THE UTILITY OF POST TRAUMATIC GROWTH IN CLINICAL PRACTICE, FROM THE PERSPECTIVE OF THERAPISTS WORKING WITH REFUGEES IN THE UK: A THEMATIC ANALYSIS

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Abstract

This thesis presents a qualitative analysis that may support psychological therapists make sense of the phenomenon of PTG, in an era of rapidly growing refugee populations where there is a need to reduce psychological therapy waiting lists. Refugees in the UK represent a large part of the clinical population. Research and practice suggest that refugee clients face a multitude of challenges post and pre migration. Thus far there has been research and clinical practice that has delineated how these practices have developed within western constructs and therapeutic models of understanding and helping refugee clients. More recently, there have been attempts to shift this focus away from the level of the symptoms. It is argued that the symptom focused approach alone, does not adequately address the therapeutic needs of the refugee clients and furthermore does not include this understanding in the existing therapy models. With this clinical debate focusing on trauma and the reduction of associated symptoms, less focus has been placed on growth within therapeutic practice.

From a moderate social constructionist epistemology and critical realist ontological position the PTG phenomenon was explored. I report the results of a qualitative study of six therapists using in-depth thematic discourse analysis. Therapists that are working with refugees in the UK were asked questions on the five-factor PTG model to understand their perception and perspective of the model. The challenge of working from this perspective is to remain mindful of the wider context of the client experiences and so allow new thinking to emerge. I measured the main themes in the area of growth with a view to generalising the findings yet remain close to the particular in this type of therapy when working with refugees. To my knowledge this study is the first to examine PTG from the perspective of therapists working with refugees in the UK. It takes a deeper look at therapeutic mechanisms and how the theoretical ideas may affect therapy outcomes.

To preview the results, the themes indicate that counselling intervention is required early on with a greater focus on managing painful emotions. After presenting the results I discuss implications for therapy research, training and clinical practice.

Table of Contents

Abstract……………………………………………………………………………………...ii

Table of figures……………………………………………………………………………viii

Acknowledgements……………………………………………………………...……..ix

Dedication……………………………………………………………………...…………..x

1.Introduction………………………………………………………………………….…12

1.1 Background………………………………………………...………………….…..12

1.2 Context: The Refugee ‘Crisis’……………………….……………….………......…..12

1.3 The Social Context in the Therapeutic Space……………………………………..13

1.4 Interventions: Psychological Therapy for Refugees…………………….………...…14

1.5 Aims of the research………………………………………….……………..….16

1.6 Research Question…………………………………………………………...……17

1.7 Reflexivity…………………………………………………………..……….18

2. Literature Review…………………………………………………..……………......22

2.1. Core Terminology……………………………………………………………….….24

2.1.1. Gap Within the Psychological Therapies Offered to Refugees in the UK……..…29

2.2 The Aetiology of PTSD and Treatment in the UK: Explanation and Critique……..30

2.3 NICE PTSD Policy and Guidelines (2018): Explanation and Critique………........34

2.3.1 Symptomology and Traumatic Events………………………………………..36

2.3.2 Assessment and Formulation……………………………………………...….37

2.3.3 Psychological Interventions for the Prevention and Treatment of PTSD in Adults 38

2.3.4 Cognitive Processing Therapy and Cognitive Behavioural Therapy (CBT) for PTSD………………………………………………………………………………38

2.3.5 Narrative Exposure Therapy (N.E.T.)……………………………………………...45

2.3.6 Prolonged Exposure Therapy (P.E.T.)……………………………………………..48

2.3.7 Eye Movement Desensitisation and Reprocessing……………………………...50

2.3.8 Critique of NICE PTSD Guidelines (2018) and the Corresponding Psychological Interventions……………………………………………………………….…………52

3.1.1 Therapists Constructions of Therapy Practice……………………………………56

3.2 Introduction to Growth Focused Theoretical Perspectives to Psychological Interventions……………………………………………………………….………57

3.2.1. Adversarial Growth……………………………………………………………..59
3.2.2 Adversity Activated Development…………………………………………..…..60
3.2.3. Electing Post Traumatic Growth Over Other Growth Theories……………….…64
3.3 Identified Gap in Research……………………………………………………….67
4. Part I: Post-Traumatic Growth Theory……………………………………….…68
4.2. PTG: An Adaptive Response……………………………………………………..70
4.3 Stress and Growth: Concurrent Processes………………………………….......71
4.4 Proximate Groups and Group Interventions……………………………………....71
4.5 Other Factors that Contribute to Post-Traumatic Growth………………………...72
4.6 Critique and Limitations of PTG……………………………………………….....74
5. Part II: Post-Traumatic Growth in Clinical Practice…………………………………77
5.1 The Importance of Psychological Interventions in the Context of Social Justice…...77
5.1.1. Applying Social Justice to Clinical Practice with Refugee Clients…………….....78
5.2. Post-Traumatic Growth (PTG): A Model and Intervention…………………………78
5.2.2. PTG as a Psychological Mechanism: Cognitive Impact and Time of Intervention 83
5.3. Literature Focus in a Clinical Context……………………………………………....86
5.4 Vicarious Post-Traumatic Growth…………………………………………………...88
5.5. PTG Clinical Techniques…………………………………………………………....90
5.6 Timing of Clinical Interventions……………………………………………………..90
5.7 Recent Clinical Intervention Research into PTG…………………………………….91
6. Part III: PTG and Counselling Psychology: Clinical Application…………………....93
6.1. Therapeutic Relationship……………………………………………………...….93
6.1.1. Barriers to the Therapeutic Relationship……………………………………….93
6.2. Client-Centred Approach……………………………………………………..…..94
7.0. Growing Need and Application of PTG in Clinical Practice: Thesis Rationale…….95
7.1. Mechanisms of PTG…………………………………………………………………...96
7.2. Therapists' Knowledge………………………………………………………………...97
7.3. Adjunct Therapies……………………………………………………………………..97
7.4. Proximate Groups and Group Interventions…………………………………………..97

7.5. Clinical Training.....98
7.6 Literature Review: Conclusions.....98
7.7 Research Questions.....99
8. Methodology.....100
8.1 Introduction.....100
8.2 Social Constructionism: Multiple Realities.....100
8.3 Rationale for Qualitative Approach.....102
8.3.1 A Flexible Approach to Understanding Data.....103
7.4 Reflexivity.....106
8.5 Participants.....108
8.6 Reliability and Validity.....110
8.7 Procedure: Materials and Data Collection.....111
8.7.1 Procedure: Thematic Analysis.....112
8.7.2 Procedure: Data Analysis.....113
8.8 Ethical Considerations.....114
8.9 Therapy Oriented Research.....115
8.9.1 Conclusions on Methodology.....116
9. Analysis.....118
9.1 Theme One: "Mind Shift": A Process.....120
9.1.1 Sub-Theme 1: Emotional Pain Barrier.....120
9.1.2 Sub-Theme 2: Reframing.....127
9.1.3 Sub-Theme 3: Integration.....130
9.2 Theme Two: Towards an Empathic Self.....132
9.2.1 Sub-Theme 1: Personal Needs and Connectedness.....130
9.2.2 Sub-Theme 2: Reclaiming Language.....134
9.2.3 Sub-Theme 3: The Advocate.....136
9.3 Theme Three: Relatedness.....138
9.3.1 Sub-Theme 1: Trusting Again.....139
9.3.2 Sub-Theme 2: Group Associations.....140

9.3.3 Sub-Theme 3: Building New Relationships……………………………..142
9.4 Theme Four: Therapists Toolkit…………………………………………..………144
9.4.1 Sub-Theme 1: Metaphoric Language…………………………..……….145
9.4.2 Sub-Theme 2: Navigating Challenges……………………………….147
9.4.3 Sub-Theme 3: Theory and Techniques……………………...………..149
10. Discussion……………………………………………...…………………….……153
10.1 Summary of findings……………………………………..………………153
10.2 Recognising Post Traumatic Growth in Therapy…………………………………154
10.2.1 Clinical Guidelines: Policy Implementation……………………………..…..159
10.2.2 Evolution of Refugee services……………………………………….....…161
10.2.3 Impact on Therapist Training……………………………………...……....164
10.3 A role for Counselling Psychologists………………………………...……...165
10.3.1 The Educator………………………………………………………….165
10.3.2 The Trainee Psychologist……………………………………………166
10.3.3 The Clinical Supervisor………………………………………………166
10.3.4 The Consultant………………………………………………………..166
10.3.5 The Researcher……………………………...…………….….167
10.4 Pathway and Service Delivery……………………………………...………167
10.4.1 Post Traumatic Growth Theory: A Clinical Approach…………………………171
10.5 Impact on Doctoral Training……………………………………………………171
10.6 Recommendations Policy and Practice……………………………………………172
10.6.1 Implication for Future Research…………………………………….......174
10.6.2 Dissemination…………………………………………………………..175
10.7 Critical Evaluation of Research…………………………………………........175
10.7.1 Reflexivity: Learning Post Research……………………………………...178
10.7.1 Evaluation: Validity and Reliability…………………………………..…..179
10.8 Conclusion………………………………………………………………..180
10.9 Positive Indications from the Findings…………………………………...…183
11. References…………………………………………………………..…..185

Appendices

Appendix A: Interview Schedule……………………………………………..……..….200

Appendix B: Invitation Letter……………………………………………….…….201

Appendix C: Consent Form……………………………………………………....204

Appendix D: UEL Ethical Approval…………………...…………………………206

Appendix E: UEL Ethical Approval Amendment: Title Change…..………………..…..210

Appendix F: Example of Early Annotated Transcription…………………...……..213

Appendix G: Reflexivity Account…………………………………………….……..214

Appendix H: Debrief Form……………………………………………..……215

List of Tables and Figures

Table 1: Therapeutic Perspectives of Psychological Growth Theories……………………..66-67

Table 2: Five Factors of PTG…………………………………………………………..80-81

Table 3: Table of participant information……………………………………………...109-110

Table 4: Table to delineate the overarching themes, sub-themes and representative quotes.……………………………………………….…………….…………………118-119

Figure 1: Pathway from GP referral to psychology services. Proposed journey of the refugee service user, integrating a clinical application of post-traumatic growth…………………..…..168

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Dedication

I would like to dedicate this thesis to my mother for showing remarkable strength, courage and resilience throughout her declining health, over the duration of my Doctoral training. Your tremendous willpower to carry on in circumstances where others may have given up, has encouraged me to remain committed to my goals and aspirations.

1. Introduction

This thesis outlines the research conducted on post-traumatic growth of refugee service users in the UK, from the perspective of psychological therapists, using thematic analysis as its methodological approach. Post-traumatic growth (hereafter PTG) is the notion that through a process of deliberate rumination (i.e. deep and reflective thinking), an individual may grow and adapt, to function and cope beyond their baseline levels (Calhoun & Tedeschi, 2013; Tedeschi & Calhoun, 1995; 2006). In other words, their levels of functioning and coping exceed those of before the trauma. The psychological therapist's perspective might provide insight into how counselling psychologists consider integrating PTG into existing therapeutic work, to support refugee clients within statutory services.

Currently, psychological therapies for refugees within NHS services have predominantly focused on stress-based symptoms of traumatic experiences (Tedeschi & Calhoun, 1995; Heide et al., 2016). However, medicalised conceptualisations of trauma (Lewis & Osborn, 2004) may not account for the psychological well-being and development of the client, which growth-orientated therapeutic approaches do address (Eades, 2013). The contemporary parochial rhetoric of trauma may leave practitioners with less hope, and lack of a reflective space in which to innovate therapies. From this perspective, the research was interested in addressing a gap in the literature and based on the findings clinical recommendations were made, such as adding the PTG approach as a therapy within existing treatment pathways.

Counselling psychology is predicated on the notion of a therapeutic process that works towards the client's self-understanding (Culley & Bond, 2011). Of course, counselling psychologists acknowledge the medical relevance of a trauma diagnosis (APA, 2013). However, while acknowledging that trauma is based on the bio-medical model, counselling psychology

seeks to view this critically as just one of many ways to understand distress. One way that they would achieve this aim is to work with the client's subjective experience in a way that is meaningful and empowering for the client. Counselling psychologists conduct research to ground clinical practice in evidence, which is one of the aims of this piece of research.

1.1 Background

Refugees are people displaced from their country of residence due to conflict, persecution or natural disaster which means it is not safe for them to return home (a formal definition is in the literature review). When refugees in the UK require psychological intervention within mainstream services, the therapies offered are typically trauma-focused cognitive behavioural therapy (TFCBT) and eye-movement desensitisation and reprocessing (EMDR) (NICE, 2018). Accordingly, the emphasis of these interventions remains on eradicating negative symptoms, such as reliving, avoidance and flashbacks (Tedeschi & Calhoun, 1995; 1996). Post-traumatic stress disorder (PTSD) has been critiqued for reducing the experience of distress to trauma, which is only one way of many to understand distress (e.g. Woodcock, 2000). There is evidence, as delineated in the literature review, that focusing on a client's growth when providing therapy for refugees may be valuable (e.g. Calhoun & Tedeschi, 2013; Tedeschi & Calhoun 1995; 1996).

1.2 Context: The Refugee "Crisis"

There is a growing global refugee crisis (Silove et al., 2017). In part this notion of a 'crisis' is associated with the increasing numbers of refugees entering the UK, with the most recent figures from the United Nations High Commissioner for Refugees (UNHCR) suggesting that at the end of 2018, there were 126,720 refugees (excluding 45,244 pending asylum cases and 125 stateless cases) (UNHCR, 2018). Notably, those who seek asylum have not yet obtained the

full right to reside (and therefore cannot plan their life in the host country), whereas refugees have. This notion of a "crisis" has been further exacerbated by social, political and cultural influences that impact how refugees are socially constructed (Nyers, 2013). The wider discussion is multidimensional, with many views to consider, such as those in feminist scholarship; however, these are beyond the scope of the present discussion (McKay et al., 2012; Mohanty, 2013). It is however noteworthy that the social and political climate impacts therapy service provision. For example, recently, the UK leaving the European Union and the Covid-19 pandemic have both restricted access to services because of the limits on borders (Norris & Inglehart, 2018). This means that refugees are presented as individuals that pose an economic burden or a strain on the National Health System (NHS) and thus may not come forward to receive the economic support or health care that they may critically require. Therefore, promoting access to services should always be considered when offering psychological interventions.

1.3 The Social Context in the Therapeutic Space

One of the challenges and pressures faced by refugees is the expectation of the host country that they acclimate themselves and assimilate. In this way, it could be argued that refugees are called to reject what they know about their previous way of life, to be accepted and fit into the host country (Ayotte, 2000). While on the one hand, this may help them to integrate into everyday life, interact with social processes and work, unfortunately, the way this is communicated in the media is as a pressure to change that devalues their native culture and way of life. Therefore, this mandate positions the refugee as an individual who is devoid of good and has simply come to benefit from the host country and it is therefore implied they have no choice but to subjugate all they are e.g. their identity to live a safe life (Nyers, 2013).

Current therapeutic models disproportionately focus on alleviating symptoms (NICE, 2018). This is problematic because it assumes that the refugee experience can solely be explained through a trauma paradigm, and thus the goal of therapy is to remove distressing symptoms linked to the 'trauma' of being a refugee (Papadopoulos, 2007). However, drawing from a trauma paradigm that promotes symptom management or removal is limiting, because it does not allow for the possibility that the client can understand their experience through the lenses of psychological development, wellbeing and growth. It is argued that without an emphasis on psychological wellbeing and growth, some refugees are left to cope at an individual level with tremendous social demands, without the corresponding expansiveness in therapeutic models (Joseph & Linley, 2006). In this way, it appears that the current therapeutic models in statutory services in the UK allow fewer possibilities for development, and by exclusively working at the level of alleviating symptoms may inadvertently reinforce the adverse social discourses, by not acknowledging the social context. Furthermore, this may not permit to real therapeutic needs of the refugees to be addressed.

1.4 Interventions: Psychological Therapy for Refugees

The main diagnosis for the refugee population is typically PTSD and severe depression DSM-V (APA, 2013) and ICD-10 (WHO, 1992). Trauma may consist of symptoms such as reliving the event, avoidance of and arousal from stimuli (NICE, 2018; Woodcock, 2000); physiological symptoms of low mood such as lethargy and appetite changes; cognitive biases; and negative appraisals (Beck et al., 1979). Maslow's hierarchy of needs suggests first meeting basic human needs for survival, e.g. housing (Maslow, 1943; Lonn, 2017). Once these requirements are met there are social and emotional needs, e.g. self-esteem. These include mental health needs, which have been the focus of the work of particular agencies, including

those of the United Nations (UN) and the World Health Organization (WHO) (Martin, 2004). However, this requires the provision of psychological services that can serve the relevant population, and these are frequently underutilised for reasons such as stigma, distrust of authority and language barriers (Ellis et al., 2011), and it is important that mental health services reflect on such barriers.

The UK currently offers a range of psychological therapies (e.g. CBT) accessed via a GP referral, which clients receive in line with the stepped care model (Layard et al., 2006). This model offers interventions based on the severity of symptoms, as ascertained by a clinician through an assessment that often includes psychometric measures. Short-term interventions are usually delivered by psychological therapists, and waiting lists are frequent barriers to treatment (Spain, 2009). According to the most recent NICE guidelines, if an individual suffering from PTSD is experiencing symptoms within three months of the trauma, between eight and twelve sessions of 'trauma-focused CBT' are recommended (NICE, 2018). These guidelines recommend that CBT and EMDR should primarily focus on traumatic memories (NICE, 2018). However, the main limitation of short-term therapy is that it does not address the underlying client issues, for example, the origins and developmental history of the problem and processing of emotions (Pilecki et al., 2015). However, there are services that do offer therapy for longer periods of time, yet if they do not assess and understand the refugee client's real needs in therapy, then it is less likely that they will offer the corresponding therapy. This would leave the refugee client without having fully addressed their difficulties beyond the symptoms, to their impact at level of their personality. Furthermore, the approach may not have considered how they have been impacted by their social context pre and post migration (Ayotte, 2000). Consequently, it may also perpetuate re-presentation rates to services. To understand this

research area, the following literature review highlights the paucity in the literature with regards to understanding therapists' ideas about PTG. Hence it is suggested here that there is a gap in the existing models of refugee therapy that requires further examination, to help attend to the underlying emotions and processing required to cope with such life changes, to promote longer-term psychological recovery and acknowledge the strengths they have developed. The paradigm shift into positive psychology has challenged the predominance of the symptom-based model, where good mental health was merely an absence of symptoms, with a shift towards wellbeing and quality of life (Joseph & Linley, 2006; Calhoun & Tedeschi, 2013). However, the author does not suggest a diametrically separate model that merely focuses on strengths; rather, the message of this thesis is that clinicians working with refugees may benefit their clients by balancing the focus on both stress and growth interventions.

1.5 Aims of the Research

Research in PTG spans over two decades, and to some extent its theory is still developing, therefore the aim here is to expand knowledge and understanding of PTG in clinical practice. This expansion in knowledge is sought by aiming to understand the utility of the PTG construct in clinical practice, from the perspective of UK therapists working with refugee clients. This aim is achieved through developing psychological therapist accounts of their understanding of PTG within clinical practice. Through interviews we co-construct an understanding of PTG in clinical practice and follow this with an analysis of the findings within the social, historical and political context.

1.6 Research Question:

It is this line of enquiry that is of interest to this thesis. More explicitly, the research questions are:

1) How do therapists who provide psychological interventions for refugees in the UK construct PTG? and
2) 2) How might these constructions influence the current understanding of designing and delivering psychological therapies for refugees in the UK?

1.7 Reflexivity

a. Reflexivity: Personal Reflection on Research Topic

At the time of the labour shortage in the 1960s there was an increase in migration in the UK, in particular from the South East Asian community. As such, my parents were part of this community of people who migrated to the UK to start a new life. In order to make a start in a new country working hard was very important, contributing to society and all while accepting that you have entered at the lower echelons of society. On the one hand this came with a tenacity for hard work and maintaining a closeness to community, at the same time there were obstacles within the socio-political cultural context such as inequality and racism. As such this meant that migrants worked very hard to ensure that they could survive and take care of their family. This involved as I saw for my parents taking jobs that they were overqualified for. Inevitably this meant putting survival before looking at self-actualising needs. As a result the impact on me has been that I have taken this work ethic to a certain extent. Overall, seeing this work ethic has modelled to me first-hand how human beings are very resourceful and can grow when migrating to a new country, despite challenges such as prejudice, racism and inequality.

b. Reflexivity: How personal hopes, aspirations and assumptions about PTG impacted how I reviewed the literature and what I focused on.

I am hopeful that human beings can grow, particularly in the area of refugee therapy as I think that the one of the main barriers is resources. Having seen that the need to earn an income while having to accept a lower position in society can be demoralising, I recognise that opening up opportunities for refugees may help them flourish in their host country.

Although my parents were not refugees, these experiences make me mindful and reflective of not reinforcing these experiences of prejudice for refugee clients and supporting them to develop agency to self-actualise and reach their potential. I do not wish to contribute to an oppressive structure that may serve to reinforce negative experiences for people and therefore I attempt to take a reflective position when meeting this population in my clinical work. Therefore, I hold realistic hope that this research may illuminate a neglected area and I recognise that there is potentially a missed opportunity here to offer more psychological interventions.

A balanced critique of this perspective may be that the optimistic view of growth may lead to some unconscious and conscious bias about growth and development. Therefore, it is important to remain mindful of this within the research. Nevertheless, the PTSD discourse that is embedded in policy spans four decades and while some of this time frame runs parallel to growth theories, the key difference is that they are enshrined in policy and legitimised by guidelines. Therefore, these biases are accounted for by providing a critique of both symptom based approaches and the implementation of growth based theories in the clinical practice of working with refugees.

C. Reflexivity: Reflection from a Practitioner Perspective

I consider how my professional experience has shaped my approach to delivering psychological interventions. It was through my role as a team leader within a mental health recovery centre, overseeing the wellbeing of more than 150 service users with severe and enduring mental health difficulties, that I first worked with refugees. I appreciated that the organisation adopted a client-centred perspective where service users could define their own mental health. I observed how clients found their own purpose despite having a diagnosis; for example, pursuing training courses or helping at the recovery centre. I observed how much

value the organisation placed on service-user contribution and how empowering that was. It meant that clients could experience who they were outside of the frameworks and language of their diagnoses and symptoms and potentially reclaim parts of their lives where they had been labelled as merely patients. In this way, as a practitioner, I had a role in helping clients co-construct a reality that was meaningful to them. This required a level of sensitivity, to listen and remain mindful of how they defined their hopes, while being responsible for changes in their mental health.

Later I worked in statutory services where the terminology used was through a medicalised lens and even as a psychology professional, I was required to offer therapy that worked within this remit. For example, after experiencing trauma following forced migration, an individual was likely to be offered trauma-focused CBT to alleviate immediate symptoms but, due to time restricted therapy, there was not always the possibility of therapy that extended beyond symptom relief to aid emotional processing and longer term well-being. Lack of emotional expression and lack of social support, may contribute towards further stress over a period of time (Joseph, 2004), therefore the challenge here was on remaining reflective of practice and mindful of not inadvertently reinforcing pathologising language and thereby reinforcing power differences. A more therapeutic approach could have been to engage clients with the emotional process and to work through emotional and thought processes to develop their own meaning and interpretation of events.

As a second generation descendent of migrants, I have developed awareness of some of the challenges faced by those in a new country. Having personally encountered inequality has allowed me to develop my understanding of growing up within a multicultural context. However, my experiences are not from a refugee perspective, and therefore they cannot reflect a

true understanding of the myriad of challenges faced by refugees. Therefore, at all stages of the research, I remained open to understanding psychological interventions for refugees through the perspective of a therapist.

7. Literature Review

Considering the continued leading role of a stress-symptom-based approach in mainstream refugee psychological therapy (Palic & Elklit, 2011), it is necessary to establish whether the exclusive use of such an intervention is warranted (NICE, 2018). To realise this - aim, the present thesis considers other constructions of post-trauma experiences from the perspectives of psychological therapists in the UK (Calhoun & Tedeschi, 2013). Subsequently, there is an exploration of a potential adjunct therapeutic approach, Post-Traumatic Growth (PTG), in clinical practice. The literature in this review charts the introduction of growth-based psychological theories and relevant clinical interventions in the field of refugee psychotherapy. Within this scope, the review delineates the development of the PTG phenomenon since its inception in the 1990s to more recent clinical discussions (e.g. Calhoun & Tedeschi, 2013).

This thesis challenges how the remit of psychological therapies for refugees in statutory services in the UK is predominantly restricted to Cognitive Behavioural Therapy-based (CBT) interventions and Eye Movement Desensitisation and Reprocessing (EMDR), as stated in the NICE guidelines (NICE, 2018). Central to this argument is the notion that the essential needs of refuges are misunderstood and that subsequently, psychological therapies do not meet these needs adequately (Papadopoulos, 2000). Although within the most recent guidelines it is acknowledged that there are other therapeutic models such as narrative exposure therapy ((Schauer, et. al., 2011); NICE, 2018), it is, nevertheless, proposed that an additional theoretical lens may be required. The purpose of such a theoretical lens may assist the practitioner to facilitate a more holistic therapeutic intervention, accounting for new possibilities of psychological growth beyond the focus on discrete trauma symptoms currently used. This would

follow the aim of expanding the therapeutic approach to support the goals of wellbeing and self-actualisation (Rogers, 1961) to help the refugee clients reach their potential.

However, the barrier remains the existing recommended therapeutic approaches (NICE, 2018) that appear to provide less opportunity for such a possibility of psychological development and treatment outcomes within therapeutic interventions. Therefore, it is reasonable to suggest that further research may help psychological practitioners become aware of the background and utility of such approaches in clinical practice, therefore posing the following questions: to what extent have the theoretical ideas of psychological growth developed within therapeutic literature to date; how might we commence the initiation of theory practice links; and how would such growth-based psychological interventions work in clinical practice. The literature review addresses these questions by considering the psychological growth theories that have been developed within the literature (Joseph & Linley, 2004; Papadopoulos, 2007; Calhoun & Tedeschi, 2013). These theories are considered within the context of refugee psychological therapy work. Following this, PTG's scope in clinical practice is explored. A critical reflection is applied to these theories to enable an understanding of their strengths and limitations in clinical practice.

The scope of this review is delimited to relevant studies pertaining to PTG in clinical practice. While there are numerous studies on health psychology (e.g. Turner & Cox, 2004), the main focus of this research is on PTG in refugee populations. Therefore, such studies are referred to but not covered in detail. Overall, the trend in the literature reveals greater attention to stress-symptoms-based psychological interventions and less to the growth spectrum (Woodcock, 2000). Nevertheless, studies in PTG indicate a trend towards early development of

PTG-based models of trauma therapy (Linley & Joseph, 2004; Calhoun & Tedeschi, 2013), establishing the basis to develop this therapy-orientated research.

2.1 Core Terminology

Refugee

According to the United Nations High Commissioner for Refugees (UNHCR), the definition of a refugee is an individual who,

> "…owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it. (UNHCR, 1951, 8-10)".

This thesis utilises the UNHCR definition as opposed to the legal one in an attempt to re-humanise refugees and to shift from viewing them as politicised objects to human beings who have faced much struggle existing within the socio-political context. Notably, this definition of refugees is internationally recognised; however, it is acknowledged that "refugee" is often used as a legal term and as such there are limitations to the definition. First, it is necessary to highlight that the legal status of refugees is frequently misconstrued into negative social narratives that serve to marginalise entire groups. This may influence the way that refugees are perceived in their host society and consequently detracts from the very social injustices of warfare and deprivation that they escape. Second, this stance may position refugees in homogenised categories, underestimating their capacity to direct their own lives and further contribute positively to society (Nyers, 2013). It is acknowledged that protecting the needs of

refugees was a chief concern of the 1942 Haig Convention, ratified in 1951, by 144 states, and present in a vast corpus of international and domestic case law (e.g. UNHCR, 2011). Third, this Western gaze (the perspective of Western norms, traditions and practices) may over time problematise refugees as completely helpless which may potentially exacerbate saviour narratives (Mutua, 2001). Fourth, the legal definition could intensify security-based narratives, constructing refugees as potentially entering a country to commit crimes, a narrative that is further intensified by impending political changes such as the UK exiting the European Union (e.g. Norris & Inglehart, 2018).

At other times of threat, refugees may be perceived as a source of risk to others, particularly those at the early stage of migration where movement of people is seen as a threat, e.g. during the current COVID-19 pandemic (Junior et al., 2020). The concern is that this may serve to increasingly marginalise vulnerable people who have already experienced great hardships and therefore deny them of the very support they require.

Finally, the proliferation of this term in everyday vernacular is intensified through constructions and discourses in policies, media and even psychological therapy. It is acknowledged that using the term refugee may tacitly imply that all their experiences are generalisable. Yet, in reality, there are a multitude of refugee experiences, e.g. taking a risky journey to the host country, differences in social and economic resources, their status in the home and host country and so on. These are some explanations of why a legal term is insufficient in explaining the full scope of refugee experiences. It is with this understanding that the author acknowledges the issue while embarking on the present research, thus using this term with sensitivity to the social context, while remaining aware of the nuances and complexity in refugee experiences.

b. Traumatic Stress

Experiencing traumatic stress is typically regarded as a consequence of a distressing life event such as being in a car accident, experiencing a terminal illness or becoming a refugee (NICE, 2018). According to psychological literature, the impact of this event may appear in the form of psychological and physiological symptoms; for example, flashbacks, recurrent nightmares and reliving the event (Ehlers & Clark, 2000). Conventionally, in accordance with these experiences, psychological therapy is directed towards alleviating these symptoms to promote improved psychological functioning (Cohen, 2006; Ehlers & Clark, 2000). Yet, the limitation with such a perspective starts from the way that it is established by situating the problem at an individual level; that is, implying that "symptoms" have emerged in isolation, without considering important social factors (Parker, 2011). Additionally, this perspective accentuates the power imbalance between the client as helpless and the practitioner as an expert (Boyd, 1996). Thus, it is always necessary to remain mindful that traumatic stress is a diagnosis specified by professionals in order to measure and treat a human experience (Parker, 2011). This can also be seen in the work of Watters (2001), where he refers to the term the "Americanisation" of mental illness, i.e. influenced by the culture and practices from the US and laden with these values. Therefore, the very definition of what "should" be experienced after a tragic event then dictates the trajectory of the psychological intervention and the subsequent client experience, without considering how the experience after a life-changing event may have different meanings across different countries, cultures and contexts (Papadopoulos, 2007).

Thus, a more accurate construction of trauma may take into account the social context, acknowledging that refugees usually experience multiple losses (e.g. of loved ones, land, etc.) prior to arriving in the UK and may have experienced several incidents of abuse and

mistreatment (e.g. torture or witnessing trauma), as well as made multiple adjustments and changes (e.g. new language, role in the society, etc.) (Ayotte, 2000). It is possible that these adjustments in their role in the society may have negatively impacted their self-esteem and how they view themselves (Colucci et al., 2014). Furthermore, there is frequent upheaval in the process of adapting to a new culture and a different way of life than what was known to them (Hughes & Rees, 2016). Hence, under this level of stress, such a psychological reaction may be considered a perfectly normal human response (Woodcock, 2000). Therefore, it is necessary to challenge how this human experience is pathologised.

As stated, the biomedical lens (biological and medical explanation) when viewed through a Western gaze (through the perspective of Western norms, traditions and practices) frames the traumatic experience as a set of specific symptoms that require attention. As such, this does not provide space for a therapeutic model that considers the clients social and cultural context and their ability to reflect on their experiences (Woodcock, 2000).

Furthermore, groups of individuals often experience trauma that is collective in nature, i.e. a shared experience. This idea of collective trauma is often ignored in individualistic models' characteristic of the West, as highlighted by Watkins and Shulman's (2008) work on collective trauma and their corresponding critique of the individualist models. Overall, by ignoring such shared experiences, the social and collective influences are not accounted for and may leave a tremendous burden at the individual level. Therefore, it is possible to suggest that the individual may unnecessarily assume that their mental health difficulties are a personal weakness rather than a legitimate reaction to tragic events. Thus, the present work argues that only by practitioners becoming cognisant of this in clinical practice can we facilitate the removal of this psychological burden from the refugee client. This stance is legitimised through scientific

studies that contribute to an empirical base in the research which is ultimately enshrined in policy and institutions (Parker, 2011).

Furthermore, it is possible to reflect on how other traumas may be exacerbated within institutions and systems, as highlighted in feminist literature, i.e. on the "double trauma" of sexual violence – first, the violence that is inflicted on the individual and, second, the violence inflicted by the system, i.e. making an individual provide evidence and then subjecting them to cross-examination. It is also possible to speculate that therapy itself could be another form of asking the individual to verify what they have experienced (Gavey, 2011), thus removing the context from their experiences. Hence, professionals in positions of power and therapists need to be mindful of such power imbalances. Counselling psychologists must certainly abide by these policies and ensure that their practice does not unnecessarily trigger clients (e.g. BPS, 2018).

Overall, this is a powerful construction of trauma as it dictates the trajectory of trauma recovery and the following protocols that therapists may deliver in the UK (e.g. NICE, 2018). It is with this understanding that it is suggested that the way psychological therapists develop knowledge and professional behaviour from clinical training to practice is formed in a specific manner which is also socially and culturally informed. With this definition of trauma and taking into account these critiques, the present thesis tentatively uses the term trauma.

This thesis attempts to expand the understanding of the aftermath of a traumatic event, acknowledging multiple human responses, thus widening the understanding of human experience and the corresponding psychological interventions that may be accessible, thereby potentially allowing the refugee client to find their own meaning in their experience, which may impact how they process the trauma within the context of their therapy sessions. Finally, it is important to differentiate between a formal diagnosis of PTSD by symptoms outlined in the DSM-V (APA,

2013) and ICD-10 (WHO, 1992) as well as trauma in general which may require an intervention focused on emotional processing rather than symptoms. The former is determined as forming in a particular time-period and impacting the individual with symptoms such as flashbacks, while the latter may take a long time to come into the client's conscious awareness. Notwithstanding these symptoms are socially constructed terms and this is reflected on in the following sections.

2.1.1. Gap Within the Psychological Therapies Offered to Refugees in the UK

As the NICE (2018) guidelines state, Cognitive Therapy Trauma-focused interventions and EMDR are the main focus of psychological therapies for those struggling with trauma in the UK. There may be some strengths associated with this such as isolating specific symptoms and working on each one in a treatment plan, thereby helping clients understand their traumatic experience within their overall life narrative in Narrative Exposure Therapy (NET) and helping them face their fears that stop them from living in the present moment through Prolonged Exposure Therapy (PET). Nevertheless, all these interventions pertain to isolating and managing symptoms, i.e. flashbacks, memories, reliving or facing their fears through shifting thoughts and behaviours. This limits a vast experience as outlined, from pre- and post-migration into a rather parochial experience. Although there may be some advantages of therapy in terms of improvement in symptoms and reduction of psychometric test scores, they do not account for meaning making and empowering the refugee service user.

It must be noted that narrative therapy does offer some promise for refugee clients in terms of them being able to tell their life story through the lens of their personal lived experience and understand their trauma within it. It is possible this intervention may have scope for the development of further therapies that can speak to client's need to find their own meaning of their trauma (Frankl, 2000) and in turn acknowledge the social context (Mutua, 2001). Some

evidence already alludes to the idea that narrative therapy is effective in working with refugees (Lely et al., 2019).

2.2 The Aetiology of PTSD and Treatment in the UK: Explanation and Critique

Anxiety is the basis for the mental health diagnosis of PTSD, historically originating from times when soldiers were treated for shellshock (Jones et al., 2003). Tedeschi and Calhoun (2004) state that after a traumatic life event, the typical affliction that affects an individual is anxiety (i.e. a fear of an anticipated event that is perceived as beyond their capacity to cope from). PTSD is characterised by symptoms that threaten an individual's wellbeing, including flashbacks, reliving and avoidance (Ehlers & Clark, 2000; APA, 2013; Jones et al., 2003) as well as intrusive, ruminative thoughts over an extended period of time (Tedeschi & Calhoun, 2004). It is acknowledged that while there may be a "risk" of being diagnosed with "psychiatric disorders" such as severe depression and PTSD after a trauma, it is necessary to remain reflective and critical of such labels, remaining consistent with counselling psychology (Rentoul, 1995). PTSD is not an inevitable and predestined human experience after a traumatic event (Bonanno, 2005). Therefore, this work highlights that a diagnosis in isolation omits the notion of social and political influences, thereby shifting the attention away from the social context (Parker, 2011).

With this purpose, Watters (2001) discusses the role of warfare in relation to those affected by PTSD and how the gaze of such social and political injustices, for instance witnessing violence, is deviated from by locating the problem at the individual level. It is argued this possibly leaves refugees at the peril of internalising such traumatic events, attributing an inappropriate and disproportionate interpretation of their role in this experience. Similarly, culture and individual differences are often overlooked within the lens of diagnosis (Woodcock, 2000). Therefore, one academic task is to reflect on which individuals and what social

institutions may benefit from any given diagnosis (Gergen, 1973, 1985, 2008), i.e. the notion of a diagnosis may serve certain entities such as institutions, yet it may not always work to the highest benefit of the client. Readdressing this dynamic is something that academics have tried to balance out to shift the position to better support and empower clients (Parker, 2011).

Reflecting on this critique further, Woodcock (2000) attempts to challenge such an interpretation of what is deemed a traumatic experience. He first attempts to deconstruct the notion of trauma and differentiates between trauma as an "event" and trauma as "a set of psychological sequalae", (i.e. an inevitable illness preceded by a traumatic event). Furthermore, he highlights that responses to an adverse event are limited to only symptoms in discrete categories of re-experiencing, avoidance and persistent arousal (that would have been prevalent for a month) that "causes significant distress or impairment" (Woodcock, 2000, p. 2) to be considered PTSD. Woodcock (2000) critiques this clinical explanation as pathologising a normal human response to an extremely challenging life event. Furthermore, he states that this stance positions itself "to privilege a biomedical discourse about human suffering" (Woodcock, 2000, p. 2). One could suggest it then de-emphasises other explanations of how an individual may experience trauma to the detriment of the client as it does not afford them freedom of expression and self-understanding. Therefore, this perspective highlights that PTSD itself is a socially constructed phenomenon (Parker, 2011) and this research is navigated with this understanding.

Although there are potentially other ways to understand and process trauma, e.g. narrative therapy (Schauer et al., 2011), most therapeutic interventions delivered in mainstream NHS services since the 1980s have been influenced by this stance. Therefore, it is important to be aware of such perspectives and how they are potentially restrictive. The main scientific

framework for PTSD is established from the medical model, which, as highlighted, may be perceived as pathologising a traumatic human experience in a reductionist manner (Lewis & Osborn, 2004). While this may have utility to the extent that it permits for a very specific psychological intervention, the main limitation of such a stance is its aim to eradicate symptoms. This objective often occurs to the omission of personal client reflection and understanding behind the traumatic events, i.e. how the refugee client may recall and understand their traumatic experience within the context of their own life (Woodcock, 2000). Moreover, clients may understand and attribute meaning to their experiences in a manner that is outside the remit of treatment protocols as prescribed by evidence-based models and thereby outside the clinical training of the therapist. To not address this impasse leaves a framework that potentially ignores the actual experiences of refugees (Afuape, 2011; Papadopoulos, 2002). A system that does not acknowledge these needs, may inadvertently reinforce negative messages e.g. about power. In this way, one could suggest that there is discrepancy between the clinical training in standard evidence-based therapy models and interventions that may support the refuge client's needs. The present research focuses on this absence in service delivery.

Furthermore, a symptom-focused approach that reduces the experience to thoughts and behaviour, requiring modification to improve moods alludes to a fixed traumatic experience for refugees. However, the client's experiences may be more complex than this explanation suggests (e.g. Pilgram, 2011). This underscores an inability to understand the extent of the client experience and how they process and work towards their personal recovery. This omits vital client constructions and understandings that may illuminate their full experience (Levers, 2012). Thus, such approaches detract from the client's personal resources, skills and agency and reinforce the negative social narratives stated earlier (Nyers, 2013).

As stated previously, the diagnosis itself is a construct and not necessarily a human experience that emanates from and preserves institutions and their practices (Parker, 2011), i.e. from a research perspective, the diagnosis has been constructed from quantitative research that has predefined variables, set up within a particular context and evidenced in a reductionist form of research findings. This is important to acknowledge as it can set up a powerful rhetoric that influences the trajectory of mental health care services. From this perspective, policy guidelines may construct a notion of good mental health clinical practices to follow.

Although notions such as that of *reflective practitioner* and *integrating therapies* are encouraged, the policies that govern services and guide interventions use the medical explanations that they are presented with (NICE, 2018). Overall, it is pertinent to understand that such a parochial lens may impede ideas that may extend explanations of refugee mental health and the corresponding psychological interventions delivered to serve the needs of the client group. Nevertheless, it is acknowledged that diagnosis is the preliminary step to discussing existing practice; therefore, it cannot be entirely disregarded as it informs the governing policies that guide psychological interventions used in statutory services (NICE, 2005). Therefore, it is recognised that to a large extent, psychologists are required to engage with medical language in order to facilitate working within statutory NHS services to make a contribution. In doing so, it is accepted that there are multiple ways of constructing a post-traumatic experience (Gergen, 1973; Burr, 2003, 2015). Accordingly, the present thesis purports that it may be useful to consider the multiple constructions of meaning making when working with refugees in clinical practice that co-exist within the existing framework, guidelines and practice. Thus, at this juncture, it is possible that we may commence an academic discussion on the possibility of considering adjunct interventions to existing therapies such as PTG in clinical

practice (Calhoun & Tedeschi, 2013). While the terms trauma and PTSD are utilised within this thesis, they are done so with the understanding of and sensitivity to the complexity they exist in within a wider socio-economic, political and cultural context.

2.3 NICE PTSD Policy and Guidelines (2018): Explanation and Critique

The National Institute of Clinical Excellence (NICE) guidelines for PTSD state that when working with refugees and asylum seekers, practitioners may consider "the routine use of a validated, brief screening instrument for PTSD as part of any comprehensive physical and mental health screen" (NICE, 2018, p. 9). Therefore, one could suggest that practitioners are primed to consider that being a refugee implies developing PTSD. Therefore, it is possible to see how the policy is laden with a presumption that influences, with a degree of authority, the thinking and decision making of the practitioners. As Woodcock (2000) purported in his critique of PTSD, there is immediately an assumption that locates the problems of the refugee client into reduced measures, i.e. symptoms of flashbacks, which inform the practitioner that they have experienced trauma in a specified manner. Thus, from the outset, this presupposition has removed the social context, narrowing down the explanation of the client's experience and difficulties. The result is that the client's experiences must fit into these labels rather than the therapy adapting to the experiences, therefore limiting the therapeutic experience to one that is overshadowed by static explanations of trauma. Conversely, the benefit of such guidelines is that they are "ensuring that methods of access to services take into account the needs of specific populations of people with PTSD, including migrants and asylum seekers" (NICE, 2018, p. 10). Thus, one could suggest that, to a certain extent, the guidelines afford refugee clients some prospect to access psychological support within statutory NHS services in the UK. However, this of course is contingent upon guidelines being operationalised in practice. This is not to suggest that the

guidelines are presented as a truth in opposition to the critique of PTSD, but rather where the guidelines do shift towards supporting a more holistic understanding, this is acknowledged and highlighted. Therefore, it is evident that there is some attempt to include some nuance in current clinical approaches that do consider the wider context. Nevertheless, this is still yet to be universally implemented from an organisational and practitioner perspective.

There is evidence showing the effectiveness of Trauma-Focused CBT in the UK (Cohen et al., 2006), EMDR, PET and NET, indicating some utility in the long-term management of PTSD (NICE, 2018). However, a lack of focus is apparent on the real needs for the long-term psychological functioning of refugees, their quality of life and how they may develop and sustain a mental state that is strong enough to allow them to flourish (Papadopoulos, 2007). Therefore, without understanding refugee needs, the psychological therapies available are not considered to cater to them. Although some NGOs and statutory services in the UK may offer some long-term psychological therapies, they make assumptions about what the traumatic experience is and what the therapeutic work should focus on. Therefore, psychological therapies are not of a consistent standard, which means that not all refugees receive the same service. This gap in therapeutic clinical interventions is of particular interest in the present research, as well as the role of counselling psychologists and the contribution they make as they are expressly trained to work at relational depth (Cooper, 2005; Geller, 2013). They connect with the client on a profound level, demonstrating empathy, congruence, acceptance and transparency and in turn acknowledging that the client is impacted by the therapist's empathy (Mearns, 1999). It is hoped that such a position facilitates meaningful change for the refugee client.

2.3.1 Symptomology and Traumatic Events

The NICE (2018) guidelines outline the following list of symptoms as being associated with PTSD: "re-experiencing, avoidance, hyperarousal (including hypervigilance, anger and irritability), negative alterations in mood and thinking, emotional numbing, dissociation, emotional dysregulation, interpersonal difficulties or problems in relationships, negative self-perception (including feeling diminished, defeated or worthless)" (p. 6). It is important to remain mindful that while these symptoms may guide the psychological practitioner to measure and ascertain how the refugee client has been impacted, they will exclude the socio-economic circumstances. The guidance also places labels in the place where clients could have developed their own description and explanation informing their unique understanding of the traumatic event. Thus interrupting the refugee client's opportunity to reflect and find meaning within the therapy session. The guideline may achieve this by directly priming the therapeutic approach of the therapist and the kind of language they may use and how they may interact with the client.

The guidelines ask practitioners to establish whether the client has experienced specific symptoms and specific traumatic events (see 1.1.3–1.1.5), (NICE, 2018, p. 7). However, the concern is that practitioners are directed to ask these closed questions and thereby containing and limiting what may be a difficult experience within the confines of such reductionist language and terminology, which may be a highly restrictive experience for the client. It is argued that such a position immediately constrains the approach of the therapist when working with this presentation and therefore strongly influences and directs how the client may respond. This would inevitably inhibit the content of the therapy sessions to stay within such narrow parameters.

In the list of traumatic events, the guidelines ask practitioners to "be aware" of the events "associated with the development of PTSD" of which are included "war and conflict, torture" (NICE, 2018, p. 7). However, asking practitioners to simply be aware may not be enough. These "events" are not expanded upon further in the guidelines in terms of how they may impact an individual and how their social circumstances in the host country may perpetuate and exacerbate PTSD symptoms. It is thus argued that an understanding in this regard may help develop a more contextual understanding (Afuape, 2011), i.e. one that considers that social context plays a role in the refugee client's psychological experience. Instead, this is left to the interpretation of the psychological practitioner which may be problematic and lead to inconsistencies, especially if there are discrepancies in clinical training from one practitioner to another. Overall, this would impact the provision and delivery of statutory psychological services, meaning that refugees in one service or geographical area may receive a different experience to another area.

2.3.2 Assessment and Formulation

Within the most recent NICE (2018) guidelines, the onus is placed upon general practitioners to screen clients that they believe demonstrate PTSD symptoms. Furthermore, an update in the 2018 guidelines includes a recognition that the social "assessment of people with PTSD should be comprehensive, including an assessment of physical, psychological and social needs and a risk assessment [2005, amended 2018]", (NICE, 2018, p. 8). In principle, this statement would legitimise the consideration of social factors. However, again, what constitutes "comprehensive" is left to the interpretation of the practitioner. For example, a nurse may take into account the social needs and provide a social care referral if required. Yet, in terms of the psychological needs, this would be up to the psychological practitioner to complete a

comprehensive psychology assessment and formulation collaboratively with the client, taking into account the social context. However, this would also depend to a great extent on the clinical training received by the psychological therapist. The training differs, with some programmes emphasising the CBT formulation and others on psychodynamic theory. However, while a social constructionist-based formulation is available (Harper & Moss, 2003), it is not necessarily used in practice. Therefore, it is argued here that the therapeutic outcome for each client experience may vary due to what theoretical approaches the therapists training has emphasised and de-emphasised.

2.3.3 Psychological Interventions for the Prevention and Treatment of PTSD in Adults

Statutory health services provide psychological interventions within mainstream mental health services, mainly comprised of the NHS. The NHS services are the main focus of the present work; they usually offer evidence-based therapies that are supported by research. The two main therapies within the NICE guidelines for PTSD (NICE, 2018) are CBT-based interventions and EMDR, outlined next. In this section, the recommended psychological therapies are explained first, followed by a critique.

2.3.4 Cognitive Processing Therapy and Cognitive Behavioural Therapy (CBT) for PTSD

From its early origins in the 1960s, Cognitive Behavioural Therapy (CBT) has brought together the client's negative automatic thoughts (NATs) (i.e. frequently accessible thoughts that impact the client's day to day thinking and mindset), the origin of maladaptive thinking (i.e. thoughts that emanate from negative early experiences that are no longer relevant to the client's context) and strategies to make behavioural changes (i.e. behavioural experiments to test negative thoughts against reality) (Beck et al., 1979, Beck & Beck, 2011). Many variations of CBT have been formed to help manage specific presenting problems (e.g. generalised anxiety

disorder, social anxiety, low mood), while for trauma, one of the leading models was presented by Ehlers and Clark (2000). In this model, PTSD was positioned as a consequence of the memory processing becoming negatively impacted by the trauma. The authors conceive of trauma as a cyclical process of negative appraisal's (Ehlers & Clark, 2000) and the notion that the traumatic memory has not been appropriately integrated, i.e. has not been understood in the context of other memories and life experiences. This, they suggested, may impede the natural cognitive process (with the symptoms that follow this; e.g. avoidance); therefore, one aim in CBT is to confront the dysfunctional coping (Ehlers & Clark, 2000). It is suggested that even though the individual has attempted survival, they remain immobilised in their negative experiences (Fragkaki et. al., 2017). This approach has been shown to have higher effect sizes (Ehlers et al., 2005), compared to other CBT approaches (Van Etten & Taylor, 1998) and therefore has gained much momentum as the trauma therapy of choice, dominating psychological services working with PTSD. Herman (1998) suggests that there are three stages of trauma recovery within therapy: 1) stabilisation, 2) reprocessing and 3) integration. The first stage, stabilisation, involves providing the client with psychoeducation about trauma, teaching grounding and soothing skills, so that the client can stabilise themselves and activate the soothing system (Gilbert, 2010). This is explained within the "window of tolerance" (Siegal, 1999) – the notion that exposure to a traumatic event can result in an individual's natural calm coping state within this window to become interrupted. The result may be that they become hypo-aroused (i.e. low, shut down, flat, lacking emotions, fatigued, sleeping too much disassociating and numb) or hyper-aroused (i.e. irritable, angry, exaggerated startle response and anxious). Then the therapeutic goal is for the practitioner to teach the client skills that help them stay within this window of tolerance. This originates from the idea that infants form a healthy

attachment with their caregiver when they see co-regulation of stressful emotions modelled to them, leading to self-regulation (Bowlby, 1988). However, when an individual experiences any trauma, they may have a disruption to this self-regulation and their usual strategy for self-soothing and managing their emotions are less readily available. They may experience a loss of control over their sense of safety and have a reduction in their window of tolerance, thus feeling overwhelmed. The therapy goal would then be to teach skills that bring the client back into the window of tolerance, e.g. grounding skills, self-soothing techniques, deep breathing, emotional regulation and challenging limiting beliefs (Siegal, 1999).

The second stage of CBT for trauma is re-processing (that follows the stabilisation stage, where the client would have learned to regulate their emotions), which involves individual psychology sessions where the client discusses the trauma in more detail, with the goal to understand and manage symptoms such as flashbacks. Before each therapy session, measures are taken in the form of psychometric test, e.g. PHQ-9 measure for low mood (Kroenke & Spitzer, 2001) and the goal is to offer an objective measure of how the client is developing.

Cognitive Processing Therapy (CPT) is a specific type of cognitive therapy which focuses on PTSD (Cusack et al., 2016). Its primary aim is to challenge unhelpful cognitions related to safety, trust, relationships, power and self-esteem. The therapist may first provide psychological psychoeducation and explain how trauma-related thoughts keep the trauma active and then through the sessions and homework tasks, work to challenge these thoughts. Some therapists may choose to incorporate a statement completed by the client which they then read out in a session to work through with their therapist in understanding how the event impacted their thoughts about themselves, others and the world. The therapist may use Socratic questioning to help the client develop alternative thoughts (Beck et al., 1995) to understand how

their worldview has been impacted and then to ameliorate the feelings of anxiety, anger and guilt. This therapy has been known to be effective (e.g. Ehlers & Clark, 2000). The third and final stage is to integrate the experiences of trauma into the client's memories and beliefs.

Mainstream therapies are often delivered on a large scale and are usually driven by policy, as is the case in the UK primary care system. CBT interventions are the therapies of choice, and the Improving Access to Psychological Therapies (IAPT) initiative was driven by a socio-economic argument to establish a therapy that supports employees getting back into the workforce (e.g. Layard, 2006). The NICE guidelines recommend "individual trauma-focused CBT intervention", which, according to the policy, includes "cognitive processing therapy, cognitive therapy for PTSD, narrative exposure therapy, prolonged exposure therapy" (NICE, 2018, p. 17). In the most recent NICE guidelines, the recommendation has been to deliver up to 12 weeks of Trauma-Focused CBT and EMDR to refugee clients (NICE, 2018). Thus, the large evidence base and the short-term duration of the therapy support the rationale for its widespread use. However, for long-term interventions, clients may be offered psychotherapy to make sense of their traumatic life experience. Yet, before the refugee client is able to function well psychologically, in order to reach the stage of thriving and contribute to a wider social sphere, they may need support with real-life challenges such as obtaining a house and seeking employment, which act as confounding variables (Phillimore & Goodson, 2008). Moreover, the present thesis argues that for refugees to participate in their own care, a shift from a lens constructing them as devoid of agency is required. Therefore, it is argued that the timelines of the psychological interventions may need to factor in the wider context to establish pre- and post-therapy psychological needs.

Critique and Limitations of Cognitive Approaches

As stated, although the evidence base has argued for the widespread delivery of cognitive psychological interventions across statutory services across the UK, cognitive approaches have limitations, which are explored in the following sections.

Reductionism

While cognitive approaches seek to treat the client's negative thoughts to shift their mood, this stance may be criticised as shifting towards a reductionist perspective (Parker, 2011). Through this reductionism of client experiences into discrete categories of thoughts, feelings and behaviours, there is a shift away from client reflection outside of these boundaries. Similarly, using measures suggests that a set calculation in a session indicates how the client is developing and yet does not account for their internal processes, which may indicate their personal or subjective development. Thus, the client's personal voice may be removed from the therapy process as they have been given restricted parameters within which to specify their experience. Outside of the personal experience, the social context is also, to some degree, omitted in cognitive therapy sessions (Parker & Fletcher, 2007). The psychological formulation may include references to some early client experiences or traumas and how they impacted subsequent thinking, however, this understanding may not incorporate the social context (Harper & Moss, 2003).

Victimisation and Power Imbalance

It is possible that within the delivery of cognitive approaches, the clients are placed in the position of a helpless individual who requires their emotions to be altered, which can only be achieved through the input of a therapist with these skills. It could thus be argued that the notion of stabilisation itself may suggest that the refugee is at fault for their emotions and wholly

responsible for how they feel after forced migration, and the burden of managing this is placed upon them. While it may be helpful for individuals to calm down from what was termed a "hyper-arousal" state or activate a "hypo-arousal" state, it may be implied that the refugee has poor mental health due to their own weaknesses. This is problematic because while the refugee client may come across as stressed or numb in feelings, their real feelings, e.g. anger, may not be validated within the right context. This could impact their understanding of their own experiences. Thus, it is possible that a narrative approach instead may address this issue and allow for refugee clients to tell their story and make their own meaning.

Homogenisation and Pathologising

It is possible that standardised therapeutic approaches do not account for the individual differences of refugee experiences, pre- and post-migration. That is, what one refugee may experience coming from the same country and arriving in the same host country as another, may be two very different experiences. Therefore, generalising refugee experiences that have experienced trauma may be of less utility within the clinical context.

Westernisation

Cognitive approaches emanate from the US during early 20th century, therefore, they have originated from a particular cultural and socio-economic context (Beck et, al., 1979). The notion of what is good mental health is dictated by the relief of symptoms; however, it could be argued that imposing the idea of shifting cognitions for alternative thoughts may be stopping legitimate thoughts and questioning of what has happened to a person, thus questioning and placating valid feelings.

Didactic

There is a focus on "teaching" skills as opposed to understanding the experience. There is also a power dynamic established, whereby the therapist has the knowledge which they impart upon the client. It is possible that engaging in "reprocessing" of memories can re-trigger the trauma and thus should be done with care. It may potentially establish negative power dynamics and thus does not empower the client.

Individualistic

Ideas such as the window of tolerance emphasise self-control and self-management without seeing what other factors may have contributed to the traumatic experience. Furthermore, setting homework tasks may elicit language and cultural barriers, which may reinforce the power imbalance and potentially re-trigger trauma. In addition, it is important for the practitioner to be mindful of how the tools they use may indeed exacerbate any previous experiences of power imbalances. Therefore, while cognitive approaches to psychological interventions may be helpful in cases of mild depression and anxiety in challenging unhelpful thinking and shifting negative reinforcing behaviours, there is a gap in exploring the complexity of the issues. Depression and anxiety are also contested categories and the evidence based on which this supposed helpfulness is based is built from studies that are based on controversial categories and assumptions. It is thus worth stating that although depression and anxiety could be perceived as constructs, they are not taken issue with here because unlike trauma, they are not widely associated with socio-political events that have impacted an individual's mental health. The cognitive triangle may only afford the opportunity to explore the issue at a superficial level and the duration of therapy does not permit the practitioner exploration into their core beliefs

(deeper and more enduring beliefs at the personality level). Young et al. (2003) developed the schema therapy model that examines core beliefs and allows the possibility of change and understanding at a latent level. However, most cognitive approaches are based on Beck et al.'s (1979) model. Therefore, working at a greater relational depth can promote deeper understanding, yet it still does not prepare therapists to take into consideration the wider social impact.

Eventually, whichever level of theoretical reasoning is applied cannot remove the reality of what has occurred in the social context; consequently, a therapeutic intervention based on encouraging the refugee client to reason their way from traumatic events would lack full impact, without processing their feelings and helping them find personal meaning. Therefore, particularly when thinking about interventions for refugees, it is important to consider the extent to which cognitive approaches are helpful and what other ways of conceptualising the client's difficulties are required to facilitate meeting their therapeutic needs.

2.3.5 Narrative Exposure Therapy (N.E.T.)

Another therapy recommended under the umbrella of cognitive therapy as per the NICE (2018) guidelines is Narrative Exposure Therapy (NET). The purpose of NET is to help the client understand and put into context traumatic memories (Schauer et al., 2011). There is evidence supporting its efficacy in refugee group therapy, owing to its effectiveness in community settings (Lely et al., 2019). This is a client-centred therapy that allows them to relay their narrative and situate their trauma within the overall events and context of their life. The therapy aims at the client's understanding of their traumatic experience within the context of their overall life journey. With the therapist as their witness, the client works through how they arrived where they are and how their experiences make sense within their narrative. Some

aspects of narrative approaches involve reliving and reprocessing memories are similar to those in cognitive approaches. Thus, therapists facilitate this process by reflecting back the narrative to the client, facilitating client understanding and reintegrating their negative schemas (latent maladaptive beliefs that may have developed in childhood) (Young et al., 2003).

The NET process involves clients linking their life journey with wellbeing rather than seeing the experience through the lens of distress, which is a departure from diagnostically led therapies such as cognitive ones. At the end of the therapy, the treatment outcome is not an objectified measure set from a psychometric test, e.g. PHQ-9 measure for low mood (Kroenke & Spitzer, 2001) as each story is unique to each client. Therefore, the onus is on the psychological therapist to be able to provide a safe, therapeutic space to facilitate this process. The settings within which this therapy may take place can vary from the third sector to NGOs. Although NET is in the guidelines, the NHS frequently opts for CBT approaches, therefore refugees may not have the same access to this treatment. A recent study by Lely et al. (2019) sought to measure the effectiveness of NET on trauma survivors and the findings of the meta review suggest that there are "sustained treatment results" (p. 1). However, in order to increase reliability, research still lacks controlled comparison studies with other evidence-based trauma interventions that fall under the guidelines. This evidence is within the context of a scientific evidence-making process, i.e. fundamental parts of the therapy process are reduced to laboratory-based settings. In this way, it is difficult to compare the effectiveness of CBT with NET.

Critique and Limitations of Narrative Exposure Therapy

As one of the recommendations for therapies, NET is an intervention that begins to acknowledge the personal experiences of the client (Lely et al., 2019). It is a person-centred therapy, thereby instead of imposing narrow parameters of constructing the client's problems, it

allows the client to become the author of their life story. However, there are also criticisms that should be considered.

Too Process-Driven

First, using an approach such as NET poses a risk owing to its person-centred focus. Although initially this may not seem to be an issue as the critique usually regards a power imbalance in clinical approaches. However, if taken too far, it may reinforce the idea of abandonment and that others cannot help them by not interacting with and going towards the client. However, it is acknowledged here that all clients will not respond the same way to having less direction than CBT approaches.

Complex

Second, NET is predicated on philosophies and ideas that may complicate the therapy and impede client understanding, i.e. what should be a simple task is imbued in complex philosophical ideas. However, this is possibly mediated by the therapist and the quality of the therapeutic relationship (Rogers, 1961).

Lack of Cultural Understanding

Third, if cultural understanding is not present in the client's personal constructs and reality, there may not be enough understanding and support from the therapist to facilitate a good outcome. Therefore, the therapist's own clinical training, personal and cultural background and the organisation's values can impact the cultural understanding while applying NET.

Lack of Direction

Fourth, the refugee client may have already experienced multiple losses. Therefore, they may need therapeutic engagement from a therapist to have somewhere to start from which may require a more active stance exploring the client's difficulties.

De-Skills Therapist

Finally, although the therapist may on the one hand try to empower the client by allowing them to lead based on their personal experiences, the client may be seeking a therapist that is knowledgeable and dependable.

Overall, NET approaches help facilitate the refugee client's storytelling, understanding and integrating all of their experiences within the context of their life. However, they pose the risk of becoming too process driven, lacking understanding of cultural constructs and not providing enough structure within the therapeutic space from where the refugee client can safely explore.

2.3.6 Prolonged Exposure Therapy (P.E.T.)

The next type of psychological therapy under the NICE (2018) guidelines is Prolonged Exposure Therapy (PET), which purports the notion that supporting the client in facing their fears will over time reduce their PTSD symptoms (Hembree et al., 2003; Rothbaum et al., 2007). This approach involves teaching the client to slowly access specific traumatic memories, thoughts, feelings, places and situations (N.B.: doing so should not cause the client any danger). As with any exposure therapy, this is a graded process that starts with one small step, guided by the therapist. It has been suggested that the client may need 12 90-minute sessions over three months (Foa & Rothbaum, 1998) wherein the therapist would assess the past and traumas, provide psychoeducation and teach skills to manage any anxiety. The therapist may also use imaginal (in session) and in-vivo (real-life behavioural experiments) exposure, aiming to reduce PTSD symptoms. In one way, this approach has real-life implications in helping client's face their fears, even though it is the most reductionist therapy in that it targets a particular behaviour.

If not managed well, it could inadvertently shift the responsibility of the trauma on the client, which is why context is crucial.

Critique and Limitations of Prolonged Exposure Therapy

Although there is extensive literature illustrating how exposure therapy used with cognitive therapy approaches can help clients with various types of anxiety, it has its limitations.

Potentially Triggering

On the one hand, approaching a place or activity that one has avoided may help the person resume their social and vocational life. While there may be very clear benefits, especially in case of social anxiety, there is a risk of triggering the client. For example, it is possible that the imaginal (in session) exposure exercises may trigger flashbacks. If this is not recognised by the therapist, it could leave the client more vulnerable and destabilised. More so, if the refugee client is not ready for an in-vivo intervention (real life), exposure exercises may be harmful to their detriment and re-trigger a fight-or-flight or freeze (activation of a threat response) response. Therefore, such a therapy depends heavily on the therapist's training, the client's readiness toward and understanding of the process and for the therapist to consider why this intervention is used and how it may fit into an overall therapy plan.

Reductionist

Prolonged Exposure Therapy (PET) is possibly the most reductionist approach of the other approaches recommended by the NICE (2018) guidelines as it focuses on one particular behaviour of avoidance and tries to shift behaviour in order to reduce anxiety. While this may have some efficacy and allow the person to complete certain tasks, it may not address difficult beliefs and understandings they have about their experience. Therefore, this approach may not help meaning making and understanding, possibly undermining the refugee client's self-esteem.

Power Imbalance and Didactic

Like CBT, this approach reduces the client experience into smaller goals. However, this goes further than a standard cognitive approach and focuses only on one safety behaviour. The client is taught that by removing this safety behaviour, they are being encouraged to face their fears and reduce anxiety. Yet, the psychological therapist has a great deal of control and dictates the trajectory of the therapy, assessing whether the client has overcome the anxiety or not. Therefore, this approach requires a self-aware and reflective practitioner who is mindful of such limitations.

2.3.7 Eye Movement Desensitisation and Reprocessing

After cognitive approaches, the second evidence-based approach that is recommended in the NICE guidelines is the Eye Movement Desensitisation and Reprocessing (EMDR), which seeks to teach the brain how to process and release the memory of the trauma. The first step involves reliving work (similar to cognitive approaches) and then the therapist uses eye movement to facilitate the client to reach a point where they are no longer distressed by the memory. The process was first developed by Francine Shapiro in the 1990s after she experienced a reduction in her distress following a walk. During this walk, she noticed that her attention moved side to side and after the walk she had appeared to have processed her distress (Shapiro, 1989). This was subsequently followed up by research (Shapiro, 2001) and thousands of practitioners have been trained worldwide since due to the ease of delivering this therapy. It is viewed as a particularly appropriate intervention with clients who prefer not discussing their trauma or cannot access their memories. Therefore, this may be an alternative to Trauma-Focused CBT. However, it is important to remain critical of its limitations.

Critique and Limitations of Eye Movement Desensitisation and Reprocessing

Newer Approach

Although thousands of practitioners have trained and utilised EMDR since the 1990s, it is still four decades behind the beginnings of cognitive approaches. Therefore, cognitive therapy-based approaches have developed a greater evidence base and have been used in practice for longer. The second issue is that although there has been research, it is not fully established that EMDR actually works and is effective for those struggling with trauma.

Didactic, Reductionist and Power Imbalance

Again, similar to CBT, the teaching element reduces the client experience to set variables, thus not permitting other experiences for the client. Also, the psychological therapist may be setting the standard of what they regard as good mental health which is absence of symptoms. This places the therapist into a powerful position, where they are effectively directing the course of the client experiences. More than the other approaches, this one possibly actively encourages the client to forget and may inadvertently negate the reality of the tragedy that they faced.

Potentially Triggering

Finally, there is a risk that reliving the memory may trigger the trauma itself, especially if the eye movement part of the session did not help the person process and integrate the memory. Therefore, there still may be some reasons to proceed with caution in this intervention. It may be necessary to return to stabilisation to help the client learn grounding skills.

2.3.8 Critique of NICE PTSD Guidelines (2018) and the Corresponding Psychological Interventions

Ethnocentric

One criticism of these guidelines is that they are ethnocentric (Woodcock, 2000), leaning towards Western ideas of wellbeing which are prevalent within the medical model. This removes the personal and interpersonal construction of therapy, thus disallowing the unique client experience to emerge (Levers, 2012).

Absence of Multiculturalism

Furthermore, there is a shift towards a multicultural framework (Adams & Kivlighan, 2019), focusing on concepts such as wellbeing, resilience and hope (Papadopoulos, 2007). It is especially evident in research and third-sector organisations that the shift has not been accounted for in these policies (NICE, 2018).

Reductionist

While the guidelines acknowledge language barriers and for the practitioner to “be aware” of the traumatic event, not giving this further explanation seeks to de-prioritise the importance of social context as if therapy is delivered in a vacuum. The guidelines discuss symptoms that remove an individual from their context. This reductionist perspective leaves only one option: a patient requires treatment to change their thinking (Parker, 2011). Thus the way of understanding and supporting the client is pre-determined.

Power and Power Imbalances

The notion that the practitioner is the expert with the knowledge and that the client is merely the recipient of this knowledge and treatment is implicit in this approach. This implies that due to the practitioner’s knowledge of theories constructed within a socio-political cultural

and temporal context, they have gained a superior position. This could invalidate the pre, post and present experiences of the refugee clients. Therefore, there's a risk in that the approach removes the notion that refugees also have skills and resources that they may bring to their own recovery (Nyers, 2013). The danger in such reductionism is that it places the power in the hands of the practitioner and not the clients. This is because theories, policies and practice decide what constitutes trauma, how it must be approached and what determines a successful treatment outcome. From this standpoint, it appears that in the best case scenario, the client is expected to have a reduction or eradication of their symptoms and, if they are fortunate, their therapist may be trained in and value the formulation that considers the wider social context. However, it must be noted that this approach does not consider an extended treatment outcome, which includes personal understanding and development.

Misunderstanding Refugee Needs in Therapy

There is a great deal of misrepresentation about refugee needs in therapy (Papadopoulos, 2002). This is largely due to service providers and their therapists who simply follow policies, making assumptions about what should be the focus in therapy work as they have a pre-determined idea of what the trauma means to the client. For example, it has been noted that there can be a perceived trauma at the level of the family and as such the refugee family is inappropriately labelled as "traumatised" (Papadopoulos, 2002). Furthermore, their ability to be resilient may not be validated by practitioners, which Papadopoulos (2007) suggests is an issue that should be raised in clinical supervision.

The guidelines do not sufficiently account for the fact that refugee clients may have experienced major consequences of experiencing violence and forced migration. Thus it is suggested that practitioners should be aware of balancing both the vulnerability and resilience of

the refugee client (Papadopoulos, 2018). Thus resulting in practitioners that know when to provide support and when to allow the refugee client to draw on their own resources.

Assumptions About the Foci of Refugee Therapy Work

It is acknowledged that outside of statutory services, there are other therapeutic models. For example, in NGOs and the third sector, there may be greater use of narrative approaches and access to longer term therapy. However, the present thesis focuses only on statutory services in the UK.

3. Critique of Psychological Interventions for Refugees in the UK

Although the NICE (2018) guidelines clearly outline PTSD symptoms and state what practitioners should look for in the client's presentation, to some extent, they still overlook a comprehensive understanding of refugee therapeutic needs. It can therefore be argued that these symptoms seek to legitimise what constitutes a traumatic experience for the refugee client, thereby delimiting other experiences.

When such therapies are specifically applied to refugee clients, they often raise challenges. The limitations of therapeutic work with refugees are well documented across multiple areas, but a general critique is provided as follows. First, many therapeutic approaches can be individualistic and focus on a person's experiences, possibly excluding those close to them, their community and their culture. These experiences of social connections are an important part of life and how people understand their world. Thus, the exclusion of social context may not account for the importance of particular roles and relationships in their life. Removing this cultural lens denies other beliefs, understandings of the world and what it means to be within them, seeing the world from their perspective. Further, this perspective that looks at refugees' difficulties through a Western lens may manipulate the meaning and the understanding

that could develop between a client and therapist. Furthermore, medical language and diagnostic labels may remove the ability to describe psychological distress in a more nuanced manner using specific words.

Thus, this removes aspects such as how they have grown to understand their social world, what is a good life and what are the markers of success and wellbeing. Second, service providers may make assumptions about the therapeutic work that should be completed, i.e. it may be about reducing the scores of anxiety on the GAD-7 (Spitzer et al., 2006) questionnaire from moderate and severe to mild anxiety. However, such a goal may not address the underlying difficulties and social problems that the refugee client faces e.g. the anxiety itself could be the result of inequality faced in the home or host country. Third, they may extend no or little focus onto matters such as the social impact of the journey of forced migration, the multiple challenges and losses faced (Ayotte, 2000), thereby not understanding the unique experience of being a refugee and what it entails, which is based outside of the ordinary day-to-day challenges. Fourth, there is a rather detached perspective of focusing on external symptoms but not enquiring about how they came into existence, i.e. the process behind the presentation. Making such assumptions creates a rather mechanical interaction between the therapist and client that seeks to obtain a clear result. However, human experiences of trauma are far more nuanced which extend beyond textbook explanations, which may provide a preliminary point but do not account for the multitude of experiences nor do they fully recognise the socio-economic, political and cultural perspectives that have brought the refugee client to this place (Nyers, 2013).

These are some of the factors that may not be accounted for in mainstream therapy services (with a particular focus on NHS services) and are not discussed within the policies that guide such interventions at a national level. One may ask why is this important when

considering psychological interventions for refugees? One reason to consider is that refugees are more likely to have mental health issues, compared to the general population and are less likely to get support (Ayotte, 2000). In addition, it is important to consider that refugees may have suffered negative pre- as well as post-migration experiences, in turn exacerbating any other mental health difficulties. Therefore, therapists with cultural and social understandings of mental health and moreover of the psychological interventions that acknowledge these experiences are necessary (Satinsky, 2007). Notably, NGOs do take consideration of some of these factors; however, when discussing therapies in mainstream NHS services, the same is lacking.

Overall, with a shift towards wellbeing, resilience, hope and a multicultural understanding, there is some evidence of a departure from the reductionist medical model (Papadopoulos, 2007). Nevertheless, this shift could still be criticised as falling under the Western gaze. Furthermore, it may be considered just as important to question the validity of growth-based approaches that exist under the umbrella of positive psychology.

3.1.1 Therapists Constructions of Therapy Practice

The knowledge and experience of the practitioner is a valued resource that has been considered in the knowledge development of the present research. Therapists' perspective may highlight how the disparities in the current guidelines and therapies is truly accounted for in practice, i.e. what the policies say and what happens in clinical practice. How therapists construct trauma work in general clinical practice with a focus on how they negotiate the therapeutic relationship was explored by D'Mello (2016). The findings differentiated between pathologising and non-pathologising discourses of trauma. Specifically using the Foucauldian Discourse Analysis (FDA), the findings showed that pathologising discourses were areas such as "psychiatry" and "cognitive discourse" and the non-pathologising discourse was in areas such as

"Post-Traumatic Growth", "embodiment" and "feminism". First, the area of accord with this thesis is D'Mello's (2016) idea that positive discourses such as PTG permit a more "enriching" perspective and therefore the work is more "fluid". In this way, it extends the possibilities of the direction in which therapy may develop. Conversely, the significant difference in this research is that while D'Mello (2016) makes clear distinctions about these binary ways of working, the focus of the research is on how these binary constructions create an imbalance in the therapeutic relationship, and ultimately the research seeks a more fluid and "aligned" therapeutic relationship with non-pathologising constructions. Moreover, this is also in line with a radical social constructionist perspective, which differs from the present thesis that seeks to stay within a critical, realist and moderate social constructionist perspective. In other words, this thesis accepts the institutions, policies and services that exist but tries to establish critique and discussion within them, as opposed to questioning their entire existence. Moreover, the present research differs as it focuses on a specialist area of psychological therapists and their clinical practice who work with refugees in the UK. Also, this research has specifically been designed with the aim of exploring PTG in clinical practice and is therefore, to a certain extent, data driven. While this research does seek to make theory practice links, the wider organisational and policy implications are also considered. Hence, this study utilises a moderate social constructionist epistemology and a thematic analysis. Thus, existing clinical models are considered a point from which to develop the growth perspective further.

3.2 Introduction to Growth Focused Theoretical Perspectives to Psychological Interventions

From the 1990s, a new wave of theoretical ideas of growth developed within psychological discourse. Over this timeframe, there has been an increasing interest in growth

and resilience within therapies (e.g. Tedeschi & Calhoun 1995, 1996, 2006). Two of the early theorists to address this were Joseph and Linley (2004, 2006), who developed the notion of adversarial growth and later integrated the ideas of accommodation (integrating experiences into overall life narrative) and assimilation (integrating experiences into pre-trauma life view). Another theory in growth was based on Papodopolous' (2007) work, which highlights a type of growth called Adversity-Activated Development (AAD) (Papadopoulos, 2007). This initial contribution pertaining to potential growth in refugees provided some interest within the area of psychological growth and certainly has been discussed within the field of refugee therapy (e.g. Davidson et al., 2010; Ligabue, 2018; Small et al., 2016; Badri et al., 2020; Meili et al., 2019; Meili et al., 2020; McGregor et al., 2016).

Broadly, the idea of resilience suggests that individuals maintain their baseline level of coping. For example, O'Leary et al. (1995, 1996) offer an alternative idea of "thriving", which suggests there are three possible outcomes to trauma: recovery, survival and thriving. The authors assert that there is a sense of living one's life with vigour and purpose. However, this theory does not state a clear shift determined through cognitive and affective components.

It is important to establish that the idea of growth through challenges is not a novel concept and the meaning behind tragic life events was spoken about in the past (e.g. Frankl, 2000). There are discussions dating back to Greek philosophy and other traditions which highlight the human experience of growth. There are other theories as well that also attempt to explain growth. In this section, the rationale for selecting PTG is explained, discussing in detail theories of growth that have entered the field of psychology and how they have contributed in the understanding of psychological growth in therapeutic practice.

3.2.1. Adversarial Growth

Joseph and Linley (2004) suggest that one of the goals while working with trauma in therapy is to resolve the tension between the pre-existing assumptions of the client and the trauma-related information that they are now aware of. This means reconciling one's original worldview with how the world changes post trauma. In order to successfully manage the adversity, i.e. trauma and forced migration, Joseph and Linley (2006) suggest that the individual redraw their internal mental maps, accommodating new information about their world. However, the authors acknowledge that this may be a distressing process as it requires letting go of previous assumptions about the world. Thus, it is suggested that the client engages in processes of post-trauma assimilation and accommodation to help them integrate the difficult experiences (Joseph & Linley, 2006).

First, with assimilation, it is suggested that the client may ignore, deny or distort what happened (Joseph & Linley, 2006). The techniques to do this may be via blaming themselves to protect their treasured beliefs about controlling their lives, predicting or having justice in the world. The function of this perspective is to keep the worldview as just and to confirm that others are not to blame.

The other technique is to blame others which functions to protect the individual's self-esteem and therefore means that they cannot take responsibility for what has happened. With either of these responses, the individual holds onto existing models of understanding the world and seeks to interpret new experiences within these views and not accommodate new information. However, Joseph and Linley (2006) suggest that the trauma has presented new information about the world that is now difficult to ignore. As such, assimilation may produce increased defensiveness, fragility and vulnerability after the trauma. However, it is suggested

that after trauma, the client's assumptive worldview clashes with existential truths about life, thus trying to merely assimilate the new information after the trauma becomes unrealistic.

Alternatively, accommodation is deemed a more realistic response to a difficult experience, according to Joseph and Linley (2006). By accommodating new truths about the world, the client may experience a shift in their assumptive worldview. For example, they may accommodate ideas such as bad things can happen to good people and that sometimes life is dangerous, arbitrary and random (Joseph & Linley, 2006). It is suggested that trauma survivors who accommodate rather than assimilate, acknowledge the challenges of their difficult experiences, the mental effort required when making sense of the past experiences and more readily place their life story into a wider context, being able to accept the positives and negatives of what they have experienced. Therefore, accommodation is seen as a useful mental strategy to modify the assumptive worldview that has been disrupted to become more in line with the new reality.

However, over the long term, there is a danger of developing new negative worldviews. Therefore, accommodation is perceived as a good short-term strategy to cope after trauma, but in the long term, it may be maladaptive. It is helpful to remain critical of ideas related to these clearly defined states of assimilation and accommodation which arguably set up only two possible ways of reacting to traumatic events, potentially leaving less room for nuances in the refugee client experiences.

3.2.2 Adversity Activated Development

In this approach, it is purported that the matter of becoming a refugee is "exclusively a socio-political and legal one, with psychological implications" (Papadopoulos, 2007, p. 301). Therefore, AAD acknowledges the social context within which individuals have forcibly been

displaced. AAD purports that with "reasonably facilitative conditions" (Papadopoulos, 2007, p. 302) after forced migration, most refugees will be resilient, i.e. able to adapt back to their previous levels of functioning. It must be stated that not all refugees have a homogeneous experience and one cannot generalise the same. However, once a refugee client's own resourcefulness and resilience is reduced, they may require more support to cope. Papadopoulos (2007) names this term the "psychological immune system" (p. 302). This idea is potentially not in line with considering the social context as it may be pathologising the way that refugees cope, hence suggesting those that lack this response may somehow have a deficit in some way. Papadopoulos (2007) suggests that the more this psychological system has been reduced, the more help the individual may require, yet he asserts that the experience of forced migration does not inevitably lead to distress. It is acknowledged that displacement brings with it challenges but theory emphasises the individual response according to this "psychological immune system" and that some individuals may cope with the same level of stress in different ways. Therefore, it is emphasised that it is important not to generalise universal theories about trauma as if they are universal experiences and thus refugees are not one homogeneous group.

In AAD, there are three possible ways that an individual may deal with trauma: First, through Ordinary Human Suffering (OHS): when faced with suffering where expectations are not met, individuals are still able to accept what has happened within the context of their life and make use of support systems. Second, through Distressful Psychological Reaction (DPR): where the person has greater discomfort but they are able to draw on their "ordinary human resilience" (Papadopoulos, 2007, p. 305) without needing professional help. Finally, Psychiatric Disorder (PD): Papadopoulos (2007) views this as the most severe form of having experienced adversity, which may be PTSD. However, these approaches are possibly equally reductionist in forming

neat categories, and one may ask whether the development of more labels is a helpful endeavour.

Finally, Papadopoulos (2007) stated that there are a group of refugees that may survive the adversity and also become “strengthened by their particular exposure to adversity” (p. 306), which he calls AAD. In AAD, a therapist may struggle with “awkward moral dilemmas and complexities when mental health professionals work with such refugees, as one does not wish to focus on the positive outcomes of despicable acts of political violence” (Papadopoulos, 2007, p. 306). This is important to acknowledge as it may also hinder the exploration of growth areas in therapy sessions. For example, this may impact how much a psychological therapist will explore this material with a client, leaving a question about how much this may adversely impact the client’s psychological development.

The main difference between AAD and PTG is that AAD does not require an individual to have experienced trauma. Papadopoulos (2007) makes the distinction that his approach in AAD is about being exposed to *adversity* rather than having been *traumatised*. Papadopoulos (2007) also differentiates the experience of PTG as during the post-trauma stages; however, with his approach he emphasises that the refugee will experience further adversity. He also purports that “positive effects” can be experienced during an adversity (Papadopoulos, 2007, p. 307). His critique of the term growth is that it suggests “inevitability”, whereas his term AAD denotes “development”, which he argues is neutral. However, Tedeschi and Calhoun (1995, 1996, 2006) emphasise that PTG is not an inevitable outcome for everyone after trauma. It is suggested that AAD brings “positive ‘growthful’ development” after the trauma. Thus, the individual forms “new elements – characteristics” that were not there before Papadopoulos (2007, p. 307). However, it is also emphasised that others may notice these elements before the refugee client does. Equally, reaching a limit that helps an individual transform, is also described in Tedeshi

and Calhoun's (1998) idea of an individual having their assumptive worldview shattered and having to develop new understandings through the process of deliberate rumination.

Overall, these terms demonstrate that there are other ways to describe the concept of growth after a traumatic life event. The present research contributes to reflection and debate on psychological growth in the field of interventions for refugees. Furthermore, some of the studies show an acknowledgement of growth within refugee's mental health and psychological interventions (Papadopoulos, 2007). Unfortunately, however, irrespective of this interest and discussion within the field of refugee therapy, such an approach does not yet have a place within the guidelines that govern the psychological interventions delivered in statutory services within the UK.

It is argued here that without a wider awareness, these approaches cannot integrate within symptom-based ones in a wider geographical area. While these explanations of psychological growth provide some theoretical perspectives to encourage thought in such a direction, these ideas arguably need to extend further in research and academic discussion in order to be implemented into clinical practice. Although there has been attempts to delineate the fundamental ideas of growth theories, e.g. PTG (Calhoun & Tedeschi, 2013), the mechanisms of growth development in therapy need to be further established, specifically to facilitate further understanding, which could benefit in seeing greater information on how any potential growth therapeutic models work in clinical practice, how they elicit and understand growth from the client perspective and how they may be delivered within statutory services in the UK. This may further support discussion and application in clinical practice.

Therefore, PTG has been the construct chosen to illustrate how growth-based thinking could be introduced into therapeutic practice because it delineates clear factors that define

growth, established from qualitative research and then became possible to begin to measure growth within individuals. It is acknowledged that these factors also risk becoming reductionist; however, as they were obtained from qualitative research and not from pre-conceived ideas, they are founded in client data. The development of a psychological therapy model may facilitate the task of establishing how a therapist recognises what growth is and how it may work at the level of the therapeutic relationship. Although Linley and Joseph (2004) have started developing a model, their theory may require further evidence-based studies.

3.2.3. Electing Post Traumatic Growth Over Other Growth Theories

Post-Traumatic Growth (PTG) emphasises that the assumptions upon which an individual bases their beliefs about the world, people and themselves are critically challenged after experiencing trauma (Tedeschi & Calhoun, 1996). These rules for living life become shattered (Beck et al., 1979), and according to the PTG theory, it causes a seismic shift in that person's worldview. Although Joseph and Linley (2006) make a valid contribution when explaining that an individual may need to accommodate their traumatic experiences in order to be able to move forward rather than just accommodate, such an explanation does not include how the individual's worldview may change. This is something that PTG may be able to facilitate, helping theorists and practitioners illuminate growth experiences in therapy.

Although there are other possible theories that attempt to explain psychological growth (as highlighted earlier), PTG was favourable for the present work as it is comprised of five factors that allow measurability to permit deductive study as well as scope for the development of the inductive data. Furthermore, PTG research spans three decades and across various groups, looking at coping beyond previous levels of functioning (Tedeschi & Calhoun, 2006). Faced sometimes with complex trauma, the therapist tries their best to apply a model onto severe

problems. The disadvantage of this approach is that it omits the context that places the refugee within the social world, giving multiple meanings to f their experiences. Therefore, widening the scope of the intervention so that clients can add their voice to their experiences may provide clinicians with greater hope.

PTG is a construct; thus, unlike CBT, it is not imbued in policies and institutions which is an advantage. Therefore, at this stage, PTG remains in a position to be shaped by the client and psychological therapist. In this research, PTG is the chosen phenomenon because other terms such as thriving, AAD and resilience do not take into account that an entire worldview can be shattered and that concurrently PTG is experienced (Calhoun & Tedeschi, 2013). Therefore, the construct of PTG does not merely pertain to coping or surviving a traumatic event. Rather, it purports psychological development and adaptation that has transformed beyond pre-trauma levels, which is not a mere return to baseline. Thus, there is a clear adaptation after the event, pertaining to the struggle with the trauma that is a critical component for PTG (Tedeschi & Calhoun, 1995), denoting that the individual has developed a greater level of coping than before. To experience PTG, the event would have created irrevocable change and damage to an individual's life. This differs from resilience, which would suggest that the individual has managed to cope with a low level of struggle and shifted back to their original coping with not much hindrance to their life. Similarly, the same level of deliberate rumination is not required. Thus, they have not experienced psychological change as suggested in PTG. The five factors of PTG and research are the key points that distinguish this from other growth theories that also facilitate the research design of the semi-structured interview schedule (see methodology, section 7).

Despite advances in the field of refugee psychotherapy with the development of narrative therapy (e.g. Schauer et al., 2011), which offers some hope in terms of advocating the client's story and the introduction of theories in resilience and growth, it is argued that for clients to benefit in therapy, the introduction of growth ideas into psychological interventions needs to be developed in clinical practice. In order to achieve this, research on PTG application in clinical practice and understanding the mechanisms of this phenomenon in practice from the perspective of therapists is required. It is hoped that the data from the present research may permit better understanding of the deductive element of PTG and how it contributes to the research design. This could provide an opportunity to find inductive data that may inform how this could work in clinical practice, i.e. the research must be driven by theory (deductive) and also produce new data (inductive) (see methodology, section7).

Table 1: *Therapeutic Perspectives of Psychological Growth Theories*

Growth Theory	**Main Theoretical Ideas**	**Theory to Practice Application**	**Critique and Areas for Development**
Adversarial Growth	Focus on the ideas of accommodation and assimilation (e.g. Joseph et al., 2006)	Assimilation: Brings new understanding in line with previous beliefs. Accommodation: Shifts assumptive beliefs to integrate understanding of what has happened.	Eclectic Not coherent enough

Adversity Activated Growth	1) The negative effects of trauma. 2) The development of resilience 3)Adversity Activated Development (AAD)	Resilience, Community therapy, Systemic approach	Does not explain the mechanisms of the therapy and how the client would change
Post Traumatic Growth	Mental shift through psychological rumination X5 factors 1. New possibilities 2. Relating to others 3. Personal strength 4. Spiritual change 5. Appreciation of life	5 factors that illustrate areas of growth that were developed through qualitative research: Expert companions – reducing the power imbalance, Research with many client populations.	Long-term study in psychotherapy services needed; Further demonstration of how the model could be integrated into psychological formulations

3.3 Identified Gap in Research

Counselling psychologists are faced with the task of supporting clients through difficulties and providing a safe space to explore and facilitate helpful change. Often, the limited repertoire of theories and therapies unfortunately leave psychological therapists with limited scope of areas to explore in therapy. Certain approaches such as cognitive are emphasised and recommended in guidelines, while others are deemphasised. This may remove the power from

the practitioner to deliver a more suitable and bespoke intervention. It is argued that the shift towards a growth perspective may open up possibilities in delivering therapies and permitting an acknowledgement of wellbeing, growth and positive psychology. Hence, the present thesis explores how the development of PTG can be considered within therapeutic approaches for refugees.

4. Part I: Post-Traumatic Growth Theory

During the 1990s, researchers Tedeschi and Calhoun (1995, 1996) introduced a new construct called Post-Traumatic Growth (PTG) to the traumatic stress vocabulary. They observed that in addition to negative symptoms, individuals often reported different forms of psychological growth in the aftermath of extremely traumatic events and that this growth occurred concurrently with stress. Thus, they developed the theory of PTG, which was followed by the Post-Traumatic Growth Inventory (PTGI) to measure this type of growth (Tedeschi & Calhoun, 1996). PTG is predicated on the notion that an individual can experience personal growth after a very stressful and traumatic event with the distinguishing idea that after struggling with stress, an individual may move beyond baseline levels of psychological functioning (Wilson, 2004). It is suggested here that this particular aspect indicates how PTG may support those who have been directly affected by forced migration as it provides insight into how refugee clients not only survive or cope, as in the case of resilience, but also emerge stronger than they were prior to the event. Calhoun and Tedeschi (2006) claim that PTG does not concern a mere hedonic pursuit of growth; rather, it is an experience that acknowledges loss and devastation while continuing to move forward. This offers a theoretical lens through which psychological therapists may start to consider how to manage growth raised by the client in the therapy session. However, without further theoretical exploration and application into practice, we cannot afford

the psychological therapists the endorsement and opportunity to start building such connections.

To explain what they mean by this shift, Tedeschi and Calhoun (1995) state that during a traumatic event, individuals may experience a serious challenge to their assumptive worldview or core beliefs about themselves, others and their place in the world. They purport that this challenge compels the individual to reconsider such core beliefs. It is reported in cognitive approaches that such beliefs are formed early in an individual's life and may be relatively stable across their lifespan (e.g. Beck et al., 1979; Beck, 1995). Therefore, this implies why this major internal shift could destabilise an individual's mental health to such an extent. Paradoxically, it is precisely through this cognitive disruption that PTG offers some insight into how an individual can rebuild their beliefs and personal meaning after such a difficult experience and how this deep reflection can affect the client by eliciting new beliefs and understanding (Calhoun & Tedeschi, 2006). This challenging process that involves rumination is a critical component to comprehend in PTG. However, it is also important to consider that the idea that mental health can be reduced to thoughts, feelings and behaviour is a rather parochial lens (cognitive approaches), which is suggested by professionals as providing a structure yet also limiting the scope of experiences. It permits the psychological therapist to guide the client to elicit their thoughts and feelings, yet may be equally directive and didactic. Therefore, in a similar vein to cognitive approaches, when applying PTG to clinical practice, practitioners need to remain mindful of this so that they understand its limitations.

The conceptual framework may be located in the area of positive psychology (e.g. Seligman, 2011; Lyubomirsky & Layous, 2013), where the emphasis remains on positive human experience and intervention focused on enhancing an individual's wellbeing, rather than merely eradicating symptoms. Accordingly, PTG as an intervention may be positioned within third-

wave CBT psychotherapies (Ost, 2008), which are newer adaptations of CBT which consider integrating concepts of positive psychology. The clinical outcomes of PTG would pertain to individuals not only experiencing fewer symptoms but also having grown in one of the five domains outlined by Tedeschi and Calhoun (1995, 1996) after processing their experience. It is recognised that reverting to the use of *symptom* reduction and then using factors that may be considered *reductionist* is maintaining limiting ways of working. However, the present thesis takes a moderate social constructionist approach (explained in the methodology) that accepts the systems that we work in, while maintaining a critical stance that allows new ways of thinking.

4.2. PTG: An Adaptive Response

In contrast to an inordinate focus on stress-based symptoms, PTG redirects the therapy emphasis towards growth-related psychological development. A distinctive feature of PTG is that it conceptualises an individual as capable of exceeding previous levels of coping. Therefore, PTG is an adaptive response that does not merely return to a baseline level of functioning (Jayawickreme & Blackie, 2014) and in this, it differs from other concepts of growth, as explained earlier. Therefore, the distinction here between a symptom-based and a growth-based approach is a shift towards expansion, where the former acts to relieve stress and the latter additionally considers longer term wellbeing. Any therapy considering psychological growth would support the client to think about how they are developing after the trauma. This denotes a shift in mindset for both the practitioner and client.

At this juncture, it is imperative to highlight that PTG does not negate the devastating impact of traumatic life events. Rather, PTG implies that growth can occur in parallel with suffering (Tedeschi & Calhoun, 1995, 1996, 2004), which is explained next.

4.3 Stress and Growth: Concurrent Processes

According to Tedeschi and Calhoun (2004), PTG occurs concomitantly with stress symptoms such as flashbacks. This dual process was explored by studying the relationship between growth and depreciation following a "highly stressful event" (Baker et al., 2008). The researchers administered the PTGI (Tedeschi & Calhoun, 2004) and an equivalent depreciation scale. The main finding described that while both types of change were reported, there was no correlation between the two and growth was seen at much higher level. In this way, Baker et al. (2008) supported the idea proposed by Tedeschi and Calhoun (2006) that growth is an adaptation that moves beyond previous levels of functioning. Furthermore, this finding may also support the notion that stress is an initial part of coping that can be followed by PTG in the longer term.

However, stress is reported as having a curvilinear relationship to growth, i.e. after a certain point the growth diminishes. Notwithstanding that there are individual differences, the sooner PTG is experienced, the less likely individuals are to develop PTSD. The stress is seen as a catalyst towards PTG wherein a new sense of self and understanding of life is transformed. Therefore, when assessing and treating stress, this is considered in parallel to growth experiences. In this way, PTG is not something to replace existing therapeutic interventions but rather to work alongside them. Thus, it is of interest to this thesis to understand in greater detail the mechanism by which this process takes place, in particular how the time frame may facilitate PTG and how the process of PTG may occur alongside stress.

4.4 Proximate Groups and Group Interventions

Tedeschi and Calhoun (2010) suggest that there are two major influences within the social and cultural context related to how an individual may come to understand and process the trauma. First, they state that there are "proximate groups", which are formal and informal groups

that the individual belongs to: for example, family, friends, tribes, clubs, etc. How the group behaves towards the individual will influence their behaviour. In this case, how the group conceptualises and understands post-trauma experiences may influence the degree to which the individual experiences PTG (Tedeschi & Calhoun, 2006, p. 3). The social norms set up by the "primary reference group" (Arglye et al., 1981) create approval and disapproval according to adherence. The group may set up norms related to how to cope after a traumatic event, understandings around what helps and to what degree emotion is accepted. Tedeschi and Calhoun (2006) suggest that this establishes how an individual may be influenced by their primary reference group with regards to the degree they experience PTG. Second, there are "distal" influences that are mediums such as books, films and television. Therefore, depending on how the refugee client was influenced by their groups, it may promote or inhibit their recovery and growth in therapy. The impact of these social groups is therefore an important factor to consider in recovery from trauma for refugee clients and when designing and delivering corresponding interventions.

4.5 Other Factors that Contribute to Post-Traumatic Growth

4.5.1 Adjustment

In addition to the relationship between stress and growth, there are other psychological factors that may contribute to PTG. For example, adjustment is a factor that is defined as balancing their behaviours to better enable an individual to reconcile an obstacle. To achieve this, they adjust their perception as needed. This is illustrated in a longitudinal study by Zoellner and Maercker (2006), focusing on perceived growth and adjustment. The results indicate that PTG had a moderating effect (a changing effect) on adjustment, showing some correlation. The key difference is that adjustment usually pertains to needing to shift behaviour and activity in

order to meet a human need such as hunger and social activity. However, it does not reflect an internal rumination as with PTG, as outlined earlier, which is a deliberate reflection in thinking and feeling that is an attempt at survival and a need to lower distress levels. In comparison, adjustment is a more simplistic process linked to human survival, involving negotiating the balance between needs and obstacles. Thus, PTG could be perceived as a process that develops over time and adjustment is a survival technique.

4.5.2 Self-Coherence

Second, self-coherence has manifested as a trait that has been shown to contribute to PTG as it helps individuals cope with adversity in the process of managing external stimuli. There is a degree of self-integration at the level of individual traits that permits a person to better engage in the PTG internal rumination process (e.g. Aldwin, 1994; Tedeschi & Calhoun, 1995).

Additionally, personality factors have been noted as affecting PTG – a study found positive relationships between the five dimensions of openness and extraversion (e.g. Evers et al., 2001). Overall, these findings may provide further support for the idea of baseline factors contributing to how and to what extent one experiences PTG. Therefore, it may be necessary to consider individual differences in any clinical application of PTG.

4.5.3 Key Differences Between Adjustment and Resilience

Resilience is the notion that, despite the challenges an individual has faced, they have maintained aspects of their emotional, psychological and physical wellbeing. Therefore, after the challenge has passed, they are able to return to a "baseline" level of functioning. In this way, the individual has not become excessively impacted by the change, and it has not left irrevocable damage in their life (Tedeschi & Calhoun, 1995, 1996). Equally, they did not necessarily develop new cognitive and emotional strategies to cope; rather, they used coping strategies that

were already familiar to them. Therefore, they have not had to change much of their internal coping processes.

In comparison, PTG takes the individual beyond their original baseline levels of functioning. This is because they have suffered from a traumatic event that has left a permanent mark on them. Tedeschi and Calhoun (1995) suggest that, due to a life-shattering event leading to an individual questioning themselves, the world and others, an internal rumination process is triggered, and that it is through this process that an internal shift occurs. They call this shift PTG and, as a result, the individual develops new cognitive and emotional coping strategies. In addition, it is posited that they develop new ways of understanding the self, others and the world. In this way, the individual has shifted beyond the baseline levels of coping that were stated in the case of resilience. As such it is important to understand that PTG is never the goal of the individual but the result of a difficult internal process.

4.6 Critique and Limitations of PTG

The PTG theory is introduced by the author with some reflection and to guide the readers' understanding of this new type of approach within psychological therapies. However, as with any theory, there are some critiques to consider.

There are limitations to PTG and Tedeschi and Calhoun's model that require further clarification, and these have been addressed in their recent work (2013, 2015). First, a challenge to its validity is posed by the Post Traumatic Growth Inventory (PTGI) measure that relies on perceptions of how much and in what manner an individual experiences PTG. These accounts can vary among individuals and may also depend on their individual differences, their developmental history, their personality, internal resources, coping mechanisms and their support

system. Therefore, the question of how accurately this measure changes from person to person arises.

Also, before and after research studies are challenging as trauma is an unpredictable event and, therefore, obtaining such data is not a straightforward task. If a client is extremely overwhelmed by trauma, they will not immediately experience PTG; however, at moderate levels of stress, the client can experience PTG (Tedeshi & Calhoun, 2006). Therefore, it is not guaranteed that every refugee client will experience PTG, as some experiences may have deeply impacted their internal resources and ability to cope.

Further, it is important for practitioners to be mindful that PTG may not be a possibility for every client. There is a risk of the model becoming reductive, fixed on measures and, therefore, positivist. One critique here is that a PTG approach may still take on a reductionist stance towards the experience by defining what does and does not constitute growth through its use of the five factors (1. New possibilities, 2. Relating to others, 3. Personal strength, 4. Spiritual change, and 5. Appreciation of life). Thus, practitioners should acknowledge that processing a traumatic event is a continuous experience that may extend beyond the five factors.

Nevertheless, due to the dominance of the stress paradigm, new theories such as PTG pose less of a threat. However, it is still useful to remain critical and reflect on how a theory could develop over time. For example, using this approach may invite clinicians to adopt a saviour discourse (Mutua, 2001) in reprisal towards an oppressive medical model that still shifts the gaze away from the contextual structure to a certain extent. Thus, when refugees are not from the West (or Western developed countries), this gaze may reemphasise social inequalities. That is to say that social discourses disadvantage migrant populations settling in the UK. As a

result, psychologists need to remain reflective and ensure that they do not become complicit in such a dynamic.

Of course, such limitations of this perspective should be acknowledged and raised during clinical supervision and in forums outside of this space as these issues have a wider significance. Nevertheless, it is possible that PTG in clinical practice enhances the conceptual value of how refugee trauma is understood and, therefore, reveals a scope beyond a symptom-based approach, permitting therapists to explore the personal significance of the experience. In this way, the PTG phenomenon may expand upon previous understandings of what happens after trauma, while encouraging practitioners to remain reflective. Overall, PTG would be considered less reductionist than other approaches such as CBT, as it contemplates that the client may have a range of experiences that extend outside of their symptoms, and it seriously considers that they have a range of resources to cope and thrive (Calhoun & Tedeschi, 2013).

Without such discussions, practitioners run the risk of not questioning the accepted models that dominate statutory services. Trauma can be critiqued without necessarily shifting towards PTG; however, clients have a multitude of post-trauma experiences that need to be validated. As such, there is a tension between focusing on the experience of trauma as real and appreciating the wider social context, which is why a moderate social construction epistemology (theory of knowledge) has been adopted (as explained in section 8). In brief, the material reality of the PTG phenomenon has been acknowledged, and the social processes that generate this knowledge have been considered (Willig, 2012). Thus, by shifting the lens towards PTG in clinical practice, it is argued here that there is an interruption in the accepted power dynamics that has developed over a temporal and historical context. This involves the power of policies

and institutions to define cause, symptoms and treatment in such a definitive manner that has left an impact on refugee clients.

5. Part II: Post-Traumatic Growth in Clinical Practice

5.1 The Importance of Psychological Interventions in the Context of Social Justice

Social justice is the notion that the social inequalities within the wider context are considered and challenged for groups and individuals. An example of a social justice initiative in practice is highlighted in the sections below to demonstrate what psychologists may do and how they may use this additional lens to support their practice, specifically pertaining to working with refugee clients.

In 2015, the psychologists in the British Psychological Society (BPS) initiated a public initiative towards supporting those that have experienced forced migration by developing the Presidential Refugee Migration Taskforce (BPS, 2018), which comprises expert psychologists in the field of trauma and refugee work in the UK. The board members within the BPS have contributed to refugee work from a theoretical perspective and in clinical practice, with the chief aim of supporting psychological knowledge and practice in this field. This endeavour by psychologists highlights refugee needs in order to influence psychological therapies for this client group in the UK. It also demonstrates the profession stepping into the social and political field.

If psychological therapies were informed by a social justice perspective, the distribution of power would be challenged through the questioning of existing norms in therapy practices. Of course, there are limitations, and larger institutions may need to be questioned to take on a fuller social justice perspective. It is by addressing these power imbalances that psychologists working with refugee clients can return power to the disenfranchised. In this way, the refugee clients are

not labelled as devoid of personal agency or helpless, and psychologists are not merely their helpers perpetuating a saviour discourse or presenting a solution based on Western norms (Mutua, 2001). Accordingly, reflective psychologists are required to be mindful of social justice in their clinical practice to avoid reinforcing individualism as this may deny the real experiences of refugees that are very much impacted by social forces.

5.1.1. Applying Social Justice to Clinical Practice with Refugee Clients

It is important that the therapist does not view the client's presenting issue and circumstances as solely limited to the therapy session and acknowledges the wider context. After all, clients and their therapists are individuals that are part of the wider fabric of society. For example, at the stage of referral, there may be information regarding the client's social circumstances (housing, immigration status), and this may be factored into the psychology assessment when considering their readiness for therapy. Also, when considering the goals of therapy during an assessment, their social needs, beyond their thoughts, feelings and behaviour, could be considered within the formulation. In addition, when planning the client's treatment, an individual client's circumstances and social needs, as well as the needs of the communities to which the client belongs, should be considered. The wider implications of this thesis within the context of service delivery are considered in the discussion (section 10).

5.2. Post-Traumatic Growth (PTG): A Model and Intervention

Using qualitative data derived from individuals that have experienced trauma, Tedeschi and Calhoun (1996) divided the PTG construct into three broad areas which are comparatively less narrow than in a symptom-focused approach. The following perspective presented is to apply PTG clinically within a refugee population as an intervention in which therapists facilitate and support growth experience.

Self-Perception

This entails changes in an individual's *self-perception* (resulting in feeling more self-assured and confident as a result of having found new strength). This is a subjective assessment of how an individual views their self-concept. In this regard, a refugee client may view themselves as having developed new qualities, a construction perhaps less encouraged in more symptom-focused approaches.

Interpersonal Relationships

This entails changes in an individual's *interpersonal relationships* (increased appreciation and compassion towards others and a greater capacity to receive support from others) (Aldwin, 1994). This idea concerns the feeling that one is connected to others and, therefore, may affect one's behaviour towards them. A meta-analysis studying the factors related to PTSD found that social support was a protective factor. In particular, the early responses and reactions were crucial (Brewin et al., 2000). Again, the refugee client may develop self-compassion and may also reach out for support. This construction allows the client some control within a therapeutic setting by breaking down power dynamics.

Philosophy

This entails changes in an individual's *philosophy* (appreciating the value of life, setting new positive goals and finding new spiritual meaning) (Tedeschi & Calhoun, 2006). Thus, individuals revaluate what they believe is actually possible for them. This permits refugee clients to be reflective about what life means to them and allows them to construct a more nuanced interpretation of their personal beliefs.

The Five PTG Factors Explained

PTG in clinical practice suggests that there is a simultaneous process of loss and growth involving the reconstruction and development of multiple aspects of the self. There is a possibility that individuals perceive themselves as not destroyed by their trauma. Thus, there may be an overall shift in how the client views themselves, the world and others (Beck, 1995; Beck et al., 1979). Tedeschi and Calhoun (1995) assert that the greater the traumatic experience, the higher the likelihood of experiencing PTG. Therefore, lower levels of PTG may be reported in some cases.

Continuing from the three broad areas discussed previously, Tedeschi and Calhoun (1995, 1996) further developed the notion of PTG by defining five factors in the construct, as follows: new possibilities; relating to others; personal strength; spiritual change; and appreciation of life.

Table 2: *Five Factors of PTG*

	Tedeschi & Calhoun's Five Factor Model	Description of Factors
1.	New possibilities	Being open to new experiences Thinking that new things can happen Making future plans
2.	Relating to others	Appreciating existing relationships

		Accepting changes in relationships Openness towards building new relationships
3.	Personal strength	Discovering and becoming aware of newfound strength
4.	Spiritual change	Reflecting on the meaning of life and one's place in the world Expanding one's worldview
5.	Appreciation of life	Appreciating small and bigger things in life Appreciating shifts in priorities

According to the theorists, individuals reported a change in their priorities and an appreciation of the smaller things in life (Tedeschi & Calhoun, 1995, 1996). They also reported more meaningful relationships and presented as having greater compassion for others in similar situations.

Individuals also showed an increased recognition of personal strength. This is obtained by becoming vulnerable and knowing that if one's difficulty has been overcome, other obstacles can be overcome as well. Furthermore, new spiritual beliefs or asking existential questions may also form a part of this experience of growth. It is paradoxical that strength develops out of

vulnerability and that deeper faith comes from spiritual doubt. Yet, Calhoun and Tedeschi (1998) argue it is precisely these paradoxes that promote dialectical thinking, which reviews the experience post-trauma from multiple perspectives. It is this deliberation that may consequently lead to developing critical insight into the experience.

Of course, one needs to remain critical that such ideas of growth are derived from positive psychology that may foster a saviour discourse, implying that refugees are helpless and need to be saved. However, a growth perspective still permits greater freedom in client engagement, unlike identifying predefined symptoms that individuals possess. Of course, such symptoms have a function to guide practitioners and ascertain means to support a client, yet other aspects of the impact of the traumatic event should not be excluded. As such, it is suggested that refugee clients define their own experience and that their expertise is valued. In practice, this may involve shifting the focus from mechanical therapy questions, that lead to a predefined outcome, to a qualitative approach, that facilitates further understanding. The criteria of success in the former would be an improvement in symptoms, while that in the latter would shift towards a subjective appraisal by the client. The first is verified by questionnaire scores and the second is verified through a shared understanding reached by the therapist and client.

Individuals reconstruct their lives after trauma in different ways and research has left little doubt that some of this growth is facilitated by cognitive and emotional processes (Calhoun & Tedeschi, 2013). This process gives the individual the ability to construct meaning from how they understand the aftermath of the traumatic event. To support an understanding of this process, PTG has been established as a way to explore, define and measure such growth. However, beyond establishing the base that psychological growth can occur, such studies have said very little about the precise mechanisms that PTG involves, explores and understands in the

context of the therapy room. Furthermore, one could suggest that understanding growth might improve clinical practice and therapeutic outcomes. This is because learning to understand the processes of growth in clinical refugee populations might disclose the aspects of intervention that a therapist could use to provide greater attention in delivering therapy.

Using any such intervention would need to be considered in the context of the referral, assessment and formulation. From this point, the clinician would consider which intervention would be most appropriate. This thesis takes on the task to consider such a shift in clinical practice.

5.2.2. PTG as a Psychological Mechanism: Cognitive Impact and Time of Intervention

Internal Rumination

It is argued that considering the difficulties at the level of thoughts, feelings and behaviours does not take the intervention far enough. PTG would have to include the concept of deliberate rumination, which would involve the individual reflecting on their difficulties that then culminates at a point where they see a new perspective (Tedeschi & Calhoun, 2006). This moves beyond the rather mechanical view of the cognitive triangle that challenges thoughts to impact feelings or changes behaviours to shift feelings (Beck, 1995). Rather, PTG is considered a transformational process that happens within the individual's mind.

Tedeschi and Calhoun (2006) suggest that the intrusive thoughts an individual has early on in the post-trauma period are related to higher levels of emotional distress and a greater disruption of beliefs. Rumination that occurs later on is less intrusive and more deliberate. The individual is still in some distress; however, they are now making sense of and rebuilding their assumptive beliefs by using the distress as a motivator. This may in turn reduce their levels of distress.

In therapy, the role of the practitioner is to listen, engage the client and elicit and engage with such thinking (Culley & Bond, 2011). They must reflect back this kind of thinking until the client reaches the stage of a new perspective. Therefore, PTG serves as an adjunct construct that adds to the already established cognitive therapeutic approach. However, it is acknowledged that the limitations of CBT would still co-exist with this approach.

Shift in Core Beliefs and Assumptions about the World

Tedeschi and Calhoun (1996) assert that it is not the traumatic event itself that is responsible for PTG; rather, it is the internal rumination within the individual that leads to them developing a new cognitive understanding. Through this process, set beliefs may be nullified in an instant. For example, an individual may have believed that all people are good; however, the traumatic experience revealed another side of human nature to them. It is the internal cognitive restructuring after the event that produces new schemas (beliefs about the self, others and the world). These beliefs may replace or redefine old beliefs. Here, the vital feature is that experiences have an affective rather than a merely intellectual component (Joseph et al., 2012).

Calhoun and Tedeschi also suggest that PTG is a result of attempting psychological survival rather than consciously trying to find meaning in what has happened (2006). This can be compared with CBT for PTSD, which would stop at the level of symptoms. However, PTG may offer a paradigm shift as such processes of deliberate rumination are not merely thinking differently or even positively. Rather, they are processes of internal struggle and reflection. This can be differentiated from CBT processes where an individual ruminates and the psychological therapist facilitates a shift of the client's attention away from negative thinking (Beck, 1995). Thus, PTG in clinical practice may allow the practitioner to encourage a client to think about

their experience in a way that allows them to define what it means while also looking towards the future (Calhoun & Tedeschi, 2013).

At the core of the PTG theory is the premise that growth emerges from a guided reflection of a life event that seriously challenges an individual's "assumptive worldview" or their beliefs about the self, the world and others (Tedeschi & Calhoun, 2004). This suggests that an individual who has experienced trauma engages in deeper rumination. This is similar to depressive rumination as it entails repeatedly thinking about the event. (Beck, 1995). However, the differentiating factor is that this progresses into a rumination that is focused on meaning-making for the individual. It involves shifting from a complete focus on the loss to reflections and questions about the future, and this is when PTG becomes possible. This process can also be facilitated through psychological therapy (Calhoun & Tedeschi, 2013). Another key feature is that PTG is influenced by pre-trauma variables such as personal and social support (Tedeschi & Calhoun, 2004). Thus, baseline feelings can affect how the individual processes the event, how they experience PTG and to what extent. Hence, when considering the effect of PTG, it is necessary that existing vulnerability is taken into account and also that individual differences are considered on a case-by-case basis (Peterson et al., 2008).

In their revised model, Tedeschi and Calhoun (2010) also showed the relationship of PTG with indicators of wellbeing. They are quite clear that PTG is not reducible to a measure such as happiness. Instead, they relate PTG to developing wisdom in the context of their life narrative that recognises the complexity of the world (Tedeschi & Calhoun, 2006).

Summary

Overall, it is claimed that there is a psychological mechanism that works in the development of PTG emotions and cognition, as defined by Calhoun and Tedeschi (2013).

However, a criticism of this approach may be that it lacks the extensive evidence base consisting of randomised controlled trials (RCTs) that exists for CBT (Layard, 2006). This is not to uncritically accept RCTs as a gold standard but to acknowledge that this is the standard set within current practice. As such, CBT itself may be criticised as limiting the individual to the level at which they are cognisant of their mental health, or how much they are able to access their cognitions at that moment.

The conceptual framework of thoughts, feelings and behaviour could be viewed as positing an objective truth that only negative thoughts are to be studied and, subsequently, explored in therapy. However, it is argued here that it may be possible to think beyond such a narrow lens. There is already data on the biological processes of traumatic stress (Ehlers & Clark, 2000) and it is argued that there is a need for greater research on PTG processes. The present argument encourages an understanding of the development of other constructions when approaching refugee psychological therapy. However, the challenge of a clinical approach such as PTG is that it is less established than PTSD and CBT, its matching trauma-focused therapy (Cohen et al., 2006). Hence, the aim of this thesis is to further emphasise the urgency of researchers such Joseph and Linley (2004) and Papadopoulos (2007).

5.3. Literature Focus in a Clinical Context

The benefits of the clinical relevance of PTG theory to various populations have been researched from the perspective of different types of traumatic experiences and populations. These include military combat (Aldwin, et al., 1994), individuals who have survived abuse from an intimate partner (Cobb, et al., 2006), rape (Borja et al., 2006; Smith & Kelly, 2001) and bereavement (Taku et al., 2015). These studies demonstrate how PTG may develop within different clinical populations and illustrate that there is some evidence supporting such a stance.

While there isn't any scope here to examine each of these clinical areas in detail, I shall discuss the PTG research that is particularly relevant for both the discipline of counselling psychology and its clinical applications below. The purpose of this approach is to understand the utility of this construct from the perspective of psychological therapists, with the aim of facilitating an understanding of its possible influence on clinical practice and therapeutic outcomes when working with refugee clients.

The discrepancy between the focus on stress-related symptoms and the rarity of studies that explore growth development in therapy settings has been highlighted as a problem of inordinate focus on distress and psychopathology (Calhoun & Tedeschi, 2013; Tedeschi & Calhoun, 1995, 1996, 2006). Therefore, it is necessary to develop research that expands the current understanding of the PTG phenomenon within clinical settings, specifically pertaining to working with refugee clients.

This thesis examines the limitations of stress-symptom-based approaches and how growth-orientated psychological interventions may support psychological distress following human displacement. This field of enquiry was neglected until the end of the twentieth century. More recently, as the vast majority of studies on refugee interventions have focused on policy-led therapies that are aimed at short-term treatment, this continues to have been less of a priority. Maintaining a critical position is pertinent to developing new ways of viewing knowledge in this area; however, the institutionalisation of such ways of working informs how psychological therapists think and what is subsequently offered to clients. One possible reason for this paradox is that a great deal of the terminology belonging to clinical practice was taken from the medical domain and sits well in clinical psychology. Hence, the first task is to situate PTG in a counselling psychology domain. By doing so, psychological therapists can construct therapy that

is commensurate to counselling psychology values, as they reflect on their clinical practice within the context of their clients' experiences, permitting more self-authored client material to emerge.

5.4 Vicarious Post-Traumatic Growth

Overall, the main area of PTG therapy research on refugees has been vicarious stress and growth. For example, a study of clinicians working with distressed trauma clients looked at 430 care workers using a 21-item belief survey (Tehrani, 2007). Factor analysis indicated that three factors showed a negative impact on beliefs and one factor labelled "growth" indicated that positive beliefs had been reported. These results provide some evidence of PTG occurring at the same time as stressors when working with trauma clients. This may even support the idea that stress and growth occur concurrently and that initially, stress may have a greater impact. However, more evidence is required. The following study is a more recent example of how stress and growth can affect such workers. Therapists are part of a shared experience and they simply cannot be bracketed out from the client's experiences of both stress and growth. Therefore, therapists simply cannot omit this aspect of PTG from themselves or their clients.

The manner in which therapists are affected by PTG through their work with refugee clients is elucidated in the work of Barrington and Shakespeare-Finch (2012). The authors reported that PTSD and PTG took place simultaneously, which is consistent with the findings of other studies (Baker et al., 2008). The qualitative study was conducted in Australia using interpretative phenomenological analysis (IPA) (Smith, 1996) and included interviews to explore vicarious PTG experienced by 17 therapists and other workers who had contact with refugees. It is important to note that the focus was on the lived experiences of therapists, which is not the focus of this current research. Both vicarious trauma and growth were reported (Barrington &

Shakespeare-Finch, 2012, p. 89) and a key finding of this study was that "effortful meaning making" facilitated positive change. Although the interest of this paper is not in the therapists' experience, this finding supports the earlier literature of Tedeschi and Calhoun (1995, 1996, 2004) that rumination is a deliberative process that works to develop positive affect in clients. Other studies have also focused on concepts such as burnout and secondary trauma (Century et al., 2007; Eleftheriadou, 1999).

One systematic review tried to understand the main factors that were important in delivering therapy to refugees. The findings showed that areas such as "mutual understanding", addressing the complexity, raising cultural issues were important to working well with the refugee client (Karageorge et. al., 2017). Overall, it was deemed important to provide continuity with the refugee client's narrative and to empower them. This study demonstrated some utility in interviewing psychological therapists to understand their views on providing therapy to refugee clients.

These studies show some evidence of PTG; however, as in the abovementioned study, they have a greater focus on personal experience and focus less on the theoretical construct itself. Therefore, it appears that there is still a discrepancy in the literature between experiencing PTG personally and reflecting on the theory's practice. This provides an opportunity to examine how PTG could be used in clinical practice to better the current understanding of refugee psychological therapy.

Studies expressly concerned with PTG and clinical interventions are explored in the next section. As there is limited research on counselling psychology and refugees, and the area of interest is usually the mechanism of PTG and how it develops in therapy, this research has been better developed in other areas, some of which are also discussed below.

5.5. PTG Clinical Techniques

It is useful to understand how PTG has been studied in relation to clinical interventions and applied to therapy. This section explores the same.

5.6 Timing of Clinical Interventions

As previously mentioned, rumination following a traumatic event plays a fundamental role in how PTG develops. An example of this is a cross-cultural study of American and Japanese university student samples, which measured intrusive versus deliberate rumination (Taku et al., 2009). The hypothesis that there would be a relationship between all the types of rumination and PTG was supported. The authors concluded that rumination is multi-dimensional, meaning that it occurs at more than one point in time, either immediately after the traumatic event or at a later time. The key finding was that recent deliberate rumination best predicted the PTG levels of both samples. While the authors mentioned that one limitation was that the study had a cross-sectional design, the findings support the idea that earlier rumination is most indicative of PTG.

The recommendation for therapists and educators is that recognising immediate, deliberate rumination may facilitate an understanding of recent emotional coping and, therefore, may have implications for longer term coping beyond the previous levels of functioning. Early intervention could take the form of immediate therapeutic intervention by trained clinicians offered closer to the site of trauma. There may be some reflection required to appropriately integrate this therapy into existing treatment. However, it is suggested that barriers to this may be clients requiring access to other kinds of support and having basic needs such as housing, as well as waiting lists. Later, this intervention may then be repeated as aftercare to ensure the

impact of the therapy and as a relapse-prevention method. Another reflection is that seeing clients at the asylum-seeking stage may support their subsequent wellbeing. In summary, early counselling could be seen as a way of preventing the exacerbation of emotional problems.

5.7 Recent Clinical Intervention Research into PTG

Recent literature has provided further understanding of what the application of PTG to clinical practice could look like. This has the potential to explain how therapies are designed and delivered, particularly for a UK-based refugee client group. Some studies that have explored PTG in clinical practice are outlined in the following sections.

5.7.1. Solution-Focused Therapy (SFBT).

First, a study by Zhang et al. (2014) demonstrated the impact of delivering solution-focused brief therapy (SFBT) group work on PTG. A quasi-experimental design used a sample of 43 mothers, each with a child that had autistic spectrum disorder (ASD). Of those 43 mothers, 18 were in two SFBT groups, while the remaining 25 were in a control group that received no psychotherapy. Using the PTGI to measure PTG levels at baseline and at six months after therapy, the results indicated that those who attended SFBT reported higher PTG scores at both time intervals. In this case, the authors suggested that further research might indicate whether SFBT can demonstrate the benefit of promoting such therapy to increase what they term as the "positivity of clients".

It may be useful to ask if this addresses the wider question of whether psychotherapy itself can invoke PTG in order to help clients function better. As such, it may be beneficial to study the components of SFBT and how it works to foster positive treatment outcomes in order to gain a greater understanding of how PTG develops and how it enhances mental health. In this way, clients are allowed to look for solutions, rather than focusing on problems. Conversely, by

ignoring an individual’s capacity to solve problems, we further contribute to their sense of victimhood. A psychological therapist mind-set that facilitates exploring solutions to challenges agreed with the refugee client may be helpful for them facing many practical daily challenges. This contrasts a mind-set where therapists explore symptoms, which makes it is necessary to ask whom such a perspective serves. It is possible to suggest that PTG may serve neoliberalism, with its focus on personal responsibility, thereby potentially distancing itself from the social structures that shape our lives. However, understanding that the client has some intrinsic value to offer is a crucial part of therapy that seeks to uplift their self-esteem and fosters growth (Rogers, 1961).

5.7.2. Cognitive Behavioural Therapy (CBT)

An alternative opinion was formed when PTG was examined as an automatic outcome to CBT (Zoellner et al., 2011). The outcome of the study cautioned researchers not to prematurely anticipate PTG as a standard positive outcome to measure the effectiveness of treatment. Rather, they put forward two PTG factors that emerged as increasing after delivering CBT. Here, the PTG theory is explored from another perspective; the research explored the treatment effects on PTG and subdomains using an RCT design of CBT for PTSD with a sample of 40 road-traffic-accident survivors assigned at random to either a waiting or treatment condition. The PTGI was used as a measurement of PTG. While CBT was shown to be highly effective for PTSD symptom reduction, there was no general effect on PTG, which contrasted with previous studies. Therefore, such a study shows that it is possible that some aspects of PTG may develop to a greater extent than others. However, this does not negate the idea that PTG can be positively influenced in therapy. It is possible that the increase of a positive affect (emotion) could include aspects of PTG.

Certain aspects of Tedeschi and Calhoun's theory (1995, 1996) may be more relevant to refugee clients than others. The remaining task would be to determine how one makes a clinical application of this learning. One idea is that PTG may shift towards disrupting the idea of the client being labelled a victim but rather viewing the client as an individual that has internal resources that they can utilise. Of course, the notion of the victim may be a necessary part of maintaining distinctions between perpetrators and those impacted and to ensure that individuals receive support from services. However, this may also be an indicator that in the long term we need to reconceptualise how services are delivered and how we use language.

6. Part III: PTG and Counselling Psychology: Clinical Application

6.1. Therapeutic Relationship

A common understanding in psychological therapies is that, regardless of therapy model, the therapeutic relationship is the vital component in intervention success. Therefore, focusing on this aspect is central to developing any therapy model (Norcross, 2001, 2002). As one of the founders of the humanistic approach to psychology, Carl Rogers supported the idea that therapists who were genuine, warm and offered unconditional positive regards in the therapy process facilitated the greatest therapeutic change in their clients (1961). Notwithstanding some contemporary literature that may call for a more broad and nuanced approach (Cooper, 2008), the therapist will still typically have these innate and learned attributes and have developed them through practice, along with other skills. Furthermore, the literature has illustrated that developing a therapeutic relationship with the clients in such a way may facilitate PTG and this can most noticeably be seen in the more recent work of Calhoun and Tedeschi (2013).

6.1.1. Barriers to the Therapeutic Relationship

However, although most therapists will show respect and warmth towards their clients, along with unconditional positive regard, if they have not taken into account the refugee client's social context, this may limit the therapy. Obvious barriers such as language and power imbalances may also be present, but also not understanding the person's pre-and post-migration experiences, their proximate group experiences and distal cultural expectations will mean that the therapist is operating outside of the client's frame of reference. Thus it is possible that this lack of perspective may impede the initial assessment and the development of therapy.

6.2. Client-Centred Approach

Calhoun and Tedeschi (2013) locate the practice of PTG in the remit of practitioners that they call "expert companions". They are not exclusively clinicians, yet they have a reason to be considered experts either through experience or education. The PTG clinical model shifts away from clinical expertise and shares the power of expertise. Such an intervention of sharing expertise guides the refugee client and helps them to rescript their experience in a way that is empowering and understand how to live with what has happened. This could be viewed as a person-centred approach to recovery and facilitates a shift towards self-exploration (e.g. Rogers, 1961). It does so by moving beyond the boundaries of CBT-based therapy protocols and permitting clients to discover new things about themselves as a result of having to ruminate as a means of psychological survival. The psychological therapist may be able to facilitate such an environment that acknowledges that the refugee client is the expert on their experience and that more may be required from the therapist. It is by understanding the mechanisms of PTG clinical intervention through psychological therapist accounts that this research aims to secure an understanding of how it develops in therapy.

7. Growing Need and Application of PTG in Clinical Practice: Thesis Rationale

Regardless of a therapist's conceptual preferences, when adopting a critical stance towards the social construction of popular ways of delivering therapy, they may understand how the current practice positions refugees and how this influences subsequent interventions. Psychological therapists may begin to think about how they can offer more to refugee clients in clinical practice and, therefore, it is vital to expand knowledge in this area.

Recently, the PTG phenomenon has initiated a shift towards clinical practice (Calhoun & Tedeschi, 2013). As earlier emphasised, while other psychotherapies already in use are evidence-based (such as CBT), this research focuses on longer-term coping mechanisms for refugee clients that have suffered trauma. Hence, it shifts away from a predominantly pathological perspective. Although CBT skills can be learned and clients can be re-referred for therapy, the focus here is on how the therapist uses their skills to facilitate more open-ended client-therapist interactions and facilitates growth. This growth perspective seeks to understand how individuals can rewrite their personal narratives in a way that shifts them, for example, from "victims" to "survivors" and, thereby, allows them to have greater control over how they perceive their experience. However, it is necessary to be careful not to homogenise such experiences or views.

The recent advent of PTG in clinical practice (Calhoun & Tedeschi, 2013) offers counselling psychology a timely opportunity to understand the therapeutic mechanisms of PTG (Joseph & Linley, 2006) that facilitate the psychological growth process in greater detail and how this may contribute to treatment outcomes (Lambert, 2013) for refugee clients.

Psychological therapists' theoretical and reflective knowledge of PTG may inform how PTG emerges when interacting with clients, how the therapist plays a role in eliciting this

growth, how this co-construction creates changes in the client, how the therapeutic techniques facilitate change and how clinical practice interacts with theory. A useful exercise may be to identify the conceptual framework that growth occurs within, the processes, terminology and overall knowledge, and to understand how psychological therapists construct ideas of the mechanisms of PTG in clinical practice.

Here, even a minor understanding of the mechanisms of PTG processes may demonstrate a benefit to psychological therapists working with refugee clients for the following reasons.

7.1. Mechanisms of PTG

First, the exploration of PTG may clarify the actual therapy mechanisms that underlie PTG. For example, a mechanistic role for rumination is exploring the pain of what has been lost. On the other hand, findings from the research have suggested that a psychological therapist facilitating emotional processing helps their clients to achieve growth (Calhoun & Tedeschi, 2013). Therefore, it is conceivable that expressly targeting such rumination at an early point in therapy is most beneficial to the client (Taku et al., 2009). Further, just as therapists have learned how to help clients manage chronic and acute symptoms of emotional distress (Linehan, 2015), discoveries in other areas e.g. with cancer patients (Ochoa & Casellas-Grau, 2015) may help the profession to comprehend concepts such as PTG, which plays a role in defining refugee wellbeing into psychologically-relevant subcomponents. However, to make such elementary steps, psychological therapists would require permission to expand such knowledge and understanding, followed by support in using this agency of seeking and facilitating growth in their clients.

7.2. Therapists' Knowledge

Second, the psychological therapists would be regarded as having knowledge of delivering interventions. This means that they are the experts of their own interpretation and implementation of psychological therapies. Although psychological therapists may have much knowledge, this is not comparable to theoretical knowledge. They can demonstrate how theory–practice links are implemented in the therapy session. For example, some research has shown that therapists themselves experience PTG, and one might speculate that, in this research, therapists demonstrate this knowledge of PTG when working with refugee clients (Barrington-Finch & Shakespeare, 2012). It is possible that this knowledge could then be applied to data to better understand the function of PTG in clinical practice when working with refugee clients, which was formerly an area only addressed by the client.

7.3. Adjunct Therapies

Third, knowledge of PTG could help target psychological interventions for refugee clients, with an application of ideas from personalised psychotherapy sessions, generic psychology treatment plans and public health policy. Such an outcome may especially benefit younger refugees as they have a greater potential for neuroplasticity (Brohawn et al., 2010) and are most likely to go into education at this stage of their development. For example, refugees settling in the UK who have experienced PTSD may be offered PTG therapy as a follow-up to Trauma Focused Cognitive Behavioural Therapy (TFCBT).

7.4. Proximate Groups and Group Interventions

Fourth, Calhoun and Tedeschi (2013) have noted the benefits of social support to those that have suffered trauma and how this plays a role in recovery (Slavin-Spenny et al., 2011). In particular, how a person grows is attributed to the acceptance of others of what has happened

within the group session, and this may extend to developing new therapy groups that integrate PTG and offer acceptance. This can highlight the psychological therapist's role in the community and what may be achieved beyond the therapy room. It can also call for a pathway that acknowledges and includes PTG as a part of clinical practice.

7.5. Clinical Training

Finally, if the effect of PTG is to benefit clients, then it is important that the knowledge is understood theoretically during the clinical training stage. This can prepare trainees to begin thinking about psychological growth and can encourage therapists to be mindful of it during the therapy session. This may increase the likelihood of psychological therapists identifying growth earlier as well as reflecting on and facilitating growth reflection in their refugee clients as an active part of their role. In this way, practitioners are encouraged to develop independent thinking early on in their career that is then maintained in clinical supervision.

7.6 Literature Review: Conclusions

It is argued that gaining knowledge of PTG and moving away from the present stress-based paradigm may assist not only counselling psychologists and other psychological therapists but also potentially benefit any social healthcare staff interested in how to support and facilitate the mental wellbeing of refugee clients. Not only does an individual psychological therapist's perspective on growth account for elements of how they work with refugees in a growth-orientated way, the collective data set of PTG theory gives some indication of how therapists can take this notion forward in their clinical practice. For example, after it was discovered that psychological therapists' early intervention could have a greater impact on clients, it was also demonstrated that clients recovered much faster (Taku et al., 2009). Such insights are relevant to

the hitherto stress-focused paradigm and advancing current practice may allow clients to arrive at a growth perspective.

Elucidating the processes of PTG from the perspective of psychological therapists, that could support refugee service-user mental health and inform clinical practice and treatment outcomes is one goal of this research. It is possible that this may help with waiting lists, access to services and employment, which are crucial components in facilitating a healthy assimilation into daily life, and this may have positive implications for the wider community. The findings of this thesis advocate such service provision to maintain longer-term refugee support. Research into understanding how therapists construct the utility of PTG when working with refugees in the UK is a starting point to further understand the potential clinical benefits it offers to this client group.

The literature has provided an overview of studies supporting PTG, and, more recently, the phenomenon has been studied in counselling psychology and in psychological therapists' working with refugees. However, what is of further interest are the attempts to study its application in clinical practice and understand the perceived benefits that integrating PTG in psychological therapy could yield. Equally, this is completed, with consideration of the wider and social implications of such practice. In summary, this literature review has detailed the construct of PTG with a particular focus on how it is applied to clinical populations.

7.7 Research Questions

This literature review also informs this paper's research questions, which are the following: 1) How do therapists who work with refugees in the UK construct PTG? and 2) How might these constructions influence the design and delivery of psychological therapies for refugees in the UK?

8. Methodology

8.1 Introduction

The methodology is concerned with how research is conducted. Throughout this research process this involved making choices about the epistemology (theory of knowledge) that has led the research in order to better understand the PTG phenomenon. A judicious approach was used in selecting one particular methodological approach over another. Subsequently these decisions have impacted the data generated and the way the data have been analysed. For example, themes were co-constructed with participants (therapists) and subsequently analysed. The rationale for these research decisions is outlined in this chapter.

8.2 Social Constructionism: Multiple Realities

Selecting a moderate social constructionist epistemology with a critical realist perspective has enabled a focus on the material reality of the world, while acknowledging that this reality is constructed within a wider social field. The rationale for this choice is that it may provide the research with greater scope than afforded by the parochial lens of quantitative approaches (Cheek & Gough, 2005; Pilgram & Bentall, 1999; Willig, 2008). This stance is a departure from previous PTG studies that have approached knowledge from a position of material reality or the phenomenology of personal experience (Willig, 2012). Here the focus remains on the multiple ways of constructing reality (Burr, 2003; 2015).

The ontology (the nature of being) is realist, which accepts that a phenomenon exists while the epistemology (the theory of knowledge) is moderate social constructionist, which suggests that there are multiple perspectives (Harper, 2011). When approaching the data, this perspective has provided the researcher with an interface between the PTG phenomenon and its

relationship to the social world, thus shifting the research from a mere dichotomy between these positions (Liebrucks, 2001). As a result, there is an opportunity to approach the data from both the social and material and therefore provide a more nuanced understanding (Harper, 2011). This permits an exploration of PTG in clinical practice while accounting for the wider social environment (Willig, 2013). Furthermore, at the point of data analysis and interpretation the researcher can focus on the accounts of the participants' as accurate according to their experience, while simultaneously moving beyond the data to the social environment (Willig, 1999). One may critique this approach as reductionist, seeking one truth, however this is tempered by a search for multiple explanations of PTG that are filtered through social, political and historical contexts, contributing to a greater understanding of the phenomenon.

The aim is for the moderate social constructionist perspective to produce therapist accounts of addressing psychological trauma in refugee clients from *constructed* terminology. Notwithstanding, it is acknowledged that, to some extent, language may derive from medical and psychological models that originated in a positivist epistemology. As PTG is a particular framework, making assumptions about -an individual's experience, the critical realist element accounts for this tension with the social constructionism. Nevertheless, it is expected that participants' accounts may provide new insight into the *skills* and *resources* that therapists employ, in what style, and what potential benefits they may yield to the refugee client group.

Due to the fact that co-construction of therapists' ideas is not entirely value free (Willig, 2008; Sullivan, 2010), an element of subjectivity in the accounts is anticipated (Madill, Jordan & Shirley, 2000). This subjectivity may, to some extent, influence their therapy practice (Harre & Van Langenhove, 1999). In this way the psychological therapists' expertise may be seen as a result of relationships and social processes, rather than a static reality based on permanent

structures (Silverman, 2010). Thus, to deny this social process would assume that a therapist's knowledge is created in isolation and the consequences of such a perspective would depict the therapist as generating an objective truth in isolation.

Adopting a social constructionist approach to research permits a critical perspective on reputed ways of defining the world, unlike approaches categorising phenomena in a reductionist way, further legitimising dominant perspectives on the world (Willig, 2008). This is supported by the critical realist approach, which does not claim to mirror reality, but rather provides a perspective through individual beliefs and understanding. These beliefs are filtered by social processes that may provide insight into the PTG phenomenon (Harper, 2011).

8.3 Rationale for a Qualitative Approach

The majority of PTG studies have been quantitative, with an inordinate focus on health psychology, for example serious physical illness (Barskova & Oesterreich, 2009). Previous quantitative approaches have drawn on self-report measures such as the post traumatic growth inventory (PTGI), thereby taking a reductionist approach of bracketing participants into predefined categories (e.g. Min et al., 2013). Overall, little attention has been given to refugees and their therapists (e.g. Barrington & Shakespeare-Finch, 2012), so it is possible that individualistic ideas have reinforced this method which serves to locate the problem at the level of the refugee client. While this may have yielded statistical data, it has not revealed how the PTG concept is *constructed* by individuals, and therefore misses the nuances of individual therapist's accounts in further understanding the phenomenon. This study departs from such a quantitative design, testing the relationship between variables, which may seek to form a hypothesis to establish universal truths underpinned by a positivist epistemology. Instead the purpose of this research is to find deeper meaning in the pursuit of knowledge about the PTG

phenomenon, not to form a definitive hypothesis. As a result, this qualitative research design facilitates an in-depth exploration of the phenomenon of PTG from the perspective of psychological therapists, while highlighting intricacies in the data.

Beyond this crude distinction there are particular aspects of qualitative data that are deemed appropriate for this study. Qualitative research is primarily *inductive* – that is, data emerge from the participants – and does not usually conform to the "hypothetico-deductive" idea of quantitative research (e.g. Willig, 2012, p. 3), that is, it does not form a hypotheses from existing theory. The impact at data level is that new ideas can be generated from the data-collection process. However, it is important to state that five factors from PTG theory have informed the basis of the semi-structured interview schedule for this thesis and have therefore added a *deductive* element to the data collection, whereby new data are influenced by existing theory. While a quantitative method may have been rigidly related to data output, the qualitative data still allow for wider possibilities in the findings. For example, the individual *data sets* may show PTG themes – for example *strength* – and the *data corpus* may reveal overall patterns (Braun & Clarke, 2006, p. 6). Although some qualitative studies may be positivist, they are predominantly borne out of a need to challenge the status quo in a particular field of enquiry. Of course, it should be acknowledged that a qualitative standpoint entails challenges such as objectively verifying the results. Nevertheless, the richness of the data shows that this approach is of particular relevance to counselling psychology (McLeod, 2003).

8.3.1 A Flexible Approach to Understanding Data

Thematic analysis – considered a flexible approach that aims to identify themes in research data – is not embedded in a clear epistemological framework, granting study of the detail as well as complexity in the data (Braun & Clarke, 2006, p. 78). The choice of thematic

analysis in preference to an experiential research method, such as interpretative phenomenological analysis (IPA) (e.g. Smith, 1996, 2008), was due to a desire to explore "collective or shared meanings and experiences" (Braun & Clarke, 2012, p. 57) over idiosyncratic lived experience. Braun and Clarke (2006) clearly state that it is possible to take thematic analysis in either a *realist*, *contextualist* or *constructionist* direction (2006, p. 9), and while an essentialist approach may study the experience and the contextualist approach would account for the experience within the social context (e.g. Braun & Clarke, 2012), this research is interested in therapists' perspectives and perceptions of a phenomenon, and not their lived experience. More specifically it was used to obtain accounts that had a wider relevance to clinical interventions in the refugee client group, ascertained by obtaining themes that show patterns across the data (Braun & Clarke, 2006; 2012).

One of the useful features of thematic discourse analysis is that it produces a "pattern type" analysis through which themes and patterns are identified in the data (Braun & Clarke, 2006, p. 8). Here there is an interest in the phenomenon of PTG and how this concept is constructed in the participants' (therapists') accounts. Therefore there is a juncture of theory with a constructed account to "unravel the processes through which this discourse and the subject's internal world is constructed" (Taylor & Ussher, 2001, p. 296). Furthermore, this is an alternative to a predominantly discursive research method – for example discourse analysis, where a greater detailed knowledge would be required. Instead thematic discourse analysis offers an "accessible form of analysis" (Braun & Clarke, 2006, p. 8). Therefore there is a shift from positing knowledge as a static truth to an acceptance that that one is always making constructions about the world.

Another useful feature of selecting this method is that it "theorises language as constitutive of meaning" (Braun & Clarke, 2006, p. 8) and this focus on speech is considered useful as it is the avenue through which the refugee client's problem is articulated to the therapist. Other approaches that do not account for language may omit such a perspective.

However, care must be taken during interactions as a psychological therapist's language may actively replicate power relations that exist externally (Gergen, 1999). In this way, language has an active function through which a world can be socially constructed by constituting objects and use the of ideas, otherwise known as discourse, and these discourses perform a function (Burr, 2003; 2015; Potter & Wetherell, 1987). Only when research excludes the social do these influences become obscured. Therefore, it is important to remain critical of the language that is used to make a particular phenomenon real.

To achieve this research aim, thematic discourse analysis would elucidate how PTG is co-constructed, while using an interpretative repertoire to elicit meaning from the data (e.g. Taylor & Ussher, 2001). During this process the researcher plays an active role. Themes are not merely *"emerging"* in a passive manner, which is how they may be presented in a "naïve realist position" (Braun & Clarke, 2006, p.7). From this perspective, knowledge construction is viewed as a process that involves the researcher, rather than perceiving research as a completely unfiltered access to a social context. Hence it is expected that there will be disparities between accounts, which will further depend on the social context of the participants' and the subject positions that they adopt (Potter & Wetherell, 1987). As a result, individual constructions from each participant have been taken into account as well as the disparities within them (e.g. Lyons, 2007).

8.4 Reflexivity

Throughout the research process a reflective journal has supported the task of reflexivity as one method to ascertain rigour in the research (e.g. Gough, 2017).

8.4.1 Reflexivity: Reconsidered Methodology

In the early stages of this research, after a good deal of reflection, an interpretive phenomenological analysis (IPA) methodology was initially adopted with a phenomenological influence (Smith,1996), with a view to understand the accounts that therapists put forward.

However, after further exploration, at this early conceptualisation stage it did not appear that IPA would adequately answer the research questions. The research was seeking to understand a phenomenon and how it is constructed by humans, so a moderate social constructionist epistemological position would be better suited to the study of knowledge that is formed within the world rather than from one's experience (Willig, 2008). Subsequently, the methodology also required revision and, following consultation with the research supervisor, it was decided that thematic analysis (Braun & Clarke, 2012) was the most appropriate system to capture the socially constructed ideas as themes that emerged from perceptions and perspectives as opposed to phenomenological lived experience. Yet there still remained the challenge of the scope of the depth of interpretation that would be achieved using this method. Further reflection on Braun and Clarke (2012) and relevant papers highlighted that thematic discourse analysis would capture functional semantic level themes and more in-depth latent data (Taylor & Ussher, 2001).

8.4.2 Reflexivity: Recruitment & Interview Process

Initially, the aim was for participants (psychological therapists) to be purposively recruited from a therapy centre whose services specifically catered to refugees (e.g. the Refugee Therapy Centre in London) using a snowballing approach to recruitment (Braun & Clark, 2006). However, one of the barriers to recruiting in this way was that organisations were conducting their own in-house research, thus necessitating a change in my approach to recruitment. Following reflective conversations with my supervisor, discussions with research groups at university as well as inquiring whether organisations could assist in recruitment, I turned to social media to conduct my recruitment. On reflection, this enabled access to a larger number of therapists with a range of training and therapeutic skills who were already signed up to a professional platform. From an initial set of participants recruited via social media, snowballing was employed to obtain additional volunteers. Such a recruitment process may have influenced subsequent interviews as individuals were self-selecting and may have sought out such a topic to discuss or perhaps felt a need to discuss PTG. It is worth noting that there may be psychological therapists who wish to discuss ideas of growth in therapy, equally there are those who may not have an interest in PTG.

Six psychological therapists were recruited in total. These included psychotherapists with training in person-centred, gestalt and psychodynamic approaches, as well as a counselling psychologist who had trained in CBT and psychodynamic therapy. The majority of the psychological therapists' had worked in NGOs offering therapy to refugees and therefore it is possible that due to their professional experience, they may have had an increased sympathy and understanding of refugee needs compared to other practitioners whose experience was working with a different population. The level of training and experience of the psychological therapists'

may have impacted the research, as they would already approach their therapy from a perspective of understanding emotional depth and they will have their own understanding of what is involved when working with refugees.

8.5 Participants

The study recruited psychological therapists' to enable the research aim of exploring their constructions of PTG when working with refugees. The homogeneous sample has accounted for parity of experience and reliability of data, yet heterogeneity of interpretation due to the methodology (Willig, 2012) and is considered a representative sample so conclusions can be drawn from the data. Participants were required to have worked as a therapist for at least two years post-qualification and completed an accredited qualification in their field, verified by a governing body such as the British Psychological Society (BPS), UKCP or HCPC. This was to ensure that they had a significant body of experience to draw upon.

Refugee therapy services were contacted directly to recruit a random sample of participants. A professional networking site was also used to attract prospective participants, and this included directly contacting therapists after establishing from their profiles that they appeared to meet the qualifying criteria. Four participants were recruited through their organisations and two responded via online networking. Interviews took place at a location convenient to participants, such as in a private room in a therapy centre, on a university campus, or at a mutually agreed neutral location that provided space and allowed confidentiality to be maintained.

As this study is informed by a social constructionist epistemology, a sample of six participants may allow for the appropriate level of analysis (Wood & Kroger, 2000) and thematic

analysis for the generalisation of results (Braun & Clarke, 2006). In the interests of protecting the anonymity of the participants pseudonyms are used and a breakdown of demographics (e.g. gender, age, job title) is not provided.

Table 3: *Table of participant information*

Pseudonym	**Gender**	**Therapeutic training/background**	**Years qualified**	**Relevant experience of working with refugees**
Sophie	Female	Psychodynamic psychotherapy	25	Third sector/charity organisation, Individual psychotherapy in community setting.
John	Male	Gestalt psychotherapy	7	NGO, Refugee individuals and families.
Sally	Female	Person centred psychotherapy	3	NGO, Individual counselling, and psychotherapy.

Jackie	Female	CBT and psychodynamic counselling psychology	20	NHS, Individuals, groups and families.
Mary	Female	Integrative psychotherapy	7	NGO, Individual psychotherapy.
Peter	Male	Person centred psychotherapy	30	NHS, Individual counselling and psychotherapy.

8.6 Reliability and Validity

Qualitative methods permit many divergent perspectives on data. Still, there are decisions to make about establishing the validity and reliability of the research to ensure the quality of the data outcomes. Therefore, at this juncture it is helpful to comment on how such decisions were reached. In this process of establishing quality of output, there are several approaches that may be applied to demonstrate research rigour (Golafshani, 2003). Moving beyond validity and reliability as markers for credible research, Robson (1993) recommended that alternative criteria are required that are specific to qualitative data. The rationale is that complete objectivity is not possible in qualitative research and a fairer evaluation of the research can be made using the following criteria. First, *credibility* – how believable are the findings? That is, instead of looking for internal experimental measures of validity, each result is based on wide ranging evidence. Second, *transferability* – do the findings apply to other contexts? Here,

rather than generalise to the population at large and therefore become externally valid, the research is transferable to specific groups and/or situations. Third, *dependability* – do the findings apply at other times? That is, rather than systematically collecting data to replicate studies to denote reliability, this criteria suggests that there is the ability to discover the results in a similar setting, some of the time, but perhaps not consistently in every setting. Willig (2009) has a further criterion: *confirmability* – to what extent does the researcher reflect on their own role? This goes beyond laboratory objectivity to involve the researcher as part of the process. It is this re-evaluation of research criteria that is applied to the thesis analysis and evaluation process.

The analysis process of selecting themes engendered, to some degree, the perspective and the values of the researcher, therefore a level of clarity was required when exploring the rationale for the themes (Braun and Clark, 2006). Themes emerging as patterns of ideas across the data set and frequency may be one particular indicator, but this is not exhaustive, as a less prevalent theme may emerge as more significant. This subtle judgement lies with the researcher, which is why methodological rigour is required.

8.7 Procedure: Materials and Data Collection

The choice of a semi-structured interview was considered to be well matched to a thematic analysis approach (Braun & Clarke, 2012). As this thesis has taken an inductive and deductive approach to data, this is reflected in the design of the interview schedule (Appendix A). Broader questions were placed in the first half of the interview schedule to facilitate open discussion with participants, allowing *inductive* data to be constructed. The researcher prefaced the briefing by explaining that an exploratory study was being conducted to understand what participants thought about the phenomenon of PTG. The meaning of PTG was left open to their

own interpretation, so co-creation started early on and the researcher was mindful of not imposing their own ideas.

Questions specific to the five factors of PTG were added to the remainder of the interview schedule, which was constructed *deductively* to reflect the main aspects of the PTG construct as captured in the PTG inventory: 1. new possibilities; 2. relating to others; 3. personal strength; 4. spiritual change; and 5. appreciation of life. It was expected that further clarity on the factors in the construct would become evident from themes from the data.

Thus, theory merged with practice to facilitate the creation of new data. This hybrid inductive and deductive method is supported by Fereday (2006). A potential negative aspect of a therapy-focused study may be that the focus is either too narrow or too wide, potentially affecting the way in which the research may be applied in clinical practice (e.g. Morrow-Bradley & Elliott, 1986). However, this issue was accounted for throughout the analysis and considered in the findings.

8.7.1 Procedure: Thematic Analysis

The process of analysis of this method involved six steps (Braun & Clarke, 2006).

1. The interviews were listened to and transcribed verbatim. The transcripts were then read, the interviews listened to a second time to provide a reminder of the interaction, and finally the data were reread. At this initial stage, patterns were observed.

2. Systematic coding across the data corpus was completed while searching for a connection between the ideas. The themes came from recurring ideas in the text and at this stage it was possible to draw inferences about the meaning of the data. At this stage initial codes were selected.

3. Codes were collated into overarching themes of how they most accurately depicted the data. The meaning of the themes, how the themes supported the data, and the overarching theoretical perspective were fully articulated by the researcher.

4. The development of a thematic map occurred after a review of themes had been checked against the coded extracts, permitting external heterogeneity and internal homogeneity (Patton, 2002). At this stage, if a gap emerged, then the researcher reviewed the data.

5. At this point the themes were fully defined and the final parts of the data used were included with the rationale for the choice illustrated.

6. Finally, the interviews were listened to again to confirm an appropriate justification for the themes, and to decide which themes made significant additions to the data. The themes were named and defined, with names taken directly from within the text as much as possible to maintain parity with the data.

8.7.2 Procedure: Data Analysis

The recorded interviews were uploaded from a digital recorder to a laptop and manually transcribed by the researcher. The transcripts and recordings were stored in a secure filing cabinet and will be destroyed within an agreed time period, in line with the Data Protection Act (1998). The researcher and, when necessary, the supervisor had access to the data. Pseudonyms were given to participants to maintain anonymity, and any identifying details were altered. The system of “I” (interviewer) and “P” (participant) was used to identify speakers in the transcript and a simple verbatim transcription of accounts was used (Braun & Clarke, 2006). The lines of text were numbered in the transcripts and, once printed out, the codes were highlighted

manually. In this case a theme was highlighted as a short passage describing a relevant feature of the data related to the research question (Braun & Clarke, 2006).

The analysis chapter begins with a selection of appropriate excerpts to highlight themes and to relate the text to the overarching research question and literature. In line with the epistemology, an analysis of how these themes related to the social context was considered. In particular, how language is used to construct ideas and how this construction occurs within a particular discourse.

As previously mentioned, the analysis has a primarily inductive focus. However, the theory is accounted for, so an element of deductive analysis would also emerge as a secondary approach. An example of this is seen in Fereday (2006), whose study recommends using a hybrid process of inductive and deductive thematic analysis for coding qualitative data. In the study, data-driven codes were combined with theory-driven codes. In the social constructionist epistemological stance, concern is with the position rather than the functionality of the data, which is why references to construction are made in the analysis and such references to the participants' speech are made in relation to the research question.

8.8 Ethical Considerations

Prior to data collection, ethical approval was obtained (Appendix D). Before an interview, a participant's role in the research was explained in the context of confidentiality, consent and the right to withdraw. This was further communicated in participants' informed consent and later in the debrief form (Appendix H). Anonymity was maintained throughout. The context of the research was highlighted by introducing the research phenomenon PTG (as therapists, not clients, were interviewed). The main potential hazard to participants was that they

might become distressed during interview, due to the sensitive information that they might describe. In anticipation of this, before interview they were provided with details of appropriate support organisations, such as the Samaritans and SANEline, and, if they became upset during the session, details were again provided in a debriefing sheet. Participants were also asked if they would like to take a break or stop the interview. Furthermore, during interview the researcher was mindful of participants becoming upset or distressed, and the manner in which questions were asked was managed sensitively. Interviews always took place in the workplace setting of the participant or researcher, so no ethical issue arose during the study at either data collection or analysis stage.

8.9 Therapy-Orientated Research

It is believed that therapists are viewed as experts in their field by the services that deliver therapy and policy providers and therefore the data sought were used to understand their expert perspective and thereby contribute to clinical understanding. The PTG phenomenon has been recognised in theoretical psychology since the 1990s (Tedeschi & Calhoun, 1995, 1996) and in clinical practice more recently (Calhoun & Tedeschi, 2013). Psychological therapists' ideas concerning PTG were deconstructed in discussion, with attention given to how these ideas were constructed and how they differed from accepted truths. To achieve this the enquiry sought to move beyond the semantic level of data – which develops themes at a descriptive level – to an interpretive level, which goes further into the assumptions and ideas of the therapists, aligning to the social constructionist framework and the research question (Braun & Clarke, 2012). Research in PTG from the perspective of therapists working with refugees sought to comprehend how PTG is constructed by therapists and the meaning they place on these positions through talk

and, furthermore, by adopting a critical perspective on the underlying ideas that inform and perpetuate normative practices and policies.

8.9.1 Conclusions on Methodology

An intended outcome of the study is to find significant patterns in the data that translate to themes of PTG. These themes may tell us what aspects of PTG are potentially relevant in the work of therapists – that is, what themes are the most dominant and what they tell us about therapeutic work. Overall, the findings could provide further information about PTG as a construct when applied to refugees in clinical practice. Due to the method of thematic analysis, it is possible that the findings may also provide generalisable results that could influence policy, thus prompting a move away from a negative symptom focus (Braun & Clarke, 2012) to a more nuanced approach to clinical practice. For example, it is possible that this research could highlight one factor out of the five factors in PTG as the most relevant to clinical practice, or a new PTG outcome is discovered. An original contribution to counselling psychology may involve discussions about shifting towards a growth agenda. This may provide insight into facilitating growth in the therapy session and allow psychological therapists access to a wider repertoire of tools when working with client groups such as refugees.

It is important to note that while this research is not positivist, it does not subscribe to a radical social constructionist perspective either. Rather, it leans towards a critical realist perspective, suggesting that while ideas are constructed in a social context, this context exists within a material reality i.e. institutions, policy frameworks and guidelines, the NHS, clinical training institutions such as universities. Therefore, this study does not seek data that merely informs us about a set of ideas that exist as relative concepts. While being mindful of the socio-political and cultural context over time, it is necessary to note that the therapy system operates

within institutions such as hospitals and clinics, which abide by policies and procedures. However, as psychological therapists', it is possible to develop perspective in order to understand that the role is complicit in these constructions and that research is important to expand understanding of how this co-creation happens and in what way psychological therapists' may remain critical of ideas.

9. Analysis

The purpose of this chapter is to illustrate the therapist participant constructions of PTG in relation to delivering therapy for refugee clients in the UK. The themes show how the issues raised range from level of the intra-psychic, interpersonal and social spheres. Equally they highlight challenges and opportunities regarding PTG, faced by psychological therapists working with this refugee clients.

After setting out the academic task of trying to understand the area of PTG in clinical practice, with the aim of collecting data from the perspective of psychological therapists working with refugees in the UK the data has been analysed. As outlined in the methodology section this has permitted understanding of themes at a semantic and latent level. As a result after coding the data using thematic analysis, four higher order themes were identified as follows: 1. "Mind Shift": A Process, 2. Towards an Empathic Self, 3. Relatedness and 4. The Therapists' Toolkit. A summary of these themes and their constituent sub themes are illustrated in Figure 1.

Table 4: *Table to delineate the overarching themes, sub-themes and representative quotes*

Superordinate Themes	**Sub-Themes**	**Representative Quote for Sub-Themes**
1) "Mind Shift": A Process	1. Emotional Pain Barrier	"They need to go through that pain … and it is painful"
	2. Reframing	"For me to accept the difficulties that I had in my life, I actually have a mind shift"
	3. Integration	"Finding a way to use that experience, to move on as a

		different person from where you were before”
2) Towards an Empathic Self	1. Personal Needs & Connectedness	“Until people can have compassion for themselves, I don’t think they can flourish really”
	2. Reclaiming Language	“Shift away from victim to survivor”
	3. The Advocate	“To have a voice .. gives you different perspectives and it … makes you feel empowered”
3) Relatedness	1. Trusting Again	“The person feels free and happy within themselves.. without feeling too anxious or depressed”
	2. Group Associations	“How they feel they are accepted after the trauma”
	3. Building New Relationships	“They have to find a way… back to others”
4) Therapists Toolkit	1. Metaphoric Language	“Seeing the growth as a spiral”
	2. Navigating Challenges	“I’ve worked with people that have challenged me to my core”
	3. Theory Practice Links & Therapy Techniques	“It has to be in the mind of the therapist that this is what can happen … that there’s a hope”

9.1 Theme One: "Mind Shift": A Process

The first theme of a *"Mind Shift": A Process*, identified how the process of making sense of and living with the impact of a trauma may develop for the refugee client. This delineates a process from contending with the pain to constructing a new understanding of the experience, within the context of an individual's life. This was articulated into three stages, reflected in the subthemes: 1. Emotional Pain Barrier (depicts the emotional struggle that must proceed growth); 2. Reframing (constructed as a new way of viewing the traumatic experience); and 3. Integration (accounts for the way the emotional processing and reframing is assimilated into a new understanding).

One prevalent idea throughout the data was how participants' (psychological therapists) depicted the process of refugee clients coping with changes in the aftermath of the trauma.

> *"P: Okay well that's, that's less formed in my mind that's the concept, that's more, well I suppose from experience noticing that some people recover much more from trauma than others, erm and also I've been looking at erm vicarious resilience and so rather than vicarious trauma".* Sophie (1).

During the interviews the processing of trauma was constructed as a unique experience and not everyone experiencing trauma in the same way. The main points within this psychological shift, which involves reflection from the client experienced by the therapist participants are covered in the sub themes.

9.1.1 Sub-Theme 1: Emotional Pain Barrier

Firstly, it was highlighted by the participants' (psychological therapists) how initially the coming to terms with the trauma can be a very painful process and challenging experience for the client. It appears that this theme relates to what seems to be the therapist-participants

constructing an idea of refugee clients navigating difficult emotions to start to understand and reach a point of growth.

Further, John asserted that stress was indeed a necessary component of the growth process and that this growth is a continuous process. In this way it appears that growth is constructed as a continued process implying that there is no beginning and no end.

> *"The natural organismic development level we all will grow naturally, erm which would be the same as change erm yeah I think again in my theoretical background what we think is that would happen naturally unless things would happen people get stuck or they get stalled in the development they do but that change will always happen".* John (1).

This was further supported by Sally's ideas that growth is a never-ending process and it is situated within the pain. It seems that Sally's perspective depicts pain as a barrier and a facilitative factor that permits growth. Overall, it appeared that participants (psychological therapists) viewed the pain as not only natural but also a necessary part of the process. Therefore it appears that the therapists are constructing the management of this pain as part of the therapy process and part of their role to engage with this material.

> *"P: "When I think about growth, like something that is ongoing that never stops and usually comes with pain or like. I think about labels as well, like pain and then something potentially wonderful could happen depending on how you frame it. So erm yeah that's what I think about when I think about growth and erm it's ..a process.*
>
> *R: Could you talk a bit more about that.*
>
> *P: Growth involves change erm and depending on the individual or individuals, you can process that in different ways. I think for me erm growth never happens without change like erm in some ways I think growth usually something that happens externally, and you respond or an individual responds to that erm..It's quite hard process erm but normally I think about process when I think about change, cause I think about erm I think even when it's not positive, I think there is a way to find some kind of learning experience or an adaptation through that process, that maybe it's not always by choice. I think that it can only you don't always want to change but we have to in order to grow".* Sally (1).

Sally expresses how change whether chosen or not appears to create growth and change appears to be a necessary catalyst in the process. It is possible that this change may imply a poignant shift categorised at a moment in time and within a particular context, which triggers particular emotions. This seems to be a depiction of growth as a product of much struggle, which is purported by Tedeschi and Calhoun (1996, 1998) as a step towards the mental shift that develops post traumatic growth. It is possible that through such a construction the participants (psychological therapists) perspectives acknowledge the internal psychological struggle of the refugee client. It appears that in part this may come from developing a therapeutic relationship with the client (Rogers, 1961).

At this very challenging stage, life may also lack meaning and additionally, there may be a comparison to their former self, which may also be the source of pain. Especially if there are associated negative core beliefs (Beck et. al., 1973). As the process of change was not chosen it is something that the client has to face because of an external event.

> *"A lot of times people will tell you that 'I was somebody that was really happy, I was someone that was very positive'. They need you to know 'this hasn't always been me, if that didn't happen, this wouldn't be me' and that is very painful and you can sense their pain and you feel for their pain as well but that's part of the pain that erm that you're fighting your instincts not to want to just go in there and rush and take it away cause they need to know that what life was before and they need to go through that pain and it is painful and the fact that you end up feeling this powerlessness that is may be not even one fifth of what they're feeling but erm what to them very powerful erm I've kind of gone off on a tangent but I think, you know, that's the way the appreciation of life can be effected by trauma both positive and not so positive".* Sally (7).

In these accounts it appears that the therapists are constructed as observing the refugee client's process while having the power to refrain from intervening, in order to allow a natural emotional process to unfold. The therapist's process and awareness of the client's feelings appears to be part of this intervention and this could be contrasted with a CBT approach that

would decide the therapist's actions based on a set protocol and the client's negative thoughts (e.g. Beck et al., 1995). Therefore, the sentiment in this data is that therapists are vicariously impacted by the pain of the refugee client and this impact has a function in terms of deciding the trajectory of the therapy session.

Furthermore, it appears that Sally believes that it is a natural and necessary process that the psychological therapist seems to want to rescue the refugee client and in this way therapists are impacted at a vicarious level (e.g. Barrington, Shakespeare-Finch, 2012). Sally stated that it was not a choice and that an individual may at first have what may seem like a maladaptive response (Young et. al., 2003). The underpinning assumption of CBT epistemology is that psychological intervention can be targeted at the level of cognitions, is constructed as involuntary and therefore a maladaptive response. To some extent a cognitive intervention used in psychological may have utility, however utilising this approach in isolation may omit the social context (e.g. Woodcock, 2000).

> *"P: Erm, I think it's very subjective in what happens for different people. I think at times erm not to be depressing, I think in some people they have to cope in a maladaptive way and may be that's enough. I think that at times trauma can you can embody the trauma and never really get the chance, unfortunately for some people they never really get the chance to really erm deal with that trauma".* Sally (2).

According to Sally facing the trauma entails exploring feelings in therapy. However, to facilitate this process it may be first necessary to work through any defense mechanisms, which are ways in which clients avoid feelings and this is drawn on from psychodynamic theory (e.g. Klein, 1975). It is possible to suggest that these defences may be impeding the refugee client from accessing their true emotions and reaching an understanding of how they have been impacted. It appears that the participant constructs an account that the client's feelings are

inaccessible, therefore the possibility of processing stress and by proxy hinders the possibility of growth, which may stall development.

> *"There were aspects of her not feeling understood. The fear that she had of being attacked at any moment, these were all exacerbating factors of not being able to grow a really or even in therapy and I found that she, her defenses were very strong, so all of her focus was on maintaining herself in that space".* Mary (21).

> *"She comes with a defence of being extremely and happy and giving me flowers every time and she as I got to know her, I found out that she really worries that if she looks sad that she's going to upset me and I won't like her and I'll reject her, so I see the growth in a different way with her. She's started to break down errr cause she's trusting me, so that's how I interpret it, so she's starting to cry a lot and errr fall apart really. So I think that's a growth but that's the opposite to the guy that I'm describing, she is letting herself go, so people can defend themselves in different ways".* Sophie (3).

Sophie reflects that until some clients can process and face more difficult feelings they may need to operate with a maladaptive and outdated coping mechanism that helps them operate in the world. It may be that this way of approaching therapy means that the therapist has to then facilitate this process of working through defences to access emotions. The observing and working through defences is depicted as a task for therapists. This extract evokes the sentiment and an image of therapists using themselves to achieve such an aim. However, to be able to action such an aim this would require reflection at the level of policy, which focuses interventions at the level of cognitions and memory processing (NICE, 2018).

Equally, it is important to note, as pointed out by John it seems to be suggested that clients may get stuck in 'survival mode' for some period of time however at some point, they will return to their natural path of growth. It is possible that one could conclude that his account depicts challenge as necessary and feeling stuck as part of the process.

> *"P: And again I think the language doesn't help, while we're talking about growth, because in my mind it is about how fast the growth is happening and how slow it is happening, because I think the growth is always going to be happening. But I do think a*

traumatic event can really impair somebody, growth is a natural process because they get stuck in survival mode. They get stuck in the trauma and or in the mind gets really focused on 'I need to survive', which actually doesn't allow them to carry on in life and develop as they naturally could". John (1).

It appears that John has emphasised the degree to which an individual is impaired after trauma and this may only be recognised by therapists that trained to work in certain amount of relational depth (Cooper, 2005; Gellar, 2013).

"I think they would return to this natural path once what they can process part of their trauma and become more present in their here and now, so once these movements start happening erm they feel more settled they feel more faith, they are able to acknowledge what is happening in the present the relevant things from the past, then it becomes easier for them to continue growing in a pace that feels more suitable, more appropriate in someway". John (1)

In order for stress to contribute towards growth John states that the level of challenge needs to be enough to support growth and but not to the level that would overwhelm the individual. This would relate to the idea that an individual can experience PTG with pain that is challenging yet not overwhelming. Equally Tedeschi and Calhoun (1995, 1996) do accept that some trauma is very difficult to grow from. It appears that John perceives processing as working through emotions in the moment and this relates to Calhoun & Tedeschi's (2013) idea of having the appropriate level of struggle from which to grow.

"P: I think quite often stress can be, I think stress is part of life we're always going to feel stressed about something erm if you see stress as a challenge, then challenge is necessary for us to continue growing. When you feel the challenge is too large, but realistically we do need these challenges, we do need these changes erm just to keep us going, just to keep us motivated, just to keep us interested erm. If you using stress as being an overwhelming challenge then the help to growth for me would be if the person can survive the challenge then there's a sense of accomplishment, the sense of learning". John (2).

It appears that John argues further that stress is necessary to an extent yet recognised it can reach a level that is overwhelming and therefore may compromise the individual. This is also acknowledged by Tedeschi and Calhoun (2004).

Mary expressed that appreciation is not something that can be artificially created at will and how it is paradoxical that appreciation is only as a result of the trauma. It seems that the appreciation is a new understanding that only came to light after the trauma.

> *"R: What do you think about that? What do you make of that, appreciating life after trauma?*
>
> *P: Erm it's a shame it brings. It's a shame that trauma is the thing that brings about appreciation. Erm it means the person has been through something horrible that they wish didn't happen. Even after having the experience they would go back and change it erm I mean but the irony is actually, the lessons that you learned or the reassessing of values are really valuable or you wouldn't have gotten them. You wouldn't have those values had you not had the trauma, so there's a catch 22".* Mary (65).

Taking the idea further Mary sees the trauma as a condition from which the learning arrives. This is a strong assumption which may be true for some clients, however it's useful to point out that clients may have existing values and continue to develop after the trauma. This may be a case by case reflection. This appears to have not been fully accounted for in policy that recommends short term therapy (fully expanded on in discussion).

Overall, there appears to be agreement in the accounts that pain is an unavoidable part of processing trauma and that pain precedes any growth, and the degree of the trauma may impact the degree of growth. Thereby there is a relationship with the processing of the pain and the subsequent growth experienced. It appears that here therapists construct PTG in clinical practice as requiring an initial process of exploring difficult feelings. The implications for this when designing and delivering therapy for refugee clients in the UK is discussed in the next chapter.

9.1.2 Sub-Theme 2: Reframing

The therapist participants appear to depict that, once the refugee client has expressed the emotional pain pertaining to their traumatic experiences and is cognisant of this, there then may be some reflections made that impact how they make sense of what happened. It was suggested by Sophie that at some point a sense of acceptance and strength helps the client to move forward.

> *"Something like that has happened where I think that is through acceptance and learning to understand what he's doing with his mind, that he's thinking so negatively".* Sophie (6).

In a different way from acceptance, one participant responded that spirituality may make pain more bearable and help certain individuals cope better. The therapist expressed that this would be articulated directly from the client. This draws on an element of PTG theory and indicates that acknowledging reflections about spirituality may support the client in therapy (Calhoun & Tedeschi, 2013).

> *"P: But it's just erm (pause) it's like it's the ideas or beliefs that individuals can hold about religion or about erm other dimensions of the world if makes (pause) it makes their pain more, it makes their pain feel almost more bearable for them and I think in a lot of ways I guess it makes it more easier to contain that pain erm you know I'm never one to I don't know mean"* Sally (9).

Here Sally appears to elude to one role for the therapist is to that can be achieved by the therapist to some degree supporting the client to find meaning in their experiences, e.g. through Narrative Exposure Therapy (NET) (Schauer, et. al., 2011). However, in order to do this the therapist also needs the freedom within the often rigid therapy protocols, to truly deliver such client centred care.

> *"I don't think it's necessarily important for me to force any views erm as the client even question the beliefs. It's what it means to them and how they view that. I think that's very important that, that it's very important to get on board and explore that with them, to feel what it means to them and how what what strengths or sometimes not strength that they get from them and how you can work on that with them and so I think it's definitely been*

> *an important part of the work and it's been for me as well it's been a learning part of the work, as well because people or their attitudes and beliefs is very personal and very different".* Sally (9).

This depicts an existential reflection that creates perspective and is a departure from CBT which may have a mechanistic procedure (Parker & Fletcher, 2007). Moreover, it appears that there may be a specific point where the individual has a "mind-shift", where they reflect on who they are in relation to what has happened and they are then able to see what they may have learned. In these accounts therapists are constructed as being mindful of the spiritual and existential meaning of the client's experiences. However, if this matter is not acknowledged, discussed and reflected on in clinical practice, then it remains a topic left for the therapist to manage alone. At best it may be acknowledged and at worst totally ignored and misunderstood.

> *"P: So I think it happens when the individual has managed to do this mind shift. They find that they are the people who they are now because the things that happens. For me to accept the difficulties that I had in my life, I actually have a mind shift and say I am who I am because of what happened, so whatever happened good or bad actually makes me who I am today and that's what I think helps me to accept what happened in the past and be able to move on and carry on and I think probably, if they are able to get this mindset, it really helps them to grow to look back on the situation and kind of realise, 'although difficult, I survived, I learned from it and I know things that I didn't know before and I can use those things'".* John, (3).

It is not always about viewing stress and growth as mutually exclusive, as Sally purports that it is possible to take a more nuanced perspective. It is conceivable that in this way an individual may still be functioning despite still struggling with aspects of the trauma. This is what Sally describes as a "tight rope" between functioning and breaking down. It appears that the therapist is managing this space where the client is impacted by the trauma, where they may reach a 'breaking point' or 'break through. It may be possible to conclude that a psychological therapist has a role to play that ethically facilitates this process, so that the client is able to function well.

> *"I think it's possible that stress and growth can even can coexist but at the same time she's often very fragile so there's a sense of the next stress might be the breaking point or the break through you know that kind of thing. So it is possible for them to coexist. It's a tight rope kind of experience if it's too much if stress is too much you know stress and growth, yeah".* Sally (4).

The construction of human resilience presented here seems to be one of moving through a very challenging point and emerging stronger. Therefore, it is viewed as a subjective process which suggests that an individual may be able to reframe their experience in an empowering manner. This deliberate rumination is acknowledged by Calhoun and Tedeschi as beyond resilience (e.g. 2013), yet is not accounted for in cognitive therapy approaches.

Jackie depicted how the therapist may facilitate eliciting a growth narrative from the refugee client, particularly when it was difficult to see their own strengths at the time.

> *"They will often present with already victimised inside themselves, so it would be back to you to be able to remind them of the ways in which they are resilient..I worked with a client in .. who was tortured erm he felt completely helpless and lacking in resources, never being fed and 'I can't do anything for myself' and when we were talking about torture he just described how they were going to …. Beating him, he reached out and hit the legs of his guard and 'I said that's amazing how brave would that be', to actually reach out and whack the guards that go around beating. You don't think about that because he found himself to be so helpless and resourceless and I was really struck by the contrast between that and sort of the image of him sort of retaliating. So you're always working with that." Jackie (34).*

There is an acknowledgement by Jackie that the therapist will witness examples of the client bringing material that is both distressing, yet containing anecdotes about strength and that there is an impact on the therapist vicariously. However, it appears that this inner conflict within the therapist only permits them to develop the psychological intervention to a certain extent. This inner conflict, that was also highlighted by Papadopoulos (2007) may be due to them trying to understand how this material conflicts with their role as a therapist and what they should be

doing. However, it appears that this inner conflict denies the therapist the confidence to facilitate the client's exploration of this material.

9.1.3 Sub-Theme 3: Integration

The idea that growth was an ongoing process was prevalent across the data.

> *"P: And again I think the language doesn't help, while we're talking about growth because in my mind it is about how fast the growth is happening and how slow it is happening, because I think the growth is always going to be happening. But I do think a traumatic event can really impair somebody, growth is a natural process because they get stuck in survival mode. They get stuck in the trauma and or in the mind gets really focused on I need to survive, which actually doesn't allow them to carry on in life and develop as they naturally could. I think they would return to this natural path once what they can process part of their trauma and become more present in their here and now". John (1).*

There was a particular focus on how an individual was at baseline and how this may impact to which extent the trauma is processed. Here trauma was viewed as a disturbance within a natural process of growth. This is echoed in the literature (Tedeschi & Calhoun, 1995, 1996). It appears that the therapists have knowledge of this shift and are able to reflect this to their refugee clients.

> *"P: Which would adapt the situation according to your needs and being able to find what feels right at the time, but there are some people who are not able to do that usually if they had. So it's hard to find a way that the trauma itself can help. I think that the client could become more empathetic about it but then we could challenge was he more empathetic because of the trauma or was he already empathetic before the trauma and the trauma gave him odd experiences that he could empathise with so it's hard to".* John (5).

John suggested that to make concrete the goal of making themselves safe the client could initiate a real process of growth. In this way it appears that the participant (psychological therapist) constructs the therapist as empowering their client and thereby supporting how they take back control of their recovery. It appears that this creates a key function for the therapist

but it is not an intervention that is to the detriment of understanding the client's personal experience.

> *"For a person to achieve their level of awareness they need to feel safe, they need to be able to make themselves feel safe and only then the process of the trauma can really work and that's the point when you can start looking back at the trauma and realise that whatever happens is going to have an impact on you and that impact is not necessarily defined by the trauma but it is defined by yourself in the present but to get to that point there are two stages which is the person feels safe and person is able to make them self feel safe needs to happen first". John (3).*

It appears that this depiction of creating safety is an idea that could be viewed as an empowering perspective. This is in line with counselling psychology and the person centred view, where the therapist may co-construct such a perspective. Therefore the data indicates how therapists can facilitate this in clinical practice. It seems that with growth comes the courage to attempt new things and embark on new goals and thereby entering new territory.

> *"P: Yeah well I think that people can erm have the courage to do lots of new things. I think it's possible to perhaps take up some education, so they don't see themselves as stupid anymore, you know. Basically take more risks in life".* Sophie (6).

Here Sophie refers to clients viewing themselves as human beings with something to offer and appears to suggest that ultimately integrating the trauma may facilitate the process of the refugee client trying to move forward with their lives.

> *"finding a way to use that experience, to move on as a different person from where you were before erm so that is somehow to integrate the trauma and find out who you are, but no one has the trouble to find who you are and I think in some ways that is quite similar to the work of Gestalt and of all these approaches as well".* John (8).

It seems that there is acknowledgement here that there is a shift at the level of the personality and that Joseph and Linley's (2004) idea of accommodation, that prior beliefs are adjusted in light of the new experience, may be an applicable intervention. Of course it is acknowledged that personality itself could be viewed a construction of Western psychology.

9.2 Theme Two: Towards an Empathic Self

The second theme, *Towards an Empathic Self*, identifies how an individual may develop greater empathy towards themselves and others. That is the relationship with themselves in terms of how they are kind to themselves and how they are then able to relate to other people in this way. In the process of coding, the data were clustered into three subthemes of 1. Personal Needs & Connectedness (how the therapist perceives the refugee client's ability to connect to others), 2. Reclaiming Language (how the therapists construct refugees taking back control) and 3. The Advocate (how refugees are seen to empower others). This identifies how the therapist perceived the shift from the personal struggle of the refugee client and then how this may relate to a wider community.

Another theme that was prominent in the interviews was the idea of how an individual may relate to oneself in an empathic manner and the role of language in this defining process and it's possible that on some occasions the individual may extend this to others. This could also be viewed as an outcome of processing the trauma.

9.2.1 Sub-Theme 1: Personal Needs & Connectedness

The individual may over time develop a better understanding of themselves. In trying to explain this process there is a reference to humanistic theory as a vehicle towards growth and Carl Rogers (e.g. 1961) is drawn on as an example. Through personal reflection there is self-understanding. However, often in cognitive approaches the goal is to adjust cognitions and there is less focus on meaning.

> *"I'm informed by Carl Rogers about growth: that's another simple way to think of from my childhood and about the parables of sea, you know where the seas are thrown and it can be thrown and it goes into erm rough ground and it will wither and die or it will fall in a place where the light and nourishment is just right for growth and that's the optimum*

condition, so my role is to help people to erm find a way to give up, break off bits that have withered away, aren't useful erm yeah so you can see there that I'm thinking in a psychoanalytic way about human development erm and then humanistic is the idea that what in the environment is terribly important is how we, whether we flourish or not". Sophie (1).

The therapist can make choices about what may help the refugee client to reconnect with what is important to help them think about the future. Thus the role of the therapist is depicted as proactive that can lead the client towards growth. Furthermore, it was emphasised how the importance of becoming attuned to one's body was a way to developing an awareness of one's needs, instead of existing to meet the needs of others. Again it seems that a therapist would require a level of training beyond the psychological interventions suggested in the guidelines (NICE, 2018).

"I'm trying to think what I can say about a person that was a very traumatised person. I'm trying to think how I can talk about his growth. Well, I think the main thing say for this man is that he, he's become much more aware of his body and his feelings, so he came to me because he kept collapsing and he was a teacher and he had to go to the school nurse to lie down 'cause, he just had no sense of self care erm and erm that he now is attuned to who he is instead of worrying about what other people want and being something for them".

"He's aware of what he needs and erm he's become very successful in his career, you know by attuning to his body and being able to discuss his feelings. In a way he disassociated, so until people can have compassion for themselves, I don't think they can flourish really. They don't know how to take care of themselves". Sophie (6).

Perhaps such ideas can be thought of in Tedeschi & Calhoun's model (2006). Growth is constructed as as a "leveler" that allows the individual to find a level of authenticity. In this way, it seems that the participant (psychological therapist) perceives a "spiritual meeting" between individuals and acknowledging that another has helped. Professions such as counselling psychology permit the therapist to reflect on their own influences in therapy as do some psychotherapy approaches.

> *"P: Well I think you make a deeper connection if you support each other or you support a person. There's erm something about, it's difficult to describe but the spiritual connection that is, that once you pass through that, it's a given that you meet with authenticity".*

Here Sophie suggests that there is a point where a part of yourself that requires help meets the helper. There is a shift from the therapist to the client and vice versa. It seems that there is a construction of the therapist as a human participant working with the client. This may support shifting the power dynamic, by applying PTG in clinical practice as recommended by Calhoun and Tedeschi (2013).

> *"You meet someone because they've helped you and you know supported you and it's like that's about your life and living and enjoyment and celebration of connection that makes you feel alive".* Sophie (4).

This alludes to the ideas of vicarious PTG discussed (Shakespeare & Barrington-Finch, 2012) and in this way the therapist gains something. Overall, an individual learns about the part of them that needs support and consequently they are able to accept it from another. Therefore developing therapists that can develop such therapeutic relationships to foster such an outcome may be helpful.

9.2.2 Sub-Theme 2: Reclaiming Language

While initially the term victim is used within the wider context of trauma services, later there may be a shift in the terminology used due to an acknowledgment that they have survived a challenging ordeal. There is a sense of having survived this and the language shifts from victim to survivor. However, it is noted that sometimes the client may not feel like a survivor. Therefore it appears that therapists need to straddle multiple meanings and understandings of how refugee clients articulate their experiences.

"P: Well one of the concepts that I use quite a lot with the clients who are erm survivors or refugees or seekers, the difference between the term victim and survivor and trying to actually educate them in some ways how it's natural that they might feel like a victim, but feeling like a victim can usually add to a feeling of being powerless or erm low self esteem and feeling stuck, but if we are able to focus on being a survivor within those difficulties and I got better and I learned and I'm still here actually that gives you strength to carry on and grow, so I think that metaphor will be very helpful to talk to the client about the concept that you can grow even when things are very difficult, that is the - factors that support you to do that. It's normal that you feel like a victim it's okay, it's understandable you can't always feel like a survivor but there's something about the mindset and using the experience to evolve, that can really help". John (3).

The acknowledgement of survivor holds some merit, yet while this permits a shift away from victim discourse there is a danger of developing a saviour discourse. The therapist may to a certain extent play a part in the process of the refugee client defining where they are on this spectrum. That is one could suggest that the therapist holds some agency to reflect back resilient and growth experiences to the clients that empower, as well as acknowledging the challenging experiences.

It is noted that there is a greater engagement with life. Individuals may shift in their use of language from victim to survivor and in this way language becomes a way to feel empowered and it's possible that language is reclaimed. Furthermore, therapists that have a multicultural understanding of key terminology may be critical in developing these narratives.

"P: I would say one of the areas is about women that have experienced sexual violence but in the field of gender, there is a conflict, shift away from victim to survivor, there's quite a, and it's funny because you'll see those two words used interchangeably and you might not have wanted, I think the politically correct this is to use the word survivor, but for good reason and that's because it's trying to get everyone -both people who have had experiences and those who work with them- to recognise that the first has their lives rather than victim gives it a very kind of, not a very empowering word, whereas survivor. Unfortunately, in this area of work you're not, when you're working with refugees, there's so much about labeling". Mary (41).

The terminology used by professionals can be undermining such as *victim*, *patient* and perhaps to some extent *refugee*. In this way by acknowledging such labels they can be

challenged, as victimisation may serve to keep the client where they are. As such pathologising experiences would perpetuate ideas within the medical model (Parker, 2011). A shift towards less labelling may be more supportive and instead shifting towards labels that the client can claim and relate to in a way that looks towards their future. This may require acknowledgement and transparency about the wider social context within the therapeutic session.

9.2.3 Sub-Theme 3: The Advocate

The shift from kindness towards the self and using more empowering language may contribute towards another stage of extending goodwill to others. This is defined by the participants (psychological therapists) as the refugees wish to give back to others, having survived themselves and this voice allows an individual to feel empowered. This idea may represent the refugee client having worked on their own emotional processes, made reflections and made meaning of their experiences and then finding a purpose in using their experiences to help others.

> *"There's a couple of clients that I've worked with and you know towards the end they tell you how they're gonna view this and tell other people about their experiences and that is such even how they talk about that, is such an empowering thing and it's something that at times giving people job opportunities if you like but it's ultimately them erm redefines that experience and in telling their story in a different kind of way it and sharing it with someone else they can feel their giving back to society but their also making new links and their having a voice and I think to be under control".*
>
> *"To have a voice it's such a I don't know it gives you different perspectives of different perspectives of in life and it makes you yeah it makes you feel empowered and it makes you yeah you feel like you've overcome something yeah you know it's a I think that itself presents like a new possibility in life and some people write about their stories some people write poetry and they may be with other people, they're going to other groups for example".* Sally (9).

Furthermore, it was suggested that there may be a determination and pursuit towards political growth and that clients become more active in this domain. This constructs refugees as

having a voice, which provides a sense of empowerment. The account appears to depict ideas of social justice, where power goes back to communities. This may relate to Tedeschi and Calhoun's ideas of new possibilities (1995, 1996, 2004).

> *"Where politically active groups err refugees you know they'd fled their countries for political reasons and they remain politically active about that issue that forced them out of their home country. And that would suggest a lack of willingness to engage and integrate into the Canadian culture, because they were so focused on what was going on at home, but actually what it ended up doing was that it did lead to growth in their own Canadian lives, because it meant that in their pursuit of advocacy they actually had to reach out to lots of kind of civil society organisations, media, you know, they met with a lot of Canadians in order to erm foster their ultimate goals related to their political aims back home erm so there was the political growth, there was a growth there".* Mary (99).

Mary and Sally suggest that it is possible for refugee clients to be activists sand empower others from their own experiences and challenging the status quo. It appears that there is a shared feeling where an individual's narrative joins with others and this change occurs outside of the therapy room. Therefore it appears that the therapy work is depicted as requiring a greater awareness of the client's social context.

> *"in response to that experience and also trying to prevent other people from going through whatever they -I'm just trying to think about an example- erm I think (pause) there's another area about becoming more of an activist and becoming somebody that can challenge the status quo erm as a way of presenting experiences that may be (pause) the belief is not necessary and you don't want to repeat it. I don't know if that makes any sense to you erm I think that's an area".* Sally (10).

Here there is an account of reaching out into new groups and an extension of identity into a new culture. In this way one may become critical of challenging ideas and valuing the mind and contribution of the refugee. The therapist may see this strength emerging in their clients, however this is not a standard part of a therapy training protocol and therefore may seem outside of the remit of therapy. However, without acknowledgement of the real social context and at

times injustices experiences, the therapy may reinforce the client's previous disempowerment and perpetuate the idea that they are still powerless.

9.3 Theme Three: Relatedness

Thirdly, is the theme of *Relatedness* that identifies how the therapist participants depicted different modes of relating impact a refugee individual's psychological growth, that is how social connections and personal relationships facilitate their growth. This theme was clustered into three subthemes: 1. Trusting again (factors that the therapists depict as construing trust) 2. Group Associations (the importance of groups in building self-esteem) and 3. Building New Relationships (connecting with new people and building new relationships). Here there is recognition from the therapists of how the refugee client may grow in relation to others, specifically how they build trust and therefore can make use of a therapeutic relationship. The group aspect relates to how individuals may grow within the group environment and there is awareness of connecting to new people after trauma and this is reflected on in the data.

Relationships emerged as a vital component within a client's growth. As a reoccurring theme in the data participants (psychological therapists) constructed relationships as a vital component of clients' recovery after trauma and in their experience of growth.

As a result, the quality of the therapeutic relationship was essential in their journey. In addition, this appeared to impact the level in which individuals engaged with and therefore gain from therapeutic sessions. It was emphasised by participants (psychological therapists) that this depends a great deal on the client and therapist interaction and being able to trust the therapist is a crucial part of the journey for refugee clients and may be further generalised to trauma clients.

9.3.1 Sub Theme 1: Trusting Again

Through the research interviews, some of the therapist participants seemed to suggest that the quality of earlier relationships were indicators of how much refugee clients could make use of a helping relationship post trauma. That is the notion that depending on how well the refugee clients had their emotional needs met as a child, they may my be able to better use the therapeutic relationship to process their emotions. From the perspective of Sophie it is pointed out how the early environment may impact how an individual experiences growth.

> *"P: Erm well I think it's where the in child development infant development erm the development has been arrested, so within work that I do erm growth means that something is being erm but there's a second chance to go through a developmental window and grow and feel erm, feel in the simplest way way the person feels free and happy within themselves to meet the environment, meet the context of their life without feeling too anxious or depressed you know or the arousal being too extreme, being okay".* Sophie (4).

It is noted that it is important to develop trust to help the individual to change and this may be a challenge if earlier life experiences were difficult. The underlying idea is that this aspect relies on existing models of relating to others and it appears that this implies that the role of the therapist is to support this. This aspect cannot be negated as therapies shift towards manualised therapies and may not provide appropriate time to this part of the intervention.

> *"P: It is, I think, so down to how people defend themselves so and that is conceptual to how people have treated them, so erm, yeah".* Sophie (3).

There is an awareness on the part of the therapist regarding the client's reactions, however, some experiences may make this task challenging. For example, the breakage of trust in instances such as torture make the use of a healing relationship very challenging. There is an understanding of how bad individuals can be and therefore it is emphasised how much of a challenge it is to move past this perception. It appears therefore, it is required that the therapist

would need to be mindful of this process. John emphasises that the very method which has hurt the individual is used as a mechanism to heal. The construction here appears to be the therapist that may be perceived as a powerful individual within this process.

> *"So I think it's very challenging work with clients that have suffered torture, because again torture is a breakage of trust on the relationship, so then it's even harder to heal because there's lots of contradiction, the same thing that's going to heal you is this thing that has really traumatised you erm in a very extreme way, even more extreme than the trauma I would say".* John (5).

John reflects on how the use of therapeutic relationship is a necessary yet challenging aspect for the client in order to process the very difficult events that they have faced. It would seem to be incumbent upon the therapist to be trustworthy, in this way it is not just a problem located in the refugee. Sally suggests that an individual may not be engaging with others and be depressed and at this point a safe relationship becomes crucial.

> *"P: "And there's a lot of loneliness within her depression, it's not just anger it's a lot of. At first when they come to see me it's a relationship for that in itself not to say that's not healing but for the relation other than being at work if that makes sense. To relate to somebody else in a way that feels safe and contained somebody that is focused solely on her and she is very isolated and she's also been through quite a lot so".* Sally (7).

There is an acknowledgment of the atrocities that the individual has faced and potentially this could be explored in mediums such as therapy, support group and signposting. It is communicated that there is meaning in the therapeutic relationship and that the therapist may be doing a great deal e.g. containment, however this is not explicitly accounted for in the policies.

9.3.2 Sub Theme 2: Groups Associations

It was noted that rejection by a group can impact an individual's ability to recover. Mary commented that less liberal cultures may not be able to accept certain trauma at all and how this may impede the individual's recovery. It seems that the therapist has to hold in mind this tension

between different cultural understandings of trauma and facilitate an empowering understanding for the client.

> *"The fact that she had been raped her community and family, there was no appreciation that the rape had been a violation of her. The idea that she was no longer a virgin and that, so all the secrecy that goes around that meant that she was tainted for the rest of her life. Which was that far after she was twelve she was ready to be married, there was this huge fear from her family and her that if it was discovered that she was not a virgin what implications would that have for her being accepted by her husband and her family".* Mary (49).

Peter depicts how acceptance can help the refugee to rebuild themselves and is constructed as a human need.

> *"On a practical level are they able to form relationships with others are they able to project some level of empathy, reconnect with some of their families, so (intonated voice) are they able to have feeling that, that they are in terrible trouble with the trauma that they are going through but they are also able to say … is but I have moved on it's going to take some time and everything but I think how they move on, how they feel they are accepted after the trauma which I think feelings towards their families but they have moved in respect to some level of acceptance, some level of understanding, some level of connection with the important people in their life and also in themselves" Peter (10).*

Relationships with self and others are seen as a way of redefining the self. The perception and values of the group is echoed in the work of Calhoun and Tedeschi (2013). Particularly the treatment by the client's proximate groups. Therefore it seems that the therapist is a juncture between an experience of rejection by their own social group and the refugee client developing a new understanding of their trauma.

> *"P: It's I guess there is potentially there's a lot of satisfying things in their life, there is potential for new relationships erm personal relationships how they view themselves as well as relationships outside of themselves".* Sally (9).

There are new connections and an attachment to others in a new way. It appears that groups have a great impact on how the client may process the trauma and how they may make

use of help. Again the application of this idea when integrating PTG in clinical practice is considered in the next chapter.

9.3.3 Sub Theme 3: Building New Relationships

At some point in their recovery journey the refugee client may wish to start to connect with new people. The therapist participants acknowledge that humans are intrinsically social beings, however trauma may cause a rupture in this natural behaviour and reparative relations may be required.

> *"P: Usually trauma shakes someone to the core and that effects everything and erm yes it effects relationships. It effects how you perceive others or it can only effect how you perceive yourself and how you relate to others maybe I don't know that trauma can. It brings about change and yes that impacts and it's anyway it forces yourself to go through a process where you can be alone or feel very alone and feel very isolated erm and usually people around us or people close to us that are used to relating to us in a certain kind of way and when that's different also they are at a loss on how to relate to us so the trauma effects everything or potentially effects everything".*
>
> *"and they have to find a way of deciding if you want to find a way back to others then people who do go through trauma, go through trauma and they become very very isolated as a result and a way to cope so my to relate to people that also happens and at times I've worked with clients that the work has basically when found out they're working their own way of relating to another you is relating this might be the only relationship apart from may be relationships and other services they're not relating to anyone else and that's what the work is".* Sally (6).

It appears that the therapist participant describes a shattering of old beliefs, finding one's way back to self and an empowerment in moving forward. In this way refugees are constructed as active participants (psychological therapists) in constructing their narrative, as opposed to mere recipients of treatment. It appears that the therapist participants positioned relationships as a vital component in connecting self to others, and significant relationships can impact how individuals feel and the future actions we take. Although relating is not a new idea in therapy the importance of developing trust again appears to be a key component in refugee trauma work.

> *"P: Erm because we're all. We're just one we're connected so the way we feel about our relationship has a direct impact on the way we think about ourselves which is connected to the way we feel connected to the our future which is ultimately connected to how we feel about our spiritual side".* John (7).

Participants (psychological therapists) reflected that solid relationship structures may enhance an individual's ability to cope or the lack of it create a psychic retreat (Klein, 1975). It appears that ultimately relationships are the overarching factor that create growth. It is possible that this demonstrates how PTG is an interpersonal aspect and that others are a necessary part of eliciting PTG (Calhoun & Tedeschi, 2013).

> *"P: Erm I guess possibilities erm you know there can be negative changes, there can be people erm who are retracting into themselves not engaging with people or erm, it depends on how people react you know".* Mary (89).

It may be about making choices about relationships and letting go of bad relationships or finding a "way back" to others. It would seem that psychological therapists require an understanding of how an individual relates to themselves, their early experiences and others now, to facilitate this process. Potentially therapists may require certain clinical training and supervision reflected on in the discussion.

> *"P: In the hope that in time there'll be some acceptance towards that growth as an example for instance may be clients might think that decided to like end a relationship that has been so important to them that has helped to them as a response to whatever comes up in counselling, for example erm even (pause) even though that change and that position might feel very painful and very final to them the fact that actually, may be from the start, they never they could live without that relationship that now they realise they are in a different space, where they've actually decided that this ultimately is not the best relationship for me and I want to end that. They come to the realisation that actually there is a to that relationship and you know, they discover that actually they can manage without something that in some ways has become like a crutch, an unhelpful crutch, a crutch nonetheless they get to discover they can survive that, erm yeah".* Sally (6).

Overall developing new relationships becomes a focus and therefore shifting towards the future. It seems that the therapist supports the client to let go of what does not work for them and in this way shifting the refugee client's narrative from the past to the present.

> *"They're making new relationships they inspire somebody else and they see something valuable in that and erm so that's the first thing I think. It can bring a whole host of possibilities and opportunities".* Sally (9).

In this way refugee clients are constructed as having some good qualities to offer. It appears that there is a challenge in facing the trauma and relating again, yet when new connections are made an individual can start relating in a healthy manner that promotes growth.

9.4 Theme Four: Therapists Toolkit

The fourth and last theme represents the *Therapists' Toolkit*, i.e. the psychological therapists' particular points of reference for understanding growth processes within their refugee client work. These were articulated into three subthemes: 1. Metaphoric Language, 2. Navigating Challenges and 3. Theory Practice links and Therapy Techniques. These provided some insight into how the therapist navigated the process of working with their client, by using an element of creativity in their speech, also how they faced challenges and worked through them with the client and any particular theories that they drew on to help work through therapy material. How they may have drawn on their existing theoretical knowledge to help the process of their clients of working through emotions.

A prominent theme throughout was how the therapists made sense of the process towards recovery. This involved use of metaphoric examples, challenges faced and theories and interventions that they made use of.

9.4.1 Sub Theme 1: Metaphoric Language

Throughout all of the interviews the therapists made numerous references to metaphors in order to explain working with trauma. This is relevant to the research as it shows how the therapists perceptions about PTG are formed in the process of their work and how they facilitate change for the clients. This is important to the research as its helpful to understand how PTG manifests in therapy and is used by the therapist to potentially elicit growth in the client.

> *"It really woke me up because I was just doing just trying to think of what they wanted instead of like showing my characteristics. Because people are, we're full of all of these different thoughts and feelings and that's where life is and it's like erm the fizzy like effervescent essence. If you're always going to be sweet and thoughtful then there's something flat and dead".* Sophie (7)

Sophie emphasised that accessing their emotions, is where the very life of the client lies. It would seem that an awareness of how the client uses their defense mechanisms is seen as a useful way for the therapist to start working with the client to work on the difficult feelings and access any reflections on growth. It may be the therapist's job to find what form this may exist in. One participant described the experience as the 'carpet' being pulled from underneath and surviving something unexpected can set the individual up to face the future much with less fear.

> *"P: We all have a sense of safety and what will or won't happen huge fear of what could happen and when you experience the trauma people can be quite surprised that they have survived. Alongside all the negative parts of the trauma there is an aspect of the person that is, sometimes it's almost like having the carpet pulled out from beneath you make you, you almost are less fearful of the future. Recognising that you can survive something is going to make you less fearful about what could happen in the future, where you live not fearfully".* Mary (1).

There is a description of things being up in the air and the floor falling out. This refers to losing something that you previously relied on. It seems that there is a vicarious impact on the therapist at the level of trying to comprehend the tragedies the refugee client may have faced (Barascova, 2015).

"R: What does that look like?

P: Errr I guess it's when you can't make sense of something, rationally, you know if something horrible happened and whether in a rational way, whether it's horrible something happening or the reality that it has happened all of a sudden there's these gaping holes (pause) in your appreciation of the world or world view, you know may be structures that held you up, that have previously held when you've lived your life all of a sudden the floor falls out from underneath and so it doesn't surprise me that spirituality of any kind and that can be anything really can come, can rise up for someone to hold the floor again as they continue with life and dealing with that trauma, erm". Mary (73).

The idea of the individual having a secure base (Bowlby, 1988) is important as they are shifting their relationship with a key object, they are rebuilding and re-attaching. It seems that the clinical approach available may not fully account for what this means.

Equally a metaphor of a spiral is used to make sense of how the client may grow over time. This could be seen as a generic metaphor to growth and also specific to PTG, as the client ruminates, they discover a deeper understanding of themselves and their relationships. The spiral is not linear and is perhaps therefore a more realistic perception of changes, beyond symptom relief.

"And a metaphor we like to use is seeing the growth as a spiral actually, people go around going through similar topic, but also always in a different level. Erm yeah.

R: Could you say more about that metaphor?

P: Well erm it's interesting because in my mind because I've seen growth as change. ...realise they are not. Erm they somehow have the perception that we would change or develop in a straight line going from A to B and that's not realistic. What's more realistic is we might go through things that might be very similar, we might get stuck but actually we're always developing we're always growing because you're always learning and even if we feel the same we're different people, so we will always be moving on". John (1).

Overall, the therapists' appear to use metaphors to describe the pivotal change that the trauma brought about, to illustrate the magnitude of the loss and how from this point an individual may

grow and move forward. It would seem that therapists require the use of creative language to demonstrate what they see in therapy.

9.4.2 Sub Theme 2: Navigating Challenges

There were some challenges faced by the therapists that they found a way to make sense of in the therapy room. At times it seems that a therapist can feel very challenged on a personal level as described by Sally accounting for the impact of vicarious trauma.

> *"There might be a desire to transcend all human experiences or there might be a recent suicide or some kind of closure or ending and I've worked with people that have challenged me to my core as well erm presenting with a lot of you know difficult questions about life and what's the meaning of life and wants all the pain to end".* Sally (7).

One participant reflected on how self disclosure can be a challenge and is seen as contextual within the therapeutic relationship. However, it is possible that to have this level of self-awareness, self understanding and reflecting on this in the session may require this to be supported in the clinical training and supervision.

> *"P: Sometimes you can be with somebody and they're such a good listener and you could tell them things that would help you and that's what frightens the psychoanalytic world that we might use clients in that way but I think, I think if you can erm show that you struggle too, that will help the person feel good and okay…*
>
> *so it's very contextual to the person as to what I reveal of myself but with this person she came back with "You really get me and you're really thoughtful", because there's a meeting through that, but with someone else who say, someone who has a very narcissistic personality, they would just rip me apart and they would not have any faith in me. They would just dig in and say "You're pathetic" you know, it's all according to where people are that you've got to be careful about erm self disclosure. But I think it has its place because if we can all feel that we're the same then people can drop shame".* Sophie, (83).

Therefore it appears that self-disclosure is constructed as a strategy in releasing shame and not being held back by narratives of shame. In this way it would seem that the therapist

makes a reflective operationalisation of such a strategy in order to achieve a new experience for the refugee client. It is possible that such a perspective adopted by expert companions (Calhoun & Tedeschi, 2013) may be comparable for approaches used in CBT and psychodynamic therapy and may be viewed more in line with a congruent approach. An example was provided of the therapist being impacted by the client's feelings and feeling sleepy. There was a sense of not being able to connect very well with the client and it seems that this demonstrated how powerful emotions can impede therapy progress, yet provide opportunities for opening up.

> *"I've actually that's helped me to give you an example. Like one person I work with I'm just so worried I want to be and make sure I'm as awake as I can, because I can't see him on Friday afternoons because he's so not with me that I'm going to go to sleep and I really have to make a big effort to make sure that I'm thinking about what he means to him, trying to encourage him to get in touch with himself and keep him safe because he's been severely traumatised err so you know it affects me so badly, I'm worried and don't go to sleep very often with people (laughs) or feel sleepy. I never go to sleep but I feel sleepy with certain people that dissociate, because they're not with me. I'm on my own and I'm working hard and I can't keep it up, so if I happen to be tired, I've had it. You know I've got to pinch myself (laughs) to keep to make sure I'm with them". Sophie (7).*

Conversely it appears that the therapist may overcome challenges by engaging with the process by asking empathic questions about how the individual might cope.

> *"If instead we think of the erm that's amazing survivor who has come through things we wonder whether we could manage ourselves and it's like a massive celebration to think they're here and they are coping with being able to manage with different cultures erm all that goes with it and you know not sure about safety of where they're going to live or having any money, or how people are going to treat them*
>
> *and yet there they are and so if you have that attitude when you see them a person that, it must be resilience it must be painful to cope with so much erm there's a different energy that goes out and we loop it around and so we send that out to them and things build on that and help them erm regain what you might say growth from the trauma and if in order to grow erm that would mean that there was some deprivation, before they had to leave the war whatever erm so, so that difference for me between two accounts".* Sophie (2).

One could suggest that the therapist incorporates how the client was prior to trauma and how they were subsequently impacted. This may indicate to the therapist how well the refugee client copes and makes use of the therapy.

9.4.3 Sub Theme 3: Theory Practice Links & Techniques

At times the participant therapists draw on different theories to illustrate their points: Sensory motor psychotherapy (Sophie), Mark Epstein (Mary), Winnicott & Bion and this was to illustrate the concept of holding and containing and emphasising the importance of the Psychodynamic frame within this process (Mary). Gestalt (John), Rothschild and LK Chanel (John), Carl Rogers (Sally) and they all referred to theories to make sense of key client experiences. Sophie puts forward the idea that growth starts in the mind of the therapist and therefore she seems to suggest that they may determine what is possible.

> *"P: How could I summarise it? Well (pause) it's something that the therapist, it has to start with the therapist okay. It has to be in the mind of the therapist that this is what can happen erm and that there's a hope. You have to have hope that that can happen. It's not going to happen if that isn't within the therapist or the other person. So you fundamentally have to have that erm because it's all created between the two people, well if the therapist hasn't got it where's it going to go? So you have to have an idea that that can happen for the other person and then that, they can pick that up, they can run with it so there's practically the therapist has to be careful to make sure that they understand what they're going to say, what impact it's going to have".* Sophie (8).

It appears that Sally is suggesting that the therapist is in a powerful position, with their training and knowledge and they have a particular specialism which can to an extent steer the therapy. Therefore it would appear that they also have the power to shift the focus towards a growth agenda and not merely therapy dictated to by policy. This is reflected on in the discussion.

This idea is echoed by Sally.

"P: I think people that's what I think erm growth can I think people learn about their personal strengths through something difficult erm even at times when I think clients that may be as a result of the process they might have decided to make changes in their life that might seem difficult or not what they had hoped so some kind of I don't know may be I hold that hope for them at times some kind of hope that in the hope that in time there'll be some acceptance towards that growth". Sally (6).

In the next extract there is explanation of the therapist participant using an intervention around loss and how they ask the refugee client about what their parents gave them earlier in their life, as a way of helping them to hold onto good objects.

"R: When we talk about loss we also talk about what kinds of things their parents gave them that they still carry with them. They are still who they are, they never stopped being a part of who they are and I think this can bring them closer internally and come to terms with the loss but also with the memories that will be there erm I think you should really give them the thoughts to deal with the loss and difficulties in a different way in the future, erm I think also I have seen clients they have used the difficulties as motivation to do better and to do the right thing. Especially as I work with minors and a lot of children come without parents, for them quite often the traumatic experiences can pushes them towards the right direction: ' I have been through all this and I want to do great things, I want to make it worth it, the terrible things and what's happened but I can make things better'". John, P3 (4).

It appears that such experiences can change the trajectory of the refugee client's life towards positive goals and therefore pushing them in a growth direction. To reflect with the client about early losses and think about what they have learned from early development may develop understanding of how they have coped as an adult. Furthermore, there is an intervention that has questions about coming to terms with the difficulties.

"R: How could we make sense of it, in a way that is realistic, with reality?

P: Yeah and there's something about you know when you say people being depressed and then perhaps them having dark sunglasses but that's a perception of how bad things can be and I think that's something they've created, they are quite quickly aware of how bad things can be actually and that's something really hard to let go. So really I think it's useful sometimes because things could get really bad again but when you try to move on that actually doesn't help". John, P3 (6).

The importance of showing respect was seen as important and to contain and hold the difficult experience. This might involve the therapist having patience and it was seen as a condition that might activate a 'break through' rather than a break down. Therefore it appears to be about moving beyond seeing the objective of the session as a treatment outcome and that pain and catharsis is very much part of the therapeutic process. This construction explains how pain may be the vehicle to access further understanding.

> *"P:I think for me it's made me really respectful of people's journeys of growth. I think erm may be I should have said it earlier. I think from my point of view I think it feels like it's impossible to have growth without having pain and when I see clients in front of me going through pain, I think it's really important to allow that process and not take away their pain (intonated) because it's almost, I don't know I think there's something it's human nature you want to not see people in pain but I think almost something almost [...] about somebody's process if you try to let go of the pain from them. I don't know but there's an ego that can't cope with their pain but their pain is not valuable. I think the pain is unfortunately part of the process and it's really important to help contain that but allow them to experience their pain so that they can go towards growth erm".* Sally, *P4 (5).*

> *"P: Yeah erm (pause) it's you know there's been a lot of thought about the therapeutic relationship, but I think it's changing a bit now that we realise it's there's more to it, that there's more to it. We need to respect the client so much that we think, we're thinking that we're going to learn from them erm which is a quite an achievement to let go of our so the more we can do that, the more the person can come forward and join us.*
>
> *R: So that facilitates their growth.*
>
> *P: Yes it does. If there's ego in the analyst or psychotherapist, I just think it's a waste of time quite frankly."* Sophie, P6 (7).

The theories provide an anchor for the therapists to draw support from and each theory is used to illustrate different points. Equally the therapists reflect on how they use their own techniques within this process. In this research it appears that the therapist is communicating the idea that working towards sharing the power with the client which requires the therapist to be

aware of their ego and accept that the client has some good that they can offer and it is possible that this can facilitate growth. To illustrate this one of the main techniques drawn on is containment and this appears to facilitate an ability to manage the painful emotions.

Now that some key findings have been presented an evaluation of this data follows.

10. Discussion

This chapter extrapolates from the findings to demonstrate the relevance of PTG theory as part of a psychological therapy protocol for refugee clients and thereby addresses the research questions:

- 1) How do therapists who provide psychological interventions for refugees in the UK construct PTG?
- 2) How might these constructions influence the current understanding of designing and delivering psychological therapies for refugees in the UK?

10.1 Summary of Findings

The findings have shown four superordinate themes that were extracted from the research data, starting with Mind Shift, a process whereby clients are depicted as experiencing a cognitive shift that is a change in their thinking processes. Within this construction, there was considerable emphasis on emotional pain as an essential path to reach a stage where an individual may reframe and integrate the past, in order to then think about the future. Overall, the data have highlighted a pattern of psychological therapists working with emotional pain to help the refugee client to move forward and start thinking about the future.

Towards an Empathic Self demonstrated how the therapists depicted refugee clients who may develop greater awareness of their own needs, which unfortunately may have been understood through the experience of great vulnerability, that is, through becoming aware of deeper feelings and personal needs (e.g. Mary). With this awareness, the therapist participants facilitated the development of a defining process that could manifest in the use of empowering words and language, e.g. “survivor”. The data suggest that later on the refugee client may take this understanding and shift towards the role of the “advocate”. In this way, such a perspective

establishes a shift from the intra-psychic to the interpersonal and into wider social interaction, shifting from understanding the self to others and the world.

Relationships feature in the data and they comprise individual and group-based relationships. The data pertains to how existing relationships may change over time and how the refugee client may find their way back to others (e.g. Sally) and therefore make use of needed social support. In this way, such relationships are constructed by the therapist participants as supportive and facilitative of growth. Similarly, groups are depicted as supportive, or at other times not providing support to the refugee client.

Finally, the Therapist's Toolkit takes the clinical work back to the mind of the therapist. A reflection of their process is seen in the depiction of pain through metaphoric language, e.g. Mary (7). There are also some accounts of the challenges faced in therapy, as well as reflections on specific theoretical examples and techniques they might draw on to make sense of the presenting difficulty. Ultimately these are clinical techniques that work through the therapy process with clients and facilitate growth. The accounts depicted how the participating therapists use their therapy skills when working with refugee clients. This adds to the understanding of how therapists work with challenges in the therapy room.

10.2 Recognising Post-Traumatic Growth in Therapy

This section refers to the first research question: 1) How do therapists who provide psychological interventions for refugees in the UK construct PTG?

The theory introduced in Chapter Two (e.g. Calhoun and Tedeschi, 2013) delineated a chronology of the development of PTG studies with a focus on the cognitive and affective process of PTG that may develop in an individual (e.g. Taku et al., 2009) and how this process relates to their social interactions in the world. The research questions were explored through

interviewing psychological therapists working with refugees in the UK. A thematic analysis of the data showed interesting insights into how the PTG construct may inform clinical practice. One exception, however, is findings pertaining to "the advocate". Depicting the political growth of refugees, this subtheme appears to have no existing corollary in the literature, and as such offers some exciting new insights. Overall, it was observed that several constructions from the above findings concurred with established concepts in counselling psychology and provided support for Tedeschi and Calhoun's (1996) PTG theory, for example, developing new relationships, or the notion of deliberate rumination leading to better personal understanding. Indeed, there was also new information in the form of political growth, and this was labelled in the subtheme "the advocate". In this subtheme, the participants depicted the social agency of the refugee creating change for others in the wider community, and this may add further information to existing PTG theory.

Growing Through Feeling the Emotional Pain

As referred to earlier in the work of Baker et al. (2008), it was suggested by the therapist participants that emotional pain and growth coexist. Therefore it was interesting to see more than once in the data the idea of pain as a barrier that an individual must work through as a critical factor. This was described as a crucial part of reaching psychological growth, and echoes more traditional views of therapy, e.g. psychodynamic psychotherapy (Winnicott, 1957; 1965). Furthermore, it is a necessary condition of therapy that the therapist listens non-judgmentally (Rogers, 1961), which permits the client to begin to reframe the perspective. Listening in this way may facilitate Tedeschi and Calhoun's (1995; 1996) idea of deliberate rumination, and how an individual begins to reach a new understanding of their reality post-trauma. Yet it appears from the data that there is no fixed time for this stage of continual psychological pain to end (e.g.

John) and this time could vary from individual to individual (e.g. Sophie); therefore, a bespoke approach may prove beneficial in therapy interventions. In practice, an exploration of such material may work at the assessment stage, where a therapy plan can be devised, and implemented as needed.

Psychological Shift

Upon probing further, constructions were obtained from the therapist participants that described how they perceived the internal change, called a "mind shift" (John, 3). However, to facilitate this process appropriately it is clear that a trained professional is a fundamental component of delivering PTG in clinical practice, as well as expert companions (Calhoun & -Tedeschi, 2013). In pursuing this enquiry, therapists may be required to remain mindful of the risk of transference (Winnicott, 1957) and ask appropriate therapy questions, integrated into the relevant phase of therapy (Culley & Bond, 2011).

Empathy is a crucial emotion in helping build good relationships and fostering pro-social behaviour (e.g. Rogers, 1961), and participants indicated in the data that developing greater proximity to one's personal needs was a crucial part of developing this empathy for oneself (Sophie, 1). This finding is most comparable with the factor of personal strength from PTG (Tedeschi & Calhoun, 1996), as understanding oneself has meant that the individual could then identify strengths. Yet it appears necessary to develop this idea of personal strength further to include personal needs so that one may develop the capacity for self-care.

In this research, language was used by the therapist participants as a powerful tool in the way it may value and devalue a human being, particularly regarding the idea that an individual may move from the identity of a victim to a survivor. Recognising this use of language appears

to be a pertinent shift that supports refugee clients in developing self-belief that they will be able to cope. The term 'survivor' indeed entered the field of trauma long ago and it supports Tedeschi and Calhoun's factor of strength (1996). However, in this research, the therapist participant constructions highlighted that it was what the refugee client might wish to do that is of further interest, and what emerged from the data was the idea that the refugee client may wish to pursue social and political causes for those who still need support. From this perspective, the data appeared to account for a new factor, "advocate", where an individual develops a passion and drive to help others (Sally and Mary). This social perspective may first require internal reflection of the refugee client, assisted by a therapist to help work through the internal negative patterns of groups that may emerge, and the individual may develop more positive ways to engage with the external world (John). Facilitating such change to understand the impact of proximate groups was further supported by the work of Calhoun & Tedeschi (2013).

Relationships

"Relatedness" is a theme in the data that is considered a cornerstone of psychological therapeutic practice (Culley and Bond, 2011). Of particular interest was the way that the participants constructed how a refugee client may relate to others, both before and after trauma (John and Mary), and the barriers to relating that subsequently emerged in therapy. Trust appeared to be a crucial factor in facilitating change (Culley & Bond, 2011). On the one hand, this is not novel to therapeutic practice, yet it stresses a particular kind of therapy practice that cannot be achieved by following a manualised version of therapy. Furthermore, trust is something that has been called into question by the refugee clients' experiences and requires special attention.

Group Support

An individual may have to come to terms with denunciation by their primary group. Calhoun and Tedeschi (2006) discuss this challenge extensively, stating the impact of proximate groups. In the data this was particularly demonstrated by the case of Mary, who depicted how rejection can slow down the processing of the trauma even further, and this in itself may become an obstacle to an area of growth. Acceptance and rejection by groups may indicate an area for therapists to focus on during therapy sessions. Furthermore, there is the hope that individuals will develop relationships after a traumatic event, which would allow them to connect with others, process the past and move towards new social connections with others. Taking into account an individual's needs for group acceptance, the participants echoed Tedeschi and Calhoun's ideas about groups (2008) and taking time to develop trust is vital in developing the capacity for new relationships.

Clinical Skills

The 'therapist's toolkit' constructs how the participants see the processing of trauma from their role as a therapist. The main findings were the use of metaphoric language by the therapist participants to describe very different emotional states (e.g. John). The function of metaphor is typically to illustrate emotions (e.g. Wachtel, 2014). In this case, the metaphor of a "spiral" was used to represent the journey from trauma to recovery, and this highlighted the layers of the therapeutic journey. It was suggested that the challenges in the therapy might be related to the client's projection or lack of engagement (Sophie) and how this has affected the therapist (Sally). Just as the client is going through a process, the therapist is also affected (e.g. Sophie, Mary). The theoretical concepts may then become relevant as a structure to support the therapist in navigating the content of the therapy and making associations between the challenges presented

in the therapy. There are strategies or interventions that the therapist might draw on when they are supporting the client in understanding their challenges, for example in the case of John (4), where he explored the client's experiences prior to the trauma to determine the good objects that he might still be able to draw upon.

Overall, the participants (therapists) are challenged to the extent that they need to draw upon theories and metaphors as ways to think through the difficulties to help their clients. This parallel process demonstrates the level of clinical training that might be required to be able to competently manage and remain focused on the overall intervention planning, delivery and completion of therapy outcomes. This means the kind of training that equips psychological therapists to prepare for the processing of difficult events and anticipate any aspects of psychological growth that might emerge.

10.2.1 Clinical Guidelines: Policy Implementation

This following part of the discussion responds to the second part of the research question: 2) How might these constructions influence the current understanding of designing and delivering psychological therapies for refugees in the UK?

The NICE guidelines recommend TFCBT and EMDR for working with PTSD, and that remains the main psychological therapy of choice (NICE, 2018). However, as delineated in the literature review, there has been a movement towards the concept of growth since the 1990s (Tedeschi & Calhoun, 1995, 1996). From the data there appear to be therapist participant constructions that depict the refugee client as highly emotionally challenged, and this indicates a poignant step in the therapy process that may lead to greater insights for future interventions, and indicate where the therapist could position an intervention. That is, in the psychological

formulation the therapists may wish to collaboratively understand the refugee client's therapy goals within the social context (e.g. Harper & Moss, 2003). While TFCBT provides some interaction with cognition and reliving, the short permitted timeframe of twelve weeks may not be adequate for processing such painful feelings. Moreover, as it was reflected on in the literature review, to a large extent refugee needs and subsequent therapies often are misunderstood (Papadopoulos, 2002, 2007). Thus the refugee needs and understanding of their social context would need to be better understood in policies, which also help determine the types of interventions delivered. According to the data of this research, greater focus on this aspect may facilitate growth; for example, it may be possible to integrate extra time to explore client challenges into existing therapies and increase the time period in which to deliver therapy sessions. Furthermore, ensuring that therapists have a better understanding of the social context, culture and experiences of the refugee client may be helpful. However, as Papadopoulos asserted (2007), often the therapists may experience approaching the subject of growth as an internal struggle and therefore support from training, supervision and greater direction in policies may help for them to develop confidence.

Moreover, developing self-understanding, and then being able to help others, seemed to be a crucial aspect of development in the data. Here there is an opportunity, not presented in the guidelines, to consider the social context and what the refugee clients' needs are, so that the psychological therapy process and outcome are designed with these considerations at the core.

The way one relates to oneself is crucial in an individual's recovery, and the current therapies do not appear to adequately focus on self-compassion, thus missing out on this way of contributing to relating to and supporting others. Relationships are the central part of any therapeutic intervention. In particular, the trust element in one-to-one relationships and

acceptance in groups appears to be crucial to growth. Especially where it was highlighted in the data that trust may have been broken through torture and therefore a therapist would need to be trained to approach this with much sensitivity. However, if this is not more explicit in guidelines, then it is challenging to ensure this standard is set and maintained throughout services. Therefore, therapy group work may be a helpful factor in providing a learning environment, social support and relationship building for individuals, thus facilitating their growth. In other words, the guidelines would need to encourage the use of groups to facilitate this environment.

10.2.2 Evolution of Refugee Services

Previous research had highlighted that TFCBT continues to be the recommended therapy for (individuals with) trauma problems (Cohen et al., 2006). Tedeschi and Calhoun discuss the potential benefits of PTG in clinical application (Calhoun & Tedeschi, 2013) and some studies have started to explore the benefits of PTG in therapy (e.g. Zhang et al., 2014). Yet there remains a gap in how PTG-orientated application within clinical practice may benefit refugee services in the UK. While there is some evidence showing the benefits of compassion-focused therapy (e.g. Gilbert & Proctar, 2006) used to target shame-based feelings and solution-focused therapy (e.g. Molnar & Shazar, 1987) in addiction therapy, refugee work remains focused on treating symptoms (NICE, 2018). Although some early efforts have been made to conceptualise growth within refugee work and differentiate this from other concepts such as resilience (e.g. Papadopoulos, 2002), the theory-practice link to training and practice remains to be seen and developed in clinical practice.

Referral Process

The refugee client may have been referred by their GP to receive a therapeutic intervention, for which they will most likely have to wait for several months. It may be that they have to receive therapy from a local primary care team, for example, an IAPT service, which was traditionally set up to manage low to moderate level mental health problems, and therefore such services may be inadequately equipped to deal with the severity of the presenting problem (Layard, 2006). It may then take time before the refugee client is referred on to an appropriate secondary-care service to receive a higher intensity intervention, e.g. for trauma processing, for which they can again expect a waiting list (which is likely to be longer than primary care waiting times). The purpose here is to identify the obstacles a refugee client may face when trying to secure appropriate, timely intervention by the right service. Therapist participants in the research reflected on the limited resources and delay that they often faced (e.g. Mary). Reducing this external barrier is important to enable psychological therapists to provide the best intervention possible.

Range of Therapy Skills

The intervention most likely to be offered is trauma-focused CBT, after which they may have resolved their symptoms; and if deemed to have scored appropriately on a diagnostic metric, e.g. PHQ-9/GAD-7 (Kroenke et al., 2001; Williams & Kessler, 2014) they may be discharged from the services. These assessment tools have a ten-point scale that indicates whether an individual is mildly, moderately or severely depressed or anxious. However, in reality the participants revealed that they were drawing on a wider repertoire of counselling tools and techniques that range from holding and containing to helping process the pain (e.g. Mary), Gestalt-orientated questioning to elicit solution-focused understanding (e.g. John) or body

psychotherapy (e.g. Sophie). This means that to meet the real needs of the refugee clients in the therapy sessions and the overall episode of intervention the psychological therapist needs to apply a range of skills not accounted for in the guidelines. It may be helpful that the discrepancy between the therapy skills and models utilised in refugee therapy and those highlighted in the guidelines is addressed.

Understanding the Therapeutic Needs of the Refugee Client

NICE (2018) guidelines restrict what is expected of services to the evidence-based therapies, and mostly advocate a time-limited intervention. Yet this does not adequately reflect the real therapeutic dilemmas faced by psychological therapists actively working with clients, such as clients who wish to work through their trauma and also reflect on what is positive in their life, to continue to grow and develop. Participants said that the refugee client needed to process the emotional pain first, for the client to start shifting towards the reframing that Calhoun & Tedeschi (2013) discuss, and then integrate the trauma. In light of this evidence, it is suggested that it is possible to aim beyond mere symptom relief and offer therapy that works towards growth and development. This is in line with what has been advocated by proponents of growth approaches (e.g. Joseph & Linley, 2006). This may involve using counselling skills to allow the client to reflect with more freedom so that they may access their painful feelings, permitting the refugee client the time to start forming their own definition of their experience, then with the help of the therapist, reflect on aspects of PTG relevant to their experience, therefore necessitating therapy beyond the timelines stated in the guidelines.

10.2.3 Impact on Therapist Training

Socially Aware Psychological Therapists

From the data analysis, it emerged that there was a gap between policy and clinical practice that represented the degree to which the psychological therapist invests in containing emotions, which may also involve developing techniques and knowledge of theory to support refugee clients. To help manage these clinical dilemmas in the future, it is argued that further training provision would need to be established. For example, this could be in the form of training sessions focused on teaching the theory of the containment of emotions (e.g. Winnicott, 1957) followed by triad work, observed by qualified psychologists who provide necessary feedback. Within this, it is helpful if the psychological therapist has had training on social factors, i.e. how social and political factors impact refugee mental health, and to expand this further to develop social constructionist formulations (Harper & Moss, 2003). An additional element of dealing with deliberate rumination (Calhoun & Tedeschi, 2008, 2013; Taku et al., 2009) may develop the clients' problem-solving ability. Accordingly, trainee therapists need to be supported in moving from the cognitive to the affective, thereby managing challenges that emerge in the therapy on a moment-by-moment basis. This approach may be less reductionist than CBT and encourage the practitioner to become reflective, thus helping them to guide the refugee client towards an empowered position.

Awareness of Growth Theories & Application in Clinical Practice

These findings suggest it might be of benefit for psychological therapists to develop an understanding of growth-orientated therapy, so that when they are faced with growth issues in therapy they can confidently introduce growth terminology and engage with client material. By

not reflecting on this issue leaves psychological therapists without a clear understanding of what their role and expectations are in relation to managing such material, and they continue to focus on a role that reinforces pathologising clients and mere relief of symptoms. As pointed out by Papadopoulos (2007) this may be a barrier within the mind of the psychological therapist. By integrating the notion of psychological growth in training, it is no longer a grey area avoided by therapists, and as Papadopoulos (2007) claimed, something that they consider contrary to their training; rather, it is viewed as another technique by which to help the client. It is argued that in ignoring PTG, therapists remain unprepared for what may emerge in therapy.

10.3 A Role for Counselling Psychologists

Given the findings described in the analysis (section 9), there appears to be scope for counselling psychologists to develop the notion of post-traumatic growth in therapeutic practice, training and research.

10.3.1 The Educator

The understanding of psychological growth can be introduced even during clinical training. The trainee may be provided with teaching in this area alongside other parts of the curriculum. To facilitate this, the curriculum can be adapted to provide clinical practice and problem-solving challenges that arise in the therapeutic session, particularly in relation to managing clients' emotional pain and working with growth-orientated cognition and affect. This may take the form of theoretical explanations about how to integrate PTG into the formulation, as well as practising these in role play. A further factor is ensuring that the trainees are taught how to integrate socio-economic and political factors into the psychological formulation, so that they become socially aware practitioners.

10.3.2 The Trainee Psychologist

Trainees may develop an openness to therapy that is growth-orientated, in line with core counselling psychology values. However, in practice, this would require the support of educators to facilitate such psychotherapy. Such an intervention may navigate the emotional pain and understand how to shift to the cognitive aspects of growth experiences as outlined by Calhoun and Tedeschi (2013). In practice, this may introduce new vocabulary to the trainee and teach them the ability to assimilate a growth approach with existing therapies and adapt the formulation and intervention plans accordingly. Practising this further in training and placements may develop a growth skillset, e.g. working through deliberate ruminations in supervised triad work. This may help to develop the professional confidence of the trainee to anticipate, listen to and intervene when growth matters are raised by the refugee client.

10.3.3 The Clinical Supervisor

To develop theory-practice links, practising these skills in clinical placements and in services would encourage trainees to learn in a safe environment. This may highlight the CPD need for training in this area, so that the clinical supervisor may proactively encourage the trainee to detect growth in clients and support them with interventions at the appropriate moment. This could be achieved reflectively by listening to session tapes and taking the learning back to the therapy sessions. Overall, the learning may be integrated into intervention plans, formulation and the therapy outcome.

10.3.4 The Consultant

During multi-disciplinary team (MDT) meetings the consultant psychologist may suggest an intervention plan that links several professionals, with a combination of group and individual

interventions, and consider how the clinical workforce becomes aware of therapy challenges in the context of growth. Furthermore, they would support the longer-term plan for therapy beyond symptom relief and encourage the training and development of psychological therapy staff. Their role in reflective practice sessions would facilitate a place for practitioners to reflect on the application of PTG skills.

10.3.5 The Researcher

Of course, the role of scientist-practitioner remains vital to drive forward the development of refugee psychological interventions, and by highlighting this in research may continue to point out the absence of growth approaches. The research completed may also help to elucidate an understanding of the mechanisms of psychological growth that may facilitate a shift into recovery for the refugee client. Their role would be to understand the theory and how this would link to practice, and to disseminate this information to the clinicians.

10.4 Pathway and Service Delivery

A further question is what the impact of growth-orientated approaches for refugees at the level of front-line service delivery might be. At present, there are NHS services, independent services and charities that serve the refugee population, and the mainstream services adopt NICE-recommended psychological therapies (2005; 2018).

This research suggests that psychological growth is possible, which after a period of emotional processing may facilitate the refugee client's ability to cope and function for themselves and others. This supports earlier claims made by Tedeschi and Calhoun (2004). However, how can we think of operationalising such a goal?

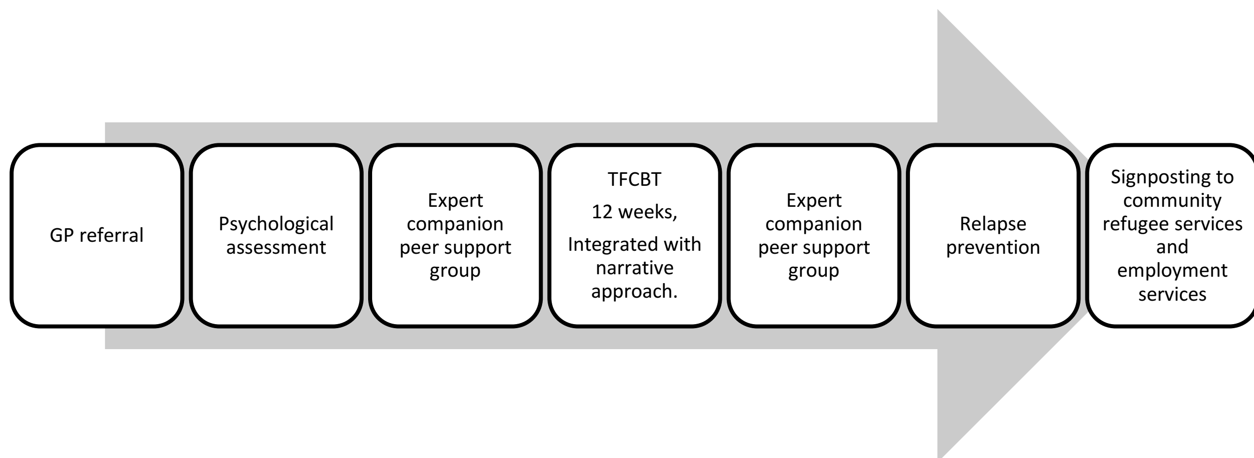

Figure 1: Pathway from GP referral to psychology services. Proposed journey of the refugee service user, integrating a clinical application of post-traumatic growth.

The process proposed by this research is explained here and illustrated in Figure 2. It starts at the point of GP referral, after which the client is invited to an appointment for a psychological assessment to understand their needs. In line with the need for group and social support, the client would then be allocated a peer support group and provided with an 'expert companion' (Calhoun & Tedeschi, 2013). This may facilitate socialising in group settings to provide an external environment that is accepting and non-judgemental. The refugee client may then, as at present, begin the recommended CBT therapy with a qualified therapist for up to twelve weeks (Cohen et al., 2006; NICE, 2005; 2018). However, it is recommended here to integrate CBT with a narrative approach. The significant difference is that it is proposed that this intervention is facilitated by psychological therapists. Due to the relational depth (Cooper, 2005) in the therapeutic training, the role of the counselling psychologist may be to work with the challenging mental, emotional and embodied processes that are preventing the client from reaching their optimal mental wellbeing.

Furthermore professionals such as counselling psychologists are trained to integrate and assimilate therapies, which would be required to skillfully use CBT and narrative approaches together (e.g. Wachtel, 2014). This role is vital, and the psychological therapist may need to have more flexibility in the therapy session, e.g. introduce several exploratory sessions to work through difficult emotions. Therefore the twelve-week model may need to be adapted, as well as changing the emphasis of the intensity and techniques of the intervention for its duration. The need to process such emotional pain and challenging feelings is met with listening and empathy, which is a fundamental tenet of counselling psychology values (Mearns, 1999). It may also be useful to work with a clinical model, such as the assimilative version proposed by Wachtel (2010). The therapist might here integrate therapies using a major and a minor therapy, and tailor therapies according to the client's needs. The suggestion here is a cognitive and narrative approach assimilated together.

The data indicated that holding and containment were key techniques drawn on by the therapist to facilitate the processing of emotions and work towards growth. In this case drawing on the work on Donald Winnicott (1957) (holding) and Wilfred Bion (containment) (cited in Ogden, 2004) may be useful in managing these emotions. That is the psychological therapist may work to create a 'good enough' holding environment that would accept and tolerate the difficult feelings (Winnicott, 1957). Allowing such a space would permit these feelings to emerge, which might then take several sessions to explore. Therefore psychological therapists who are able to contain difficult emotions, within therapy and offer them back to the refugee client in a more manageable form may be able to complete this aspect of the therapy work (Ogden, 2004). After this point, the refugee client may be able to engage with the cognitive component of their trauma as proposed by Calhoun and Tedeschi (2013). Concepts of PTG may

be integrated into the therapy sessions, and this opens up the possibilities of PTG in clinical practice and what counts as a therapeutic outcome.

It is at this moment that the reframing aspect would be supported, which may facilitate an understanding of rumination (Taku et al., 2009), and working with this over time may help to rewrite and break through the traumatic memories. It may be helpful to work with the refugee clients' feelings towards him/herself and work towards self-compassion, using approaches such as compassion-focused therapy (CFT) (e.g. Gilbert, 2010). With this, they may be able to develop compassion for themselves and help to extend this goodwill to others.

Within this framework, it would also be important to consider the socio-economic and political context. This may be achieved at the referral stage with screening questions, followed by a psychological assessment considering the social context and needs, and to collaboratively integrate this information about the refugee client into a socially constructed informed psychological formulation.

At this point, the 'expert companion' role may be a position offered to service users (Calhoun & Tedeschi, 2013), either as an engagement- or relapse-prevention tool, which also fits in the service user empowerment agenda. Moreover, the group is crucial to developing PTG, and remaining in a group throughout the intervention would be a critical factor in supporting clients in gaining self-acceptance and trust (Calhoun & Tedeschi, 2013).

Permitting therapists to access a range of theory beyond the evidence-based policy appears to be a vital factor in the delivery of a bespoke therapy, aligning with their values as counselling psychologists. This not only supports them in challenging situations, as outlined in the data, but also allows them more creativity in the therapy room.

10.4.1 Post-Traumatic Growth Theory: A Clinical Approach

Overall, curiosity was evinced by the psychological therapists when asked about PTG in their clinical work. They were keen to speak of the challenges when supporting refugee clients to process their traumatic experience, and yet they were optimistic about the recovery of their clients. Thus it appeared that in these data there is support for the claim that it is possible for an individual to move past pain and equally exceed baseline levels, as originally proposed by Tedeschi and Calhoun (1995; 1996).

The therapy constructions from the therapist participants demonstrated that this stage is only reached after some emotional processing. There appears to be evidence of the development of a self that is able to do more for others, and as expected, relationships appear to play a fundamental role in this process. In order to work through this challenge, a therapist may need further support at the level of training, supervision, policy and practice to be able to work with refugee clients. Of course, as discussed in the literature, it is important not to become reductionist or assume that all clients wish to focus on psychological growth, and this can be achieved by always collaborating with the client.

10.5 Impact on Doctoral Training

The therapist accounts in the data indicated a complex and painful process in the unfolding of the therapy sessions. Experienced psychological therapists faced with such challenges drew on their theory, their own experience and theory-practice links to facilitate interventions. At times psychological therapists can feel challenged and vicariously affected (Barrington & Shakespeare-Finch, 2012), and this demonstrates how ongoing continued professional development (CPD) and improvement of training are crucial to helping therapists to

manage and work through these emotions. At present doctoral training may cover person-centred, CBT, psychodynamic and integrative therapy with varying levels of focus on trauma. Yet it is argued that this may not adequately equip trainees to deal with real-life challenges in therapy to the full extent that is required.

10.6 Recommendations: Policy and Practice

Given the analysis and theory-practice links, the implications and recommendations of this study are considered next. As discussed, there are set guidelines that govern the delivery of psychological therapies, yet it is agreed here that allowing for more flexibility within the interventions may permit the client to work through very challenging feelings earlier in the therapy and also support the therapist in managing and staying with the client in a personalised manner, rather than imposing a set protocol. Some ways of managing this in the clinical context are considered next.

1. It may be useful to include interpersonal therapy that works with the client earlier in their intervention, and introduce the cognitive aspects of CBT later. The rationale for this proposal is from evidence in the data suggesting that emotional processing is necessary before growth, and this is further supported by counselling psychology theory (Mearns, 1999). Then other therapies such as CBT might be integrated, and Watchtel's (2014) assimilative model is a possible way of supporting such an endeavour.
2. Given the above, an introduction of Calhoun & Tedeschi's 'expert companion' model (2013) may be useful in service user empowerment and encourage engagement with services. This approach may allow therapists to help the refugee client develop a secure base (Bowlby, 1988) where they can feel accepted and reflect on their experiences safely. From this point, they may seek and make better use of psychological interventions.

3. It may be useful if doctoral programmes in counselling psychology include training on growth-related development and positive psychology. This could be further extended to clinical and health psychology, as an interdisciplinary focus. Additionally, it may be useful to teach aspects of psychodynamic theory with a view to supporting the containment of very difficult feelings, and how one may integrate the approach with CBT to work with cognition, all with a focus on eliciting growth. Although this is taught to some degree, greater emphasis on technique development is recommended.
4. A new pathway (Figure 1) in services may help to shift the service user's journey away from one exclusively aimed at symptom relief towards an adjunct perspective of growth-orientated living. To a certain extent, the cost could be managed by using trainees to deliver some of the PTG sessions, and given that there are limited resources within NHS services, this is a practical measure to lower costs.
5. It may be helpful if in the workplace counselling psychologists are permitted to use their specialist training and allowed greater flexibility in their intervention planning. Often counselling psychologists have to subjugate their primary training in favour of being more employable in IAPT based settings. This may lead to tension between the way that counselling psychologists are trained to provide greater focus to the therapeutic relationship and work at relational depth, and how statutory services may expect a primary focus on the cognitive model, thus not permitting a more extensive formulation. Thus it is argued that a counselling psychology approach would permit space for processing and facilitation of difficult experiences and emotions.
6. Allowing counselling psychologists a key role in the MDT to provide consultancy may permit expertise in counselling psychology to influence the overall psychotherapy model and

intervention planning for individual clients. Reflective practice sessions would promote an opportunity to explore PTG ideas.

7. At a wider level, counselling psychologists showing greater involvement in the social justice agenda, continuing to argue for greater care for refugee service users, and build awareness of how the social context impacts mental health.

10.6.1 Implications for Future Research

This research has introduced a theory developed by Tedeschi and Calhoun (1995; 1996; 2004) and explored the notion of PTG through constructed accounts obtained in interviews with psychological therapists working with refugees in the UK. The data have been analysed and interpreted using a qualitative method, thematic analysis. Further qualitative enquiry into how therapists adjust and work in therapy sessions may also help to inform effective service delivery.

The research data from the participant accounts constructed interesting perspectives into the strengths and challenges of PTG theories in therapy. It may also be beneficial to use outcome data to compare and contrast both clients' and therapists' perspectives, and to critically evaluate the use of assessment tools to elucidate the effectiveness of growth-orientated therapy for this client group.

Additional research into how growth-orientated approaches may be implemented in doctoral programmes and therapy training may offer insights into how clinical placements can be further developed to integrate this approach. Interviewing settled refugees may also be a way of understanding how they have successfully managed mental health challenges. This may further help to inform how mental health services for refugee clients can be developed.

10.6.2 Dissemination

Dissemination of research is an important aspect of contributing to the development of research in counselling psychology and participation in the wider debate on introducing new theoretical ideas into clinical practice, particularly from the positive psychology spectrum, such as PTG in clinical practice. Therefore the findings of this research may be shared with refugee clients and mainstream services, which would permit meaningful interactive discussion and engagement with the theory and data, to understand how PTG is applied in practice. Findings can also be disseminated within the psychology community in publications, and this may take the discussion to wider audiences, where trauma intervention and growth-related agendas can meet. Ultimately the goal is to help find new ideas and ways forward to manage the challenge of providing therapy to those affected by the changes of forced global migration. There are also plans to present the findings at several refugee services in London, to encourage discussion of the issues and findings and engage with front-line therapy staff.

10.7 Critical Evaluation of Research

The research was designed after critically reviewing the literature. Nevertheless, on reflection, there are areas for development. There are certain advantages to both qualitative and quantitative methodology. While a qualitative design has allowed in-depth study, it has not allowed the capture of measures and statistics that may help to compare participants. Also, a quantitative approach might have permitted a larger sample size and generalisation of findings.

Advertising directly to therapy organisations and on social media and using snowballing meant that there was a varied sample. This circumvented any difficulties that might otherwise have arisen by just recruiting from one organisation. Due to limitations of time and resources the

size of the study was limited. Qualitative research by its nature aims for greater depth and understanding of complex phenomena than is afforded by quantitative approaches (Willig, 2008). Nevertheless, the recruitment across organisations, instead of just one service, meant that there was a wider representation of psychological therapists than if only selected from one organisation. As many of the findings align closely with the work of Tedeschi and Calhoun (e.g. 1996) this suggests that the findings may have wider relevance to clinical populations. For example, the impact of group reaction to a trauma, and how this can hinder coming to terms with the trauma, has implications on the kind of group therapy that may be offered to refugee clients. That is, the group members may need to be interviewed before attending the group.

It is also likely that the method of recruitment chosen in the research design may have created a bias in the sampling. As the small sample was self-selecting this may have increased the likelihood of a certain kind of participant being recruited: i.e. it is likely that therapists with a preference for growth may have opted to take part. Therefore it cannot be concluded that the viewpoints represent all psychological therapists working with refugee clients. Nevertheless, a range of therapists with different training experience and professional backgrounds were recruited. Furthermore, the therapist participants were required to be accredited with two years of post-qualification studies, to develop some parity of experience.

While the research method chosen was best suited to the generation of the data sought, it is worthwhile considering how an alternative choice might have yielded different results, and with what implications. Selecting an IPA method might have allowed an understanding of the continuous process of how the participants make sense of the phenomenon, as well as allowing individual differences to stand out. However, due to the nature of the research questions, which sought to understand a theory in practice, an IPA method might have overemphasised the

individual experience and also posed the hazard of acting as a triple hermeneutic (Smith, 1996). Moreover, such an approach might have made the results less accessible. Since it is an objective for this research to be accessible to a wider audience, including therapists working with refugees, and that it might to some extent inform practice and policy, thematic analysis has been considered an appropriate method to achieve this aim (Braun & Clarke, 2012).

The psychological therapists in this study re-iterated the importance of using empowering language and they were conscious how these socially constructed labels can hinder the refugee client (Nyers, 2018).

The discussion on growth by the psychological therapists highlighted multiple ways of conceptualising refugee experiences. The use of metaphors highlighted how allowing clients to explore their own understanding of their experiences may shift the power back to the refugee client to state their own narrative. Also the use of multiple techniques such as holding and containing allowed the therapists access to more tools to help their clients. Moreover they have access to more techniques to help the refugee client and they sit outside of the framework of the guidelines and policies.

The issue of how refugee clients can be victimised was raised more than once and this issue may be addressed in therapy by opening up the possibilities for the refugee client, rather than limiting them to what keeps them as a patient. It may be that shifting towards the use of expert companions begins to shift the power imbalance and acknowledge the value that refugee clients can bring to therapy both as clients and helpers (Calhoun & Tedeschi, 2013).

The psychological therapists brought an eclectic range of skills which means that they are able to be reflective and not homogenise the refugee client group, however if too restricted by

the guidelines this is something they may have less freedom to pursue. Also the psychological therapists in this study were very much aware of social issues and thus formalising this in psychological formulations would allow a standardised way to account for this in practice (Harper & Moss, 2003). Specifically the therapists being able to use their insight and skills to validate cultural and even spiritual experiences, may allow the client permission to raise their own cultural interpretations. This may relate to the therapists knowing how much to lead and when to let the client lead (Papadopoulos, 2018). It was clear from the data that the therapists were highly skilled and the guidelines themselves may de-skill them from offering the refugee client the best outcome.

Using a narrative approach may be helpful, however if the therapist is aware of how much the client needs them and when to allow them to explore by themselves, then they may adapt this approach to suit the client (Papadopoulos, 2018). Of course it was important that any approach does not diminish the clients ideas through a Western lens (Mohanty, 2013) and that an ethnocentric approach is avoided (Woodcock, 2000).

10.7.1 Reflexivity: Learning Post-Research

Now that the research has been completed, I reflect on what has been learned from the research process. Firstly, learning about designing a qualitative project in order to construct research data through talk, has taught me the value of the individual knowledge of psychological therapists. For example, the ideas that the therapist participants relayed may not have been as easily captured in quantitative studies and are unique to their perspectives. Through the process of developing qualitative research, I have observed how it may help guide practitioners within therapy work to inform and continue to improve their practice. I have learned that my own cultural understandings and of the social context, widen the scope of the research and therefore

being an aware and reflective clinician and researcher is crucial to develop the profession.

Through research, academic discussion with colleagues and reflection I have developed skills about making key choices about epistemology and ontology and how this impacts the trajectory of the research. For example, within my research moving from an IPA design to a thematic analysis has constructed a very specific result that was reflected on within in the context of the research questions. I reflected earlier on an awareness that my own experience of having migrant parents may influence the research, however I think the hybrid design of the interview schedule permitted for a deductive and inductive influence on the data. Although I remain part of the co-construction of the research the theory has also guided the direction of the data collection. Overall, I think my positionality as a descendant of migrants has provided me with impetus to illuminate how refugee clients may flourish and not just stay within the realms of a saviour discourse. Therefore within the social context of inequality, such a position may be helpful in supporting developing therapies and services for refugee clients.

10.7.2 Evaluation: Validity and Reliability

The results are not based on quantitative measures and therefore require other data that lend credibility to the findings. Firstly, the professional experience of the therapists is regarded as a criterion that gives the research added validity, as they have brought a range of experiences that are embedded in their own constructions of delivering therapy. The hybrid design of an inductive and deductive interview schedule has allowed a balance between the use of theory and participant-driven data, which has also worked within the moderate social constructionist and critical realist stance that accepts the existence of particular ways of conceptualising trauma for refugees, yet equally seeks new information through the research. In terms of *transferability,* in line with the moderate social constructionist stance, it is not necessary to generalise this research

to therapists at large to gain validity. However, with a critical realist lens, it may be possible to transfer the findings to specialist refugee therapists. In terms of dependability, it is possible to discover such results in similar settings, although there will be differences. In terms of confirmability, I have reflected on my role within this thesis.

10.8 Conclusion

The thesis has presented a thematic analysis of therapists' perceptions of and perspectives on post-traumatic growth from the vantage point of working with refugees in the UK. The findings have highlighted the initial emotional pain that the clients experience while processing trauma, as well as how they work through and process these feelings towards growth. The therapist participants have depicted how the refugee clients develop goodwill towards themselves and others. Relationships were constructed as both helpful to and a hindrance to progress, but overall have continued to act as a vehicle of growth. The metaphors of the traumatic events were used to illustrate the impact of the trauma, and the theories and techniques act as tools by supporting the therapists in navigating challenges in therapy.

Some perceptions described by the psychological therapists, such as the concurrent nature of stress and growth, appeared to align closely with those in the literature (Baker at al., 2008). However, some of the techniques and theories that the psychological therapists used and found most effective were not reflected in mainstream policy, and this has highlighted a gap in practice and policy, e.g. containment of emotions (Winnicott, 1957). While participants were often aware of challenges such as denunciation by cultural groups, they lacked the resources to be able to take action on this, for example how they might help the refugee client to think about connecting with more accepting groups. Multiple theories were drawn on that extended beyond those laid out in the NICE guidelines (2018).

The psychological therapists emphasised in their accounts the challenges of the role of working with refugees who have experienced highly traumatic events, and yet this is not reflected in the training available. Furthermore, they alluded to the degree of the impact of the refugee clients' emotions, which appeared to contrast the level of the intervention offered to the intensity of the presenting problem.

While some gaps in PTG have been noted in the literature, they are mainly focused on the vicarious impact on psychological therapists (Barrington & Shakespeare-Finch, 2012). As well as more general attempts to measure PTG in a therapeutic context, the psychological therapists appeared to have faced challenges when working with this client group, their presenting problems and their emotions, which need to be worked through to process the trauma. There was a sense of seeing growth in the refugee client but not having the clinical skills nor the consent to pursue this further in therapy, or to signpost this further outside the therapy room. This raises questions about how up-to-date policy and clinical training remains on these matters, and whether psychological therapists are encouraged only in theory, but not practice, to develop a social justice agenda of fully empowering clients.

In conclusion, policy and clinical training need to align themselves more closely to the refugee service user's journey and the intervention that the psychological therapist actually uses in practice. This is to ensure that relevant therapeutic interventions which address relevant affective and cognitive issues are offered. This may mean that the agreements that services make at the commissioning level need to involve psychosocial interventions that take into consideration the actual therapeutic work required to support refugee clients' needs, and design appropriate interventions and pathways accordingly.

Studying a population of psychological therapists has allowed an expert perspective on the emergence of the PTG theory in clinical practice. The data have highlighted the significance of relatedness and how clients continue to grow in relation to others. This finding lends support to the idea of social support, informally or working with a psychological therapist, since PTG is facilitated by working with another person. The work of Calhoun and Tedeschi demonstrates this in practice (2013) and furthermore, this has highlighted the relevance of PTG theory within the therapeutic relationship. In particular, the benefits of talking about strengths can help to develop motivation. This demonstrates some merit and latent possibility in PTG theory.

The results have supported the earlier findings in the literature completed by Tedeschi and Calhoun (2004). In particular, the idea that individuals need a therapeutic environment in which to process the emotional pain related to the trauma, that they grow in relation to others, and how they define that connection is of significance. Therefore, the quality of the therapy environment needs to be considered when designing refugee therapy. Firstly, it is useful to look at what constitutes a therapeutic outcome and how this research has further defined this. The data have started to provide some evidence of how therapists see growth in their therapy.

The findings answer the research questions to the extent that the process of growth in therapy can be deconstructed and analysed for pivotal moments of change. The strengths of the data were that thematic analysis permitted a range of themes to be organised in a way that has demonstrated how PTG is active in practice, in a way that quantitative data may not have highlighted. However, equally, there were some limitations, and in the future, the use of a quantitative method may generate a breadth of results that illustrates a range of ideas across a larger sample. In light of the aforementioned reflections, it is suggested that the sample could be split into those working at an earlier stage and later stage, and a comparison made of the results.

10.9 Positive Indications from the Findings

PTG has shown some utility in facilitating understanding of therapeutic work with refugees. In particular, an early intervention focused on deliberate rumination may prove helpful in relapse prevention. Psychological therapists may deliver PTG as an adjunct intervention following initial TFCBT. Hence there is a necessity to integrate such theory into clinical practitioner training.

The recommendations suggest that the training of psychological therapists could be a way to develop psychologists who look for both evidence of psychological growth as well as painful emotions. Additionally, the policy makers need to recognise that to reach growth necessitates processing emotional pain, which may require flexibility beyond the recommended timeline to deliver therapy. Understanding the therapeutic needs of the refugee clients and designing the appropriate therapies is a necessary step to advance this matter. Applied to a clinical setting, in practice therapists could discuss the mechanics of the techniques in MDT and reflect on how they will support the refugee client to process these emotions and cognitions. Future research might study PTG from the perspective of both clients and psychological therapists to deepen understanding of how growth emerges in the therapy process. A mixed-method design may be suitable for this, which would account for trends in the data as well as the nuances in individual accounts.

The implications of the findings may be in designing and delivering early intervention therapy, and a key insight into how this may be achieved comes from understanding the deliberate rumination that the client engages in. In this, an earlier focus on processing emotion facilitated by a psychodynamic lens, followed by a CBT and compassion-focused approach, may lead to a solution-focused outcome. In working with refugee clients at the post-intervention

stage, relationships, building community, finding meaning and trying new activities may be a useful focus. Post-traumatic growth has brought a new angle when working therapeutically with refugee service users that clinicians may consider in their therapeutic practice.

Taken in isolation, the PTG construct can be easily misunderstood as a superficial bandage applied to a profound wound. However, psychological growth is part of recovery from trauma, and indeed some of the participants asserted that growth is a continual process. This continuity is thus part of the human journey and a shared universal experience, yet when the natural process of growth is interrupted at this point, it may be possible to intervene therapeutically to facilitate growth-centred thinking. The benefit to the refugee clients may be that they are supported in changing thought patterns that inhibit the natural flow of their development.

In summary, post-traumatic growth appears to show some utility, from the perspective of psychological therapists, in informing clinical practice and therapeutic outcomes for refugee clients. The specific mechanics of how PTG works in therapy need to be established further. Nevertheless, there is merit in considering the approach of PTG in clinical practice. With services facing the challenge to support refugee service users, there is an opportunity for the counselling psychology profession to focus on understanding the underlying psychological needs of the refugee clients. Then to eventually, design appropriate therapeutic interventions and pathways accordingly. It is argued that Counselling psychology needs to question decades of focus on suffering, and highlight a path towards growth, meaning, empowerment and authenticity for the refugee client.

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Appendix A: Interview Schedule

Proposed Interview Schedule:

The semi-structured interview aims to elicit responses from the perception and perspective of the therapist on Post Traumatic Growth.

1. In your own words, can you describe the concept of “Growth”?

2. Given what you have described, how do you think that growth manifests after a traumatic event?

3. In what way do you think that stress and growth can co-exist?

4. How would anyone know that growth has occurred after a traumatic event?

Please answer the following questions with examples to illustrate your understanding:

5. Given what you have highlighted, how would you describe what an individual could learn about personal strength?

6. Can you tell me how relationships and relating to others could be viewed after a traumatic event?

7. Can you give me examples of how life is appreciated differently post trauma?

8. How would you conceptualise spirituality after a traumatic event?

9. Within the context of this topic, what new possibilities and changes are possible on an individual basis?

10. Are there any other areas of growth that you would like to inform me about?

11. How would you summarise your perspective on Post Traumatic Growth?

12. Can you tell me what is the most important aspect for you and why?

Appendix B: Invitation Letter

PARTICIPANT INVITATION LETTER

UNIVERSITY OF EAST LONDON

School of Psychology

Stratford Campus

Water Lane

London E15 4LZ

The Principal Investigator

Tajinder Rai

Counselling Psychologist (in Training), Year 4, PsychD in Psychology

University of East London, Department of Psychology

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Counselling Psychology degree at the University of East London.

Project Title

Understanding the utility of the construct of Post-Traumatic Growth (PTG) for informing therapeutic outcomes, from the perspective of therapists working with refugees in the UK: A thematic analysis.

Project Description

This project is being conducted as part of a doctoral course in counselling psychology and it is hoped that the results of the study may shed new light on the Post-Traumatic Growth (PTG) construct. This could expand current understandings of what happens when making sense of a traumatic event and support post-traumatic stress services. *Post Traumatic Growth* as a construct entered psychological terminology in the 1990s (e.g. Tedeschi & Calhoun, 1995, 1996). The main premise is that an individual experiences psychological changes of a positive manner, that are characterised as beyond previous levels of functioning and that growth and stress can occur concurrently.

Post Traumatic Growth (PTG) has developed from the idea that inordinate focus has been placed on the negative symptoms of traumatic stress, such as reoccurring traumatic memories. PTG shifts the focus from stress to growth. Constructing Growth post-trauma is about how individuals make sense of a trauma and how growth is constructed through the language that is used. **NB:** At this point, it is crucial to note that PTG doesn't negate the negative impact of very difficult life events, but it demonstrates growth that occurs side by side with the stress.

Therefore in this study the focus is primarily on how PTG is constructed by individuals. Specifically it seeks to understand this from the perspective and perception of therapists. In order to conduct this study, I am seeking to interview therapists who work specifically with refugee clients. They would have at least 2 years' experience as a therapist with this client group and would be accredited with a body such as the BPS (British Psychological Society), BACP or UKCP. If you are interested in participating in this study, initially I would speak to you on the phone, so that we both agree that this is the right time for you to do this. If we agree to proceed then we would arrange an interview that would last 1-1.5 hours.

At the end of the interview, if you would like to discuss any feelings that come up, I will provide contact details for relevant support and counselling organisations. There are potential benefits and risks, such as you may find it useful to discuss how you perceive post-traumatic growth in the context of the work that you do as a therapist. This may help you gain insight into how growth from difficulty plays a role within your own work. Understandably, it could be challenging talking about growth in the context of trauma and it may bring up distressing feelings. Therefore you may want to reflect on how you feel about this study before participating.

Confidentiality of the Data

The interviews will be audio-recorded and transcribed (any potentially identifying details will be removed). Once transcribed, the recordings will be destroyed. All information will be handled confidentially, in accordance with the Data Protection Act 1998, and you have the right to withdraw from the study at any time without having to give a reason. It's possible that the data could be used for publication at a later date, therefore the electronic transcripts will be kept securely and destroyed 3 years after the end of the doctorate (until September 2019).

Location

The interviews will take place at the therapy centre, or the University of East London, Stratford Campus or at another location, depending on what is most convenient to you.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor [Dr. Edith Steffen, School of Psychology, University of East London, Water Lane, London E15 4LZ. Tel: 0208 223 4425 E.steffen@uel.ac.uk]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

How to arrange a place on this research study?

If you feel that you would like to participate in this study, you can contact me by e-mail at
and you can also leave me a telephone number and I am happy to call you at a convenient time.

Thank you in anticipation.

Yours sincerely,

Tajinder Rai

Trainee Counselling Psychologist

Appendix C: Consent Form

CONSENT FORM

UNIVERSITY OF EAST LONDON

Consent to participate in a research study:

Understanding the utility of the construct Post Traumatic Growth (PTG) for informing therapeutic outcomes, from the perspective of therapists working with refugees in the UK: A thematic analysis.

I agree to participate in this study, by taking part in an informal interview investigating the *Post Traumatic Growth* construct. I have read and understood the information sheet provided. I have been given a full explanation by the researcher, of the purpose and the nature of the research. I understand what I will be expected to do, the likely duration and the location the interview will take place in. I have been provided with an opportunity to ask questions on the study.

I understand that the interview will be digitally recorded. Data from this interview will be transcribed, used in the study and may also be used for publication after the study has ended. I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. In order to protect confidentiality, any identifying information such as names will not be recorded. Once transcribed, the recording will be erased. I understand that all data will be kept and processed in adherence with the Data Protection Act (1998). On the understanding that my confidentiality is preserved, I agree that I will not seek to restrict the use of the results of the study.

I have been given adequate time to consider my participation and I hereby freely and fully consent to participate in the study, which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time, without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Please sign to indicate agreement of the above:

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant's Signature

………………………………………………………………………………………..

Researcher's Name (BLOCK CAPITALS)

………………………………………………………………………………………..

Researcher's Signature

…………………………………………………………………………………………

Date: ……………………..…….

Appendix D: Ethical Approval

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Dr Edith Steffen **ASSESSOR:** Joy Coogan

STUDENT: Tajinder Rai **DATE (sent to assessor):** 17/07/2014

Proposed research topic: **Understanding the utility of the construct of Post Traumatic Growth (PTG) for informing therapeutic outcomes, from the perspective of therapists working with refugees in the UK: A thematic analysis.**

Course: Professional Doctorate in Counselling Psychology

1. Will free and informed consent of participants be obtained? YES
2. If there is any deception is it justified? N/A
3. Will information obtained remain confidential? YES
4. Will participants be made aware of their right to withdraw at any time? YES
5. Will participants be adequately debriefed? YES
6. If this study involves observation does it respect participants' privacy? NA
7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? NA
8. Is procedure that might cause distress to participants ethical? YES
9. If there are inducements to take part in the project is this ethical? NA

10. If there are any other ethical issues involved, are they a problem? NA

APPROVED

YES		

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: JC Date: 18/07/14

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Dr Edith Steffen **ASSESSOR:** Joy Coogan

STUDENT: Tajinder Rai **DATE (sent to assessor):** 17/07/2014

Proposed research topic: **Understanding the utility of the construct of Post Traumatic Growth (PTG) for informing therapeutic outcomes, from the perspective of therapists working with refugees in the UK: A thematic analysis.**

Course: Professional Doctorate in Counselling Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

1 Emotional NO

2. Physical NO

3. Other NO
(e.g. health & safety issues)

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES		

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: **JC** Date: 18/07/14

For the attention of the assessor: Please return the completed checklists by e-mail to ethics.applications@uel.ac.uk within 1 week.

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology

The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853

Appendix E: UEL Ethical Approval Amendment: Title Change

University of East London Psychology

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or been impacted from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: Uel.Ethics@uel.ac.uk
4. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

REQUIRED DOCUMENTS

1. A copy of the approval of your initial ethics application.

Name of applicant: Tajinder Rai Programme of study: Professional Doctorate in Counselling Psychology Name of supervisor: Dr. Claire Marshall

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
Old Title: Understanding the utility of the construct of Post Traumatic Growth (PTG) for informing therapeutic outcomes, from the perspective of therapists working with refugees in the UK: A thematic analysis.	It was recommended by the Director of Studies to shorten the original title, as it was very long.
New Title: The utility of Post Traumatic Growth in clinical practice, from the perspective of therapists working with refugees in the UK: A Thematic Analysis.	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	Yes	
Does your change of title impact the process of how you collected your data/conducted your research?		No

Student’s signature (please type your name): Tajinder Rai

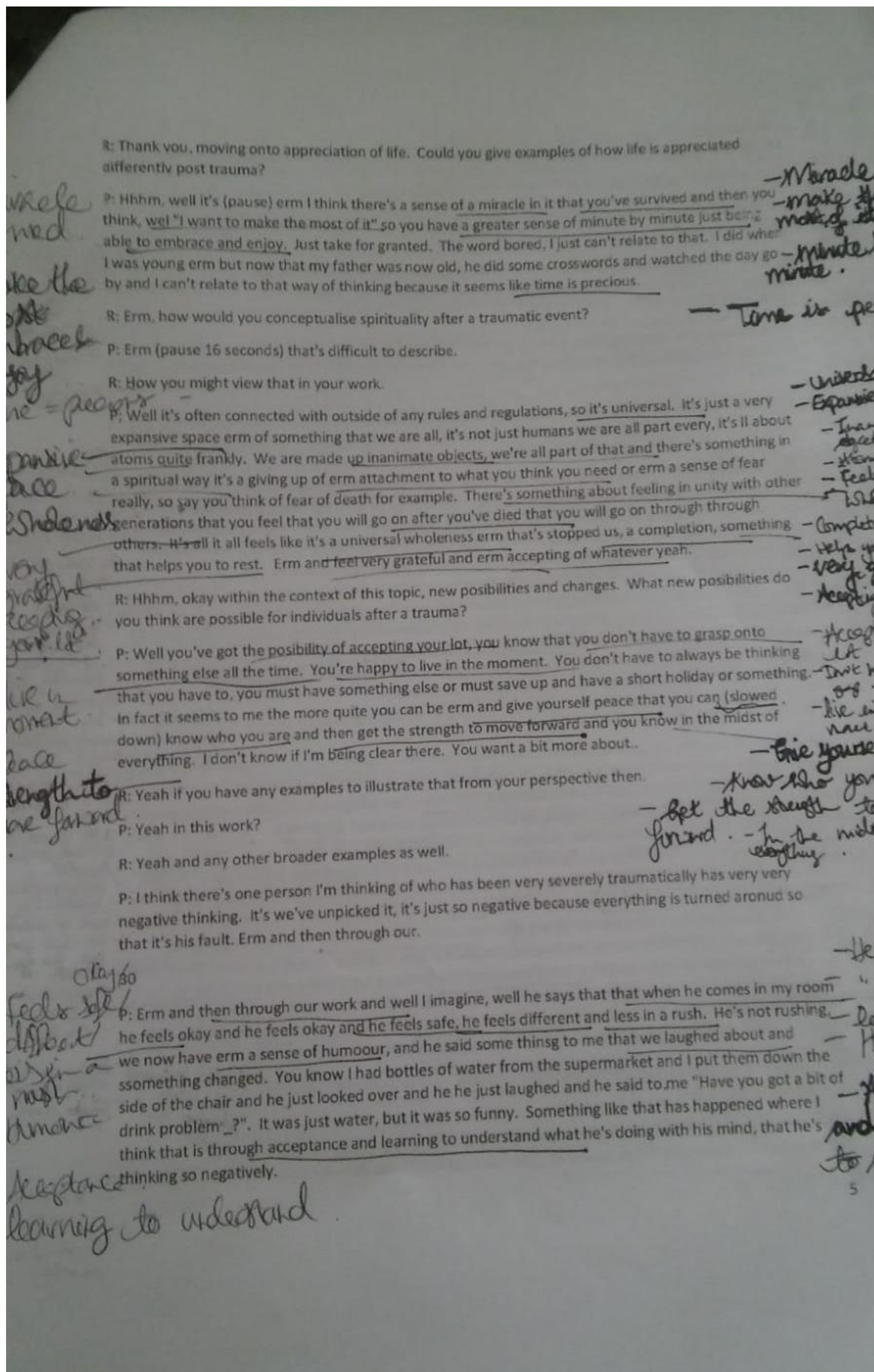
Date: 04/09/2019

TO BE COMPLETED BY REVIEWER		
Title changes approved	APPROVED	
Comments		

Reviewer: Glen Rooney

Date: Wednesday 4th September 2019

Appendix F: Example of Early Annotated Transcription



R: Thank you, moving onto appreciation of life. Could you give examples of how life is appreciated differently post trauma?

P: Hhhm, well it's (pause) erm I think there's a sense of a miracle in it that you've survived and then you think, wel "I want to make the most of it" so you have a greater sense of minute by minute just being able to embrace and enjoy. Just take for granted. The word bored, I just can't relate to that. I did when I was young erm but now that my father was now old, he did some crosswords and watched the day go by and I can't relate to that way of thinking because it seems like time is precious.

R: Erm, how would you conceptualise spirituality after a traumatic event?

P: Erm (pause 16 seconds) that's difficult to describe.

R: How you might view that in your work.

P: Well it's often connected with outside of any rules and regulations, so it's universal. It's just a very expansive space erm of something that we are all, it's not just humans we are all part every, it's ll about atoms quite frankly. We are made up inanimate objects, we're all part of that and there's something in a spiritual way it's a giving up of erm attachment to what you think you need or erm a sense of fear really, so say you think of fear of death for example. There's something about feeling in unity with other generations that you feel that you will go on after you've died that you will go on through through others. ~~It's all~~ it all feels like it's a universal wholeness erm that's stopped us, a completion, something that helps you to rest. Erm and ~~feel~~ very grateful and erm accepting of whatever yeah.

R: Hhhm, okay within the context of this topic, new posibilities and changes. What new posibilities do you think are possible for individuals after a trauma?

P: Well you've got the posibility of accepting your lot, you know that you don't have to grasp onto something else all the time. You're happy to live in the moment. You don't have to always be thinking that you have to, you must have something else or must save up and have a short holiday or something. In fact it seems to me the more quite you can be erm and give yourself peace that you can (slowed down) know who you are and then get the strength to move forward and you know in the midst of everything. I don't know if I'm being clear there. You want a bit more about..

R: Yeah if you have any examples to illustrate that from your perspective then.

P: Yeah in this work?

R: Yeah and any other broader examples as well.

P: I think there's one person I'm thinking of who has been very severely traumatically has very very negative thinking. It's we've unpicked it, it's just so negative because everything is turned aronud so that it's his fault. Erm and then through our.

P: Erm and then through our work and well I imagine, well he says that that when he comes in my room he feels okay and he feels okay and he feels safe, he feels different and less in a rush. He's not rushing, we now have erm a sense of humoour, and he said some thinsg to me that we laughed about and ssomething changed. You know I had bottles of water from the supermarket and I put them down the side of the chair and he just looked over and he he just laughed and he said to me "Have you got a bit of drink problem _?". It was just water, but it was so funny. Something like that has happened where I think that is through acceptance and learning to understand what he's doing with his mind, that he's thinking so negatively.

5

Appendix G: Reflexivity Account

Methodology Reconsidered

At the early stages of the research an interpretive phenomenological analysis (IPA) methodology had been adopted (Smith,1996). However, on reflection it did not appear that IPA would adequately answer the research questions. As the research was seeking to understand a phenomenon and how this is constructed by therapists, a moderate social constructionist epistemological position was decided as better suited to the thesis, so that it would aim to study knowledge that is formed within the world rather than from one's experience Willig (2008). The research question better fitted with the research implications for social constructionism and thematic analysis (Braun & Clarke, 2012). Yet there still remained the challenge of the scope and depth of this method, therefore, further reflection on Braun and Clarke and relevant papers highlighted that thematic discourse analysis would move beyond functional semantic level themes towards in depth latent data (Taylor and Ussher, 2001).

Appendix H: Debrief Form

OTHER ATTACHMENTS

Debriefing Sheet

Thank you for participating in this study. If you feel uncomfortable or are in any distress as a result of your participation, we advise you to contact:

Tajinder Rai, Principal Investigator

Tel: (TBC)

E-mail:

Dr Edith Steffen, Director of Studies

University of East London, Water Lane, London E15 4LZ

Tel: 0208 223 4425

Email: E.steffen@uel.ac.uk

In addition, if any distressing issues have been raised for you by participating in the research and should you require further support, please consult the following agencies:

Support Organisations:

Samaritans

Tel: 08457 909090

Helpline for people in distress.

SANELine

Tel: 0845 767 8000 between 6pm and 11pm each evening

A specialist mental health helpline.

The British Psychological Society

St Andrews House

48 Princess Road East

Leicester, LE1 7DR

Tel: 0116 254 9568

E-mail: enquires@bps.org.uk

www.bps.org.uk

United Kingdom Council for Psychotherapists

Edward House

2 Wakley Street

London, EC1V 7LT

Tel: 0207 014 9955

E-mail: info@psychotherapy.org.uk

www.psycholotherapy.org.uk

The British Association for Counselling and Psychotherapy

BACP House

15 St John's Business Park

Lutterworth, LE17 4HD

Tel: 01455 883300

E-mail: bacp@bacp.co.uk, www.bacp.co.uk