequent change in the self after completing NET was on a smaller scale than in Shearing et al. who focus on non-forced migrants' experiences of TF-CBT. The forced migrant's PTSD difficulties in this study confirm Courtois and Ford's (2013) criteria for complex PTSD: 'alterations in self-perception', alternations in the regulation of affective impulses', 'alterations in the perceptions of perpetrators', and 'alterations in systems of meaning'.

Amid the ambivalence, agitation of PTSD symptoms, and intrusive re-experiencing, several participants reported that the lifeline and chronological nature of NET afforded them a lens from which to view their trauma memories, a physical reference point which enabled new perspectives. The chronological aspect allowed them to see their life as one of more than just trauma, a whole perspective, comprising key relationships and achievements, as well as their social-political struggles and trauma. This enabled

reflections on their pre-trauma self, selfhood, identity and the self in relation to their key relationships.

Herman (1992) states that re-creating an ideal self is an active exercise of imagination and fantasy, capacities which are subsumed by repetitions of the traumas. For all but one participant, the future was one that they were orientating towards with hope and resilience. Brison (2002) maintains “It is the transformation of the self as autonomous agent that is perhaps most apparent in survivors of trauma” (p. 59).

Participants’ accounts detailed their struggle to feel the range of human emotions including affiliative emotions. Herman (1992) states that the patient has a fantasy that they are already among the dead, due to an inability to feel love. However, participants’ account of the interweaving of positive declarative cold memories indicated a shift towards accessing social connectedness which in turn triggered affiliative emotions – feelings of being loved and connected – which are fundamental to re-establishing connections with selfhood and reconstructing narratives of the self.

Schauer et al. assert that those who have experienced continuous trauma not only lose their biography but that “other memories cease to exist alongside” (2011, p. 35). Through the weaving in of the flowers or positive declarative memories, participants accessed personal resources, and memories that constituted significant embodiments of the self and the self in relation to significant others, supporting Schauer et al.’s assertion that during NET personal resources and strengths assembled via the lifespan of the individual can be uncovered.

One participant shifted towards thinking about the self as a ‘victim’ to thinking about the self as a ‘survivor’, and in doing so began externalising their anger towards their abusers. Meichenbaum (2006) proposes that the kinds of thinking and behavioural patterns that lead survivors towards growth are: finding benefit in the experience relative to the self, e.g., ‘I am less afraid of change’; finding others; shifting meaning from ‘I am a victim to I am a survivor’; and establishing a future orientation. Several participants began to establish a future orientation through making a choice to take up volunteering opportunities, albeit one participant continued to struggle with chronic guilt and self-flagellation, and another was awaiting a decision on their asylum status. Both these participants struggled to position their self in the future. Brison (1992) states that the undoing of the self in trauma involves a severing of past from present, and an inability to envision a future. Thus, one remakes oneself by finding meaning in a life of

caring for others and establishing connections essential to selfhood. Others began to see their life story as a commemorative activity and their narratives as a token of their achievements and resilience. Meichenbaum maintains that moving forward from resilience to post-traumatic-growth requires activities such as constructing meaning, finding a future orientation, and retelling stories as artistic and commemorative activities.

Although one participant's account alluded to fundamental shifts in emotions such as shame and other trauma-associated feelings, another referred to reduced intensity of negative emotions, and another to having a shift of feelings, these shifts were not in motion for all, at least not immediately after completing NET. Feeling less intense emotions took them by surprise during the course of the therapy and enabled them to come closer to their trauma narrative, allowing for capacity to reflect on selfhood. Lustig et al. (2004) state that the narrative creates a testimony which not only serves as a historical record, but gives meaning to the individual's experience, allowing for the re-evaluation of emotions like shame and guilt, whilst highlighting courage and resilience.

In contrast to Ehlers and Clark's (2000) assertion that clients reclaim their former selves following reliving, for several participants, NET facilitated access to a self that they experienced as no longer static but fluid, and as belonging in the future. This freed them up to make the choice to reinvest in the self and thus begin the process of reclaiming that self. Their experiences of accessing selfhood during their trauma narrative reflect Crossley's (2000) work, that narratives are an organising structure for human life, and that "…the individual, at the level of tacit, phenomenological experience, is constantly projecting backwards and forwards in a manner that maintains a sense of coherence, unity, meaningfulness and identity" (p. 542). Rather than returning to the pre-trauma self as conceptualised by Ehlers and Clark (2000), Brison (2002) states that if one's self is considered identical to one's will, the individual cannot be the same as the pre-trauma self, as what they are able to will post-trauma is drastically different. Schauer et al. (2011) maintain that after treatment, the individual may experience significant changes in life and real-world outcomes, such as sudden joy on going for walk in nature, which are neglected by systematic trials. Participants experienced access to their imagination, reconnection with their emotions and their emotional range, as well as access to memories that had been previously subsumed by their network of trauma memories.

4.8 **From trauma and despair to understanding the big things in life – 'something to navigate from'**

For the majority of participants, NET facilitated shifts from a position of despair to hope, and in parallel gave perspective in understanding their traumas as part of the bigger social and political struggles in their life. Amid the experience of having to wrestle with moving through their lifeline and chronological exposure to their traumas, as well as the re-narration of these, was a juxtaposed feeling of the therapy as giving rise to a tangible and vivid experience of their life, illuminating fundamental meanings of structure and order in their life story. For many, the practical, tangible and experiential aspects of the therapy contributed to being able to 'see the bigger picture', e.g., on a micro gestalt level of flashbacks, and a macro gestalt level of seeing the self as a 'survivor' and as having 'a life more than just trauma'. This is consistent with Ehlers & Clark's (2000) conceptualisation of PTSD as leading to a distortion in the autobiographical memory of traumatic events. It lends support to Brewin et al.'s (1996) VAM memory system, which is designed for the individual to give a narrative account which becomes contextualised and elaborated, and Schauer et al.'s (2011) conceptualisation of NET as enhancing the encoding of autobiographical memory. Danieli (as cited in Herman, 1992) speaks of the importance of reclaiming the patient's past life to recreate the flow of continuity with the past, alongside the importance of being encouraged to talk about important relationships and reassemble a verbal account of the traumas, oriented in time and historical context. Moreover, according to Crossley (2000), narratives like autobiographies reveal implicit structures which otherwise may be unrecognised. She contends that traumatisation disrupts the orderly sense of existence, "throwing into radical doubt our taken-for-granted assumptions about time, identity, meaning and life itself" (p. 542). Polkinghorne (1988) maintains that an 'order of meaning' constitutes human consciousness. A unique feature of this is time and temporality, and the use of 'relationships' and 'connections', as we interpret the events around us. This involves recollection with affect whilst holding on to safe connection that was destroyed in the traumatic moments (Herman, 1992).

Seeing the self within the wider context of their life and life circumstances was described as "revealing" and "powerful" by participants. Several participants reflected that NET facilitated an inner process of understanding the origin and implicit network of their thoughts, feelings and behaviours as argued by Schauer et al. (2011). This is consistent with Foa et al.'s (1995) premise that those who most benefited from exposure

were also those who could construct a meaningful and consistent narrative, albeit Brewin (2001) suggests that creating a complete narrative may not be necessary to achieve therapeutic effect.

The lifeline and chronological nature of NET took participants by surprise, since it did not conform to their perception of psychotherapy, and this further enticed them to continue engaging with NET. The gestalt of the lifeline component for many offered 'something to navigate from', reinstating order of meaning and time to the life of the individual, consistent with the notion that human psychology has a narrative structure (Crossley, 2000). Contrary to Mundt et al.'s (2014) assertion that non-Western cultures may not share similar conceptions of chronology, since this varies as a function of age and culture, all participants shared an appreciation of the chronological understanding that the lifeline afforded them within NET. Mengel and Borzaga (2012) state that the construction of a story gives shape to an unclaimed experience and that, as with a novel, it is the structure and form of the narrative that 'contains' and 'claims' it. The gestalt nature of NET enabled several participants to begin to develop an understanding from the trauma and their life context through implicit meaning-making during the course of their narrative.

Accounts show a degree of depersonalising of their traumas by participants during the course of their narrative, as they began to see that their traumas were out of their control and socio-contextually driven. Accounts also reveal an understanding of their trauma within the bigger issues in their life. This lends support to Schauer et al.'s (2011) premise that working through the lifeline (biography) highlights the meaning of inter-related emotional networks from various traumatic events, and facilitates the understanding of behavioural patterns and schemas through implicit meaning-making during processing. Further, Kaminer (2006) maintains that NET aids with emotional catharsis, as it develops an explanation of the traumatic incidences and facilitates the identification of the causes of and responsibilities for the horror and atrocities.

4.9 **A life more than just trauma**

The opportunity to develop a testimony, a narration of their life to date, offered participants a reflective experience of seeing the self at different time points – a self connected to affiliative experiences – and an opportunity to see their life as one 'more than just trauma'. This is consistent with Herman's account of recovery: "It occurs to

the survivor that perhaps the trauma is not the most important, or even the most interesting, part of her life story" (1992, p. 195). This indicates a degree of self-discovery and growth, consistent with the phenomenon of 'post-traumatic growth' (Tedeschi & Calhoun, 2004), albeit Schauer et al. (2011) maintain that the experimental evidence is limited according to whether there is a sense of post-traumatic growth following NET with this group; there is some evidence from accounts that traumatic experiences were seen as an individual's history of survival and resistance.

For many, despite having frequent intrusive flashbacks during their therapy, they were able to contrast their experience with the here and now, enabling modulation of feelings. NET incorporates stabilisation into memory processing, while the process of contrasting feeling, sensations and thoughts in the present and past and the interactive style of memory processing helps mitigate dissociative tendencies (Schauer et al., 2011). Several participants reported being able to put their peri-traumatic feelings about their traumas into words. Schauer et al. state that putting feelings into words regulates amygdala activity.

4.10 **Acceptability of NET for this group**

In contrast to Vincent et al.'s (2012) study of TF-CBT with forced migrants, and despite participants' asserted struggle with NET, all seven participants in this study reported valuing NET as a trauma therapy and completed therapy through to the end. Participants found NET to be a validating and cathartic experience in offering them the opportunity to fully share their story. Moreover, all recommended this therapy for forced migrants who had been traumatised by their experience of war and persecution.

All participants reported residual (and some reported considerable) PTSD symptoms that they struggled with immediately after completing NET and during the process of being discharged. However, all had the expectation that this would be the case and were waiting for their symptoms to subside in the future. Schauer et al. (2011) argue that "NET initiates a healing process that requires time, if not a year to fully unfold" (p. 57). The findings are consistent with Bradley, Greene, Russ, Dutra and Westen's (2005) findings that those with chronic PTSD often suffer from residual symptoms after treatment, and with Neuner et al.'s (2004) finding that at 4 months follow-up those in the NET condition had an increase in symptoms but these were significantly lower at one year. This raises questions about therapeutic care and containment following

completion of their lifeline and the reading of their testimony. Therapy for this group and for those with complex PTSD should be multi-model and phase-based and should ensure reintegration (Herman, 1992). Therapy should recommend reconnecting with people and engaging in meaningful activities, via signposting or by ensuring follow-up sessions after the end of the testimony phase. Herman argues that the course of recovery is far from a linear progression and often meanders back and forth.

4.11 **Methodological considerations and personal reflexive overview**

To ensure the credibility of this qualitative study, in addition to Yardley's (2000) criteria, the researcher addressed Williams and Morrow's (2009) criteria for assessing 'trustworthiness' in qualitative research ('integrity of the data', 'the balance between reflexivity and subjectivity', and 'clear communication and application of findings'). This is discussed in the rest of this chapter.

IPA is an idiographic approach, and therefore the findings from this study are not intended to be generalised as being the experience of NET for all forced migrants. Nevertheless, the study offers one of the first contributions to the literature on the experience of NET and its real-world outcomes in clinical settings. The purpose of producing an interpretation of the data was to capture the quality and richness of participants' experience of NET.

To ensure 'integrity of the data', the researcher re-read transcripts several times throughout the analytic process to ensure that the final themes identified reflected the original data (Smith & Osborn, 2003). The researcher reflected on the interview process and analysis, and acted on these reflections in subsequent interviews and analysis beyond the pilot interview. Reflections on the pilot interview highlighted the overuse of prompting and over-adherence to structure in the interview, and at times a tendency to offer vocabulary to the participant. Being too tied to the interview schedule had the unintended effect of hastening the interview flow, reducing the richness of a response, and offering prompting, e.g., 'did you feel any shame or guilt', thereby preventing any novel avenues to be explored should they appear to deviate from the schedule. This perhaps reflected my inexperience with qualitative research, and paralleled my CBT therapist stance in being directive and attempting to unpack meaning.

In order to maintain 'a balance between reflexivity and subjectivity' and ensure reflexive scrutiny of the data collection and analysis, the researcher reflected on the

language used in interviews and interpretations. During the analytic process of the pilot interview, the emergent themes were grouped according to the chronological order of the therapy, which also reflected the interview schedule. Reflecting on this raised the question of whether the themes should have been clustered in this way, as this moves away from the spirit of IPA in which you would expect a more 'bottom-up' approach. In subsequent interviews, the researcher adopted a more flexible approach to gathering information and did not conform to the structure of the interview schedule, instead using this as a prompt to ensure richness in data collection. Data was analysed according to participants' emerging experience rather than to the chronological aspects of this therapy. Moving away from the language of the order of the therapy led to a more synthesised and rich account of participant experiences of NET.

The researcher noted the use at times of the therapist self when making therapeutic interpretations – and the need to refrain from this to ensure a privileging of the participants' meaning. The researcher took care to detach herself from the language of PTSD – e.g., terms such as 'grounding' and 'elaboration' – during the initial coding of the data, and to only use this during the conceptual coding and more analytic coding stages. The researcher reflected on her tendency to interpret participants' experiences through a medical lens or bring a therapeutic understanding during the initial stages of the analysis (use of the word 'symptom' – symptom reduction; shaking up the mind as activating symptoms), and noted the need to revert to exploring the meaning of these rather than assigning reductionist medical terminology. In view of this, the researcher endeavoured to privilege the participant's voice through staying as close to the text as possible, consistent with Levinas's (1969) considerations on relational ethics in analysis.

The sample was homogenous in that all had experienced traumatic events, were being treated for PTSD, and had completed a course of NET. However, there was diversity in the sample regarding age, gender, country of origin, and traumas experienced, albeit all traumas were within the sphere of war, abuse and political persecution. Six of the seven participants had their indefinite leave to remain in the country, all were on benefits (some had worked but due to their symptoms had been unable to return to work), and all expressed having some connections with their local community. Some participants were also engaged with other health services, such as chronic pain clinics, or were under medical consultants within the NHS for chronic physical health conditions. Some were under the care of their local CMHT. One participant was an asylum-seeker and was grappling with the uncertainty of his asylum application outcome. Two participants had

previous counselling or mental health input which was not trauma focused. However, for all, trauma therapy was alien to them prior to commencing NET. All were from collectivist cultures from East Africa and the Middle East. All participants had specific personal and socio-cultural circumstances, but all were linked by their experiences of war and persecution, political instability in their country of origin, and their status as forced migrants.

4.12 **Limitations**

Ethical challenges were carefully considered throughout the study, and it was rigorously assessed by the NHS regional ethics committee, NOCLOR, as well as by the University ethics department.

IPA does not seek to generate a representative sample; rather, it aims to produce in-depth analysis of a small number of accounts. The intersubjective focus of IPA means that the results are a co-creation between the participants and the researcher, and thus the seven participants who took part in this study cannot be seen to represent forced migrants who have had NET. Thus, caution must be exercised about generalising the findings of this group more widely. However, the emergence of similar themes within a sample such as this may be relevant to individuals from comparable populations.

Although the aim of the interview schedule was to provide a map and a prompt for participants to explore their lived experience of NET, on reflection the interview schedule was complex, and having a schedule or questions pertaining to the different components of NET may have been leading, thereby challenging the free association nature of IPA. Further, having these different dimensions of NET to explore may have impacted on staying with the phenomenon of NET or even capturing the richness of their experience. With time pressures to manage the interview within the window of a typical session, there was at times a tension between letting the participant speak freely and make associations in relation to my questions in order to access richness in their accounts, and ensuring there was no significant drift from the phenomenon under investigation. An ideal interview schedule would be one that is less complex but which still allows exploration of the different components of NET, and with room to drift from the schedule whilst enabling prompting of the different areas of the therapy.

IPA is heavily reliant on language which mediates the transmission of ‘experience’ from participant to researcher. IPA presupposes that language provides participants with

the necessary tools to capture the actual experience. Thus, it relies on the assumption that each participant can provide a rich, accurate and sufficient account of their experience of NET through their language (Willig, 2008). The population under study, forced migrants, compromises this assumption, as being merely conversant in English does not guarantee articulate accounts or fluency in communicating emotional and physical experiences of NET, further challenging access to their direct experience.

Willig (2008) maintains that language precedes experience, which can limit the full expression of experience (Willig, 2008). Forced migrants are not accustomed to giving voice to their experiences, and full expression is likely to have been thwarted by a lack of fluency and full command of the English language, and also by their different cultures which may not have equivalent words to those used in the English language for specific emotions. Thus, the availability of particular ways of expressing or talking about an issue also provides the categories of that experience, prescribing what we think rather than what we may really be thinking and feeling about an issue (Willig, 2012).

Although conversant in English, some participants struggled to elaborate on particular aspects of their experience due to a lack of fluency in the language, and restricted use of vocabulary. At times, this complicated the interview process, and necessitated the use of more prompts, paraphrasing, and reflecting to elicit a richer account of their experience of the therapy. However, taking an active stance during the interview at times led to a more in-depth enquiry of their experience. It is noteworthy that phenomenological research has been 'criticised for not engaging with language and its constitutive role (Willig, 2012). Further, IPA does not claim to capture the truth about an experience, rather it aims to get as close as possible to the experience.

Given that the average number of sessions of NET was 20–25, it is possible that participants' memories of their experience of NET in earlier sessions were degradable over time, and it can be argued that IPA has interpreted their memory of their experience rather than their experience per se. Further, the findings were not cross-validated by the participants as this would have proved ethically and clinically challenging. The themes were explored within an IPA group which had academic experience of IPA but no experience of working with this group or with war-related PTSD. However, research supervision proved invaluable in critiquing the analysis chapter, and the results of this have been addressed.

It is important to consider issues of power involved in research of this nature with a group whose voice has been undone following persecution. All participants had partaken in the research with a view to helping other forced migrants and those afflicted by war and persecution, and to have a voice in how they have experienced NET. Participants valued the researcher bearing witness to their experience of NET and experienced the interview as a validating and reflective experience, especially since they had just ended therapy.

Selection for this study was through therapists identifying appropriate participants who had met the inclusion criteria, which inevitably created a bias. Therapists by no means put forward their most successful cases. Instead, this group represented seven participants who were willing to engage in a research interview about their experience of NET, whether they felt it was a successful intervention or not, who were conversant enough in English to not require an interpreter, and who were being prepared to be discharged from the therapy, across three large NHS Trusts in London.

However, some referring therapists may have had concerns that the research interview would evaluate their skills as therapists. It is noteworthy that the sample that came forward experienced NET as helpful, and therefore may have been more inclined to partake due their positive experience of their therapeutic relationship. Further, those who did participate in this research unanimously reported that their motivation for partaking in this research was for the purposes of sharing therapy experiences in order to help other forced migrants, and to be able to give something back following a relatively positive experience of NET. The data may well have been different from a group less keen to come forward, such as those using interpreters, those who did not find NET to have therapeutic effects, or those who may be dependent on care in the UK and may feel a dissonance in providing feedback that conveys their therapy or therapeutic experience as being unhelpful. In this way, the findings in this study can only be understood in the context of people who experienced NET as a helpful therapy, and does not represent the experiences of those who may have dropped out or those who had NET and subsequently another trauma-focused approach, such as EMDR or rescripting, to manage their residual or primary symptoms.

Further, it is important to acknowledge the researcher’s experience in NET as both practitioner and researcher, and the beliefs, experience and assumptions when using this approach with this population, as this would have inevitably influenced the interpretative process. Nevertheless, Willig (2012, p. 156) maintains that the researcher

will always bring some conceptual and experiential tools to their understanding of the text, whilst needing to be open to being changed by the encounter with the text, and this was the stance taken in the research – open and curious to this group's experience of NET as a trauma therapy.

4.13 **Implications for practice**

The final criterion for trustworthiness in qualitative research as prescribed by Williams and Morrow (2009) is the 'clear communication and application of findings'. This study has highlighted some key findings which can be assimilated and addressed in clinical practice.

The key findings were that NET exacerbated symptoms and that all participants struggled with ambivalence and fear about exposure and reliving, as well as with narrating their trauma narrative.

The findings indicate four factors practitioners may need to consider in delivering NET with this population. The first is the need for motivational interviewing as an adjunct to NET. Motivational interviewing can be employed as a prelude to prepare clients to undertake NET as an exposure therapy. This would help address ambivalence about engaging in NET before and following the lifeline component, and during the course of NET to ameliorate further ambivalence about engaging in exposure to trauma memories. This is consistent with findings from Slagle and Gray's (2007) work on the use of motivational interviewing as an adjunct to exposure therapy.

Secondly, participants experienced NET as shaking up their trauma network, leading to the expression of symptoms extending beyond the end phase of NET. As an exposure-informed therapy, NET is likely to be challenging for all groups, as the obvious task is to confront trauma and the associated fears and emotions. It is debatable whether a phased-based approach necessarily improves the experience, although it may make trauma-focused therapy more manageable for those who are vulnerable to risk, or not emotionally engaged. In relation to the NET protocol, perhaps the implementation of NET within a phase-based approach rather than as a stand-alone trauma therapy could be considered for those within this group who find it difficult to regulate their affect – those vulnerable to risk, prolonged dissociative episodes, chronic feelings of guilt, or difficulties in trusting others, where these difficulties have a pervasive impact on interpersonal functioning. In this way, a phase-based approach could be recommended

according to the context of the patient's difficulties rather than for all forced migrants who present with trauma associated difficulties.

An allied recommendation based on these findings is that follow-up sessions be provided by trauma services delivering NET as a stand-alone intervention. All participants in this study would have benefited from additional psychological input focused on managing residual PTSD symptoms, in order to facilitate progress in developing continuity and integration of the self and in adapting to their present life circumstances. Whilst NET is delivered as a stand-alone intervention, it can also be implemented within the context of a phase-based approach. Neuner et al. (2014) maintain that "NET be embedded in a comprehensive system of care alongside other systems of assistance" (p. 271), (although it is unclear what exactly the authors mean by "comprehensive system of care"). When NET is implemented as a stand-alone trauma-focused intervention, care should be taken to ensure patients are not discharged at the point of ending the protocol, following the narrating of the testimony or autobiography. Rather, review sessions should be offered for those who at the end of their therapy remain significantly symptomatic.

Thirdly, this research illuminates the importance of the therapeutic relationship as the lynchpin for the successful delivery of NET, in providing safety and containment for the horrors witnessed and experienced by this group, and as a medium through which patients find their voice within the narrative. Courtois and Ford (2013) encapsulate this by highlighting that "The treatment relationship is at once technique, relational bond, and container" (p. 287). In a review of the efficacy of NET, Gwozdziewycz and Madrona (2013) argue that NET requires less professional training compared to other therapies and can be delivered by lay counsellors, as it revolves around the ability to listen to narratives, and that the patient does the bulk of the work by telling their story until their anxiety reduces. However, more than just having the ability to listen to a story, the therapist has an active and intricate role in providing attunement, containment, and a staying power during the narrative, enabling the patient to become the subject of their voice in the narrative. Herman (1992) maintains that reconstructing the trauma story or relieving intrusive symptoms, whilst necessary, is not sufficient by itself. If one does not address the relational dimension of the traumatic experience, the patient may be reluctant to give up intrusive symptoms because they have acquired important meanings. Thus, to describe the delivery of NET as merely having an ability to listen to narratives is to reduce it to a set of techniques.

Finally, although six of the seven participants experienced the interweaving of the positive declarative memories as facilitating emotional processing, one participant experienced these memories as triggering his grief and amplifying self-blame, as all his declarative memories were linked to his time with his family and associated with ambiguous loss, which was making it difficult for him to move on with life (Lane & Tribe, 2014). His experience of the interweaving of cool memories may echo the experience of many forced migrants who have been traumatised by their experiences of persecution. Caution must be taken not to assume that the interweaving of cool memories is experienced positively by forced migrants during NET.

4.14 **Suggestions for future research**

Further research is required to confirm the preliminary findings of this study and to ascertain the acceptability and effectiveness of NET for forced migrants with PTSD. Further qualitative studies are needed to expand the range of narratives describing the experience of forced migrants with PTSD undertaking NET. This has been a hard-to-reach group; it was only possible to recruit seven participants from three NHS Trusts in and across London who fit the criteria for the study during the recruitment period.

Comparative IPA studies looking at this group's experience at post-therapy (at 4–6 months and 1 year) would yield important information pertaining to their experience of NET at follow-up and over time. A retrospective study was considered in which more participants might have been able to partake, however, practical and ethical concerns about recalling patients back to the therapeutic setting and managing any residual symptoms or risk concerns were an issue with this method of recruitment. Moreover, clinicians did not approach clients who had disengaged from therapy as they would have been discharged from services, making their recruitment challenging for the same reasons.

4.15 **Conclusion**

The existing literature on NET has reported promising outcomes for this group in both low- and high-income countries. This study adds another layer to the existing literature which has to date employed a medicalised lens, exclusively focusing on symptom reduction. It contributes detailed narratives of forced migrants' experiences of NET and highlights the theme of ambivalence to exposure and to narrating their trauma narrative, and describes a therapeutic journey through their lifeline characterised by loss, grief and

uncertainty. It highlights the subjective real-life outcomes and meaning-making that RCTs fail to capture: participants regaining connection with the range of human emotions; developing a future orientation; choosing to reinvest in the self; a shift in perspective; and a narrative from trauma and despair to the realisation of the individual's life being one of more than just trauma. In Herman's (1992) work on stages of trauma recovery, the work of the second phase is accomplished when the patient reclaims their own history and feels renewed energy from engaging with life and feeling hope for the future. This study lends support to the premise that "patients prefer to tell their stories in a graded, guided way that places the traumatic memory into a full lifeline…remembering the whole story allows them to update and consolidate the past and move to the present and the future" (d'Ardenne & Heke, 2014, p. 223)

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REFERENCES

Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Cuijpers, P., & Aker, T. (2015). EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. *European Journal of Psychotraumatology*, *6*(1). DOI: 10.3402/ejpt.v6.27414

Adenauer, H., Catani, C., Gola, H., Keil, J., Ruf, M., Schauer, M., & Neuner, F. (2011). Narrative exposure therapy for PTSD increases top-down processing of aversive stimuli – evidence from a randomized controlled treatment trial. *BMC Neuroscience*, *12*(127), 1-13.

American Psychiatric Association (APA) (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed). Washington, DC: APA.

American Psychiatric Association (APA) (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: APA.

American Psychoanalytic Association (2009). Psychoanalytic theory and approaches. Retrieved (2018) from: http://www.apsa.org/content/psychoanalytic-theory-approaches

Basoglu, M., Kilic, N., Salcioglu, E., & Livanou, M. (2004). Prevalence of PTSD and comorbid depression in earthquake survivors in Turkey: An epidemiological study. *Journal of Traumatic Stress*, *17*(2), 133–141.

Beck, A.T. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Bichescu, D., Neuner, F., Schauer, M., & Elbert, T. (2007). Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression. *Behaviour Research and Therapy*, *45*(9), 2212–2220.

Biggerstaff, D., & Thompson, A.R. (2008). Interpretative Phenomenological Analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, *5*(3), 173–183.

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

Bisson, J.I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder post-traumatic stress

disorder: Systematic review and meta-analysis. *British Journal of Psychiatry*, *190*(2), 97–104.

Boyden, P., & Gibbs, S. (1997). *Children of war: Responses to psycho-social distress in Cambodia*. Geneva: United Nations Research Institute for Social Development.

Bracken, P.J., Giller, J.E., & Summerfield, D. (1995). Psychological responses to war and atrocity: The limitations of current concepts. *Social Science & Medicine*, *40*(8), 1073-1082.

Bracken, P., & Petty, C. (1998). *Rethinking the trauma of war*. London: Free Association Books.

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *The American Journal of Psychiatry*, *162*(2), 214–227.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Breslau, N, Kessler, R.C., Chilcoat, H.D., Schultz, L.R., Davis, G.C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit area. *Archives of General Psychiatry*, *55*(7), 578-668.

Brewin, C.R. (2001). A cognitive neuroscience account of posttraumatic stress disorder and its treatment. *Behaviour Research and Therapy, 39*(4), 373–393.

Brewin, C.R., Dalgleish, T., & Joseph, S. (1996). A dual theory of posttraumatic stress disorder. *Psychological Review*, *103*(4), 670–686.

Brewin, C.R., Gregory, J. D., Lipton, M., & Burgess, N. (2010). Intrusive images in psychological disorders: Characteristics, neural mechanisms, and treatment implications. *Psychological Review, 117*(1), 210–232.

Brewin, C.R., & Holmes, E. (2003). Psychological theories of post-traumatic stress disorder. *Clinical Psychology Review*, *23*(3), 339–376.

Brison, S.J. (2002). *Aftermath: Violence and the remaking of a self*. Princeton, NJ: Princeton University Press.

Burnell, K.J., Coleman, P.G., & Hunt, N. (2009). Coping with traumatic memories: Second World War veterans' experiences of social support in relation to the narrative coherence of war memories. *Aging and Society*, *30*(1), 57–78.

Burstow, B. (2005). A critique of posttraumatic stress disorder and the DSM. *Journal of Humanistic Psychology*, *45*(4), 429-445.

Bryant, R.A., Moulds, M.L., Guthrie, R.M., Dang, S.T., Mastrodomenico, J., Nixon, R.D., … Creamer, M. (2008). A randomised controlled-trial of exposure therapy and cognitive restructuring for post-traumatic stress disorder. *Journal of Consulting and Clinical Psychology, 76*(4), 695–703.

Chertoff, J. (1998). Psychodynamic assessment and treatment of traumatised patients. *Journal of Psychotherapy Practice and Research*, *7*(1), 35–46.

Chow, E.O. (2015). Narrative therapy an evaluated intervention to improve stroke survivors' social and emotional adaptation. *Clinical Rehabilitation*, *29*(4), 315–326.

Cienfuegos, A.J., & Monelli, C. (1983). The testimony of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry*, *53*(1), 43–51.

Clay, R.A. (2010). More than one way to measure. *Monitor on Psychology*, *41*(8), 52.

Cloitre, M., Courtois, C.A., Charuvatra, A., Carapezza, R., Stolbach, B.C., & Green, B.L. (2011). Treatment of complex PTSD: Results of the ISTSS Expert Clinician Survey on Best Practices. *Journal of Traumatic Stress*, *24*(6), 615–627.

Cloitre, M., Stolbach, B.C., Herman, J.L., Van der Kolk, B., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom severity. *Journal of Traumatic Stress*, *22*(5), 399–408.

Cohen, H. (2017). Posttraumatic Stress Disorder (PTSD) causes. Psych Central. Retrieved (2018) from: http://psychcentral.com/disorders/ptsd/posttraumatic-stress-disorder-ptsd-causes/

Conway, M.A. (2001). Sensory-perceptual episodic memory and its context: Autobiographical memory. *Philosophical Transactions of the Royal Society of London Series B: Biological Science*, *356*(1413), 1375-1384.

Cooper, M., & McLeod, J. (2007). A pluralistic framework for counselling and psychotherapy: Implications for research. *Counselling and Psychotherapy Research*, *7*(3), 135–143.

Courtois, C.A., & Ford, J.D. (2013). *Treatment of complex PTSD: A sequenced, relationship-based approach*. New York: Guilford Press.

Cresswell, J. (2009). *Research design: Qualitative, quantitative and mixed methods approaches*. London and Thousand Oaks, CA: Sage.

Crossley, M.L. (2000) *Introducing narrative psychology: Self, trauma and the construction of meaning*. Buckinghamshire: Open University Press.

Crumlish, N., & O'Rourke, K. (2010). A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. *The Journal of Nervous and Mental Disease*, *198*(4), 237–251.

d'Ardenne, P., & Heke, S. (2014). Patient-reported outcomes in post-traumatic stress disorder. Part 1: focus on psychological treatment. *Dialogues in Clinical Neuroscience, Patient-Reported Outcomes in Psychiatry*, *16*(2) 213–226.

d'Ardenne, P., Ruaro, L., Cestari, L., Fakhoury, W., & Priebe, S. (2007). Does interpreter-mediated CBT with traumatised refugee people work? A comparison of patient outcomes in East London. *Behavioural and Cognitive Psychotherapy*, *35*(03), 293–301.

De Jong, J.T., Komproe, I.H., Ommeren, V.M., Masri, M., Araya, M., Khaled, N., … Somasundaram, D. (2001). Lifetime events and posttraumatic stress disorder in 4 postconflict settings. *JAMA*, *286*(5), 555–562.

Denzin, N.K., & Lincoln, Y.S. (1994a). *Handbook of qualitative research*. London: Sage.

Denzin, N.K., & Lincoln, Y.S. (Eds.). (1994b). Introduction: entering the field of qualitative research. In N.K. Denzin & Y.S Lincoln (Eds.), *Handbook of qualitative research* (pp. 1-17). London: Sage.

Department of Health (2005). *Delivering race equality in mental health care: An action plan for reform inside and outside services*. London: Department of Health.

Desjarlais, R., Eisenberg. L., Good. B., & Kleinman, A. (1995). *World mental health: problems and priorities in low-income countries*. New York: Oxford University Press.

Ehlers, A., & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, *38*(4), 319–345.

Ertl, V., Pfeiffer, A., Schauer, E., Elbert, T., & Neuner, F. (2011). Community-implemented trauma therapy for former child soldiers in northern Uganda: A randomized controlled trial. *JAMA*, *306*(5), 503–512.

Fernando, G.A. (2014). Do we really have enough evidence on Narrative Exposure Therapy to scale it up*? Intervention*, *12*(2), 283–286.

Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice*, *3*(1), 6–25.

Foa, E.B., & Cahill, S.P. (2001). Psychological therapies: emotional processing. In N.L. Smelser & P.B. Bates, *International encyclopedia of social and behavioural sciences* (pp. 12363–12369). Oxford: Elsevier.

Foa, E. B., & Jaycox, L. H. (1999). Cognitive-behavioral theory and treatment of posttraumatic stress disorder. In D. Spiegel (Ed.), *Efficacy and cost-effectiveness of psychotherapy* (pp. 23-61). Washington, DC: American Psychiatric Press.

Foa, E.B., Keane, T.M., & Friedman, M.J. (2004). *Effective Treatments for PTSD*. New York: Guilford Press.

Foa, E.B., & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, *99*(1), 20-35.

Foa, E.B., & Meadows, E.A. (1997). Psychosocial treatments for post-traumatic stress disorder. A critical review. *Annual Review of Psychology*, *48*(1), 449-480.

Foa, E.B., Molnar, C., & Cashman, L. (1995). Change in rape narratives during therapy for post-traumatic stress disorder. *Journal of Traumatic Stress*, *8*(4), 675–690.

Fonagy, P. (2002). *Affect regulation, mentalization, and the development of the self*. Other Press LLC. New York.

Forced Migration Online (n. d.). The trauma debate. Retrieved (2018) from: http://forcedmigration.org/research-resources/expert-guides/psychosocial-issues/the-trauma-debate

Forshaw, M. J. (2007). Free qualitative research from the shackles of method. *The Psychologist*, *20*(8), 478–479.

Freud, S. & Breuer, J. (1895). A psychological history of PTSD. In. M.J. Friedman, T.M. Keane., & P.A. Resick. (Eds.), *Handbook of PTSD science and practice* (pp. 37-52). New York: Guilford Press.

Friedman, M.J., Keane, T.M., & Resick, P.A. (2010). *Handbook of PTSD, science and practice* (1st edition). New York: Guilford Press.

Friedman, M.J., Keane, T.M., & Resick, P.A. (2015). *Handbook of PTSD, science and practice* (2nd edition). New York: Guilford Press.

Frosh, S., & Saville-Young, L. (2008). Psychoanalytic approaches to qualitative psychology. In C. Willig & W. Stainton Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 109–126). London: Sage.

Full Fact (2017). Refugees in the UK. Retrieved (2017) from: https://fullfact.org/immigration/uk-refugees/

Gadamer, H. (1975). *Truth and method*. London: Bloomsbury Academic.

Garland, C. (1998). *Understanding trauma: A psychoanalytic approach*. London: Karnac.

Gergen, K.J., & Gergen, M.M. (1988). Personal narrative and social discourse. In N.C. Hunt (2010), *Memory, war and trauma* (pp. 114-126). Cambridge: Cambridge University Press.

Giddens, A. (1984). *Social theory and modern sociology*. Cambridge: Polity Press.

Gilkinson, L.J. (2009). *An Interpretative Phenomenological Analysis of refugees' experiences of psychological therapy for trauma*. Unpublished PhD thesis, University of Hertfordshire.

Giorgi, A. (1994). A phenomenological perspective on certain qualitative research methods. *Journal of Phenomenological Psychology, 25*(2), 190-220.

Giorgi, A. (2010). Phenomenology and the practice of science. *Existential Analysis*, *21*(1), 3–22.

Glaser, B.G., & Strauss, A.L. (1965). *Awareness of dying*. Chicago: Aldine.

Glasby, J., & Beresford, P. (2005). Who knows best? Evidence-based practice and the service user contribution. *Critical Social Policy*, *26*(1), 268-284.

Gojer, J., & Ellis, A. (2014). Post-traumatic stress disorder and the refugee determination process in Canada: Starting the discourse. UNHCR, Policy development and evaluation service, Research paper 270. Retrieved (2018) from http://www.unhcr.org/53356b349.pdf

Gorman, W. (2001). Refugee survivors of torture: Trauma and treatment. *Professional Psychology: Research and Practice*, *32*(5), 443–451.

Grey, N., & Young, K. (2007). Cognitive Behaviour Therapy with refugees and asylum seekers experiencing traumatic stress symptoms. *Behavioural and Cognitive Psychotherapy*, *36*(1), 3–19.

Grey, N., Young, K., & Holmes, E. (2002). Cognitive restructuring within reliving: A treatment for peritraumatic emotional “hotspots” in posttraumatic stress disorder. *Behavioural and Cognitive Psychotherapy*, *30*(1), 37–56.

Guba, E.G., & Lincoln, Y.S. (1994). Competing paradigms in qualitative research. In N. Denzin & Y.S. Lincoln, *Handbook of qualitative research* (pp. 105-117). London: Sage.

Gwozdziewycz, N., & Mehl-Madrona, L. (2013). Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations. *The Permanente Journal*, *17*(1), 70–76.

Hackmann, A., Ehlers, A., Speckens, A., & Clark, D.M. (2004). Characteristics and content of intrusive memories in PTSD and their changes with treatment. *Journal of Traumatic Stress*, *17*(3), 231–240**.**

Halligan, S., & Yehuda, R. (2000). Risk factors for PTSD. *PTSD Research Quarterly, 11*(3), 1-3.

Halvorsen, J.Ø., & Stenmark, H. (2010). Narrative exposure therapy for posttraumatic stress disorder in tortured refugees: A preliminary uncontrolled trial. *Scandinavian Journal of Psychology, 51*(6), 495–502.

Halvorsen, J. Ø, Stenmark, H., Neuner, F., & Nordahl, H. (2014). Does dissociation moderate treatment outcomes of narrative exposure therapy for PTSD? A secondary analysis from a randomised controlled clinical trial. *Behaviour Research and Therapy*, *57*(1), 21–28.

Heidegger, M. (1962). *Being and Time* (E. Macquarrie and J. Robinson, trans). Oxford: Blackwell (Original work published in 1927).

Hensel-Dittman D., Schauer, M., Ruf, M., Catani, C., Odenwald, M., Elbert, T., & Neuner, F. (2011). Treatment of traumatized victims of war and torture: A randomized controlled comparison of narrative exposure therapy and stress inoculation training. *Psychotherapy and Psychosomatics*, *80*(6), 345-352.

Herman, J.L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377–391.

Hinton, D.E., & Lewis-Fernandez, R. (2011). The cross-cultural validity of posttraumatic stress disorder: Implications for DSM-5. *Depression and Anxiety*, *28*(9), 783–801.

Hollifield, M., Warner, T., Lian, N., Karkow, B., Jenkins, J., Kesler, … Westmeyer, J. (2002). Measuring trauma and health status in refugees: A critical review. *JAMA*, *288*(5), 611–621.

Horowitz, M.J. (1974). Stress response syndromes: Character style and dynamic psychotherapy. *Arch. Gen. Psychiatry*, *31*(6), 768–781.

Hunt, N.C. (2010). *Memory, war and trauma*. Cambridge: Cambridge University Press.

Husserl, E. (1913). *Ideas pertaining to a Pure Phenomenology and to a Phenomenological Philosophy*, *(*F.Kersten, trans). The Hague: Martinus Nijhoff (Original work published in 1913).

Institute of Medicine (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.

The International Association for the Study of Forced Migration (2017). Retrieved (2018) from: http://iasfm.org/

Janet, P. (1919/1925). *Psychological healing*. New York: Macmillan.

Jaycox, L.H., Foa, E. B., & Morral, A.R. (1998). Influence of emotional engagement and habituation on exposure therapy for PTSD. *Journal of Consulting and Clinical Psychology*, *66*(1), 185–192.

Johnson, H., & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review*, *28*(1), 36–47.

Kaminer, P. (2006). Healing processes in trauma narratives: A review. *South African Journal of Psychology, 36*(3), 481–499.

Kar, N. (2011). Cognitive behavioural therapy for the treatment of post-traumatic stress disorder: A review. *Neuropsychiatric Disease and Treatment, 7*(1), 167–181.

Kasket, E. (2012). Dialogues and debates: The counselling psychologist researcher. *Counselling Psychology Review, 27*(2), 64–68.

Khawaja, N.A., White, K.M., Schwetzer, R., & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: A qualitative approach. *Transcultural Psychiatry*, *45*(3), 489-512.

Kira, I., Templin, T., Lewandowski, L., Clifford, D., Wiencek, E., Hammad, A., … Mohanesh, J. (2006). The effects of torture: Two community studies: Peace and conflict. *Journal of Peace Psychology*, *12*(3), 205–228.

Konstantinou, G. (2014). The relationship of counselling psychology training with CBT: Implications for research and practice. *Counselling Psychology Review*, *26*(4), 20–30.

Krystal, H. (1988). *Integration and self-healing: Affect, trauma, alexithymia*. Hillsdale, NY: Lawrence Erlbaum Associates.

Lab, D., Santos, I., & De Zulueta, F. (2008). Treating post-traumatic stress disorder in the ‘real world’: Evaluation of a specialist trauma service and adaptations to standard treatment approaches. *Psychiatric Bulletin*, *32*(1), 8–12.

Lambert, J.E., & Alhassoon, O.M. (2015). Trauma-focused therapy for refugees: Meta-analytic findings. *Journal of Counseling Psychology*, *62*(1), 28–37.

Lane, P., & Tribe, R. (2014). Refugees, grief and loss: Critical debates. *Grief Matters: The Australian Journal of Grief and Bereavement*, *17*(3), 74–79.

Langridge, D. (2007). *Phenomenological Psychology: Theory, Research and Method*. Harlow: Pearson Prentice Hall.

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In A. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 99-116). Oxford: John Wiley & Sons.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, *3*(2), 102–120.

Lee, C.W., & Cuijpers, P. (2013). A meta-analysis of the contribution of eye movements in processing emotional memories. *Journal of Behavior Therapy and Experimental Psychiatry*, *44*(2), 231–239.

Levinas, E. (1969). *Totality and infinity: An essay on exteriority*. Pittsburgh, PA: Duquesne University Press.

Lindert, J., Ehrenstein, O.S., Priebe, S., Mielck, A., & Brahler, E. (2009). Depression and anxiety in labor migrants and refuges – a systematic review and meta-analysis. *Social Science & Medicine, 69*(2), 246-257.

Lira, E., Becker, D., & Catillo, M.I. (1988). Psychotherapy with victims of political repression in Chile: A therapeutic and political challenge. Paper presented at meeting of the Latin American Institute of Mental Health and Human Rights, Santiago, Chile.

Logie, R. (2014). EMDR – More than just a therapy for PTSD. *The Psychologist.* Retrieved (2017) from: https://thepsychologist.bps.org.uk/volume-27/edition-7/emdr-more-just-therapy-ptsd

Lustig, S.L., Weine, S.M., Suxe, G.N., & Beardslee, W.R. (2004). Testimonial psychotherapy for adolescent refugees: A case series. *Transcultural Psychiatry, 41*(1), 31-45.

Madhill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*(1), 1–20.

Marsella, A.J., Friedman, M.J., Gerrity, E.T., & Scurfield, R.M. (Eds.). (1996). *Ethnocultural aspects of posttraumatic stress disorder*. Washington DC, US: American Psychological Association.

Mason, O., & Hargreaves, I. (2001). A qualitative study of mindfulness-based cognitive therapy for depression. *Psychology and Psychotherapy*, *74*(2), 197–212.

McDonald, W., Mead, N., & Bower, P. (2007.) A qualitative study of patients' perceptions of a 'minimal' psychological therapy. *International Journal of Social Psychiatry*, *53*(1), 23-35.

McLeod, J. (2001). Introduction: Research into the client's experience of therapy. *Counselling and Psychotherapy Research*, *1*(1). DOI: 10.1080/14733140112331385238

McPherson, J. (2012). Does narrative exposure therapy reduce PTSD in survivors of mass violence? *Research on Social Work Practice*, *22*(1), 29–42.

Meichenbaum, D. (2006). Resilience and post-traumatic growth: A constructive narrative perspective. In L.G. Calhoun & R.G. Tedeschi (2006), *Handbook of post-traumatic growth: Research and practice* (pp. 305-366). London and New York: Psychology Press.

Mengel, E., & Borzaga, M. (2012). *Trauma, memory, and narrative in the contemporary South African novel: Essays*. Amsterdam and New York: Rodopi.

Merleau-Ponty, M. (1962). *Phenomenology of Perception*. London: Routledge and Kegan Paul.

Metcalfe, J., & Jacobs, W.J. (1996). A "hot-system/cool-system" view of memory under stress, *PTSD Research Quarterly*, *7*(2), 1–6.

Morina, N., Maier, T., Byrant, R., Knaevelsrud, C., Wittman, L., Rufer, … Muller, J. (2012). Combining biofeedback and Narrative Exposure Therapy for persistent pain and PTSD in forced migrants: A pilot study. *European Journal of Psychotraumatology, 3*, 17660. Retrieved (2017) from: http://dx.doi.org/10.3402/ejpt.v3i0.17660

Mørkved, N., Hartmann, K., Aarsheim, L.M., Holen, D., Milde, A.M., & Bomyea, J. (2014). A comparison of Narrative Exposure Therapy and Prolonged Exposure therapy for PTSD. *Clinical Psychology Review, 34*(6), 453-467.

Mowrer, H. (1960). *Learning theory and behavior*. Wiley: New York.

Mueller, M., Hackmann, A., & Croft, A. (2004). Post-traumatic stress disorder. In J. Bennet-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller, & D. Westbrook (Eds.), *Oxford guide to behavioural experiments in cognitive therapy* (pp. 183–205). Oxford: Oxford University Press.

Mundt, A.P., Wunsche, P., Heinz, A., & Pross, C. (2014). Evaluating interventions for post-traumatic stress disorder in low and middle-income countries: Narrative Exposure Therapy. *Intervention*, *12*(2), 294–296.

Murray, M. (2003). Narrative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 111–131). London: Sage.

National Institute of Clinical Excellence (2005). *Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care*. NICE Clinical Guideline 26.Retrieved (2016) from: https://www.nice.org.uk/guidance/CG26

Neuner, F., Kurreck, S., Ruf, M., Odenwald, M., Elbert, T., & Schauer, M. (2010). Can asylum-seekers with posttraumatic stress disorder be successfully treated? A randomized controlled pilot study. *Cognitive Behaviour Therapy*, *39*(2), 81–91.

Neuner, F., Onyut, P.L., Ertl, V., Odenwald, M., Schauer, M., Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counsellors in an African refugee settlement: A randomised controlled trial. *Journal of Consulting and Clinical Psychology*, *76*(4), 686–694.

Neuner, F., Schauer, M., & Elbert. T. (2014). On the efficacy of Narrative Exposure Therapy: A reply to Mundt et al. *Erschienen in: Intervention*, *12*(2), 267–278.

Neuner, F., Schauer, M., Klaschik, C., Karunkara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counselling, and psychoeducation for treating post-traumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology*, *72*(4), 579–587.

Newman, E., Riggs, D.S., & Roth, S. (1996). Thematic resolution, PTSD, and Complex PTSD: The relationship between meaning and trauma-related diagnoses. *Journal of Traumatic Stress*, *10*(2), 197-213.

Nickerson, A., Byrant, R., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review*, *31*(3), 399–417.

Nosè, M., Ballette, F., Bighelli, I., Turrini, G., Purgato, M., Tol, W., … Barbui, C. (2017). Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-Analysis. *PLoS One, 12*. DOI: 10.1371/journal.pone.0171030

Nutt, D. J., & Malizia, A. L. (2004). Structural and functional brain changes in posttraumatic stress disorder. *The Journal of Clinical Psychiatry*, *65*(1), 11–17.

O'Donnell, C.A., Higgins, M., Chauhan, R., & Mullen, K. (2008). Asylum seekers' expectations of and trust in general practice: a qualitative study. *British Journal of General Practice*, December, E1-E11.

Office of the United Nations High Commissioner for Refugees (2017). Global trends forced displacement in 2015. Retrieved (2017) from: www.unhcr.org/en-us/statistics/unhcrstats/5b27be547/unhcr-global-trends-2017.html

Ogden, P., Pain, C., & Fisher, J. (2006). A sensorimotor approach to the treatment of trauma and dissociation. *Psychiatric Clinics of North America*, *29*(1), 263-279.

Otto, M.W., & Hinton, D.E. (2006). Modifying exposure-based CBT for Cambodian refugees with post-traumatic stress disorder. *Cognitive Behavioral Practice*, *13*(4), 261-270.

Pabst, A., Schauer, M., Bernhardt, K., Ruf-Leuschner, M., Goder, R., Elbert, T., … Seeck-Hirschner, M. (2014). Evaluation of Narrative Exposure Therapy (NET) for Borderline Personality Disorder with Comorbid Posttraumatic Stress Disorder. *Clinical Neuropsychiatry*, *11*(4), 108–117.

Palic, S., & Elklit, A. (2011). Psychosocial treatment of posttraumatic stress disorder in adult refugees: A systematic review of prospective treatment outcome studies and a critique. *Journal of Affective Disorders*, *131*(1), 8-23.

Patel, N., Kellezi, B., & Williams, A.C.D.C. (2014). *Psychological, social and welfare interventions for psychological health and well-being of torture survivors* (review). The Cochrane Collaboration, John Wiley & Sons, Ltd. DOI: 10.1002/14651858.CD009317

Paunovic, N., & Ost, L.G. (2001). Cognitive-behaviour therapy vs exposure therapy in the treatment of PTSD in refugees, *Behavioural Research and Therapy*, *39*(10), 1183–1197.

Pearlman, L.A., & Saakvitne, K.W. (1995*). Trauma and the therapist countertransference and vicarious traumatisation*. New York: W.W Norton.

Pickard, H. (2015). Stories of recovery: The role of narrative and hope in overcoming PTSD and PD. In J.Z. Sadler, W. Van Staden, & B. Fulford (2015), *The Oxford handbook of psychiatric ethics* (Vol. 2, pp. 1315-1327). Oxford: Oxford University Press.

Pietkiewicz, I., & Smith, J.A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne – Psychological Journal*, *20*(1), 7–14.

Polkinghorne, D.P. (1988). *Narrative knowing and the human sciences*. Albany, NY: State University of New York Press.

Ponterotto, J.G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology*, *52*(2), 126–136.

Porter, M., & Haslam, N. (2005) Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *Journal of the American Medical Association*, *294*(5), 602-612.

Power, M., & Dalgleish, T. (1997). *Cognition and emotion from order to disorder.* Hove: Psychology Press.

Priebe, S., Giacco, D., & El-Nagib, R. (2016). *Public health aspects of mental health among migrants and refuges: A review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European region*. Copenhagen: WHO Regional Office for Europe.

Pringle, D.J., McLafferty, E., & Hendry, C. (2011). Interpretative phenomenological analysis: A discussion and critique. *Nurse Researcher*, *18*(3), 20–24.

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

Refugee Council Briefing (2016). *Full fact, refugees in the UK.* Retrieved from: https://fullfact.org/immigration/uk-refugees

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience: An introduction to interpretative phenomenological analysis. *The Psychologist*, *18*(1), 20-23

Reiners, G.M. (2012). Understanding the differences between Husserl's (descriptive) and Heidegger's (interpretive) phenomenological research. *Journal of Nursing Care*, *1*(5), 1-3.

Resnick, H.S, Yehuda, R., Pitman, R.K., & Foy, D.W. (1995). Effects of previous trauma on acute plasma cortisol level following rape. *American Journal of Psychiatry, 152*(11), 1675-1677.

Ricoeur, P. (1991). Life in quest of narrative. In D. Wood (Ed.), *Paul Ricoeur: Narrative and interpretation* (pp. 20-33). London: Routledge.

Robjant, K., & Fazel, M. (2010). The emerging evidence for narrative exposure therapy: A review. *Clinical Psychology Review*, *30*(8), 1030–1039.

Rosen, G.M. (2004). *Posttraumatic stress disorder: Issues and Controversies*. Seattle, WA: John Wiley & Sons.

Schauer, M., Neuner, F., & Elbert, T. (2005). *Narrative Exposure Therapy: A short-term intervention for traumatic stress disorders after war, terror or torture*. Germany: Hogrefe & Huber.

Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative Exposure Therapy: A short-term intervention for post-traumatic stress disorders* (2nd edition). Germany: Hogrefe.

Schick, M., Zumwald, A., Knöpfli, B., Nickerson, A., Bryant, R.A., Schnyder, U., … Morina, N. (2016). Challenging future, challenging past: The relationship of social integration and psychological impairment in traumatized refugees. *European Journal of Psychotraumatology*, 7. DOI: 10.3402/ejpt.v7.28057

Schottenbauer, M.A., Glass, C.R., Arnkoff, D.B., & Gray, S.H. (2008). Contributions of psychodynamic approaches to treatment of PTSD and trauma: a review of the empirical treatment and psychopathology literature. *Psychiatry*, *71*(1), 13–23.

Schultz, P.M., Resick, P.A., Huber, L.C., & Griffin, M.G. (2006). The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. *Cognitive and Behavioural Practice 13*(4), 322–331.

Shapiro, F. (1995). *Eye Movement Desensitisation and Reprocessing (EMDR): Basic principles, protocols, and procedures*. New York: Guilford Press.

Shearing, V., Lee, D., & Clohessy, S (2011). How do clients experience reliving as part of trauma-focused cognitive behavioural therapy for posttraumatic stress disorder? *Psychology and Psychotherapy: Theory, Research and Practice*, *84*(4) 458–475.

Sigvardsdotter, E., Vaez, M., Hedman, A.R, & Saboonchi, F. (2016). Prevalence of torture and other war-related traumatic events in forced migrants: A systematic review. *Torture*, *26*(2), 41-73.

Silove, D., Steel, Z., Bauman, A., Chey, T & McFarlane, A. (2007). Trauma, PTSD and the longer-term mental health burden amongst Vietnamese refugees: A comparison with the Australian born population. *Social Psychiatry and Psychiatric Epidemiology, 42*(6), 467-476.

Slagle, D.M., & Gray, M.J. (2007). The utility of motivational interviewing as an adjunct to exposure therapy in the treatment of anxiety disorders. *Professional Psychology: Research and Practice*, *38*(2), 329–337.

Slobodin, O., & de Jong, T.V.M. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *International Journal of Social Psychiatry*, *61*(1), 17–26.

Smith, B., & Sparkes, A.C. (2006). Narrative inquiry in psychology: Exploring the tensions within. *Qualitative Research in Psychology*, *3*(3), 169-192.

Smith, J.A. (1995). Semi-structured interviewing and qualitative analysis. In J.A. Smith, R. Harre, & L. Van Langenhore (Eds.), *Rethinking methods in psychology* (pp. 9-26). London: Sage.

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

Smith, J.A. (2008). *Qualitative psychology: A practical guide to research methods*. London: Sage.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: Sage.

Smith, J.A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J.A. Smith (Ed.), *Qualitative psychology* (pp. 53-80). London: Sage.

Smith, J.A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to methods* (2nd edition) (pp. 53-80). London: Sage.

Speckens, A.E., Ehlers, A., Hackmann, A., & Clark, D.M. (2006). Changes in intrusive memories associated with imaginal reliving in posttraumatic stress disorder. *Journal of Anxiety Disorders*, *20*(3), 328–341.

Spermon, D., Darlington, Y., & Gibney, P. (2010). Psychodynamic psychotherapy for complex trauma: Targets, focus, applications, and outcomes. *Psychology Research and Behavior Management*, *3*, 119-127. DOI: 10.2147/PRBM.S10215

Spinazzola, J., Blaustein, M., & van der Kolk, B.A. (2005). Posttraumatic stress disorder treatment outcome research: the study of unrepresentative samples? *Journal of Traumatic Stress*, *18*(5), 425–436.

Starks, H., & Brown-Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis and grounded theory. *Qualitative Health Research*, *17*(10), 1372–1380.

Steel, Z., Chey, T., Silove, D., Marnane, C.., Byrant, R.A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis, *JAMA, 302*(5), 537-49.

Stenmark, H., Catani, C., Neuner, F., Elbert, T., & Holen, A. (2013). Treating PTSD in refugees and asylum seekers within the general health care system. A randomised controlled multicentre study. *Behaviour Research and Therapy*, *51*(10), 641-647.

Strawbridge, S., & Wolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd edition) (pp. 3–22). London: Sage.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine*, *48*(10), 1449–1462.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category, *British Medical Journal*, *322*(7278), 95-98.

Tedeschi, R.G., & Calhoun, L.G. (2004). Posttraumatic growth conceptual foundations and empirical evidence. *Psychological Enquiry*, *15*(1), 1–18.

Teegen, F., & Vogt, S. (2002). Torture survivors: A study of complex posttraumatic stress disorder. *Verhaltenstherapie und Verhaltensmedizin*, *23*(1), 91–106.

Teo, T. (2010). Ethics of interpretation in qualitative research. In C. Willig (2012), *Qualitative interpretation and analysis in Psychology* (pp. 55-61). Buckinghamshire: Open University Press.

Ter Heide, J.F., Mooren, T.M., & Kleber, R.J. (2016). Complex PTSD and phased treatment in refugees: a debate piece. *European Journal of Psychotraumatology*, 7. DOI: 10.3402/ejpt.v7.28687

Ter Heide, J.F., Mooren, T.M., Kleijn, W., Jongh, A., & Kleber, R.J. (2011). EMDR versus stabilisation in traumatised asylum seekers and refugees: Results of a pilot study. *European Journal of Psychotraumatology*, *2*(1). DOI: 10.3402/ejpt.v2i0.5881

Ter Heide, J.F., Mooren, T.M., Knipscheer, J.W., & Kleber, R.J. (2014). EMDR with traumatized refugees: from experience-based to evidence-based practice. *Journal of EMDR Practice and Research*, *8*(3), 147–156.

Tribe, R.H. (2002). Mental health of refugees and asylum seekers. *Advances in Psychiatric Treatment*, *8*(4), 240–248.

Tribe, R.H., & Patel, N. (2007). Refugees and asylum seekers. *The Psychologist*, *20*(3), 149–151.

Tribe, R.H., Sendt, K., & Tracy, D. (2017). A systematic review of psychosocial interventions for adult refugees and asylum seekers. *Journal of Mental Health*, *9*, 1-15. DOI: 10.1080/0963823 7

United Nations High Commission Review (2015). Global trends: Forced displacement in 2015. Retrieved from: http://www.unhcr.org/576408cd7.pdf

Van de Veer, G. (1998). *Counselling and therapy with refugees and victims of trauma* (2nd edition). Chichester: John Wiley & Sons.

Van Der Hart, O., Brown, P., & Van Der Kolk, B. (1989). Pierre Janet's treatment of post-traumatic stress. *Journal of Traumatic Stress*, *2*(4), 1-11.

Van Minnen, A., Harned, M. S., Zoellner, L., & Mills, K. (2012). Examining potential contraindications for prolonged exposure therapy for PTSD. *European Journal of Psychotraumatology*, *3*. DOI: 10.3402/ejpt.v3i0.18805

Vincent, F., Jenkins, H., Larkin, M., & Clohessy, S. (2012). Asylum seekers' experiences of Trauma-Focused Cognitive Behaviour Therapy for Post-Traumatic Stress Disorder: A qualitative study. *Behavioural and Cognitive Psychotherapy*, *41*(5), 579–593.

Walin, A.M., & Ahlstrom, G. (2006). Cross-cultural interview studies with interpreter: A systematic literature review. *Journal of Advanced Nursing*, *55*(6), 723–735.

Weine, S.M., Kulenovic, A.D., Pavkovic, I., & Gibbons, R. (1998). Testimony psychotherapy in Bosnian refugees: A pilot study. *American Journal of Psychiatry*, *155*(12), 1720–1726.

Weine, S.M., Muzurovic, N., Kulauzoviz, Y., Besic, S., Lezic, A., Mujagic, A., & Pavkovc, I. (2004). Family consequences of refugee trauma. *Family* Process, *43*(2), 147–160.

Weiseth, L., & Eitinger, L. (1991). Research on PTSD and other post-traumatic reactions: European literature (Part 2). *PTSD Research Quarterly*, *2*(3). Retrieved from: http://www.ncptsd.org/research/rq/rqhtml/V2N3.html

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

Williams, E.N., & Morrow, S.L. (2009). Achieving trustworthiness in qualitative research: A pan-paradigmatic perspective. *Psychotherapy Research, 19*(4/5), 576-582.

Willig, C. (2001). *Introducing qualitative research in psychology*. Buckinghamshire: Open University Press.

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd edition). Buckinghamshire: Open University Press.

Willig, C. (2012). Philosophical issues for research in psychology. In H. Cooper, *APA handbook of research methods in psychology: Vol. 1 foundations, planning, measures, and psychometrics* (pp. 5-21). Washington, DC: American Psychological Association.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd edition). Buckinghamshire: Open University Press.

Xenaklis, S.N. (2014). Posttraumatic stress disorder: Beyond best practices. *Psychoanalytic Psychology*, *31*(2), 236–244.

Yardley, L. J. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*(2). DOI: 10.1080/08870440008400302

Yehuda, R., Bierer, L.M., Schmeidler, J., Aferiat, D.H., Breslau, I., & Dolan, S. (2000). Low cortisol and risk for PTSD in adult offspring of Holocaust survivors. *American Journal of Psychiatry, 157*(8), 1252-1259.

Yehuda, R., Teicher, M.H., Trestman, R.L., Levengood, R.A., & Siever, J.L. (1996). Cortisol regulation in posttraumatic stress disorder and major depression: A chronological analysis. *Biological Psychiatry*, *40*(2), 79-88.

Zang, Y., Hunt, N., & Cox, T. (2013). A randomised controlled pilot study: The effectiveness of narrative exposure therapy with adult survivors of the Sichuan earthquake. *BMC Psychiatry*, *13*. DOI: 10.1186/s12888-014-0262-3

APPENDICES

PART A: The doctoral research

Appendix A: Recruitment poster

Department of Psychology
City University London

PARTICIPANTS NEEDED FOR

RESEARCH ON REFUGEE and ASYLUM-SEEKER'S EXPERIENCES

OF

NARRATIVE EXPOSURE THERAPY FOR POST-TRAUMATIC STRESS DISORDER

We are looking for participants to take part in a study on Refugee /Asylum-seekers patient experiences of Narrative Exposure Therapy for the treatment Post-Traumatic Stress Disorder.

Suitable participants will be approaching the end of their narrative and will have been read their narrative by their therapist in preparation for the end phase of their therapy.

You would be asked to undertake a 50 minutes to 1 hour semi-structured interview of your experiences coming to the end of your treatment of Narrative exposure therapy in the treatment of your Post-Traumatic stress disorder.

You will not be asked any questions about your specific trauma history but about your general experiences of this type of treatment, and

whether you found it helpful or not in the treatment of your post-traumatic stress difficulties.

The interview will be audio-recorded and confidentiality will be maintained at all times during the analysis of your interview and the write up of the study. Your identifying information will remain anonymous.

In appreciation for your time, your travel expenses will be paid.

For more information about this study please contact the researcher to register your interest in this research and to arrange a convenient interview time at the service.

Contact Najat Elwakili on [redacted]

Or email [redacted] ***Professional Doctoral Counselling Psychology student at City University, London.***

This study has been reviewed by, and received **ethics clearance** through the **NHS Research Ethics Committee** (16/LO/0320) **and Research Ethics Committee, City University London** [PSYETH (EXT) 15/16/01].

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on [redacted] or via email:

[redacted]

Appendix B: Informed consent form

Title of Study: An interpretative Phenomenological Analysis of refugee/asylum-seeker' Experiences of Narrative Exposure Therapy in the Treatment of Post-Traumatic Stress Disorder in Specialist PTSD Services.

[PSYETH (EXT) 15/16/01]

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped	
2.	This information will be held and processed for the following purpose(s): To *explore refugee /asylum-seekers experiences of Narrative exposure therapy in the treatment of their PTSD*. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I consent to the use of sections of the transcripts of the audiotapes in publications and these will always be anonymised.	
3.	I understand that my participation is voluntary, that I can choose to withdraw my interview within 2 weeks following the interview by contacting the researcher and informing them of my withdrawal from the study. I understand this will not affect my treatment in the service or other services that I may be open to.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and	

	obligations under the Data Protection Act 1998.	
5.	I understand that confidentiality will be broken in cases where there are risk concerns, and that information relating to risk or safeguarding will be shared with my clinician and GP/ Care coordinator if I report any acts of current violence, current abuse, current self-inflicted harm, current harm to myself or others, or if I disclose a recent and current criminal activity.	
6.	I agree to take part in the above study.	

____________________ ____________________________ _____________

Name of Participant Signature Date

____________________ ____________________________ _____________

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

This study has been reviewed by, and received **ethics clearance** through the **NHS Research Ethics Committee** (16/LO/0320) **and Research Ethics Committee, City University London** [PSYETH (EXT) 15/16/01].

Appendix C: Participant information sheet

Research study title: An Exploration of refugee/asylum-seeker Experiences of Narrative Exposure Therapy in the Treatment Trauma.

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the information carefully and discuss it with the researcher and professionals in the service involved in your care. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This study is academically supervised and forms part of a Doctoral Programme of study under City University London.

A number of patients from this service have been invited to take part in this study.

This study aims to explore patient experiences of Narrative Exposure as a treatment Trauma within the refugee/asylum-seeker population. The range of questions during the interview are designed to explore your experiences of this particular type of therapy and how this therapy may or may not have led to changes to your symptoms, emotions and beliefs about your sense of self. This research aims to inform both the clinical practice of clinicians delivering this type of trauma treatment for service-users like you, and service-users considering trauma-based treatment.

Please note, you will not be asked specific questions about your trauma history, as this you would have covered in your therapy. The aim of this research is to explore your experiences of this type of therapy.

You will be interviewed by the researcher regarding your experience of this therapy for the treatment of your traumas. The interview will be audio-recorded and will last for about 50 minutes to 1 hour. Your interview will be confidential and your identity will be protected at all times; during the recording, analysis, in the write-up of this study, as well as in any publications arising from the research.

Why have I been invited?

As a refugee/asylum-seeker receiving this type of treatment for your trauma symptoms, and coming to the end of your treatment, you will have been identified by your therapist as suitable to take part in this study.

Do I have to take part?
Your participation in this study is voluntary, and you can choose not to participate in this study. You can withdraw at any stage during the interview, or avoid answering questions which you feel are too personal or intrusive. If you choose to withdraw, this will not affect any future treatments you receive from the current service you are receiving treatment in or any other service you may be referred to in the future.

It is up to you to decide whether or not to take part. If you choose to take part, your information will be invaluable in understanding how refugees/asylum-seekers experience this type of treatment for their traumas.

If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

You will be involved in an interview with the researcher which will take approximately 1 hour of your time in the service and will be audio-recorded.

Expenses and payments

Your **Travel expenses will be paid** for by the researcher on proof of travel card payment.

What do I have to do?
You will be asked to answer questions relating to your experience of having had narrative exposure therapy to treat your trauma symptoms. You will be asked general questions about your experience of having had this type of treatment, and the general impact of this treatment on your emotions and beliefs about your sense of self.

What are the possible disadvantages and risks of taking part?
During the interview, you may experience emotional distress when talking about your experiences of having this treatment. You will not be asked about your specific trauma experiences and the risk of you finding it too difficult emotionally is low, especially now that you are at the final stage of your treatment. The researcher is also a mental health clinician trained in this type of therapy and will be able to help you to manage your emotional distress should it become too overwhelming, until a clinician in the service is reached.

What are the possible benefits of taking part?
This research is likely to give us a better understanding of how refugee/asylum-seekers experience this type of trauma treatment. It will also be used to inform clinicians about how refugee/asylum-seekers experience this treatment and help inform their delivery of this treatment for service-users. Other refugee/asylum-seekers will be able to access the results of this research, should they choose to understand how other refugee/asylum-seekers have experienced this type of trauma treatment.

What will happen when the research study stops?
Particular aspects of your interview answers will be referenced in the research paper, however, all of these quotes will be anonymised (the interviewee will not be identifiable). When the research is completed and written up, the audiotapes will be deleted and the paper notes from the interview will be destroyed.

Will my taking part in the study be kept confidential?

- Only the researcher will have access to the written notes taken during the interview and the audio-recording of the interview before anonymising the data. Confidentiality will be broken in cases where there are risk concerns, information relating to risk or safeguarding issues will be shared with your clinician and GP/ Care coordinator if you report any acts of current violence, current abuse, current self-inflicted harm, current harm to yourself or others, or disclosure of a recent and current criminal activity.

What will happen to the results of the research study? The research will be used as part of my Doctoral Programme requirements. However, should it be published in journals your anonymity will always be maintained.

What will happen if I don't want to carry on with the study?
You are free to withdraw from participating from the study without an explanation or penalty at any time and this will not affect your treatment in this service or any other service in the future.
If you choose to withdraw your interview from the research study, you can do so within 2 weeks after undertaking the interview by contacting the researcher directly.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team: Najat Elwakili (researcher) or Jacqui Farrants [redacted]).

If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: An interpretative Phenomenological Analysis of refugee/asylum-seekers Experiences of Narrative Exposure Therapy in the Treatment of Post-Traumatic Stress Disorder in PTSD Services.

You could also write to the Secretary at:

Anna Ramberg

Secretary to Senate Research Ethics Committee

[redacted]

City University London

Northampton Square

London

EC1V 0HB

Email: [redacted]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?
This study has been reviewed by, and received **ethics clearance** through the **NHS Research Ethics Committee** (16/LO/0320) **and Research Ethics Committee, City University London** [PSYETH (EXT) 15/16/01].

Further information and contact details

Researcher: Najat Elwakili - [redacted] Doctoral student at City University, London. Academic research supervisor: Dr. Jacqui Farrants [redacted]

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

Appendix D: Therapist information sheet

Department of Psychology
City University London

Therapist information sheet

A STUDY ON REFUGEE/ASYLUM-SEEKER **EXPERIENCES OF NARRATIVE EXPOSURE THERAPY FOR POST-TRAUMATIC STRESS DISORDER**

We are looking for participants to take part in a study on refugee/asylum-seekers Experience of Narrative Exposure Therapy for Post-Traumatic Stress Disorder as they come to the end of their treatment

Inclusion criteria

- Asylum-seekers and refugees coming towards the end of the NET treatment who have received NET as the main trauma-processing treatment
- Prior to their research interview participants would have completed their lifeline reading and are coming to the end of their treatment
- Males and females aged 18 plus
- Participants who are conversant in English and who do not require an interpreter. Participants will not be required to read or write English.

Exclusion criteria

- Participants with an active episode of psychosis, active current self-harm or active suicidal ideation or who are in a current crisis will not be recruited for this study.

Please inform the identified patient of the following when handing the information and recruitment sheet to patients deemed clinically stable and who fulfil the inclusion criteria:

- The study and researcher are independent to the service and to their therapy.
- Their decision to withdraw from the study post-interview or to not take part in the study will not affect their treatment or access to services in the future.
- Please do not ask potential participants if they plan to take part in the study as this is entirely their decision.

- If the patient is interested in taking part in the study please inform the patient to contact the researcher directly for further information and to arrange an interview time which will take place in the service.

Appendix E: Debrief sheet

An interpretative Phenomenological Analysis of Refugee/ Asylum-seekers' Experiences of Narrative Exposure Therapy in the Treatment of Post-Traumatic Stress Disorder.

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

This study aims to explore patient experiences of Narrative Exposure Therapy as a treatment for trauma and PTSD for refugees /asylum-seekers

The range of questions during the interview were designed to explore your experiences of narrative exposure therapy, and explore any changes in your beliefs, emotions and sense of personal identity following this type of treatment.

This research aims to inform both clinicians and service users about this group's experience of this type of therapy for the treatment of conflict and war-related trauma.

If the research might have raised concerns for you, please contact the service and leave a message asking for me to contact you to discuss these concerns, alternatively you may choose to speak to your allocated clinician.

We hope you found the study interesting and thank you for your time and invaluable contribution. If you have any other questions please do not hesitate to contact the research team at the following:

Contact the Service and leave a message for Najat Elwakili – Trainee Counselling Psychologist on [redacted]

This study has been reviewed by, and received **ethics clearance** through the **NHS Research Ethics Committee** (16/LO/0320) **and Research Ethics Committee, City University London** [PSYETH (EXT) 15/16/01].

Appendix F: Interview schedule

Semi-structured Interview Schedule

Please note – these questions are a guideline for the researcher as a prompt to broadly explore key areas during the interview. These will be held in mind by the researcher during the course of the interview to facilitate the conversation.

1. What made you decide to take part in this study? What were your motivations?
2. What did you think psychological therapy would involve before you started?

   Prompt – positive or negative
3. Please describe your experiences of the type of treatment you received (NET) – (prompt) before, during and approaching the end of their treatment?
4. Are there any techniques or key areas that were interesting in your treatment?

   Prompts:

   - What is your experience of developing the lifeline (the string with stones and flowers) at the beginning of therapy?
   - What are your experiences of the processing your traumas in a chronological way and in development of your trauma life story?
   - What are your experiences of the 'Then' and 'Now' questioning style in NET, please describe how this helped you in the processing of your traumas?
5. What was your experience of your beliefs about your 'self' before NET and now after your experience of this treatment? Did you experience any changes in these?
6. Can you describe your experiences of changes in negative emotions (e.g. shame and guilt), if any, in relation to your traumas during your treatment journey in NET?
7. What difficulties did you experience in your treatment journey? Can you give me examples of these?
8. What do you think were the 'most important ingredients' in your therapy? Describe whether there was anything your therapist did and said that you feel

made a difference to changes in your trauma memories or in how you view yourself?

9. Please describe your experience of having the therapist witness your traumas? Prompt – positive/ negative
10. What did you think was lacking in this type of treatment for you and what do you think would have made a greater difference to your treatment?
11. Would you recommend this type of therapy to other traumatised refugee/ asylum-seekers? Why?
12. Is there anything else you feel is important for me to know about your experiences of NET?

Appendix G: Telephone screening sheet

Pre-interview screening:

Name of participant	
Contact No.	
Male/ Female	
Ethnicity and country of origin?	
How long has the patient been in the UK?	
Can patient speak spoken English?	
Treating Clinician	
Asylum-seeker or refugee at referral?	
How long have you been in treatment for this care episode?	
Length of time with PTSD symptoms?	
Number of sessions of NET on average	
Referred to another service after completes treatment?	
Is there any active risk, active self-harming, active psychosis, or current crisis?	If YES to any of these the participant will not be suitable for this study. Please discuss further with the researcher.

Appendix H: NHS Research Ethics Committee – Ethics Approval

London - Camden & Kings Cross Research Ethics Committee
Room 001
Jarrow Business Centre
Rolling Mill Road
Jarrow
Tyne & Wear
NE32 3DT

Telephone: 0207 104 8087

27 April 2016

Mrs. Najat Elwakili
Counselling Psychologist Trainee - Professional Doctorate Counselling Psychology

Dear Mrs. Elwakili

Study title: **An interpretative Phenomenological Analysis of Refugee and Asylum-seeker Experiences of Narrative Exposure Therapy in the Treatment of Post-Traumatic Stress Disorder in PTSD Services.**
REC reference: **16/LO/0320**
IRAS project ID: **189071**

Thank you for your letter of 26 April 2016. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 07 April 2016.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Participant information sheet (PIS)	4	26 April 2016

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Recruitment sheet]	1	15 February 2016
Covering letter on headed paper [Covering Letter]	1	07 February 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor professional insurance certificate]	1	21 December 2015
GP/consultant information sheets or letters [Therapist information sheet]	1	15 February 2016

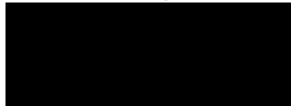
A Research Ethics Committee established by the Health Research Authority

Interview schedules or topic guides for participants [Interview Schedule]	1	15 February 2016
Interview schedules or topic guides for participants [Interview schedule guide]	3	24 March 2016
Letter from sponsor [Sponsor Letter]	1	07 February 2016
Letters of invitation to participant [Recruitment sheet]	1	15 February 2016
Non-validated questionnaire [Screening sheet]	1	15 February 2016
Other [Debrief sheet]	1	15 February 2016
Participant consent form [Participant consent form]	1	15 February 2016
Participant consent form [Participant consent form]	3	24 March 2016
Participant information sheet (PIS)	4	26 April 2016
REC Application Form [REC_Form_11022016]		11 February 2016
Research protocol or project proposal [Research proposal protocol]	1	15 February 2016
Response to Request for Further Information [Letter from Najat Elwakili]		31 March 2016
Summary CV for Chief Investigator (CI) [CV Chief Investigator]	1	07 February 2016
Summary CV for supervisor (student research) [CV Academic supervisor]	1	07 February 2016

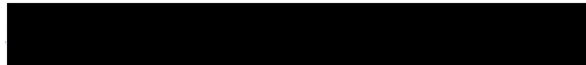
You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

16/LO/0320	**Please quote this number on all correspondence**

Yours sincerely



Kirstie Penman
REC Assistant

E-mail: 

Copy to: *Dr. Jacqui Farrants, City University London*

Ms Stephanie Butler, Noclor Research Support Team

A Research Ethics Committee established by the Health Research Authority

Appendix I: City, University of London Ethics approval code

From: Psychology Research Ethics <>
Date: 15 June 2016 at 16:15:31 BST
To: '
Subject: Ethics Approval Code

Dear Najat,

Please find below your Ethics Approval Code:

PSYETH (EXT) 15/16 01

<u>Adverse events</u>

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (, in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Kind Regards,

Hayley Glasford

Hayley Glasford
Course Officer
School of Arts and Social Sciences
Economics Department
City University London

Appendix J: Peer review Letter

CITY UNIVERSITY
LONDON

School of Social Sciences

Northampton Square
London EC1V 0HB
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29th January 2016

To whom it may concern

NHS peer review:
An Interpretative Phenomenological Analysis of Refugee and Asylum-seeker Experiences of Narrative Exposure Therapy in the Treatment of Post-Traumatic Stress Disorder in PTSD Services.

Researcher: Najat Elwakili, City University London.

The research aims and questions are clearly expressed and intend to explore specific experiences relating to the health and wellbeing of the growing population of refugees and asylum seekers within the UK. Further, it may highlight significant issues for this group with the current treatments for PTSD as recommended by NICE. The researcher has also identified and evidenced a clear gap in the literature and put forward a strong rationale for the study.

The proposed design and methods of this research are entirely appropriate for the type of knowledge sought and the researcher has outlined and demonstrated a good understanding of both methodology and procedure. She has given careful consideration to the study's proposed participants, their recruitment and also their experience throughout their involvement in the research to ensure it meets both methodological and ethical requirements. The analytical procedure is outlined sufficiently to demonstrate a knowledgeable approach and implementation.

The proposal is well written and organised in such a way as to make clear the researcher's intentions and process. The arguments put forward as to the feasibility of the research are logical and supported by evidence. Thus, its potential for enhancing the field of study and contributing to the clinical practice of Counselling Psychologists and others seems significant. Furthermore, it may illuminate investigations as to the efficacy of the current NICE treatment guidelines for PTSD within this study's population. It will also potentially offer service users a new tool for aiding recovery.

Peer Reviewer details:

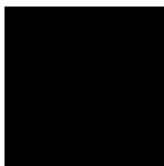
Dr Lucy Longhurst – Chartered Counselling Psychologist (Registered HCPC/BPS)
Visiting Lecturer at City University, London; Psychologist at Cygnet Hospital (Harrow-on-the-Hill) + private practice.

Appendix K: NOCLOR – Rights to access research across Trusts

1st Floor, Bloomsbury Building
St Pancras Hospital
4St Pancras Way
London, NW1 0PE

Tel: 020 3317 3045
Fax: 020 7685 5830
Email: contact.noclor@nhs.net
www.noclor.nhs.uk

21 December 2016



Dear Najat Elwakili,

Employer: **City University London**
Accountable to: **Jacqui Farrants**

This letter confirms your right of access to conduct research through the trust(s) identified in the box below, for the purpose and under the terms and conditions set out in page 2 & page 3.

Study Title: An Interpretative Phenomenological Analysis of Refugee and Asylum-seeker Experiences of Narrative Exposure Therapy in the Treatment of Post-Traumatic Stress Disorder in PTSD Services. R&D reference: 189071 REC reference: 16/LO/0320		
Letter of access duration:	**Start date:** 21/12/2016	**End date:** 30/09/2017
Central and North West London NHS Foundation Trust East London NHS Foundation Trust Barnet Enfield & Haringey Mental Health Trust ***If any information on this document is altered after the date of issue, this document will be deemed INVALID***		

Yours sincerely,

Angela Williams
Head of Research & Development

Page 1 of 3

NCLET011T - 3.0.0 - 23/07/15 - Letter of access for university employee
It is the researcher's responsibility to provide their substantive employer with a copy of this document

Appendix L: Excerpt of transcript with exploratory comments and themes

Ambivalence about treatment, holding on to the hope of being 20% better

A belief in the treatment motivated by improvement and intention to improve symptoms

Seeing theory and practice

Therapy as a persistent quest

Therapy as hell, not wanting to remember

Therapy as re-triggering nightmares

Therapy as bringing traumas to life

Trust as being a major engagement factor in therapy

Being able to see his story

Avoiding reading, distancing self from his traumas by imagining its someone else's life story.

A sense of achievement – life story being on paper

Never expected to love things again, a complete contrast in how he felt, from distress to loving things again

I still believe I had 20% and I will try other things. The treatment for me is like make me believe it. Before I told you, I had treatment before, I took medication, I read, but for me this is just waste time.

90. Th: So, what was it about this treatment that made you believe it?

91. P: First of all, really, the people I met, the way they explaining, things was visual you know more than talk, I saw theory and practical all mixed together, it made me believe you know this is now just a course for a few months, you take it and go and that's it we did our best, no this is that people are really insisting. For a year I was waiting for 1-1 sessions, and then 1-1 I said I wish I never waited for it, this is wait for hell it's like, do I need to talk about everything which I don't want to remember, its coming in my nightmares and I said Oh my good god why this nightmare happening why am I not forgetting it, to come to the treatment I need to talk about it myself, and imagine it and feel it, you know I said to X if you wire a camera and bring it here you could see vivid pictures of what I've been through in the past, I could just see it really, I could touch it the places, which is I never believed that this could happen.

92. Th: Last question is what was your experience of the therapist being a witness to our experiences whilst you told your story?

93. P: Well I just told her recently, thank you for making me trust you, thank you for making me talk with no hesitation, talk for the first time about, all the details which I been through in my life which is nobody know it, even my mum which is the next person to me, so you to make me able to say and talk about it. Still I haven't been able to tell her the secrets of my life. So you to be able to make me say it and talk about it.

94. Th: So, to tell your story to X, what did that feel like?

95. P: To be honest, when she gave me the letter I said I always think about final thing... I said right, I could write stories, the way she gave it to me, I said you know it would really be helpful for me to read it, even if I can't read it now, I can read it in the future, I can imagine it's not me its someone else. This is my life story which is I never believed could be on paper, I never dreamed of this happening. Once I was going through my treatment I remember I was crying and emotional and then click, it make me change and love things again, that is what I never expected or never experienced it before.

Emergent themes

Visual and graphic – Theory and practice

Belief in therapy

Therapist as persistent

Therapy as hell – Needing to talk Vs not wanting to remember

Visual and graphic

Achievement – "This is my life story"

Avoidance of narrative – I can imagine its someone else

Shift in undesirable feelings

Appendix M: Emergent themes in chronological order - Ashraf

Emergent themes in chronological order

Attracted to visual nature of NET – “beautiful”

Preparation prior to NET as beautiful
The struggle with remembering
Visualising lifeline
Belief in therapy

Firm and structured approach to therapy
Overwhelmed by number stones
Flowers as bringing joy
Flowers overpowering stone

Avoidance of exposing traumas vs. the need to expose and shake traumas

Hardest treatment

Lifeline as vivid, graphic

The treatment for me is connection – the voice that hold and contains

The voice that is shaking up his traumas vs. guiding voice

A balance – voices of helplessness and voices of safety

Ambivalence

Lifeline as overwhelming

Motivated to change

Getting “addicted to it” the pain

Struggle to come back and have a voice

Gaining trust vs. breaking lack of trust

Believing in therapy as synonymous with believing in therapist

Therapist commitment/ persistence

Exposing self vs. feelings like a failure
Novelty – my life to be in front of me
Sessional reading as annoying

Chronological nature – No escape from narrative

Wanting to get to end vs. Grieving the end
Annoying listening to lifeline
Testimony as final and anxiety provoking
Coming to end of lifeline as “scary”

Shift in undesirable feelings

Intention in therapy is to improve

Visual and graphic – theory and practice

Therapy as hell – Needing to talk vs. not wanting to remember

Achievement – “This is my life story”
Avoidance of narrative – I can imagine it’s someone else

A life more than just trauma

Coming to therapy to find the nice moments

Appendix N: Single case super-ordinate themes table and quotes

Superordinate themes Ashraf	Quotes and page numbers
Visualising life, seeing theory and practice - "I could see everything"	
Attracted to visual nature of NET – "beautiful"	then they explain to me on blackboard, and this is what really attracted me to go through that treatment (20); For me is, what is this, this is beautiful (20)
Visualising lifeline	You mention it now and I see it now. Off-course. I want to bring it to mind (30)
Lifeline as Vivid, graphic	I was watching everything live, I was closing my eyes and I could touch the things you know 20 years ago, I could see everything, the light the color, I never expected that (52).
Visual and graphic - theory and practice	things was visual you know more than talk, I saw theory and practical all mixed together (91); I could just see it really, I could touch it the places, which is I never believed that this could happen (91);
Novelty – my life to be in front of me	For me, I never thought about it, for my life to be in front of me and then to go through each part (79);
A life more than just traumas	
Flowers as bringing joy	plus and some flowers in, it was like happy moments of joy (38)
Flowers overpowering stone	so you don't look at the stones and things,... doesn't matter how many stones there but there is still, some rose and
Coming to therapy to find the nice moments	So coming to the session, she would help me discover nice moments, so I was mostly coming to find one of these roses, through all the stones I experienced (95)
A life more than just traumas	funny things which happened in the moment. I never saw these flowers on the floor. In my mind I was thinking that everything was stone stone stone. I never thought about it, yes, there are nice moments in my life, so if I bring them it's nice (95); so once I see all these stones, still I can see the pink and purple (40)
The therapy as Connection and balance of voices	
The treatment for me is connection – the voice that hold and contains	the treatment for me is connection, even though I was there, there was a voice coming through you know my past. Which I telling me, are you here are you there, are you listening to me. (54)
The voice that shaking up his traumas Vs guiding voice	The guiding voice it was shaking things but you know, I know I am here, like the voice, the ball, the smells, the things
A balance – voices of helplessness and voices of safety	...it was all shouting and helpless, and voices seeking help, so big voices, which is all connected with balance, misery, pain, the soft voice which is hearing you saying you are safe (58)
The struggle with remembering Vs having a voice, shift in feelings and	
The struggle with remembering	its hard to remember those things, your talking about 50 years ago (24);
Struggle to come back and have a voice	After the session, I was staying for two days at home like a failure, I don't have energies, everything I was mentioning it, I was feeling it, the pain in my heart, the torture, everywhere in my body I was feeling it, I mean everything was there, for
Achievement – "This is my life story"	This is my life story which is I never believed could be on paper, I never dreamed of this happening (95);
Shift in undesirable feelings	I'm not going to say forgive myself but like less blaming myself (87); Once I was going through my treatment I remember I was crying and emotional and then click, it make me change and love things again, that is what I never expected or

Therapy like Hell: Conflict between exposing self Vs avoiding	Quote and comment no.
Overwhelming	
Lifeline as overwhelming	I felt like first session, I say that's the last one, Im not going to be in the second one (64)
Overwhelmed by number stones	everything was like oh my good God, I never knew I had all these stones (38)
Avoidance of exposing traumas Vs the need to expose and shake traumas	First of all, very carefully, I did not go through too many details... if i don't move this information from one side of my brain to another part, if I don't try to expose it, or shake it at
Avoidance of narrative – I can imagine its someone else	even if I can't read it now, I can read it in the future, I can imagine it's not me its someone
Exposing self Vs feeling like a failure	I had to expose myself, I expose all my stories, to me it was like a failure (77);
Hardest treatment	it was the most hard treatment I ever had which I never experienced (50); I never experienced it, and was going to my room feeling empty (56); Since I started the treatment, I
Therapy as hell – Needing to talk Vs not wanting to remember	For a year I was waiting for 1-1 sessions, and then 1-1 I said I wish I never waited for it, this is wait for hell it's like, do I need to talk about everything which I don't want to remember (91);
Therapist persistent Vs believing in the therapist to believe in the	
Believing in therapy as synonymous with believing in therapist	But for me to trust someone, you know that person is not doing this for a living (73); So this is for me the thing, to find someone, I need to believe them, that that person is not just doing
Therapist commitment/ persistence	I need that person when I tell them to to go and look at it and find a solution, and once you are gonna treat one of my problems and try me to go through and move, then I will say that person is really has a name (73); You know what she didn't want to just go through the strategy, you know stage 1, stage 2, stage 3, no, she was really insisting in each stage to
Belief in therapy	I accept it, like I believed in it (32); it made me believe you know (91);
Narrative exposure as annoying and inescapable	
Sessional reading as annoying	to talk about it strictly in details, and then every session to keep reading it, which is really
Annoying listening to lifeline	Annoying. You know to be honest (83)
Chronological nature - No escape from narrative	I was trying to escape just ignore it and go to the next level but it was there you know that. Because she was leaving, the story line, avoid it but the next was going to be when I was 12 and then when I was 14. and then when it clicked in my brain. before I was 14. I was 12
Gaining trust Vs breaking lack of trust	her you broke almost 50% of my untrust, to be honest (71); The whole system, I'm telling you it's not like one person, it's the whole system, from beginning, explaining on the wall with everything is there in my head, the whole treatment (73); so for me to trust you, and concentrate on you to help me (73); , thank you for making me trust you, thank you for making me talk with no hesitation (93); very hard for me to trust and believe its going to be cure (24);
End of therapy as scary. sad. too final and anxiety-provoking	
Coming to end of lifeline as "scary"	Now it's like why should I read it and I don't know what's gonna happen. It's scary, still
Testimony as final and anxiety provoking	I told her not to go through with this, I told her I'm not happy because the last session, so you gonna tell me all this again but there is no next session (83)
Wanting to get to end Vs Grieving the end	I was waiting for the last session, which is the last part of my life, the last stone was there I just wanted to reach there and finish it (91);
The struggle with change. ambivalence and addiction to the pain	
Ambivalence	To be honest, I finished my last session yesterday, I don't believe if I left now, what will happen, (62); , and then after the time I was leaving I say this is the last session, I'm not going to go anymore (68); Until the last session, I'm not going to lie to you, you know what
Getting "addicted to it" the pain	I think I get addicted to it, do you know that, I needed to shake my brain and feel all the pains (66); You know you go through the sessions, then you feel all the pain, then you come out and you say it OK, I'm here in the UK (68); and then I get my voice back for the next
Motivated to change	then I was always remembering, look I need that treatment, its like a minimum 20% it will improve my case (64); I think I need to try it I say, I cant leave it, the more I leave it, the more my symptoms get worse (64); and then I get my voice back for the next week, and be able to come again (68); and then I get my voice back for the next week, and be able to come again,

Appendix O: Super-ordinate themes and sub-themes table across cases

Super-ordinate themes	Subthemes	Quotes: Participant initial and comment No.
Trusting someone else to be your voice	Trust in the Therapeutic relationship	G28; G24; G46; G48;
		ASH71; ASH73; ASH24; ASH93
		K105; K112; K114
		AH40; AH90; AH108
		AY74
		E110
		ASH73;ASH75;ASH32;ASH91
		G46; G48; G24
	Balance of voices and connection	ASH54;ASH56; ASH58
		AH115;AH117
The struggle with therapy, fear, ambivalence and exposure	Pessimism and anxiety	K4; K6; K8 K48; K14
		AL89; AL14; AL29; AL253
	Ambivalence	K4; K6; K10; K14; K41
		AH17, AH13, AH104; AH69
		ASH62; ASH70; ASH68; ASH26; ASH66; ASH64; ASH89
	Shaking up symptoms	F84; F86; F88; F84; F16; F120
		G14; G34
		ASH38; ASH46; ASH95; ASH77; ASH50; ASH91; ASH64
		G50; G4; G12; G8; G44; G20; G24; G22; G18
		ASH79; ASH,83; ASH81
		AH49; AH71; AH35; AH90; AH94; AH96
		G24; G34; G38; G56
		E26; E84; E88; E100; E92
Living with loss, pain, grief and uncertainty	Defective self	AL123; AL111; AL113; AL199; AL199; AL125; AL127
		AH29; AH45; AH86
	Living with uncertainty and loss	K81;K122
		AH13; AH15; AH65; AH57; AH82
		ASH83; ASH81
		AH106; AH40; AH25; AH75; AH73; AH63; AH49; AH86; AH82;AH121;AH125
A life more than just trauma - "remembering the good and the bad"	A life more than just traumas	ASH38;ASH42;ASH95;ASH40
		AL229;AL233;AL225;AL229
		G42;G44; G26
	"Remembering the good and the bad"	AH53;AH130;AH127;AH104
		G26
		AL179,AL73;AL67;AL71;AL29;AL77;AL111;AL87
		K59
		AL145;AL229;AL97; AL35;AL23;AL27;AL31;AL43;AL29;AL27;AL213;AL85
		G10;G12
		F32;F40
Reconstructing a sense of self, identity and attachment	Challenging self...sense of achievement	AL167;AL169;AL129;AL173;AL147;AL203
		ASH24, ASH68;ASH95;ASH87
	Reconstructing a new self	F60;F16;F20;F28
		E56;E58;E104;E72;E118
		K67;K73;K89;K91;K116
		ASH87
		AY24; AY35; AY39; AY53; AY80
From trauma and despair to understanding the big things in life - "something to navigate from"	From trauma to hope	K59
		AY86;AY53
		F94;F102
	"Powerful stuff"	AY28;AY26;AY12;AY14;AY22;AY20
		AY12;AY51
		K12;K22;K18;K14;K30;K71
	Understanding the big things in life	F52;F104;F56;F94;F42;F66;F60;F78;F94
		AL129; AL117;AL277;AL183;AL23;AL115;AL179;AL16;AL102;AL33; AL187
		AY43
		K52;K81;K87
		AY20;AY60;AY72
	Something to navigate from	ASH20;ASH30;ASH52;ASH91;ASH79
		K26
		AY41;AY43;AY64;AY26;AY86;AY78;AY45;AY47
		AL235;AL33;AL43;AL37;AL35;AL89;AL281

Appendix P: DSM-5 criteria for PTSD

All of the criteria are required for the diagnosis of PTSD. The following text summarizes the diagnostic criteria:

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):

- Intrusive thoughts
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.
Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).
Criterion H (required): Symptoms are not due to medication, substance use, or other illness.
Two specifications:

- **Dissociative Specification.** In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
  - Depersonalization. Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
  - Derealization. Experience of unreality, distance, or distortion (e.g., "things are not real").
- **Delayed Specification.** Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC: Author.

PART B: The Journal paper

This Journal paper is intended for The Journal of Traumatic Stress

A life more than just trauma – 'Something to navigate from Forced migrants' accounts of Narrative Exposure Therapy for PTSD

Authors: Najat Elwakili & Dr. Jacqui Farrants

City, University of London

Author note: This article is submitted as part of the doctoral thesis portfolio for the DPsych Counselling Psychology Programme at City, University of London, supervised by Dr. Jacqui Farrants. The research was conducted in accordance with ethical requirements of the Health Research Authority Research Ethics Committee and the BPS. Correspondence concerning this article should be addressed to be

Abstract

The world's biggest forced migration is currently taking place. This population now makes up a considerable proportion of those accessing specialist trauma services in the UK. Narrative exposure therapy (NET) is increasingly used with this population across the NHS. However, there are no studies reporting on how this group experiences this narrative and exposure-informed approach. Although the evidence base for NET is promising, it remains symptom-reduction focused. This study sought to capture the accounts of seven forced migrants who had undergone NET for their Post-Traumatic Stress Disorder (PTSD), using Interpretative Phenomenological Analysis. Six super-ordinate themes emerged from the data: (1) The struggle with therapy, ambivalence, fear, and exposure; (2) Living with loss, pain, grief and uncertainty; (3) Trusting someone else to be your voice; (4) A life more than just trauma – 'remembering the good and the bad'; (5) From trauma and despair to understanding the big things in life – 'something to navigate from'; and (6) Reconstructing a sense of self, identity and attachment. This article focuses on the latter three themes which are unique to NET. The interweaving of positive memories, chronological and gestalt nature of NET facilitated changes in perspective from a life of just trauma to 'a life of more than just trauma', enabling access to 'the bigger picture', a reference point from which to understand their symptoms. Together, these enabled reconstructions of self, recovery of autobiographical memories, and reconnections with emotion and selfhood. Limitations and implications are discussed.

The full text of this article has been removed for copyright reasons

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at the Library of City, University of London.