Hanif, Nadia (2020) Exploring refugees and asylum seekers experience of group work for trauma: a qualitative study. D Clin Psy thesis.

https://theses.gla.ac.uk/81651/

Copyright and moral rights for this work are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This work cannot be reproduced or quoted extensively from without first obtaining permission in writing from the author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

Enlighten: Theses
https://theses.gla.ac.uk/
research-enlighten@glasgow.ac.uk

Exploring Refugees and Asylum Seekers Experience of Group Work for Trauma: A Qualitative Study

And

Clinical Research Portfolio

Nadia Hanif

MA (Hons), MSc, MSc

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

Institute of Health and Wellbeing

College of Medical, Veterinary and Life Sciences

University of Glasgow

July 2020

Table of Contents

Acknowledgements

First and foremost, I would like to thank the participants who took part in the study. This project would not have happened if it wasn't for them. It was a privilege to hear their stories.

I would like to thank Professor Andrew Gumley for his support, guidance and expertise in helping me carry out this study. It was a pleasure having you as my research supervisor.

I would like to thank my field supervisor, Dr Andy Siddaway, and to all of the staff at The Anchor Centre, especially to Laura Barrie, Julie Jackson and Tracy MacMillan for their help and support with the recruitment process.

I especially want to thank Professor Jon Evans for his help and support and the kindness, consideration and patience he has shown every time I have asked for his advice and assistance. My thanks to Dr Caroline Bruce for her support at the start of the project.

Thank you to everyone who supported me throughout this process (you all know who you are), including the Highland trainees and to Murdo.

Last but not least, to my family and friends, I can't thank you enough for the love and the support that you have given me, especially to my Mum. Thank you for teaching me the art of patience and perseverance!

Chapter 1: Systematic Review

A Systematic Review Exploring People's Experiences of Group Interventions for the Treatment of Trauma

Nadia Hanif*

***Mental Health and Wellbeing, Institute of Health and Wellbeing, University of Glasgow**

Correspondence Address:
Mental Health and Wellbeing
Administration Building
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH
E-mail: n.hanif.1@research.gla.ac.uk

Prepared in accordance with submission requirements for the Journal of Traumatic Stress (see Appendix 1.1)

Word Count with quotes/ without quotes: 8820 / 7949

Abstract

Background: Group interventions have been found to be effective for the treatment of PTSD and for those with complex trauma, however more research is required examining how individuals have experienced these interventions. The aim of this systematic review was to explore individuals' experiences of group interventions for the treatment of PTSD and complex trauma.

Methods: A systematic search was carried out on 16 May 2020 using the following databases – CINAHL, MEDLINE, Cochrane Library, Scopus, PsycINFO and Embase. The inclusion criteria were qualitative studies including adults with PTSD, trauma or complex trauma who received group treatment for trauma, and who were describing their experiences. The COnsolidated criteria for REporting Qualitative research checklist was used to evaluate the included studies. Following this, thematic synthesis was conducted.

Results: Seventeen articles were identified describing 14 studies. Interventions ranged from stabilisation approaches, compassion-focused therapy, yoga, meditation, mindfulness and trauma-informed psychotherapy. Three main themes were identified: Process of Change, Group Processes and Individuals' Healing Process.

Conclusions: Group interventions helped individuals to develop a better understanding of their difficulties and to connect more with themselves and with others. Meeting others who had experienced similar difficulties helped to validate and normalise their experiences. Individuals

felt more empowered to focus on themselves and to live a life which they valued. Further research is required which includes people with lived experience as co-producers of research and which involves exploring in more depth the mechanisms of change involved in group interventions.

Introduction

Individuals can experience two types of trauma, Type 1 or Type 2 trauma (Terr, 1991). Type 1 trauma are single events that occur unexpectedly e.g. road traffic accidents or assaults (NES, 2017). Type 2 trauma, also known as complex trauma, occurs when traumatic events are repetitive or prolonged, where the person is vulnerable or controlled by someone, which can be of interpersonal nature, and where escape is not possible (Herman, 1992). Events of this nature include trafficking, war or childhood abuse (Courtois, 2004). Individuals who have been through trauma can experience symptoms of post-traumatic stress disorder (PTSD), which involves re-experiencing the event (nightmares/ flashbacks), avoidance (of thoughts or where the event occurred) and being hypervigilant (alert and on guard; WHO, 2018). These symptoms can affect individuals' level of functioning or their psychological, biological and physiological development (Van der Kolk, 2000). Individuals may also experience complex PTSD (cPTSD), which is a new diagnosis in the International Classification of Diseases and Related Health Problems -11th version (ICD-11). ICD-11 is a coding system which describes and outlines symptoms of health conditions, based on the most up-to-date research (The Lancet, 2019). ICD-11 describes cPTSD as symptoms of PTSD plus 'disturbances in self-organisation' (DSO), i.e. impairments with interpersonal relationships, in regulating emotions and negative views about themselves (WHO, 2018).

In a large-scale study, Koenen at al. (2017) explored the prevalence rate of PTSD, using surveys in 24 countries (n = 71083). They found that for those who experienced a traumatic event, the lifetime prevalence rate for PTSD was 5.6% (n=4103; range 0.5% - 14.5%). In relation to cPTSD, Cloitre et al. (2019) compared the prevalence rate for PTSD and cPTSD in a US

population (n = 1893), using ICD-11 definitions, and found the rate to be 3.4% (n = 62) for PTSD and 3.8% (n= 70) for cPTSD. This study showed that women were twice as likely than men to experience PTSD and cPTSD, and those who experienced childhood trauma were more likely to experience cPTSD compared to PTSD.

With regards to the natural course of PTSD, Kessler et al. (1995) compared individuals who received treatment and those who did not have treatment for symptoms of PTSD, and found that after a year both groups experienced a reduction in PTSD; however those in the treatment group recovered at a faster rate (mean = 36 months) compared to those who did not receive treatment (mean = 64 months). The study also showed that in both groups, a third of individuals continued to experience PTSD even after 6 years (Kessler et al., 1995). In relation to complex trauma, Felitti et al. (1998) found that compared to those who did not experience childhood abuse, those who experienced childhood abuse were more likely to have health issues which had lasting impacts e.g. they were up to twelve times more likely to experience depression, suicide and substance misuse. The results from these studies suggest that trauma can have long term effects.

NICE guidelines (2018) recommend using trauma-focused Cognitive Behavioural Therapy (CBT-T), Eye Movement Desensitization and Reprocessing (EMDR), prolonged exposure therapy (PE), cognitive processing therapy (CPT) or narrative approaches for treating symptoms of PTSD. As cPTSD is a new diagnosis, evidence-based treatment for this has been limited (Cloitre, 2020). NICE guidelines (2018) suggest that for those with more complex presentations, additional time should be given for treatment in order to build up the therapeutic relationship and to factor in other issues which may affect treatment e.g. emotional dysregulation.

In a systemic review, Lewis et al. (2020) explored the effectiveness of psychological therapies in reducing symptoms of PTSD, which included 114 RCTs, and found that the most effective therapies were CBT – T (especially CPT, cognitive therapy and PE) and EMDR. Their results were based mainly on individual therapies and small sample sizes. In a systematic review, Kangaslampi and Peltonen (2019) explored how changes occurred for those who received psychological interventions for symptoms of posttraumatic stress. They analysed 34 controlled trials (25 were based on adult population group) and found that interventions which focused on changes in beliefs or the ways that individuals thought about the trauma and mindfulness led to improvements in symptoms of posttraumatic stress. Caution should be taken in generalizing the findings as the studies were mainly based in US.

Fernández-Fillol et al. (2018) conducted a systematic review of psychological interventions for the treatment of complex PTSD. They included 8 articles, of which 5 articles were based on an adult population group and found that psychological interventions were effective in reducing symptoms of complex PTSD. However, it was difficult to compare the interventions as they varied in e.g. structure, therapeutic modalities and participants. This review was limited as only a small number of articles were available. Karatzias et al. (2019) carried out a systematic review exploring the effectiveness of PTSD psychological interventions for complex PTSD. They included 51 studies based on RCTs and included adults with symptoms of PTSD plus one or more clusters of DSO in complex PTSD. They found that psychological interventions were effective for those who presented with symptoms of complex PTSD, especially for 'negative self-concept' and 'disturbances in relationships'. However, those who experienced childhood trauma showed less improvement (Karatzias et al., 2019). Caution should be taken with the

findings as the researchers reported that many of the studies were of low quality (Karatzias et al., 2019).

Group interventions can help normalize the difficulties that individuals have experienced and can also provide support, which help reduce feelings of isolation, shame and guilt (Ruzek, Young & Walser, 2003). Being in a group can allow others to share and learn from each other as well as help to validate experiences (Fritch & Lynch, 2008). In a systematic review, Schwartze et al. (2019) found that in people with PTSD, in comparison to no treatment, group interventions were effective in reducing symptoms of PTSD. Their study was limited in that 15/20 RCTs focused predominantly on CBT groups. Mahoney, Karatzias and Hutton (2019) conducted a systematic review of group interventions for complex interpersonal trauma. They found that, in comparison to 'usual care', psychoeducation interventions and trauma memory processing interventions were effective in reducing symptoms of PTSD. One of the limitations of their review included the heterogeneity of the studies. Further research was required which explored in more depth the intensity and the long-term impacts that interventions have on individuals (Mahoney, Karatzias & Hutton, 2019). This could perhaps be done by exploring individuals' experiences of such interventions.

Examining how individuals experience interventions can provide a deep understanding of the impact interventions have had on them (Elliot, 2008). This is important as individuals play an active role in treatment. By exploring how changes occurred, this can help clinicians understand more about the process involved in treatment, e.g. how to structure therapy and the relational aspect of treatment (Levitt, Pomerville & Surace, 2016). Research suggests that the therapeutic

relationship is an important element in treatment, as is the clinicians' ability to adapt treatment to suit individual needs (Gostas et al., 2012; Timulak & Keogh, 2017). More research is required which explore group interventions from individuals' views. This can help gauge what has worked for individuals, shaping how we understand the mechanisms and the impact interventions had, which can help to inform intervention development and refinement. Therefore, a systematic review exploring adults' experiences of group interventions for trauma was undertaken.

Objectives

The aim of this systematic review was to explore the following research question: Amongst people with experience of trauma, PTSD or complex trauma, how do they describe their experiences of participating in any group intervention specifically aimed at alleviating or stabilizing post traumatic symptomatology?

Methods

Databases

The following electronic databases were searched on 16 May 2020 to find relevant papers for the review: CINAHL (via EBSCO host 1983 to 16 May 2020), MEDLINE (via Ovid Medline in process and other non-indexed citations), Cochrane Library (systematic review), Scopus (16 May 2020), PsycINFO (via EBSCO host 1984 to 16 May 2020) and Embase (via Ovid Embase, 1947 – 16 May 2020).

Search terms

The PICOS framework (Methley et al., 2014) was used to generate the search terms (Table 1).

Table 1: PICOS framework

Population	PTSD, cPTSD, trauma and complex trauma
Intervention	Psychological treatment or psychological intervention
Comparison	N/A
Outcome	Experience, perspective, views, perception, opinion or attitude
Study type	Qualitative research or qualitative methods

Variations of the search terms used can be found in Appendix 1.2. The same search terms were used for each of the databases. Title, abstract and keywords were used, as well as subject headings where appropriate for the databases. The PICOS domains were all combined using the 'AND' Boolean operator. English language limits were applied in all of the databases.

Once searches were completed, the articles were imported to RefWorks (https://www.refworks.com/refworks2/) and checked for duplicates, which were then removed. The researcher then screened the titles and the abstracts of the remaining papers. Following this, full texts of the articles were screened, which then resulted in the articles included in the systematic review. Additional searches were subsequently made. This involved searching the reference sections and carrying out forward citations (using Scopus) of the articles included. Where there were multiple articles from a single study, the lead author was contacted to establish the primary paper to be considered for the methodological evaluation.

Inclusion and exclusion criteria

The inclusion criteria were qualitative studies including adults with PTSD, trauma or complex trauma who received a group treatment for trauma, who were describing their experiences. Articles which included other people's views e.g. clinicians or group facilitators, were included if it was possible to identify and extract the experiences described by the individuals participating in group treatment. Only qualitative research with quotations reported were included as this ensured transparency of the data analysed (Yardley, 2000).

Systematic literature reviews, case reports, book chapters and dissertations were excluded. Studies which looked at veterans were excluded as the difficulties they experience are more specific to military and armed forces issues. Studies which included children and adolescents or focused on individual therapy or did not use a structured group treatment were also excluded.

Methodological transparency

The researcher evaluated the transparency of reporting using the 'COnsolidated criteria for REporting Qualitative research checklist' (COREQ; Tong, Sainsbury & Craig, 2007) (Appendix 1.3).

The researcher calibrated with an independent rater using one article, then purposively selected four articles and conducted inter-rater reliability based on those articles. The articles were selected by selecting one which scored highly on the COREQ compared to the rest of the articles, one article which was scored in the lower end of the COREQ and two articles which was scored in between the high and low scores of the articles selected. Four articles were selected to ensure it covered a spread of papers. The results showed that there was a moderate agreement (K=0.76; McHugh, 2012).

Data analysis

Thematic analysis (Thomas & Harden, 2008) was used by the researcher to synthesise the studies. An inductive approach was used. The results/findings sections from the articles were transferred into a word document. The analysis involved carrying out 'line by line' coding. From there, the codes were collated together and similarities and differences were explored, which then led to development of the 'descriptive themes'. The final stage involved developing the 'analytical themes' which were the 'overarching themes' of the descriptive themes developed.

A strategy was used to integrate the COREQ when synthesising the studies. The highest total score on the COREQ for the studies were used first for the thematic framework. An inductive framework was applied.

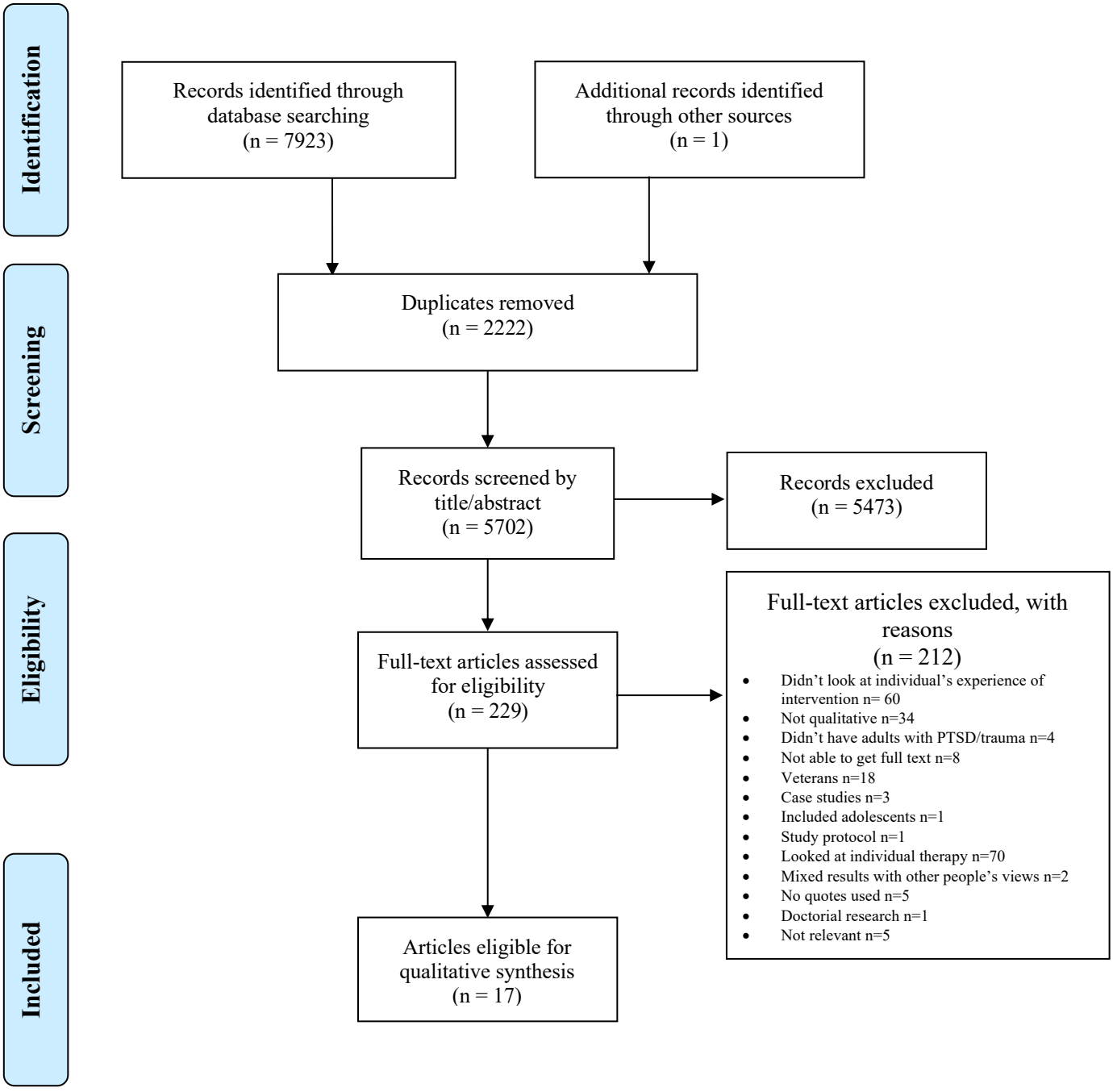
A critical realism approach was used when analysing the results. This approach suggests that the author's construction of knowledge is shaped upon their interpretation of events/ cultures or from their own experiences (Fletcher, 2017). The author is mindful that the data analysed will be based upon the patterns that are identified in the data however their interpretation of the data will be influenced by their views when it comes to analysing the data.

The 'enhancing transparency in reporting the synthesis of qualitative research: ENTREQ' standards checklist (Tong et al., 2012) was completed to evaluate this review (Appendix 1.4).

Results

The PRISMA (2009) flow diagram (Moher et al., 2009) illustrates the number of articles identified for each of the stages.

Figure 1: PRISMA Flow Diagram (Moher et al., 2009)



Seventeen articles were identified describing 14 studies comprising of 245 participants (n=49 male, n=196 female) who were describing their experiences in relation to the following interventions: 'Women Recovering from Abuse Program' (n=7, Parker et al., 2007), trauma-focused group psychotherapy (n=21, Tummala-Narra et al., 2012), mindfulness-based stress reduction group intervention (n=10, Bermudez et al., 2013), stablisation group intervention (n=13, Stige, Rosenvinge & Traeen, 2013; Stige et al., 2013; Stige & Binder, 2017; Stige, Binder & Veseth, 2019; n=5, Roberg, Nilsen & Rossberg, 2018), compassion-focused therapy (n=7, Lawrence & Lee, 2014), trauma-sensitive yoga (n=40, Jindani & Khalsa, 2015; n=39, Rhodes, 2015; n=31, West, Liang & Spinazzola, 2017; n=5, Stevens & McLeod, 2019), meditation training group (n=10, Myers, Lewis & Dutton, 2015), 'Trauma Recovery and Empowerment Model' group (n=16, Chouliara et al., 2017), group therapy utilized stabilisation techniques and guided imagery (n=30, Zehetmair et al., 2019) and 'Compassionate Resilience' group (n=11, Ashfield, Chan & Lee, 2020).

In Tummala-Nara et al (2012) only 15/21 participants who received a group intervention and in Lawrence and Lee (2014) 4/7 participants received a group intervention.

A summary of the studies included is in Appendix 1.5. The number of participants reported in the table are service users. There were four articles by Signe Stige, which have been categorized as one study. The primary study for this was by Stige, Rosenvinge and Traeen (2013).

There were two studies which reported that participants experienced complex trauma (Parker et al., 2007; Chouliara et al., 2017), two studies which reported mixed types of trauma (Myers,

Lewis & Dutton, 2015; Stevens & McLeod, 2019), one study with trauma and PTSD (Bermudez et al., 2013), one study with PTSD (Jindani & Khalsa, 2015), three studies with complex trauma and PTSD (Tummala-Narra et al., 2012; West, Liang & Spinazzola, 2017; Zehetmair et al., 2019), two studies with mixed traumas and PTSD (Lawrence & Lee, 2014; Rhodes, 2015) and two studies with complex trauma and complex PTSD (Roberg, Nilsen & Rossberg, 2018; Ashfield, Chan & Lee, 2020). The same participants were used in all of the articles by Signe Stige, where all types of traumas as well as PTSD and complex PTSD were experienced by the participants (Stige, Rosenvinge & Traeen, 2013).

With regards to the PRISMA diagram, the additional article was found from searching through the reference list of the included studies. This article may have not been found in the original search as qualitative studies can be poorly indexed (Methley et al., 2014).

Transparency of reporting

The total score on the COREQ ranged from 17 to 26 (Appendix 1.6). There were a number of strengths reported. The majority of the studies reported on who conducted the interviews and the gender, experience and training that the researchers had. This gives confidence in terms of who carried out the study and the analysis of the results. Studies were clear in terms of reporting the theoretical framework, participant selection e.g. the sampling method used and the sample size, the interview guide, audio recordings being used and data saturation. Furthermore, the studies were generally clear in terms of reporting the analysis and the findings, as well as who and how the data was coded and how themes were derived.

There were some weaknesses found. Only half of the studies reported what participants knew about the researcher and interviewers' characteristics. This can be problematic as interviewers can have certain interests or assumptions which can influence how data are interpreted. Areas which were poorly reported on included whether or not there was anyone else apart from the participant and the researcher in the setting, if repeat interviews were carried out and if field notes were made. None of the studies reported if transcripts were returned to participants. There was also poor reporting as to whether or not software was used to manage the data and if participants gave feedback on the findings. These factors can affect the validity of the findings, where questions could be raised as to how accurately the findings reflect participants responses.

Meta-Synthesis

Three overarching themes were constructed: Process of Change, Group Processes and Individuals' Healing Processes. Process of Change had four sub-themes (Understanding Difficulties, Acceptance, Being in the Present Moment, and Connections), Group Processes had two subthemes (Meeting Others and Therapeutic Relationship with Therapist/ Facilitator) and Individual's Healing Process consisted of two subthemes (Growth & Self-Development and Focus on the Future). Appendix 1.7 shows the themes that were constructed for each of the studies. Quotes are used to give examples for the themes. Those quoted from participants are in italics.

Process of Change

All of the studies reported that participants experienced some kind of change from the group interventions. The change involved participants changing the way they managed or viewed their difficulties. These changes were brought about by learning techniques or strategies in ways to 'break the cycle' or the patterns of behaviour which was causing them distress.

Understanding Difficulties

Psychoeducation played a role in terms of helping individuals to understand and normalize their difficulties (Parker et al., 2007; Roberg, Nilsen & Rossberg, 2018; Stige, Rosenvinge & Treen, 2013). By normalizing the symptoms, participants felt more in control and less distressed by their difficulties:

> *"I really liked the sort of clinical psychology aspect of it. . .explaining to us how our brain works because then you don't feel like it's such a personal problem, it's like, well all humans have the same brains and this is why my brain's done that and you don't feel alone you think oh I'm part of the human race then and this is how we all work"* (Participant's Quote, p9, Ashfield, Chan & Lee, 2020).

Some of the studies talked about how understanding difficulties meant processing and making sense of what happened to them and why difficulties had occurred (Parker et al., 2007; Lawrence & Lee, 2014; Jindani & Khalsa, 2015; Roberg, Nelson & Rossberg, 2018; Stevens & McLeod, 2019; Ashfield, Chan & Lee, 2020). This helped participants change the way they viewed themselves or the situation they were in:

> *"...I learned there that lots of things that happened in the past; it wasn't my fault. And I as a child didn't have the power to stop anything or change anything, so it wasn't my fault..."* (Participant's Quote, p66, Parker et al., 2007)

By understanding what had happened to them, they were able to 'confront' and explore the impact that the trauma had on them (Tummala-Narra et al., 2012; Chouliara et al., 2017). These impacts involved learning more about the feelings that they were experiencing and why they were feeling a particular way e.g. having panic attacks (Stevens & McLeod, 2019). Although understanding their difficulties was helpful in terms of addressing the issue, for some participants it made them feel upset when they learnt how much an impact the symptoms had on their lives (West, Liang & Spinazzola, 2017).

Acceptance

Acceptance was described in a number of ways. Some of the studies described this in the context of participants learning that the past cannot be changed (Tummala-Narra et al., 2012) and for them to change a shift was required that enabled a refocusing of their thoughts. This helped them to feel less 'controlled' by their difficulties:

> *"Now I am capable of taking the thoughts that I'm thinking about the particular trauma and...I don't want to say making them more positive, but to kind of taper off the negative, and just... it sounds so cliche´, but it's like 'it is what it is.' Maybe to let go, like it happened and that sucked but okay..."* (Participant's Quote, p494, Myers, Lewis & Dutton, 2015).

Another way of thinking about acceptance was for participants to give themselves permission to notice, become more aware and sit with their feelings e.g. "tolerating the emotions and letting them pass..." (Authors Quote, p106, Bermudez et al., 2013). This helped them to regulate and to respond to their emotions in a more helpful way (Jindani & Khalsa, 2015). Acceptance was also viewed as allowing the person to be who or how they wanted to be as a person, as well as being patient with themselves (Rhodes, 2015; West, Liang & Spinazzola, 2017; Stevens & McLeod, 2019).

Being in the Present Moment

Many of the studies reported various techniques that were used to help patients focus more in the 'here and now'. This included grounding techniques (Parker et al., 2007), meditation (Myers, Lewis & Dutton, 2015), mindfulness (Bermudez et al., 2013) and yoga (Jindani & Khalsa, 2015; Rhodes, 2015). Breathing techniques was a common technique that was helpful for participants (Bermudez et al., 2013; Roberg, Nilsen & Rossberg, 2018; Zehetmair et al., 2019). Individuals reported feeling calmer and more in control. This included having more control in managing feelings of dissociation (Myers, Lewis & Dutton, 2015) as well as rumination:

> *"I felt I was totally focusing on it [yoga] at that time, whereas a lot of time in my head....things are going on*" (Participant's Quote, p689, Stevens & McLeod, 2019)

However, some of the participants reported that the techniques were demanding at first and becoming more aware of somatic feelings could lead to feelings of discomfort:

> *"...when I go to try to ground myself, the first thing I become mindful of is really intense pain, and then if I get through to the other side and get to sort of a more grounded state then I can feel a little bit better. But there's this sort of barrier that can make it very hard to get into. It's just hard to make yourself do it. I mean it's like physical therapy if you're recovering from an injury or surgery or something..."* (Participant's Quote, p254, Rhode, 2015).

Groups which did not involve talking about trauma experiences were found to be helpful as participants felt that they were focusing more on the present i.e. what was happening for them there and then and with their symptoms (Stige, Rosenvinge & Traeen, 2013).

Connections

Most of the studies reported that connection with others was an important factor in treatment. For some participants, connection was about being able to relate to other people (Tummala-Narra et al., 2012; Chouliara et al., 2017; Zehetmair et al., 2019; Ashfield, Chan & Lee, 2020). This helped individuals to feel more confident and hopeful:

> *"You know it's like I have this sense of belonging, connectedness, whereas before I wasn't ready to involve myself, I was terrified of this world. And I think that was my outlook and I think it was very much related to the trauma. I didn't want to involve myself 'cause it was terrifying. Whereas now I love it 'cause there are opportunities for growth and development, to involve myself"* (Participant's Quote, p69, Parker et al., 2007).

Other studies looked at connection with regard to the mind and the body (Bermudez et al., 2013; Stige et al., 2013; Jindani & Khalsa, 2015; Myers, Lewis & Dutton, 2015; Rhodes, 2015). Participants felt that this helped them to understand more about their emotions and the physical feelings that they were experiencing:

> *"With yoga, I had a connection of mind, body, and spirit. During the practice and when you become aware of those three things, or be aware of them, it seems like things are more possible..."* (Participant's Quote, p403, Jindani & Khalsa, 2015).

For some, feeling more connected within themselves helped them to interact better with others as they became more attuned and comfortable with their feelings and emotions (West, Liang & Spinazzola, 2017; Ashfield, Chan & Lee, 2020).

Group Processes

One of the most important factors which individuals reported was meeting other people who had also experienced trauma. In addition to this, more than half of the studies reported that the therapist / group facilitator played a significant role in the group intervention.

Meeting Others

The majority of the studies talked about how being in a group with others helped them to recognize that they were not alone. By seeing others in the group, they became less judgmental and more accepting of themselves and of others as they saw people from different backgrounds who had similar issues (Parker et al., 2007; Lawrence & Lee, 2014; Stevens & McLeod, 2019).

Some of the participants found this therapeutic (Jindani & Khalsa, 2015) and felt that this made it easier for them to talk about their traumatic experiences (Bermudez et al., 2013). Participants also reported feeling supported in sharing their own experiences:

> *"I think the fact that I could actually share with other women my pain, where I came from because I was always minimizing it or trying to forgive people from the past, trying to let it go, trying you know. So this way, in the group (psychotherapy), I find, I found that other women could share their stories and I could be free to do it too"* (Participant's Quote, p645, Tummala-Narra et al., 2012).

There were, however, participants who felt anxious and nervous about the group as they were worried about what other people might be like:

> *"Initially, I dreaded the group, because I know I am not a verbal person, really...I dreaded beginning to speak in front of a group"* (Participant's Quote, p423, Stige, Rosenvinge & Traeen, 2013).

The 'safeness' of the group played a role in terms of whether or not participants felt comfortable disclosing or sharing their experiences in the group (Chouliara et al., 2017). Some of the participants felt that they were able to bond with others, however they continued to experience difficulties with trust:

> *"Within the group session, I can say everything but- like - something when I watch it, I prefer to share it with the therapists only*" (Participant's Quote, p7, Zehetmair et al., 2019).

One study talked about how they felt it was easier being in a group with only men as they could talk more openly about certain issues e.g. *"...feelings of weakness"* (Participant's Quote, p5, Roberg, Nilsen & Rossberg, 2018).

Therapeutic Relationship with Therapist/ Facilitator

Nine studies talked about the therapist or the group facilitator. There was a general consensus that the therapist/ group facilitators were viewed as caring, kind and empathic. This helped individuals to feel supported in the group:

> *"One of the strongest things was the actual therapists themselves. Erm they were so kind... Their generosity was, I'd never come across that level of kindness before and, and their empathy erm at the same time they were very challenging and they made us work hard" (*Participant's Quote, p499, Lawrence & Lee, 2014).

Some of the studies talked about how it was helpful having the therapists 'model' some of the skills in the group (Parker et al., 2007; Zehetmair et al., 2019) and adapt or modify the skills to their needs (Stevens & McLeod, 2019).

Individuals' Healing Process

The majority of the studies talked about how participants felt that the group helped them to value themselves more and to think more about what they desired from life. This helped them to move forward in life.

Growth & Self-Development

Some of the studies described how individuals started developing boundaries for themselves and focused more on their own needs, which helped them with the recovery process (Parker et al., 2007; Stige et al., 2013; Tammala-Narra et al., 2011). They also became more compassionate and kinder towards themselves (Bermudez et al., 2013; Lawrence & Lee, 2014; Stige, Binder & Veseth, 2019; Ashfield, Chan & Lee, 2020) where they started to *"appreciate how huge it is that I was able to survive..."* (Participant's Quote, p183, West, Liang & Spinazzola, 2017). They also learned to be compassionate to others (Myers, Lewis & Dutton, 2015). As well as this, bringing closure as to what had happened helped them to move forward:

> *"I was upset all the time because of problems with growing up in my family and childhood, like I've been able to close those doors, they don't bother me anymore, it's just things that are on-going that are bothering me . . . Well, they still bother me . . . but I've . . . talked about stuff in a lot of detail and to be able to open up to other people that have been through similar experiences and that to help me close the doors, they sort of . . . certain things don't bother me as much as what they used to . . ."* (Participant's Quote, p10, Chouliara et al., 2017)

Some of the participants also talked about taking more ownership in applying the skills themselves (Stige, Rosenvinge & Traeen, 2013). They also felt the group helped them to focus more on their strengths and capabilities and ways of applying this in their everyday life (Rhode, 2015).

Participants also talked about how recovering from their traumas had led them to feelings of empowerment, confidence and independence:

> *"...as crazy as this sounds, that [her trauma] is a huge blessing for me. I feel that it has really helped me grow and expanded what I want. I'm just happy now that I've started meditating. It's actually self-empowered me. It's made me feel more independent and more that I can handle just about anything that is thrown out me"* (Participant's Quote, p498, Myers, Lewis & Dutton, 2015).

Having said that, some of the participants felt that once they had completed the group, they would benefit from receiving additional support:

> *"But [the feeling of empowerment] wears off, it comes and goes. I have to consciously think about it now to put it into . . . but I'm not . . . I don't feel like a strong person. And I let my emotions rage around in me instead of letting them out, and letting people know how I'm feeling. It's like right, during the program and shortly after, maybe. It's almost like I needed a shot in the arm every once in a while just to kick it in gear, to reinforce it"* (Participant's Quote, p72, Parker et al., 2007).

Focus on the Future

More than half of the studies reported that participants were thinking more about what they wanted in life:

> *"My whole outlook is different. I feel like I've got a future now, which I didn't feel, well I've never felt like that really. No, so I feel like I've got a future now, which I didn't feel like 6 months ago"* (Participant's Quote, p501, Lawrence & Lee, 2014).

For some, this involved exploring what would be a meaningful life for them (Tummala-Narra et al., 2012; Rhodes, 2015). Examples of this included "the desire to help others" (Authors' Quote, p106, Bermudez et al., 2013). Individuals also felt more confident in setting goals for the future (West, Liang & Spinazzola, 2017).

Discussion

The aim of this review was to explore how people described their experiences of participating in a group intervention aimed at alleviating or stabilizing post-traumatic symptomatology. The results showed that group interventions can help change how individuals manage or view their situation. These changes were related to individuals abilities to develop better understanding of their own difficulties (e.g. making sense and normalising their difficulties), acceptance (being able to step back and sit with emotions and thoughts, as well as, learning to appreciate who they are as a person), being in the present moment (focusing on the here and now) and connections (with others, themselves and their mind and body). Furthermore, the results illustrated the importance of meeting other people in the group. Individuals felt less alone and were able to discuss, share or learn from each other's' experiences without judgement. In order for this to happen, there needed to be trust and feelings of safety within the group setting. This was provided by the therapist and the group facilitator. The review also highlighted that growth and self-development was another important factor. Being able to reflect within the group on past experiences allowed individuals to think more about themselves and their own individual needs. This involved putting into place boundaries and being more compassionate and kinder towards themselves whilst also gaining independence and empowerment to live a life that they choose.

These findings are consistent with previous research. Cushing, Braun and Alden (2018) conducted a study which explored veterans' experiences with trauma-sensitive yoga intervention. They found that yoga helped them to feel more in the present, which helped them to manage their thoughts and to feel more at ease. However, they all reported that yoga was

stereotyped as being primarily for females and was viewed as being less physically demanding. They found that having an instructor who was also a veteran helped them to feel more accepted and safer.

The results suggested that being with others in a group setting was just as important as having a good therapeutic relationship with the facilitator as this helped them to normalize their difficulties. This is in contrast to Kracen et al. (2013)'s study where they carried out a survey (n=110) which involved exploring views about group treatment for PTSD, and found that out of the 51% that had taken part in group treatment, only 32% reported positive experience, where major barriers reported were feeling uncomfortable in a group setting and worrying about showing emotions. However, Mott et al. (2013) conducted a study which explored veterans' experiences of group-based exposure therapy for PTSD (n=20). They found that the majority of those who had completed treatment had thought about dropping out of treatment but only 1/20 had dropped out. They reported that hearing and receiving feedback from other group members as well as having a strong group cohesion helped them get through treatment, which suggests that peer support is important in group treatment.

The results of this review also echoed some of Yalom's Therapeutic Factors especially in relation to providing feelings of hope, helping individuals to share and normalise their difficulties, as well as, trying out or modelling new skills without feeling judged (Yalom & Leszcz, 2005). In addition to this, being around others and seeing how they interact with others in the group can help change the way they view themselves and in relating to others (Mahon & Leszcz, 2017).

Limitations of literature

The literature reviewed included a broad range of interventions, which used different approaches and modalities and differed in terms of the length of time of the interventions or the number of sessions that individuals received. The knowledge and skills from the group facilitators may have differed as well for the interventions used in the studies. Furthermore, there was a lack of involvement of people with lived experience as co-producers of research. The sample size was also small in most of the studies. There was also a lack of male participants included in the studies. Most of the participants in the studies were female. Furthermore, the studies were all based in Western countries.

Limitations of the review

Although in this synthesis common processes were identified that appeared to be replicated across studies, there was substantial variations in the types of treatment applied in the review. Some focused on processing of memory and on broader skills and others focused on bodily experience of trauma. Moreover, there was a limitation of the analysis approach used, where themes across studies rather than a more idiosyncratic approach of elucidating treatment specific mechanisms were used. This could be due to the limitations of the literature where studies asked for variations of the questions e.g. general questions about their experiences or specific questions related to a theory of change.

Recommendations

The review highlighted that a broad range of approaches can be used to increase individuals' awareness of the symptoms and the difficulties that they had been experiencing as well as the

benefits of being around others e.g. normalization and validation, as well as a sense of empowerment. An area which could be expanded could involve exploring how decisions are made as to what kind of group interventions would be most appropriate for individuals. Although it has been suggested that a phased approach could be used when working with individuals with complex trauma (Cloitre et al., 2012), more research is required exploring in more details the mechanisms of changes that occur in interventions. This could involve looking at treatment specific methods of change versus common processes by using process evaluation. Process evaluation aims to develop a deeper understanding of how complex interventions work by exploring how they are delivered, the mechanisms involved in changes and the contextual factors that can affect interventions (Moore et al., 2015). Using a qualitative approach for this can help give a richer understanding of people's experiences. Process evaluation of PTSD treatments could explore mechanisms of change which involve e.g. cognitions related to trauma and the emotions related to their experiences (Sripada, Rauch & Liberzon, 2016), and for group intervention this could be the relational aspect of the group.

People who are subject to trauma can face structural frames of oppression, disempowerment and power. Therefore, it is important that researchers don't replicate those patterns of inclusion by not involving people who are users of interventions and the evaluation of them and be active as co-producers for interventions. Involving people with lived experience in research can provide different insights and views compared to professionals/researchers and can help ensure that the topic being researched is relevant and meaningful for them. INVOLVE (2012) describes how people can be involved at different stages of research by describing the 'research cycle'. This involves having meetings with service users, including them in designing as well as

carrying out the research and sharing or implementing the findings. Furthermore, the UK Standards for Public Involvement (2019) have outlined standards that can be used to ensure people from the public are involved in research. These standards involve building up relationships and working collaboratively with service users, providing training, research opportunities and information that is accessible, being supportive, open and transparent in communication and ensuring that there are opportunities for individuals to reflect on the research and to be involved in governance work.

Conclusion

This review aimed to explore people's experiences of group interventions for trauma, PTSD and complex trauma by using a qualitative meta-synthesis approach. The results showed that individuals experienced a number of changes which included having a better understanding of their difficulties, being able to sit with or tolerate emotions or thoughts and learning ways of being in the present moment. They also felt that connection played a role, both within themselves and in relation to others. The group processes which they found beneficial were meeting others who had experienced similar difficulties and having therapists/ group facilitators who were empathetic yet able to adapt and make changes to meet their needs. Individuals also reported that part of the healing process involved growth and self-development and for them to be able to think about what they would like for the future. Although, this review provided insights into people's experiences of the group interventions, more research is required which includes people with lived experience as co-producers for research and that involves exploring in more depth the mechanisms of change involved in group interventions.

References – included studies

1. Parker, A., Fourt, A., Langmuir, J.I., Dalton, E.J. & Classen, C.C. (2007) The experience of trauma recovery: A qualitative study of participants in the Women Recovering from Abuse Program (WRAP). *Journal of Child Sexual Abuse*. 16 (2), 55-77. DOI: 10.1300/J070v16n02_04.

2. Tummala-Narra, P., Kallivayalil, D., Singer, R. & Andreini, R.T. (2012) Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study. *Psychological Trauma: Theory, Research, Practice and Policy*. 4 (6), 640-648. DOI: 10.1037/a0024929.

3. Bermudez, D., Benjamin, M.T., Porter, S.E., Saunders, P.A., Myers, N.A. & Dutton, M.A. (2013) A qualitative analysis of beginning mindfulness experiences for women with post-traumatic stress disorder and a history of intimate partner violence. *Complementary Therapies in Clinical Practice.* 19 (2), 104-108. DOI: 10.1016/j.ctcp.2013.02.004.

4.

    a. Stige, S.H., Rosenvinge, J.H. & Traeen, B. (2013) A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach. *Psychotherapy Research*. 23 (4), 419-429. DOI: 10.1080/10503307.2013.778437.

b. Stige, S.H., Binder, P.E., Rosenvinge, J.H. & Traeen, B. (2013) Stories from the road of recovery – How adult, female survivors of childhood trauma experience ways to positive change. *Nordic Psychology*. 65 (1), 3-18. DOI: 10.1080/19012276.2013.796083.

c. Stige, S.H. & Binder, P.E. (2017) From painstaking work to a new way of meeting the world - Trauma clients' experiences with skill training in a stabilization group approach. *Psychotherapy Research*. 27 (5), 571-582. DOI: 10.1080/10503307.2016.1138335.

d. Stige, S.H., Binder, P.E. & Veseth, M. (2019) The role of therapy in personal recovery – Trauma clients' use of resources to continue positive processes following group therapy. *Qualitative Social Work.* 18 (1), 24-36. DOI: 10.1177/1473325017699264.

5. Lawrence, V.A. & Lee, D. (2014) An exploration of people's experiences of compassion-focused therapy for trauma, using interpretative phenomenological analysis. *Clinical Psychology & Psychotherapy*. 21 (6), 495-507. DOI: 10.1002/cpp.1854.

6. Jindani, F.A. & Khalsa, G.F. (2015) A yoga intervention program for patients suffering from symptoms of posttraumatic stress disorder: A qualitative descriptive study. *The Journal of Alternative and Complementary Medicine*. 21 (7), 401-408. DOI: 10.1089/acm.2014.0262.

7. Myers, N., Lewis, S. & Dutton, M.A. (2015) Open mind, open heart: An anthropological study of the therapeutics of meditation practice in the US. *Culture, Medicine & Psychiatry*. 39 (3), 487-504. DOI: 10.1007/s11013-014-9424-5.

8. Rhodes, A.M. (2015) Claiming peaceful embodiment through yoga in the aftermath of trauma. *Complementary Therapies in Clinical Practice*. 21 (4), 247-256. DOI: 10.1016/j.ctcp.2015.09.004.

9. Chouliara, Z., Karatzias, T., Gullone, A., Ferguson, S., Cosgrove, K. & Draucker, C.B. (2017) Therapeutic change in group therapy for interpersonal trauma: A relational framework for research and clinical practice. *Journal of Interpersonal Violence*. 1-20. DOI: 10.1177/0886260517696860.

10. West, J., Liang, B. & Spinazzola, J. (2017) Trauma sensitive yoga as a complementary treatment for posttraumatic stress disorder: A qualitative descriptive analysis. *International Journal of Stress Management*. 24 (2), 173-195. DOI: 10.1037/str0000040.

11. Roberg, L., Nilsen, L. & Rossberg, J.I. (2018) How do men with severe sexual and physical childhood traumatization experience trauma-stabilizing group treatment? A qualitative study. *European Journal of Psychotraumatology*. 9 (1), 1-11. DOI: 10.1080/20008198.2018.1541697.

12. Stevens, K. & McLeod, J. (2019) Yoga as an adjunct to trauma-focused counselling for survivors of sexual violence: a qualitative study. *British Journal of Guidance & Counselling*. 47 (6), 682-697. DOI: 10.1080/03069885.2018.1472368.

13. Zehetmair, C., Tegeler, I., Kaufmann, C., Klippel, A., Reddemann, L., Junne, F., Herpertz, S.C., Friederich, H.C. & Nikendei, C. (2019) Stabilizing techniques and guided imagery for traumatized male refugees in a german state registration and reception center: A qualitative study on a psychotherapeutic group intervention. *Journal of Clinical Medicine*. 8 (6), 1-16. DOI: 10.3390/jcm8060894.

14. Ashfield, E., Chan, C. & Lee, D. (2020) Building 'a compassionate armour': The journey to develop strength and self-compassion in a group treatment for complex post-traumatic stress disorder. *Psychology and Psychotherapy: Theory, Research and Practice*. 1-18. DOI: 10.1111/papt.12275.

References

Cloitre, M. (2020) ICD-11 complex post-traumatic stress disorder: simplifying diagnosis in trauma populations. *The British Journal of Psychiatry*. 216 (3), 129-131. DOI: 10.1192/bjp.2020.43.

Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A. & Van der Hart, O. (2012) *The ISTSS expert consensus treatment guidelines for complex PTSD in adults.* Available from: http://www.traumacenter.org/products/pdf_files/ISTSS_Complex_Trauma_Treatment_Guidelines_2012_Cloitre,Courtois,Ford,Green,Alexander,Briere,Herman,Lanius,Stolbach,Spinazzola,van%20der%20Kolk,van%20der%20Hart.pdf [Accessed 26 February 2020].

Cloitre, M., Hyland, P., Bisson, J.I., Brewin, C.R., Roberts, N.P., Karatzias, T. & Shevlin, M. (2019) ICD-11 posttraumatic stress disorder and complex posttraumatic stress disorder in the United States: A population-based study. *Journal of Traumatic Stress*. 32 (6), 833-842. DOI: 10.1002/jts.22454.

Courtois, C. A. (2004) Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training.* 41 *(*4), 412–425. DOI: 10.1037/0033-3204.41.4.412.

Cushing, R. E., Braun, K. L. & Alden, S. (2018) A qualitative study exploring yoga in veterans with PTSD symptoms. *International Journal of Yoga Therapy.* 28 (1), 63-70. DOI:10.17761/2018-00020.

Elliott, R. (2008) Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research.* 18 (3), 239-242. DOI: 10.1080/10503300802074513.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P. & Marks, J. S. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*. 14 (4), 245–258. DOI: 10.1016/s0749-3797(98)00017-8.

Fernández-Fillol, C., Serrano-Ibáñez, E. R., Ruiz-Párraga, G., Ramírez-Maestre, C., Esteve, R. & Lopez-Martínez, A. (2018) Effective therapies for the treatment of complex posttraumatic stress disorder: A qualitative systematic review. *Salud Mental*. 41 (2), 81-90. DOI: 10.17711/SM.0185-3325.2018.013.

Fletcher, A. J. (2017) Applying critical realism in qualitative research: Methodology meets method. *International Journal of Social Research Methodology*. 20 (2), 181-194. DOI: 10.1080/13645579.2016.1144401.

Fritch, A. M., & Lynch, S. M. (2008) Group treatment for adult survivors of interpersonal trauma. *Journal of Psychological Trauma*. 7 (3), 145–169. DOI:10.1080/19322880802266797.

Gostas, M.W., Wiberg, B., Neander, K. & Kjellin, L. (2012) 'Hard work' in a new context: Clients' experiences of psychotherapy. *Qualitative Social Work*. 12 (3), 340-357. DOI: 10.1177/1473325011431649.

Herman, J. L. (1992) Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*. 5 (3), 377- 391. DOI: 10.1002/jts.2490050305.

INVOLVE. (2012) *Briefing notes for researchers: public involvement in NHS, public health and social care research.* Available from: http://www.invo.org.uk/wp-content/uploads/2012/04/INVOLVEBriefingNotesApr2012.pdf [Accessed 7 July 2020].

Kangaslampi, S. & Peltonen, K. (2019) Mechanisms of change in psychological interventions for posttraumatic stress symptoms: A systematic review with recommendations. *Current Psychology.* 1-8. DOI: 10.1007/s12144-019-00478-5.

Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., Hyland, P., Maercker, A., Ben-Ezra, M., Coventry, P., Mason-Roberts, S., Bradley, A. & Hutton, P. (2019) Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and

meta-analysis. *Psychological Medicine*. 49 (11), 1761–1775. DOI: 10.1017/S0033291719000436.

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M. & Nelson, C.B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*. 52 (12), 1048-1060. DOI: 10.1001/archpsyc.1995.03950240066012.

Koenen, K.C, Ratanatharathorn, A., Ng, L., McLaughlin, K.A., Bromet, E.J., Stein, D.J., Karam, E.J., Ruscio, A.M., Benjet, C., Scott, K., Atwoli, L., Petukhova, M., Lim, C.C.W., Aguilar-Gaxiola, S., Al-Hamzawi, A., Alonso, J., Bunting, B., Ciutan, M., de Girolamo, G., Degenhardt, L., Gureje, O., Haro, J.M., Huang, Y., Kawakami, N., Lee, S., Navarro-Mateu, F., Pennell, B.E., Piazza, M., Sampson, N., Ten Have, M., Torres, Y., Viana, M.C., Williams, D., Xavier, M. & Kessler, R.C. (2017) Posttraumatic stress disorder in the World Mental Health Surveys. *Psychological Medicine.* 47 (13), 2260-2274. DOI: 10.1017/S0033291717000708.

Kracen, A.C., Mastnak, J.M., Loaiza, K.A. & Matthieu, M.M. (2013) Group therapy among OEF/OIF veterans: Treatment barriers and preferences. *Military Medicine.* 178 (1), e146-e149. DOI: 10.7205/MILMED-D-12-00213.

Levitt, H.M., Pomerville, A. & Surace, F.I. (2016) A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin*. 142 (8), 801-830. DOI: 10.1037/bul0000057.

Lewis, C., Roberts, N.P., Andrew, M., Starling, E. & Bisson, J.I. (2020) Psychological therapies for post-traumatic stress disorder in adults: systematic review and meta-analysis. *European Journal of Psychotraumatology.* 11 (1), 1-21. DOI:10.1080/20008198.2020.1729633.

Mahon, L. & Leszcz, M. (2017) The interpersonal model of group psychotherapy. *International Journal of Group Psychotherapy*. 67 (Supp1), S121–S130. DOI: 10.1080/00207284.2016.1218286.

Mahoney, A., Karatzias, T. & Hutton, P. (2019) A systematic review and meta-analysis of group treatments for adults with symptoms associated with complex post-traumatic stress disorder. *Journal of Affective Disorders*. 243, 305-321. DOI: 10.1016/j.jad.2018.09.059.

McHugh, M.L. (2012) Interrater reliability: the kappa statistic. *Biochemia Medica*. 22 (3), 276-282. DOI: 10.11613/BM.2012.031.

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R. & Cheraghi-Sohi, S. (2014) PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research*. 14 (579), 1-10. DOI: 10.1186/s12913-014-0579-0.

Moher, D., Liberati, A., Tetzlaff, J. & Altman, D.G. (2009) Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Medicine*. 6 (7): e1000097. DOI:10.1371/journal.pmed1000097.

Moore, G.F., Audrey, S., Barker, M., Bond, L., Bonell, C., Hardeman, W., Moore, L., O'Cathain, A., Tinati, T., Wight, D. & Baird, J. (2015) Process evaluation of complex interventions: Medical Research Council guidance. *BMJ.* 350:h1258. DOI: 10.1136/bmj.h1258.

Mott, J. M., Sutherland, R. J., Williams, W., Lanier, S. H., Ready, D. J. & Teng, E. J. (2013) Patient perspectives on the effectiveness and tolerability of group-based exposure therapy for posttraumatic stress disorder: Preliminary self-report findings from 20 veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*. 5 (5), 453–461. DOI: 10.1037/a0029386.

National Institute for Health and Care Excellence. (2018) *Post-traumatic stress disorder*. Available from: https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861 [Accessed 30 April 2020].

NHS Education for Scotland. (2017) *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce*. Available from: https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf [Accessed 7 July 2020]

Ruzek, J. I., Young, B. H. & Walser, R. D. (2003) Group treatment of posttraumatic stress disorder and other trauma-related problems. *Primary Psychiatry.* 10 (8), 53-57. Available from: http://primarypsychiatry.com/wp-content/uploads/import/0803PP_Ruzek.pdf [Accessed 21 June 2020]

Schwartze, D., Barkowski, S., Strauss, B., Knaevelsrud, C. & Rosendahl, J. (2019) Efficacy of group psychotherapy for posttraumatic stress disorder: Systematic review and meta-analysis of randomized controlled trials. *Psychotherapy Research.* 29 (4), 415-431. DOI: 10.1080/10503307.2017.1405168.

Sripada, R. K., Rauch, S. A. M. & Liberzon, I. (2016) Psychological mechanisms of PTSD and its treatment. *Current Psychiatry Reports*. 18 (11), 1 – 7. DOI: 10.1007/s11920-016-0735-9.

Terr, L. C. (1991) Childhood traumas: An outline and overview. *The American Journal of Psychiatry.* 148 (1), 10–20. DOI: 10.1176/ajp.148.1.10.

The Lancet. (2019) ICD-11. *Lancet*. 393 (10188), 2275. DOI: https://doi.org/10.1016/S0140-6736(19)31205-X. [Accessed 14 August 2020]

Thomas, J. & Harden, A. (2008) Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*. 8, 1-10. DOI: 10.1186/1471-2288-8-45.

Timulak, L. & Keogh, D. (2017) The client's perspective on (experiences of) psychotherapy: A practice friendly review. *Journal of Clinical Psychology*. 73 (11), 1556-1567. DOI: 10.1002/jclp.22532.

Tong, A., Flemming, K., McInnes, E., Oliver, S. & Craig, J. (2012) Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology*. 27, 1-8. DOI: 10.1186/1471-2288-12-181.

Tong, A., Sainsbury, P. & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 19 (6), 349-357. DOI: 10.1093/intqhc/mzm042.

UK Standards for Public Involvement. (2019) *Better public involvement for better health and social care research.* Available from: https://drive.google.com/file/d/1U-IJNJCfFepaAOruEhzz1TdLvAcHTt2Q/view [Accessed 7 July 2020].

Van der Kolk, B. (2000) Posttraumatic stress disorder and the nature of trauma. *Dialogues in Clinical Neuroscience*, 2 (1), 7–22. PMCID: PMC3181584.

World Health Organization. (2018) *ICD-11 for Mortality and Morbidity Statistics* (11th Revision). Available from: https://icd.who.int/browse11/l-m/en [Accessed 23 February 2020].

Yalom, I. D. & Leszcz, M. (2005) *The theory and practice of group psychotherapy*. 5th edition. New York: Basic Books.

Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology & Health*. 15 (2), 215-228. DOI: 10.1080/08870440008400302.

Chapter 2: Major Research Project

Exploring Refugees and Asylum Seekers Experience of Group Work for Trauma: A Qualitative Study

Nadia Hanif*

Submitted in partial fulfilment of the requirements for the degree of

Doctorate of Clinical Psychology

***Mental Health and Wellbeing, Institute of Health and Wellbeing, University of Glasgow**

Correspondence Address:
Mental Health and Wellbeing
Administration Building
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH
E-mail: n.hanif.1@research.gla.ac.uk

Prepared in accordance with submission requirements for the Journal of Cross-Cultural Psychology

Word Count (with quotes/ without quotes): 9376/ 7128

Plain English Summary

Background: Refugees and asylum seekers experience a number of traumatic events, such as war and torture, which can lead to complex post-traumatic stress disorder. Treatment for this includes the safety and stabilisation group interventions that aim to develop skills in understanding the effects of trauma, recognising and managing difficult emotions. Limited research has investigated the experiences of the safety and stabilisation groups for refugees and asylum seekers.

Aims: To explore the experiences of refugees' and asylum seekers interactions' with a safety and stabilisation group intervention and what their experience of this can reveal about the underlying mechanism used in the intervention.

Methods: Seven individuals who attended at least four sessions of a safety and stabilisation group intervention were interviewed about their experience of the group. The interviews were recorded and transcribed by the researcher. They were analysed by using thematic analysis.

Results: Three main overarching themes were constructed. These were: the 'ingredients' for the group intervention (understanding trauma and developing skills), the delivery of the group intervention (group as a context, qualities of the facilitators and being with others) and contextual factors, which influenced refugee and asylum seekers' experiences (the asylum seeking process, support and language barriers).

Conclusions: The safety and stabilisation group intervention was helpful for most of the refugees and asylum seekers in understanding and learning new ways of coping with their difficulties. However, some felt that they required more time or support after completing the group intervention

either due to the effects of trauma, or the feelings of anxiety they experienced around what might happen in relation to the asylum process.

Word count: 267 words

Abstract

Background: Refugees and asylum seekers may experience complex post-traumatic stress disorder as a result of war, violence, torture and abuse. Treatment for this includes safety and stabilisation interventions, which aim to develop skills in understanding trauma and in regulating emotional distress. Group treatment can be effective, however for refugees and asylum seekers there could be certain issues, such as cultural and contextual differences, which could make their experience different. More research is required to investigate the types of interventions being used to treat refugees and asylum seekers.

Methods: Semi-structured interviews were carried out with seven individuals, five of whom had interpreters. The interviews were transcribed and analysed using thematic analysis.

Results: Three main overarching themes with eight sub-themes were constructed from the data. These examined what the 'ingredients' were for the group intervention, the delivery of the group intervention and contextual factors, that influenced refugees and asylum seekers' experiences of the group intervention.

Conclusions: Individuals developed a better understanding of their difficulties which helped them to manage their difficulties using the strategies taught in the safety and stabilisation group. Feeling safe and secure were found to be important within the group setting. Some individuals continued to experience anxiety, either in relation to the trauma they experienced or with regard to the asylum-seeking process. Individuals may benefit from additional support. Future research is required exploring the mechanisms involved in group interventions.

Introduction

Refugees and asylum seekers can experience a number of mental health difficulties. These might include: depression, anxiety and post-traumatic stress disorder (PTSD) (Fazel, Wheeler & Danesh, 2005). Research shows that the prevalence rate for this can range from "4 to 40% for anxiety, 5 to 44% for depression and 9 to 36% for PTSD" (p8, Turrini et al., 2017). The range can vary due to the heterogeneity of this group as well as how mental health issues are defined (Silove, Ventevogel & Rees, 2017). Furthermore, the rates for mental health issues have been found to occur more frequently for those who are divorced/widowed, elderly or who are women (Tinghög et al., 2017).

Various types of traumas can be experienced by refugees and asylum seekers including torture, violence, war and sexual, emotional, physical abuse (Lindert et al., 2016). They may also experience pre-migration trauma. In particular, individuals might experience difficulties before leaving a country including losing or being forced to separate from a loved one, which can result in depression and PTSD (Cantekin & Gencoz, 2017). In addition, they may experience post-migration stress and trauma, which involve difficulties in resettling in a new place including not being able to work or living with the fear of being deported (WHO Regional Office for Europe, 2018). Furthermore, refugee and asylum seekers' difficulties may not be recognized or identified immediately, which can worsen their symptoms (Richter et al., 2018), and without treatment, they are more likely to experience persisting distress that impacts their quality of life (Priebe et al., 2009). Research suggests the severity of the trauma experienced together with individuals' experiences of post-migration influences how their symptoms of PTSD unfold over time (Kaltenbach et al., 2018).

Recently, there has been a new diagnosis of complex PTSD (cPTSD; WHO, 2018). Individuals who develop symptoms of cPTSD will experience additional difficulties in relationships, negative views about themselves or emotional dysregulation in addition to the core symptoms of PTSD (WHO, 2018). Riber (2017) showed how the complexity of trauma and the effect child abuse can have on refugees. She found that growing up in a country where there is conflict and high political instability can also increase the risk of a range of other traumas being experienced amongst refugees. Beyond the index trauma, such as exposure to conflict, refugees are also likely to experience traumatic events arising such as sociopolitical instability, which together with poverty can reinforce an ongoing sense of danger and other stressors, which increase other forms of trauma throughout the lifecycle e.g. attachment difficulties which they developed as a child due to family problems. The study suggested that refugees may experience childhood physical and emotional abuse as well as neglect, which can later have an impact on how refugees perceive themselves in adulthood in addition to the PTSD that they may have developed. This indicates that refugees and asylum seekers are at particularly high risk of complex trauma.

A range of treatments have been used for refugees and asylum seekers in relation to complex trauma. These include Cognitive Behavioral Therapy, Narrative Exposure Therapy, Trauma-focused therapies, Eye Movement Desensitization and Reprocessing therapy and transdiagnostic approaches (Uphoff et al., 2019). Family, group and multidisciplinary interventions have also been used (Slobodin & De Jong, 2015) as well as the biopsychosocial approach (Kronick, 2018).

Research suggests that psychological interventions can be effective for the treatment of post-traumatic stress disorder in this population. In a systematic review, Crumlish and O'Rourke (2010) identified 10 randomized control trials (RCTs) and found that treatment reduced symptoms of

PTSD, where narrative exposure therapy received the greatest empirical support. In an update, Thompson, Vidgen and Roberts (2018) identified 16 RCTs and also confirmed that treatments were effective in reducing symptoms of PTSD. However, the majority of the studies focused predominantly on individual rather than group interventions.

The evidence for cPTSD has been limited given its status as a new diagnosis. Barbieri et al. (2019) conducted a study which compared DSM-5 and ICD-11 definitions of PTSD and if PTSD and cPTSD were distinguishable in a refugee population group, where they carried out questionnaires on African refugees (n=120) who experienced complex trauma and were receiving psychological treatment for this. They found that 79% reported having PTSD using DSM-5 definition, and with ICD-11 definitions, 38% had PTSD and 30% had cPTSD. They suggested that ICD-11 definitions were more rigorous and that the severity of post-traumatic symptomatology was based more on the actual traumatic event rather than the number of traumatic events experienced. Moreover, research suggests that refugees with cPTSD are more likely to experience interpersonal and postmigration difficulties as well as childhood adversities when compared to other mental health conditions (Silove et al., 2018). With regards to treatment, a systematic review by Karatzias et al. (2019) showed that psychological interventions for PTSD could be used for those who presented with clusters of cPTSD (i.e. 'disturbances in self organisation'), however the interventions were not as effective for those who had experienced childhood trauma (Karatzias et al., 2019). In a systematic review, Mahoney, Karatzias and Hutton (2019) included 36 RCTs showing that group treatment for cPTSD is effective in reducing symptoms of PTSD compared to 'usual care' (e.g. waiting list / treatment as usual).

In relation to group interventions, qualitative research has shown that group treatment is helpful in normalising difficulties (Zehetmair et al., 2019) by meeting and sharing similar experiences with others, helping to reduce feelings of isolation (Stige, Rosenvinge & Tareen, 2013). Furthermore, engagement in treatment was facilitated by having a strong therapeutic alliance and feeling safe with therapist (Chouliara et al., 2017; Brochmann et al., 2019). Group interventions can also help individuals develop skills in e.g. acceptance and connection, which has enhanced feelings of empowerment and self-development (Hanif & Gumley, 2020).

In general, treatment for complex trauma involves a phase-based approach (Herman, 1992). Phase one focuses on safety and stabilisation, which emphasises the therapeutic relationship with the clinician, understanding the effects of trauma and developing skills in managing relationships, emotion regulation, social skills, anxiety management. Phase two involves interventions to facilitate the processing of traumatic memories. Phase three involves individuals reintegrating with others (Cloitre et al., 2012). Criticisms have been made with regards to Herman's (1992) phase-based approach where it has been suggested that there hasn't been strong evidence for this and trauma-focused treatment can be just as effective when treating symptoms of cPTSD (De Jongh et al., 2016).

More research is required within this area especially in the context of cPTSD with refugees and asylum seekers. Research suggests that refugees and asylum seekers may express their difficulties by describing their physical or somatic symptoms or use certain cultural phrases or idioms to communicate distress (Im, Ferguson & Hunter, 2017). Interventions should therefore be culturally adapted to meet specific needs (Hinton et al., 2012). Refugees and asylum seekers may also face barriers, such as, stigmatisation (Renner et al., 2020), immigration processes, language barriers (Byrow et al., 2020), and stressful adjustment and transitioning to a different country (Zbidat et

al., 2020). Moreover, refugees and asylum seekers are a heterogenous group who are more like to have suffered from multiple forms of trauma over their lifespan. All of these factors have an important bearing on how people might experience treatment for their trauma.

Given that there is limited research examining how interventions work for refugees and asylum seekers, this study aimed to explore the experiences of refugees and asylum seekers' interactions within a phase one safety and stabilisation group. Exploring how participants interact with an intervention can allow a deeper understanding of the complexity of the intervention and also the nature and the underlying mechanisms that support it (Thirsk & Clark, 2017). It also allows for a better understanding of whether the intervention meets the needs of refugees and asylum seekers. We therefore asked what can refugees' and asylum seekers' experiences of and interactions with the safety and stabilisation group inform us about the intervention, its mechanisms and its future implementation?

Methods

Design

A qualitative approach, involving semi-structured interviews was used. The epistemological stance was a hermeneutic approach by Thirsk and Clark (2017). This approach focused on how the safety and stabilisation group helped individuals and how they interacted with the intervention. It explored how individuals' interpretations of the intervention shaped how the intervention was understood and what new knowledge could be learnt about the intervention, based on their experience of the group.

An interview schedule was constructed with support from the researcher's supervisor (Appendix 2.2). A pilot study of the interview questions was not carried out as there was potential for different languages to be used. The length of the interviews ranged from twenty-two minutes to one hour. Interpreters were used when needed. Their role was to check the questions asked were appropriate when communicating to the individuals.

Ethical and Managerial Approval

The study received ethical approval from West of Scotland Research Ethics Committee (19/WS/0141) and NHS Research and Development approval from NHS Highland (1546) (Appendix 2.3). A 'Letter of Access' was received from NHS Greater Glasgow and Clyde to gain access to the health board. An 'Organisation Information Document' form was completed, which was part of the approval process for NHS Greater Glasgow and Clyde (Appendix 2.4).

Setting

The group was a phase one intervention designed for refugees, asylum seekers and individuals who had been subjected to trafficking. It took place at The Anchor Centre, which is a specialist mental health service for trauma at NHS Greater Glasgow and Clyde. Topics covered in the group included behavioural activation, the impact of trauma on the body and the mind, coping with nightmares, anxiety and intrusive memories, self-care and compassion. The aim of the group was to help individuals to develop skills for managing their distress. The entry criteria for the group was centred on individuals who had experienced moderate to severe levels of mental health problems associated with complex trauma.

Recruitment Procedures

Participants were recruited from a womens' group and a mens' group. The clinicians invited the participants to the study by giving them an 'Information leaflet for participants' before the group programme ended (Appendix 2.5). Following this, participants attended a review appointment when they had completed the group programme. At the review appointment, the clinicians asked if they were interested in taking part in the study. If so, a 'Participant Information Sheet' (PIS; Appendix 2.6) was provided and a meeting was arranged for participants to be interviewed by the researcher at The Anchor Centre. The clinicians booked in an interpreter when required. When the participants met with the researcher, the researcher went through the PIS with them. Once both the researcher and the participant were satisfied that they understood what the study was about, informed consent was taken (Appendix 2.7). Participants were given an honorarium of £5 for taking part in the study. The researcher made field notes whilst carrying out the interview. Further details about the procedure can be found in Appendix 2.8.

Interpreters

The researcher followed the BPS (2017) guidelines in working with interpreters. The researcher met with the interpreter in advance of the interview to discuss the interview schedule and what their role was within the interview itself. This was to ensure that they knew what was expected of them for the interview (Plumridge et al., 2012). The researcher debriefed the interpreters after the interview was completed where reflections about the interview occurred.

The researcher was mindful that using interpreters meant they were receiving the interpreters' perceptions of what was said from the participant (Temple, 2002) and that it could be more difficult in terms of asking probing questions (Bramberg & Dahberg, 2013). However, it was not feasible for interpreters to carry out the interviews as they were not trained in carrying out research interviews and using different interviewers could result in different ways of communicating or interpreting responses. The researcher carried out the interviews to ensure consistency. Professional interpreters who were employed by NHS interpreting service were used. A translation agency, linked with the NHS, was used to translate the PIS and the consent forms. This ensured the quality of the translations was at a high standard.

Participants

In total, eleven people were booked in for an interview. Seven participants attended and took part in the study. All but two participants required interpreters. The languages were Albanian, Arabic, Vietnamese and Kinyarwanda. All but one of the interpreters attended the research interview alongside with the participant; for one participant the interpreter was included via telephone.

Table 1 provides details about the participants. To ensure anonymity pseudonyms have been used as well as the age range and the continent the participants came from. The length of time spent in

the UK has also been broken down into four categories: up to a year, 1 to 3 years, 3 to 5 years and over 5 years.

Table 1 – Details of the participants

Name	Gender	Age (years)	Refugee/ Asylum seeker	Country	Length of time in the UK
Ama	Female	40s	Asylum seeker	Africa	Up to a year
Dang	Male	40s	Asylum seeker	Asia	3 – 5 years
Elisa	Female	30s	Asylum seeker	Europe	1 – 3 years
Layla	Female	30s	Asylum seeker	Africa	1 – 3 years
Miriam	Female	30s	Refugee	Asia	Over 5 years
Otis	Male	20s	Asylum seeker	Africa	Up to a year
Roze	Female	30s	Asylum seeker	Europe	Up to a year

Details about the trauma experienced are not provided for each participant as this would risk accidental deanonymization. In general, the traumatic events participants experienced support for included political conflict, trafficking, witnessing assault, torture or sexual assault.

Data Analysis

The interviews were digitally recorded, encrypted and transcribed by the researcher. This ensured consistency in terms of transcribing the interviews. Thematic analysis was used to analyse the data, which involved the steps recommended by Braun and Clarke (2006). An inductive approach was used. The steps used in analysing the results included reading and re-reading the transcript whilst taking notes on what was meaningful from the transcripts. The transcripts were then coded (Appendix 2.9). A code was given to each area of interest. The codes were then collated and the

researcher looked at what the themes were. The themes were reviewed and defined once it was clear as to how they were all connected - e.g. what the story was from the analysis. The over-arching themes were developed by thinking analytically as to what the themes meant in relation to the research question. Parts of the transcript were checked with the researcher's supervisor. The transcripts were not checked by the participants due to time and cost factors.

According to Braun and Clarke (2013), around 6-10 interviews are required for thematic analysis to be used in a report of around 10,000 words. There were difficulties in terms of having a fixed number of participants recruited for the study. Participants may all have different views, which meant different themes could emerge from each interview. Therefore, data sufficiency was taken on board when analysing the results (Braun & Clarke, 2019).

The 'consolidated criteria for reporting qualitative research' checklist (Tong, Sainsbury & Craig, 2007) was completed to evaluate this study (Appendix 2.10).

Researcher Reflexivity

The researcher worked as a trainee clinical psychologist and came from an ethnic minority background. She had experience working in Adult Mental Health Services and with interpreters when carrying out pre-assessment appointments at a trauma centre. The researcher was aware that there could be assumptions and biases based on their experience and therefore kept a research journal and had meetings with their research supervisor. The researcher did not know any of the participants.

Results

Thematic analysis resulted in three main overarching themes (Table 2). These were: the 'ingredients' for the group intervention, the delivery of the group intervention and the contextual factors, which influenced refugees and asylum seekers' experiences of and interactions with the safety and stabilization group intervention.

Pseudonyms have been used for the quotes. Due to the characteristic of the interviews, some participants provided more data, which resulted in them being quoted more than others.

Table 2 - Themes

Themes	Sub-themes
The 'ingredients' for the group intervention	Understanding trauma
	Developing skills
Delivery of the group intervention	Group as a context
	Qualities of the facilitators
	Being with others
Contextual factors	Asylum seeking process
	Support
	Language

The 'ingredients' for the group intervention

Participants identified a number of underlying mechanisms which could be viewed as active 'ingredients' with regard to the group intervention. These were understanding trauma and developing certain skills.

Understanding trauma

Understanding more about trauma helped participants to normalise what they were experiencing: "... I believe that my trauma is quite popular. So everything is actually quite normal" (Dang, p2). It also made individuals aware of what they needed to do in order to reduce the symptoms that they had: "...you have to use the tools...if you don't use it, there you will be staying in your trauma, still feeling sad, but you have to use these tools and help yourself, to get rid of these trauma" (Layla, p12). Some of the participants talked about how they understood more about why they were feeling a certain way. Roze reported that she "**...**learnt lots of things like, for example, let's say when I used to feel like stressful, or when I feel like very shivery or very shaky, er, before I didn't know why I have all these symptoms, why I feel like that, but after the group I could see like everything had like a cycle, everything was like related to each other, so I did understand why I feel that way" (Roze, p5). She explained that she had been "...concerned because I was having some tummy pain, and then I realised that actually like I don't have anything serious because it was related to my anxiety and to my stress and everything just related to each other...there was nothing there to really worry about" (Roze, p5).

Developing skills

There were various skills developed from attending the group, which individuals found helpful. Miriam talked about learning "...how to cope if you have a bad dream or bad memories, if you have flashback...how to cope with anxiety, like eh take a deep breath... maybe

exercise...sometimes, they give, like oil, just smell the oil, those things" (Miriam, p4). She felt that she was able to apply some of the skills she learnt at college: "...if I have an assessment...I try to...be calm and relax and take a deep breathe" (Miriam, p5).

Dang mentioned two main strategies which he found useful: "...the oils is helpful before sleep, it is soothing...perhaps makes sleep easier. And the stone is for the memories, so when the memories come back, I tend to just look at the stone, and the more I look at the stone, the more I feel, er, I can forget things..." (Dang, p3). He reported that by learning these skills, his "...sleep is very improved and the memories is [be]coming, gradually and steadily less" (Dang, p4).

Ama talked about how "...we were being taught about how you can, er, adjust your sleeping pattern...because so many of us have complained that we cannot sleep, so...[group facilitator]...taught us that you can adjust your sleeping, er, pattern. Maybe if you sleep very late, try and sleep early. There's some of this, er, perfume bottle that they give us...things like this, that you can even rub it as well as sniffing it, it will go into your system. Then there's some, er, printed pattern, paper, that they give you. You imagine yourself you're in a garden with lovely flowers, with water streaming. So you imagine, like I love singing, so if there's something that you can be singing and that will make you to forget your past at that particular time. And, you know, I try to put all that into, into practice." (Ama, p4 – 5).

Layla talked about how she used "five sensations... Different, different things you have to focus and to look at. Not one, just different. Listen to the people who are around you, who are talk to you, just listen to them, what are they talking, what they are doing..." (Layla, p13). Roze spoke about how she valued going to college as it allowed her to focus on herself: "I like college,

because...I go there and I know at least two or three hours I have to stay in college and I have to like, block out other things" (Roze, p3).

Otis talked about how "the group helped me accept what happened...I'm able to talk to myself that whatever happened to me was in the past and that this is the present" (Otis, p2). He felt that the group "taught me that if I have a problem, I shouldn't keep it to myself, that I should approach anyone in the supervision, and that they could help me" (Otis, p3). He mentioned that "there were some pills that they used to prescribe for me to help sleep, but once I joined the group I stopped that, because those pills never even helped me and the techniques that they taught us were the one to help me..." (Otis, p5). He talked about how the group helped him to rethink about his situation e.g. they "taught us that here, there is security, that everything is governed by the law, that everything goes according to the law, and that the people would who did the bad things to you in the past are, are no longer there, that you are in the present now being in here" (Otis, p5).

There were some concerns that the skills developed only worked up to a certain point: "...we don't expect it [trauma] to go away in one day...cause up to now, I'm still having, you know, problem, eh, sleeping in the night. The nightmare is still there. When you are alone, you think about your past. I wish I had a magic that can erase it from my memory so that I won't think about it again.." (Ama, p3). Layla talked about how she continued to remember one particular nightmare: "The people, when they came to her and investigated with her, the two person from the police, just always thinking about this nightmare... The others she forgot, but she told the GP for that, yeah. It's difficult to deal with this problem, can't, can't leave it, you know, it's a very big problem for me, I can't leave it. The other things, I could deal with them and leave them, but just one I can't leave" (Layla, p13-14).

Elisa mentioned that her mood affected how she felt about the group: “they were telling us to do things, such as like, not to feel like er, lonely, not feel like scared...and, like, what to do, like, outside of the group, but I didn’t really feel like I wanted to do the things that they were telling us to do” (Elisa, p3). She reported that she continued to struggle “to sleep, I can’t really go out. I’m scared when I’m alone and all these daily things” (Elisa, p4). Roze talked about how “they have, (recommended), when you wake up after a nightmare, you can get up from your bed and then come back to the bed but unfortunately I am not able to go back to the bed” (Roze, p4). She reported that her “issues is that I have lots of nightmares and now I feel like I can see shadows” (Roze, p7). She has felt that “...the trauma is there, you know, it’s never going to go away” (Roze, p11). She spoke about how she was going to “start like a new therapy, a new treatment, so basically it is going to be individual meetings, just like that, for example...I’m just going to write all my dreams, I don’t need to talk about it. I’m just going to write down what I see in my dreams. I will have like individual sessions...” (Roze, p7).

Delivery of the group intervention

Many of the participants commented on what the delivery of the group intervention was like for them, which included the group as a context, qualities of the facilitators and their experiences of being with others in a group setting.

Group as a context

Participants talked about how engaging with the group had helped them to give them hope: “It gives me hope because I think that the good is to come, but I will also never see that [trauma] again” (Otis, p 3). Ama reported that she felt that “...we are free here, we have hope in here...” (Ama, p15). Being engaged helped them to also feel more confident within themselves: “... they gave me support and helped me but I need to help myself on my own. I need to help myself too”

(Layla, p9). Elisa talked about how she "came to the group because I want to forget my past. I want to forget the bad things that happened to me" (Elisa, p1). However, Roze felt that the events around her, e.g. "children, my house, my husband, problems in general, everything" (Roze, p2), made it difficult for her to be engaged at times: "Obviously it was good for me to come here, but because I was overloaded, that made it even harder" (Roze, p2).

There were participants who felt that the group programme only helped up to a certain point: "... the programme that we came for, will help you, it's like a temporary thing at that time..." (Ama, p12). With regards to having separate gender groups, Miriam felt that this helped her to feel more at ease: "Yeah if there is all women that's fine, if there is like eh men, like those things, then I don't feel comfortable" (Miriam, p11). Roze talked about how being at the group was helpful however after the group, she may feel worse: "... I think these two hours when at the group, everything is okay, but afterwards when we finish, like everything starts again like the daily routine and everything, so obviously everything makes me feel even more sad because I've been asked questions, you know at the group and everything else" (Roze, p3).

Qualities of the facilitators

Participants felt that the group facilitators were very supportive and caring: "All the team... they are very good to me, help me..." (Layla, p15). Otis reported that he felt that the facilitators "...were listening a lot and they helped us tell what we had to tell. There were also a man that was there, who also was appointed at the group and it helped a lot" (Otis, p2). Ama reported that "these psychological people, they handle you like their own family member. They handle your problem, they talk to your problem, they provide solutions that will help you, if it is possible. They don't want you to remember your past, if it is possible....So I feel safe, you know" (Ama, p10). Elisa commented on how "in the group, they have tried to help us a lot, but it depends on the patients as

well, like, sometimes, like, if they are willing to do things or not, but they have tried, they've tried a lot" (Elisa, p2). This suggested that they were able to manage a wide range of individuals in the group.

Being with others

Some of the benefits of being with others in the group included individuals feeling less alone and more confident in trusting others again: "**...** because of what happened to me I don't want to trust any (one) again..., but when I come to this group...it's like I'm in a new world. I've met new friends, people who I can share the experience with, that can, you know, talk peace into your situation and, and give you that, you know, support at that time that you need it..." (Ama, p3). Some felt that it was helpful when others in the groups shared ideas, e.g. using self-talk: "... the ladies were sitting with her in the condition that they have, trauma, they were telling the group...just think about that you are safe in Scotland, you are not in danger, you are safe here, not in danger" (Layla, p10). Some felt that being in a group with other refugees and asylum seekers helped : "...we come from different backgrounds and we have different experiences and we have different traumas because we don't share the same experiences and I think it helped us let go with what was going on in our heart, especially we know that the people we are talking to are not judging us" (Otis, p4). Ama reported that "No one is here to make jokes of you. Nobody is here to cram your problem that when they see you tomorrow they will use it, no no. I have seen after that, we have met at the bus, some people we met at the stop, they say "hi, how are you doing, hope you are fine", you know, that is, er, part of the positive impact that you, you get" (Ama, p15).

There were some individuals who were uncomfortable about being around others in the group. Dang reported that he was "... not talking with other people in the group because, other people might lie about what they've been through" (Dang, p2). He explained that he would "...go over

what people try to teach in the course but other people, obviously they always have something or some sort of work to do, so it is not true that they don't do anything. So it's kind of unfair feeling" (Dang, p2). Miriam talked about how "...during the group, if there is your own country people, they ask, erm, those questions like personal thing, I don't like these things to be asked of people" (Miriam, p11). Elisa talked about how she "wasn't feeling good to be surrounded by people. I just wanted to be like on my own. I didn't want to be like with everyone else" (Elisa, p3). She reported that "I think the ladies there have really helped us a lot, but from the other hand it depends on people as well, like, I could see that the older ladies, who were the same as me, like all the refugees and stuff, they were getting a lot of help because, like, that's how their personalities, they were like happy to take part and do the activities etc, but for me it wasn't really working. It worked for other people" (Elisa, p5).

Contextual factors

There were many factors which influenced refugee and asylum seekers' experiences of the group intervention, which included the asylum seeking process, the support they had and their language barriers.

Asylum seeking process

Being an asylum seeker had an impact on what participants could do and on their general wellbeing. Ama reported that "...I used to be very, er, occupied, I'm always very, you know, working in the bank, take the children to school...go to work, come back, feed the children, go home, play together, eat, sleep, you know, all those things are no longer there. I'm just at home waiting for the children to come back, you know, those things weigh you down. So I still want to live my normal life" (Ama, p8). Roze talked about the difficulty of moving to a different country: "Because we didn't come here just for like a better life, because in [country], we did have like

everything, we had our work, we had our school and house and everything, but since we didn't know how things were going to progress, things are very hard, very difficult" (Roze, p6-7). She later talked about how the asylum process created hopelessness for her: "... I'm hopeless right now, because I don't know what's going to happen. I don't even know what's going to happen today after here or what's going to happen tomorrow, so I'm like, it's always like uncertainty in the air, so I don't know what's happening..." (Roze, p10). Miriam talked about how becoming a refugee helped to alleviate some of the anxiety she experienced: "Before I was (struggling) from everything... before I don't have permission like live to remain but now I have live to remain, so that's why, I'm (safe)" (Miriam, p6).

Support

Some of the participants felt isolated or alone once the group was completed: "**...** there is nothing to do. Most of the time I'm staying at home" (Dang, p4). Ama talked about how she developed trust with the staff and that they were her main source of support: "So I still want to keep in touch with them. I don't want to be left alone cause they are just my, they are my support. I feel free telling them this is me, this thing happened, this thing happened, because aside them I can't be telling anybody else, anyone else, so I still want to keep in touch" (Ama, p18).

Roze talked about the stress she experienced with regards to her family e.g. her husband: "He has been through a lot as well...he has been feeling like very anxious and very stressful, let's say, the slightest things that happen to him, he just have like a cold or he might have the flu, he's going to blame it on me, he's going to say that 'it's your fault that we came, we have no one here, we don't have family or anybody else here'. So everybody just blames on me" (Roze, p6). She also worries about her children: "I don't want to, my children to have any bad impact, any bad impact on the way of how my life is right now. So that's why I keep it inside, also I can't really talk to my

husband about how I feel too" (Roze, p7). When exploring this further, she stated, "**...** who can I talk to about these things? It is something that is like impossible to talk about" (Roze, p7).

For some of the participants, their children were what kept them going. For example, Ama talked about how she didn't "...want to be scared and can imagine for days you not sleep, you wake up, but the joy I have is, I'm always happy when I have my children around me..." (Ama, p17). Miriam talked about how she built more confidence within herself and "...sometimes I take my daughter to park or sometimes we go on the bike together..." (Miriam, p9).

Language

A couple of the participants talked about the impacts of being required to speak a foreign language. Dang felt that not being able to speak English had limited his opportunities and choices: "I don't know what to choose, I don't speak the language. I don't know the areas. It's difficult, there's no choice" (Dang, p 4). Whereas Otis reported that he "...didn't have an interpreter in the group" (Otis, p6) because "I think the people who interpret my language in the UK are rare, and it...pushed me to learn that language" (Otis, p6). He felt that "...because of the barriers in English that I wasn't able to understand what they were telling me, it just some small little things that I couldn't get. But also I could ask [group facilitator], [group facilitator] or [group facilitator] and that was ok" (Otis, p6).

Discussion

The aim of this study was to explore refugees and asylum seekers' experiences of and interactions with the safety and stabilisation group intervention and what this can inform us about the intervention, its mechanism and its future implication. Three main overarching themes were identified: the 'ingredients' of the group intervention, the delivery of the group intervention and the associated contextual factors.

The results suggested the group was helpful in terms of normalising experiences and gaining knowledge about how to manage their difficulties. This is in line with Stige, Rosenvinge and Traeen (2013) findings were being in a group with others helped participants to feel less judged as they were in similar positions. As the group did not explicitly involve individuals disclosing their trauma, this may have helped them to feel less anxious and to focus more in learning the skills to manage their difficulties. This helped them to recognise and understand better their symptoms, where they felt more in control of themselves and their circumstances. These results were also similar to previous research, which found that individuals were engaged in treatment when they experienced a sense of hope that something could be done about their trauma (Vincent et al., 2013).

The relationship with the group facilitators was important where they felt listened to and respected by the facilitators. Research suggests that therapists can have an impact on treatment e.g. individuals feeling supported by their therapist (Zehetmair et al., 2019). However, some individuals experienced feelings of anxiety in the group. This is understandable given that many individuals experienced difficulty in trusting other people due to their past experiences. There could be a shame factor in how they may be perceived

and stigmatised by others (Byrow et al., 2020). Other difficulties which were expressed included feelings about others in the group not being honest or being uncomfortable trying out or discussing the techniques. These issues could have been related to the confidentiality of the group or the stigma associated with the respective traumas experienced. Research has suggested these issues could have an impact in terms of refugees and asylum seekers seeking support (Byrow et al., 2020). Moreover, in relation to Riber's (2017) study, it could be that individuals with pre-exiting traumas as well as those experiencing post-migration stressors may have developed these difficulties because of how they viewed others due to the expectations that they had developed based on past experiences. The complexity of trauma suggests that certain group processes, e.g. interacting, forming relationships, responding and connecting with others, may be of importance for refugees and asylum seekers in order for them to feel comfortable being around others and in gaining more confidence in talking to other people without the fear of being judged or harmed.

Some of the participants continued to experience difficulties in relation to their anxiety around the asylum process, being around others, due to poor sleep and due to living in a new country where they were not able to work and where they had a weaker network of social support. This is in line with other studies, where asylum seekers experienced anxiety around not knowing what could happen to them and a loss in terms of their identity, which affected their mental health (Jannesari, Molyneaux & Lawrence, 2019). Smith et al. (2019) provided an additional perspective on the stresses faced by refugees, such as, housing difficulties, the impact of past experiences with regards to parenting and the barriers they faced in trying to receive support e.g. interpreters not being available, the lack of consideration given to cultural differences within the western medical model being used for trauma, such as, the

collectivist approach, and feelings of guilt experienced by some in relation to family members potentially still being in danger.

There were some challenges which the interpreters brought to the study. One participant used a telephone interpreter. This was different from having a face to face interpreter in that it took a little more time to develop a rapport with the participant, where additional time was given for pauses to ensure that both the interpreter and the researcher knew when to start or finish the conversation. Furthermore, there were times where the researcher felt that they had to check-in with the interpreters as well as with the participants to assess how they were feeling as some of the participants talked about their traumas during the interviews. This was managed by carrying out debrief sessions, in addition to the researcher monitoring the body language and the tone of the voice used by the interpreters. Some of the benefits which the interpreters brought included having a shared view as to how the interview went. For the majority of the interviews, it felt as though the dominant voices were carried out by the participants. It seemed like the interpreters had similar values in that they wanted refugees and asylum seekers to be heard and to be given a voice. However, the researcher kept an open-mind in that interpreters could bring in their own views or beliefs when translating for the participants.

Clinical implications

Refugees and asylum seekers are a group that are, in general, understudied, both as a population group and in the context of interventions. This study offered insight into how the safety and stabilisation group intervention worked for this population group and the ways in which individuals interacted with the intervention in a western culture. Individuals were able to make sense of the intervention by developing an understanding of what trauma was and

some of the signs attached to trauma. They benefited from the intervention by developing the skills in managing those difficulties. Being with others in a group helped them to feel less isolated and for some, gave them hope and confidence. There were individuals who continued to experience anxiety, sleep difficulties and were also cautious about being around others. Nickerson et al. (2011) reported that treatment for refugees may need to be widened out as the trauma they experience can be more complex, and therefore they may require more specific interventions depending on the symptoms presented. More research is required which explores the mechanisms that are involved in group interventions e.g. how cognitive processes can help refugees and asylum seekers reframe the thoughts they have in relation to ongoing threats or danger. Moreover, it may be helpful to involve those who have participated in the group intervention or come from similar backgrounds to refugees and asylum seekers who could help to deliver or adapt the intervention so that it could be more culturally appropriate.

Staff and services should be aware of the contextual factors that can affect refugees and asylum seekers, particularly in relation to the asylum process. Refugees and asylum seekers expressed that recovering from past traumas requires more time. They may not have the facilities or the support out with the group to practice or use the skills, which could e.g. reinforce the negative views that they may have about themselves or with others. Therefore, it is important that joint working or working in partnership with other organisations occurs, as this could help them to receive additional support when required, which is appropriate for them. Staff and services/ organisations should ensure that they are trauma-informed when working with refugees and asylum seekers. NES (2017) have developed a framework which describes the different levels of skills and knowledge required depending on professional roles.

Strengths and limitations

One of the strengths of this study was that it used a qualitative approach to investigate the experiences of refugees and asylum seekers, most of whom were not able to speak English. Thematic analysis was used due to the flexibility it offered for analysing data e.g. the epistemological stance that can be used (Braun & Clarke, 2006). It was felt that as interpreters were going to be used in the study, it would have been inappropriate to use Interpretative Phenomenological Analysis and Grounded Theory as these analyses were based on individuals' subjective interpretations (Starks & Trinidad, 2007).

The limitations of this study included the small sample size, participants being recruited from only two groups at a particular time, and the use of interpreters. Questions could be raised as to whose words or interpretations were being used in the study (Ingvarsdotter, Johnsdotter & Ostman, 2012). Nonetheless, this study focused on a particular intervention within a particular population group using a hermeneutic approach, where positive interactions occurred in the interviews and data was analysed using thematic analysis, which provided an in-depth and richer understanding of the intervention used by the participants. Therefore, it could be concluded that there was 'power' in the data (Malterud, Siersma & Guassora, 2016). Moreover, there was a unique context of the study with it being based in a complex service, which reinforces the importance of research to identify participants experience as a way of improving or sharing practice beyond that. Furthermore, with regards to interpreters, the delivery of group interventions will realistically involve interpreters in order for individuals to participate in the group.

Conclusions

The safety and stabilisation group intervention for refugees and asylum seekers helped individuals to recognise and understand better the symptoms for trauma. Individuals were able to learn various skills in managing their difficulties. Being in a group allowed them to normalise their experiences and enabled them greater confidence that something could be done about their difficulties. By being around others, they realized that they were not alone. However, some found it difficult to trust others or continued to feel anxious, especially in relation to the asylum process. Individuals may benefit from additional support and from services working in partnership with other organizations. More research is also required that explores the mechanisms involved in group interventions for refugees and asylum seekers.

References

Barbieri, A., Visco-Comandini, F., Alunni Fegatelli, D., Schepisi, C., Russo, V., Calò, F., Dessì, A., Cannella, G. & Stellacci, A. (2019) Complex trauma, PTSD and complex PTSD in African refugees. *European Journal of Psychotraumatology*. 10 (1), 1-15. DOI: 10.1080/20008198.2019.1700621.

Bramberg, E.B. & Dahlberg, K. (2013) Interpreters in cross-cultural interviews: A three-way coconstruction of data. *Qualitative Health Research*. 23 (2), 241-247. DOI: 10.1177/1049732312467705.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3 (2), 77-101. DOI: 10.1191/1478088706qp063oa.

Braun, V. & Clarke, V. (2013) *Successful qualitative research: A practical guide for beginners*. London: Sage.

Braun, V. & Clarke, V. (2019) Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health.* 11 (4), 1-9. DOI: 10.1080/2159676X.2019.1628806.

British Psychological Society. (2017) *Working with interpreters: Guidelines for psychologists.* Available from https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/Working%20with%20interpreters%20-%20guidelines%20for%20psychologists.pdf [Accessed 23 February 2020].

Brochmann, H.D., Calundan, J.H.N., Carlsson, J., Poulsen, S., Sonne, C. & Palic, S. (2019) Utility of group treatment for trauma-affected refugees in specialised outpatient clinics in Denmark: A mixed methods study of practitioners' experiences. *Counselling and Psychotherapy Research*. 19 (2), 105-116. DOI:10.1002/capr.12208.

Bryrow, Y., Pajak, R., Specker, P. & Nickerson, A. (2020) Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*. 75, 1 – 22. DOI: 10.1016/j.cpr.2019.101812.

Cantekin, D. & Gencoz, T. (2017) Mental health of syrian asylum seekers in Turkey: The role of pre-migration and post-migration risk factors. *Journal of Social and Clinical Psychology.* 36 (10), 835-859. DOI: 10.1521/jscp.2017.36.10.835.

Chouliara, Z., Karatzias, T., Gullone, A., Ferguson, S., Cosgrove, K. & Burke, C.D. (2017) Therapeutic change in group therapy for interpersonal trauma: A relational framework for research and clinical practice. *Journal of Interpersonal Violence*. 1-20. DOI: 10.1177/0886260517696860.

Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A. & Van der Hart, O. (2012) *The ISTSS expert consensus treatment guidelines for complex PTSD in adults*. Available from https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf [Accessed 26 February 2020].

Crumlish, N. & O'Rourke, K. (2010) A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. *The Journal of Nervous and Mental Disease*. 198 (4), 237–251. DOI: 10.1097/NMD.0b013e3181d61258.

De Jongh, A., Resick, P.A., Zoellner, L.A., Van Minnen, A., Lee, C.W., Monson, C.M., Foa, E.B., Wheeler, K., Broeke, E.T., Feeny, N., Rauch, S.A.M., Chard, K.M., Mueser, K.T., Sloan, D.M., Van Der Gaag, M., Rothbaum, B.O., Neuner, F., De Roos, C., Hehenkamp, L.M.J., Rosner, R. & Bicanic, I.A.E. (2016) Critical analysis of the current treatment guidelines for complex PTSD in adult. *Depression and Anxiety*. 33 (5), 359-369. DOI: 10.1002/da.22469.

Fazel, F., Wheeler, J. & Danesh, J. (2005) Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*. 365 (9467), 1309–1314. DOI: 10.1016/S0140-6736(05)61027-6.

Hanif, N. & Gumley, A. (2020) *A systematic review exploring people's experiences of group interventions for the treatment of trauma*. DClinPsy Thesis, University of Glasgow.

Herman, J. L. (1992) *Trauma and recovery.* New York: Basic Books.

Hinton, D.E., Rivera, E.I., Hofmann, S.G., Barlow, D.H. & Otto, M.W. (2012) Adapting CBT for traumatized refugees and ethnic minority patients: Examples from culturally adapted CBT (CA-CBT). *Transcultural Psychiatry*. 49 (2), 340-365. DOI: 10.1177/1363461512441595.

Im, H., Ferguson, A. & Hunter, M. (2017) Cultural translation of refugee trauma: Cultural idioms of distress among Somali refugees in displacement. *Transcultural Psychiatry.* 54 (5-6), 626-652. DOI: 10.1177/1363461517744989.

Ingvarsdotter, K., Johnsdotter, S. & Ostman, M. (2012) Lost in interpretation: The use of interpreters in research on mental ill health. *The International Journal of Social Psychiatry*. 58 (1), 34-40. DOI: 10.1177/0020764010382693.

Jannesari, S., Molyneaux, E. & Lawrence, V. (2019) What affects the mental health of people seeking asylum in the UK? A narrative analysis of migration stories. *Qualitative Research in Psychology*. 1- 21. DOI: 10.1080/14780887.2019.1581311.

Kaltenbach, E., Schauer, M., Hermenau, K., Elbert, T. & Schalinski, I. (2018) Course of mental health in refugees—A one year panel survey. *Front Psychiatry*. 9, 1-12. DOI: 10.3389/fpsyt.2018.00352.

Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., Hyland, P., Maercker, A., Ben-Ezra, M., Coventry, P., Mason-Roberts, S., Bradley, A. & Hutton, P. (2019) Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. *Psychological Medicine*. 49 (11), 1761-1775. DOI: 10.1017/S0033291719000436.

Kronick, R. (2018) Mental health of refugees and asylum seekers: Assessment and intervention. *Canadian Journal of Psychiatry*. 63 (5), 290-296. DOI: 10.1177/0706743717746665.

Lindert, J., Carta, M.G., Schafer, I. & Mollica, R.F. (2016) Refugees mental health – A public mental health challenge. *European Journal of Public Health*. 26 (3), 374-375. DOI: 10.1093/eurpub/ckw010.

Mahoney, A., Karatzias, T. & Hutton, P. (2019) A systematic review and meta-analysis of group treatments for adults with symptoms associated with complex post-traumatic stress disorder. *Journal of Affective Disorders*. 243, 305-321. DOI: 10.1016/j.jad.2018.09.059.

Malterud, K., Siersma, V.D. & Guassora, A.D. (2016) Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*. 26 (13), 1753-1760. DOI: 10.1177/1049732315617444.

NHS Education for Scotland. (2017) *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce*. Available from: https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf [Accessed 26 July 2020].

Nickerson, A., Bryant, R.A., Silove, D. & Steel., Z. (2011) A critical review of psychological treatments of posttraumatic stress disorder in refugees. *Clinical Psychology Review*. 31 (3), 399-417. DOI: 10.1016/j.cpr.2010.10.004.

Plumridge, G., Redwood, S., Greenfield, S., Akhter, N., Chowdhury, R., Khalade, A. & Gill, P. (2012) Involving interpreters in research studies. *Journal of Health Services Research & Policy*. 17 (3), 190-192. DOI: 10.1258/jhsrp.2012.012003.

Priebe, S., Matanov, A., Jankovic Gavrilovic, J., McCrone, P., Ljubotina, D., Knezevic, G., Kucukalic, A., Franciskovic, T. & Schutzwohl, M. (2009). Consequences of untreated posttraumatic stress disorder following war in former Yugoslavia: Morbidity, subjective quality of life, and care costs. *Croatian Medical Journal*. 50 (5), 465-475. DOI: 10.3325/cmj.2009.50.465.

Renner, A., Hoffmann, R., Nagl, M., Roehr, S., Jung, F., Grochtdreis, T., König, H-H., Riedel-Heller, S. & Kersting, A. (2020) Syrian refugees in Germany: Perspectives on mental

health and coping strategies. *Journal of Psychosomatic Research.* 129, 1-9. DOI: 10.1016/j.jpsychores.2019.109906.

Riber, K. (2017) Trauma complexity and child abuse: A qualitative study of attachment narratives in adult refugees with PTSD. *Transcultural Psychiatry*. 54 (5-6), 840-869. DOI: 10.1177/1363461517737198.

Richter, K., Peter, L., Lehfeld, H., Zaske, H., Brar-Reissinger, S. & Niklewski, G. (2018) Prevalence of psychiatric diagnoses in asylum seekers with follow-up. *BMC Psychiatry*. 18 (1), 1-7. DOI: 10.1186/s12888-018-1783-y.

Silove, D., Ventevogel, P. & Rees, S. (2017) The contemporary refugee crisis: an overview of mental health challenges. *World Psychiatry*. 16 (2), 130-139. DOI:10.1002/wps.20438.

Silove, D., Rees, S., Mohsin, M., Tam, N., Kareth, M. & Tay, A.K. (2018) Differentiating ICD-11 complex post-traumatic stress disorder from other common mental disorders based on levels of exposure to childhood adversities, the traumas of persecution and postmigration living difficulties among refugees from West Papua. *BJPsych Open*. 4 (5), 361-367. DOI: 10.1192/bjo.2018.49.

Slobodin, O. & De Jong, J.T. (2015) Mental health interventions for traumatized asylum seekers and refugees: what do we know about their efficacy? *The International Journal of Social Psychiatry*. 61 (1), 17-26. DOI: 10.1177/0020764014535752.

Smith, L.A., Reynish, T., Hoang, H., Mond, J., Hannah, C., McLeod, K., Auckland, S. & Slewa-Younan, S. (2019) The mental health of former refugees in regional Australia: A qualitative study. *Australian Journal of Rural Health.* 27 (5), 459-462. DOI: 10.1111/ajr.12583.

Starks, H. & Trinidad, S.B. (2007) Choose your method: A comparison of phenomenology, discourse analysis and grounded theory. *Qualitative Health Research*. 17 (10), 1372-1380. DOI: 10.1177/1049732307307031.

Stige, S.H., Rosenvinge, J.H. & Traeen, B. (2013) A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach. *Psychotherapy Research*. 23 (4), 419-429. DOI: 10.1080/10503307.2013.778437.

Temple. B. (2002) Crossed wires: Interpreters, translators, and bilingual workers in cross-language research. *Qualitative Health Research.* 12 (6), 844-854. DOI: 10.1177/104973230201200610.

Thirsk, L. M. & Clark, A. M. (2017) Using qualitative research for complex interventions: The contributions of hermeneutics. *International Journal of Qualitative Methods*. 16, 1-10. DOI: 10.1177/1609406917721068.

Thompson, C.T., Vidgen, A. & Roberts, N.P. (2018) Psychological interventions for post-traumatic stress disorder in refugees and asylum seekers: A systematic review and meta-analysis. *Clinical Psychology Review.* 63, 66-79. DOI: 10.1016/j.cpr.2018.06.006.

Tinghög, P., Malm, A., Arwidson, C., Sigvardsdotter, E., Lundin, A. & Saboonchi, F. (2017) Prevalence of mental ill health, traumas and postmigration stress among refugees from Syria resettled in Sweden after 2011: A population- based survey. *BMJ Open*. 7, 1-11. DOI:10.1136/ bmjopen-2017-018899.

Tong, A., Sainsbury, P. & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 19 (6), 349-357. DOI: 10.1093/intqhc/mzm042.

Turrini, G., Purgato, M., Ballette, F., Nose, M., Ostuzzi, G & Barbui, C. (2017) Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. *International Journal of Mental Health Systems*. 11, 1-14. DOI: 10.1186/s13033-017-0156-0.

Uphoff, E., Purgato, M., Churchill, R. & Barbui, C. (2019) An overview of systematic reviews on mental health promotion, prevention, and treatment of common mental disorders for refugees, asylum seekers, and internally displaced persons. *Cochrane Database of Systematic Reviews*. 10, 1-11. DOI: 10.1002/14651858.CD013458.

Vincent, F., Jenkins, H., Larkin, M. & Clohessy, S. (2013) Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: A qualitative study. *Behavioural and Cognitive Psychotherapy*. 41 (5), 579-593. DOI: 10.1017/S1352465812000550.

World Health Organization. (2018) *ICD-11 for Mortality and Morbidity Statistics* (11th Revision). Available from: https://icd.who.int/browse11/l-m/en [Accessed 13 April 2020].

WHO Regional Office for Europe. (2018) *Mental health promotion and mental health care in refugees and migrants: Technical guidance*. Available from: http://www.euro.who.int/__data/assets/pdf_file/0004/386563/mental-health-eng.pdf?ua=1 [Accessed 12 April 2020].

Zbidat, A., Georgiadou, E., Borho, A., Erim, Y. & Morawa, E. (2020) The perceptions of trauma, complaints, somatization, and coping strategies among Syrian refugees in Germany—A qualitative study of an at-risk population. *International Journal Of Environmental Research and Public Health.* 17 (3), 1-15. DOI:10.3390/ijerph17030693.

Zehetmair, C., Tegeler, I., Kaufmann, C., Klippel, A., Reddemann, L., Junne, F., Herpertz, S.C., Friederich, H.C. & Nikendei, C. (2019) Stabilizing techniques and guided imagery for traumatized male refugees in a German state registration and reception center: A qualitative study on a psychotherapeutic group intervention. *Journal of Clinical Medicine*. 8 (6), 1-16. DOI: 10.3390/jcm8060894.

Appendix 1.1:

Author Guidelines for submission to the Journal of Traumatic Stress

(https://onlinelibrary.wiley.com/pb-assets/assets/15736598/JTS_Author_Guidelines_-_revised_12.13.17.pdf [Accessed 27 February 2020])

Author Guidelines

1. **Online Submissions:** The *Journal of Traumatic Stress* accepts submission of manuscripts online at:

   http://mc.manuscriptcentral.com/jots

   Information about how to create an account or submit a manuscript may be found online on the Manuscript Central homepage in the "User Tutorials" section or, on the Author Dashboard, via the "Help" menu in the upper right corner of the screen. Personal assistance also is available by calling 434-964-4100.

2. **Article Formats:** Three article formats are accepted for consideration by JTS. All page counts should include references, tables, and figures. *Regular articles* (30 pages maximum, inclusive of all text, abstract, references, tables, and figures) include research studies, quantitative systematic reviews, and theoretical articles. Purely descriptive articles or narrative-based literature reviews are rarely accepted. In extraordinary circumstances, the editors may consider longer manuscripts that describe highly complex designs or statistical procedures but authors should seek approval prior to submitting manuscripts longer than 30 pages. *Brief reports* (18 pages maximum) are appropriate for pilot studies or uncontrolled trials of an intervention, preliminary data on a new problem or population, condensed findings from a study that does not merit a full article, or methodologically oriented papers that replicate findings in new populations or report preliminary data on new instruments. *Commentaries* (1,000 words or less) involve responses to previously published articles or, occasionally, invited essays on a professional or scientific topic of general interest. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries.

3. **Double-Blind Review:** As of January 1, 2017, the Journal of Traumatic Stress utilizes a double-blind review process in which reviewers receive manuscripts with no authors' names or affiliations listed in order to ensure unbiased review. To facilitate blinded review, the title page should be uploaded as a separate document from the body of the manuscript, identified as "Title Page," and should include the title of the article, the running head (maximum 50 characters) in uppercase flush left, author(s) byline and institutional affiliation, and author note (see pp. 23-25 of the APA 6th ed. manual). Within the main body of the manuscript, tables, and figures, authors should ensure that any identifying information (i.e., author names, affiliations, institutions where the work was performed, university whose ethics committee approved the project) is blinded; a simple way to accomplish this is by replacing the identifying text with the phrase "[edited out for blind review]". In addition, language should be used that avoids revealing the identity of the authors; e.g., rather than stating, "In other research by our lab (Bennett & Kerig, 2014), we found ..." use phrases such as, "In a previous study, Bennett and Kerig (2014) found ..." Please note that if you have uploaded the files correctly, you will **not** be able to view the title page in the PDF and HTML proofs of your manuscript; however, the Editor and JTS editorial office staff can view this information.

4. **Preferred and Non-Preferred Reviewers:** During the submission process, authors may suggest the names of preferred reviewers; authors also may request that specific individuals not be selected as reviewers.

5. **Publication Style:** JTS follows the style recommendations of the 2010 *Publication Manual of the American Psychological Association* (APA; 6th edition) and submitted manuscripts must conform to these formatting guidelines. Manuscripts should use non-sexist language. Manuscripts must be formatted using letter or A4 page size, with 1 inch (2.54 cm) margins on all sides, Times New Roman 12 point font (except for figures, which should be in 12 point Arial font), and double-spacing for text, tables, references, and figures. Submit your manuscript in .doc or .docx format.

   For assistance with APA style, in addition to consulting the manual itself, please note these helpful online sources that are freely available: http://www.apastyle.org/learn/tutorials/basics-tutorial.aspx and https://owl.english.purdue.edu/owl/section/2/10/ .

6. **APA and JTS Style Pointers:** In addition to consulting the APA 6th edition Publication Manual, the resources indexed above, and the JTS Style Sheet posted online, please consider these pointers when formatting each section of the manuscript:

   a. **Tense:** Throughout the manuscript, please use past tense for everything that has already happened, including the collection and analyses of the data being reported.

   b. **Abstract:** The Main Document of the manuscript should begin with an abstract no longer than 250 words, placed on a separate page. In addition, JTS house style requires the reporting of an effect size for each finding discussed in the abstract; if there are many findings, present the range.

   c. **Participants:** Please include in this subsection of the Method section information on sample characteristics, subsample comparisons, and analyses that describe the sample but are not focused on testing the hypotheses that are the aims of your manuscript.

   d. **Procedure:** Please describe the procedure in sufficient detail so that it could be comprehended and replicated by another investigator. Identify by name the IRB or ethics committee (edited out for blind review in the submitted manuscript) that approved the research, and the manner in which consent was obtained.

   e. **Measures:** In addition to providing citations, psychometric, and validation data for each measure administered, please provide coefficient alpha from your data for each measure for which this is appropriate.

   f. **Data Analysis:** Include a separate subsection with this header in the Method section in which you describe the analyses performed, the software program(s) used, and make an explicit statement about missing data in your data set. If there are no missing data, so state; otherwise describe the extent of missing data and how they were handled in the data analyses.

   g. **Results** (and throughout): Present percentages to 1 decimal place, means and *SD*s to 2 decimal places, and exact *p* values to 3 decimal places except for any < .001. Include leading zeros (e.g., 0.92) when reporting any statistic that can be greater than 1.00 (or less than -1.00). For example, there is no leading zero used when reporting correlations, coefficient alphas, standardized betas, *p* values, or fit indices (e.g., *r* = .47, not 0.47). Report effect sizes for analyses conducted wherever possible and appropriate.

h. **References:** Format the references using APA 6th edition style: (a) begin the reference list on a new page following the text, (b) double-space, (c) use hanging indent format, (d) italicize the journal name or book title, and (e) list alphabetically by last name of first author. Do not include journal issue numbers unless each volume begins with page 1. If a reference has a Digital Object Identifier (doi), it must be included as the last element of the reference.

(1) ***Journal Article:***

Kraemer, H. C. (2009). Events per person-time (incidence rate): A misleading statistic? *Statistics in Medicine, 28*, 1028–1039. doi: 10.1002/sim.3525

(2) ***Book:***

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

(3) ***Book Chapter:***

Meehl, P. E. (2006). The power of quantitative thinking. In N. G. Waller, L. J. Yonce, W. M. Grove, D. Faust, & M. F. Lenzenweger (Eds.), *Essays on the practice of scientific psychology* (pp. 433–444). Mahwah, NJ: Erlbaum.

i. **Footnotes:** Footnotes should be avoided. When their use is absolutely necessary, footnotes should be formatted in APA style and placed on a separate page after the reference list and before any tables.

j. **Tables:** Tables should be formatted in APA 6th edition style and should be placed after the references in the body of the manuscript. Please use Word's Table function to construct tables, not tabs and spacing. Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should begin on a separate page. Please make tables double-spaced, decimal align all numeric columns, and use sentence case for labels. Each datum should appear in its own cell (e.g., do not include *SDs* in parentheses following *M*s but instead create a separate column for *SD*s). When reporting a table of intercorrelations, fill the rows first and then the columns such that any empty cells are in the lower left-hand quadrant of the table; use dashes in any redundant cells indicating the correlation of a variable with itself. Report exact *p* values to three decimal places (e.g., $p = .043$) wherever possible; however, if doing so would make the table unruly (e.g., in a table of intercorrelations), it is permissible to use asterisks to indicate p values at the traditional cut-off points (e.g., * $p < .05$. ** $p < .01$. $p < .001$).

Color in tables: Color can be included in the online version of a manuscript at no charge; however use of color in the print version of the journal will incur additional charges (currently $600 per figure or table). If you wish to include color in only the online version, please ensure that each table will be legible in greyscale when it is published in the print version; for example, lines of different colors may be discriminable from one another when viewed in color but may not appear to be different from one another in greyscale.

k. **Figures:** All figures (graphs, photographs, drawings, and charts) should be numbered (with Arabic numerals) and referred to by number in the text. Each figure should begin on a separate page. Place figures captions at the bottom of the figure itself, not on a separate page. Include a separate legend to explain symbols if needed. Please use Arial font

throughout except for the caption, which should remain as Times New Roman. Use sentence case for titles and labels. Figures should be in Word, TIF, or EPS format.

Color in figures: Color can be included in the online version of a manuscript at no charge; however use of color in the print version of the journal will incur additional charges (currently $600 per figure or table). If you wish to include color in only the online version, please ensure that each figure will be legible in greyscale when it is published in the print version; for example, lines of different colors may be discriminable from one another when viewed in color but may not appear to be different from one another in greyscale.

7. **Uploading Files:** After the separate Title Page has been uploaded as a Word file (.doc or .docx), the remaining text (abstract, main body of the manuscript, references, and tables) should be uploaded as a separate **single** Word file (.doc or .docx) designated as "Main Document." Figures may be either included in the main document or uploaded as separate files if in a non-Word format.

8. **Supplementary Materials.** Authors may wish to place some material in the separate designation of "Supplementary file not for review," which will be made available online for optional access by interested readers. This material will not be seen by reviewers and will not be taken into consideration in their evaluation of the scientific merits of the work, and will not be included in the published article. Material appropriate for such a designation includes information that is not essential to the reader's comprehension of the study design or findings, but which might be of interest to some scholars; examples might include descriptions of a series of non-significant post-hoc analyses that were not central to the main hypotheses of the study, detailed information about the content of coding system categories, and CONSORT flow diagrams for randomized controlled trials (see below). Note well that the manuscript must stand on its own without this material; consequently, critical information reviewers and readers need to evaluate or replicate the study, such as the provenance and psychometric properties of the measures administered, is not appropriate for placement into Supplementary Materials.

9. **Statement of Ethical Standards:** In the conduct of their research, author(s) are required to adhere to the "Ethical Principles of Psychologists and Code of Conduct" of the American Psychological Association (visit http://www.apa.org/science/leadership/research/ethical-conduct-humans.aspx for human research or http://www.apa.org/science/leadership/care/guidelines.aspx for animal research) or equivalent guidelines in the study's country of origin. If the author(s) were unable to comply when conducting the research being presented, an explanation is required.

   All work submitted to the *Journal of Traumatic Stress* must conform to applicable governmental regulations and discipline-appropriate ethical standards. Responsibility for meeting these requirements rests with all authors. Human and animal research studies typically require prior approval by an institutional research or ethics committee that has been established to protect the welfare of human or animal participants.

   Data collection for the purposes of providing clinical services or conducting an internal program evaluation generally does not require approval by an institutional research committee. However, analysis and presentation of such data outside the program setting may qualify as research (which is defined as an effort to produce generalizable knowledge) and thus may require approval by an institutional committee. Those who submit manuscripts to the *Journal of Traumatic Stress* based on data from these sources are encouraged to consult with a representative of the applicable

institutional committee to determine whether approval is needed. Presentations that report on a particular person (e.g., a clinical case) also usually require written permission from that person to allow public disclosure for educational purposes, and involve alteration or withholding of information that might directly or indirectly reveal identity and breach confidentiality.

To document how these guidelines have been followed, authors are asked to identify in the online submission process the name of the authorized institution, committee, body, entity, or agency that reviewed and approved the research or that deemed it to be exempt from ethical or Internal Review Board review. Although blinded at the time of submission, the name of the IRB or ethics committee that approved the research, and the manner in which consent was obtained, also should appear in the Procedure subsection of the Method in the body of the report.

10. **Randomized Clinical Trials:** Reports of randomized clinical trials should include a flow diagram and a completed CONSORT checklist (available at http://www.consort-statement.org) indicating how the manuscript follows CONSORT Guidelines for the reporting of randomized clinical trials. The flow diagram should be included as a figure in the manuscript whereas the checklist should be designated as a "Supplementary file not for review" during the online submission process. Please visit http://consort-statement.org for information about the consort standards and to download necessary forms.

11. **Systematic Reviews:** Reports of systematic reviews follow the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (http://www.prisma-statement.org/documents/PRISMA%202009%20checklist.pdf) and should be accompanied by a flow diagram (http://www.prisma-statement.org/PRISMAStatement/FlowDiagram.aspx) mapping out the number of records identified, included, and excluded, and the reasons for exclusions.

12. **Writing for an International Readership:** As an international journal, the *Journal of Traumatic Stress* avoids the use of operational code names or nicknames to describe military actions, wars, or conflicts, given that these may not be equally familiar or meaningful to readers from other nations. Helpful guides for clear and neutral language for reporting on military-based research can be found at the following webpages: the ISTSS newsletter *StressPoints* (http://www.istss.org/education-research/traumatic-stresspoints/2015-march-(1)/media-matters-what%E2%80%99s-in-a-name-using-military-code.aspx), the *International Press Institute* (http://ethicaljournalismnetwork.org/assets/docs/197/150/4d96ac5-55a3396.pdf) and the *Associated Press Stylebook and Briefing on Media Law* (http://www.apstylebook.com/?do=help&q=48/). In addition, authors are encouraged to give consideration to whether particular research findings might be culturally-specific rather than universally established; e.g., prevalence rates derived from samples consisting of all-US participants should be identified as such.

13. **Originality and Uniqueness of Submissions.** Submission is a representation that neither the manuscript nor substantive content within in it has been published previously nor is currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to the International Society for Traumatic Stress Studies will be required after the manuscript has been accepted for publication. Authors will be prompted to complete the appropriate Copyright Transfer Agreement through their Author Services account. Such a written transfer of copyright is necessary under U.S. Copyright Law in order for the publisher

to carry through the dissemination of research results and reviews as widely and effectively as possible.

14. **Pre-Submission English-Language Editing:** Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. Japanese authors can find a list of local English improvement services at http://www.wiley.co.jp/journals/editcontribute.html. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

15. **Page Charges:** The journal makes no page charges. The only exception to this, as noted above, is if authors wish tables or figures to be printed in color.

16. **Author Services:** Online production tracking is available for your article through Wiley-Blackwell's Author Services. Author Services enables authors to track their article—once it has been accepted—through the production process to publication online and in print. Authors can check the status of their articles online and choose to receive automated emails at key stages of production. Authors will receive an email with a unique link that enables them to register and have their article automatically added to the system. Please ensure that a complete email address is provided when submitting the manuscript. Visit http://authorservices.wiley.com/ for more details on online production tracking and for a wealth of resources including FAQs and tips on article preparation, submission, and more. Corresponding authors: In lieu of a complimentary copy free access to the final PDF offprint of your article will be available via Author Services only. Please therefore sign up for Author Services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers. Should you wish to purchase reprints of your article, please click on the link and follow the instructions
provided: https://caesar.sheridan.com/reprints/redir.php?pub=10089&acro=JTS

17. **OnlineOpen** : The *Journal of Traumatic Stress* accepts articles for Open Access publication. Please visit http://olabout.wiley.com/WileyCDA/Section/id-828081.html for further information about OnlineOpen.

18. **NIH Public Access Mandate:** For those interested in the Wiley-Blackwell policy on the NIH Public Access Mandate, please visit our policy statement at www.wiley.com/go/nihmandate

Appendix 1.2: Search terms

PICOS	Search terms
Population	"PTSD" or "post-traumatic stress disorder*" or "post traumatic stress disorder*" or "posttraumatic stress disorder*" or "complex trauma" or "trauma" or "complex post traumatic stress disorder*" or "complex post-traumatic disorder*" or "complex posttraumatic disorder*" or "complex PTSD" or "CPTSD" or "Type 2" or "Type II" or "psycholog* trauma*" or "historical trauma"
Intervention	"psycholog* treatment*" or "psycholog* intervention*" or "psycholog* therapy" or "psychotherap*" or "psycholog* technique*" or "trauma treatment*" or "trauma-specific treatment*" OR "CBT" or "Cognit* behav* therap*" or "cogniti* therap*" or "TF-CBT" or "TF CBT" or "trauma-focused CBT" or "trauma focused CBT" or "trauma therap*" or "behav* modification*" OR "prolonged exposure therap*" or "prolonged exposure" or "cognitive processing therap*" or "CPT" or "trauma processing" OR "narrative exposure therap*" or "narrative therap*" or "NET" or "narrative therapy approach" OR "EMDR" or "eye movement desensitization reprocessing" or "EMD therap*" OR "psychoeducation*" or "psychoeducation* intervention*" or "stabilisation intervention*" or "stabili* intervention*" or "safety and stabili*" or "stabili* technique*" OR "mindfulness" or "relaxation therap*" or "relaxation technique*" OR "person-cent* psychotherap*" or "person cent* psychotherap*" or "client-cent* therap*" or "client cent* therap*" OR

	"group therap*" or "group psychotherap*" OR "emotion-focused therap*" or "emotion focused therap*" OR “ACT" or "acceptance and commitment therap*" OR "CFT" or "compassion focused therap*" or "compassion-focused therap*" or "compassionate mind training"
Outcome	"experience*" or “perspective*" or "view*" or "perception*" or "opinion*" or “attitud*”
Study type	"qualitative" or "qualitative research" or "qualitative stud*" or "qualitative analysis" or "interview*" or "focus group*" or "qualitative method*"

Appendix 1.3:

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist (Tong, Sainsbury & Craig, 2007)

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	
3. Occupation	What was their occupation at the time of the study?	
4. Gender	Was the researcher male or female?	
5. Experience and training	What experience or training did the researcher have?	
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
Participant selection		
10. Sampling	How were participants selected? e.g. purposive,	

	convenience, consecutive, snowball	
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	
12. Sample size	How many participants were in the study?	
13. Non-participation	How many people refused to participate or dropped out? Reasons?	
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	
20. Field notes	Were field notes made during and/or after the interview or focus group?	
21. Duration	What was the duration of the interviews or focus group?	
22. Data saturation	Was data saturation discussed?	
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	

Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	
25. Description of the coding tree	Did authors provide a description of the coding tree?	
26. Derivation of themes	Were themes identified in advance or derived from the data?	
27. Software	What software, if applicable, was used to manage the data?	
28. Participant checking	Did participants provide feedback on the findings?	
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
30. Data and findings consistent	Was there consistency between the data presented and the findings?	
31. Clarity of major themes	Were major themes clearly presented in the findings?	
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	

Appendix 1.4:

Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ (Tong, Flemming, McInnes, Oliver & Craig, 2012)

No. Item	Guide and description	Reported on Page
1. Aim	State the research question the synthesis addresses.	P11
2. Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	P14
3. Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until they theoretical saturation is achieved).	P12
4. Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	P13
5. Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists) and when the searches conducted; provide the rationale for using the data sources.	P12-13
6. Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).	P12 & P94
7. Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies).	P13 & P16

8. Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	P17-18 & P102
9. Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications to the research question and/or contribution to theory development).	P16
10. Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	P14
11. Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	P14 & P96
12. Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	P14
13. Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	P18-19 & P111
14. Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings “results /conclusions” were extracted electronically and entered into a computer software).	P14

15. Software	State the computer software used, if any.	P14
16. Number of reviewers	Identify who was involved in coding and analysis.	P14
17. Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	P14
18. Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	P14
19. Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	P14
20. Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation.	P20-29
21. Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	P20-29

Appendix 1.5: Brief summary of the included studies

Study No	Author, year, title, journal and place	Aim	Group treatment	Number of participants	Participant characteristics	Method and analysis used	Brief summary of the results from the paper
1	Parker et al. 2007 The experience of trauma recovery: A qualitative study of participants in the women recovering from abuse program (WRAP) Journal of Child Sexual Abuse Canada	To explore women's experiences of the Women Recovering from Abuse Program	The program looked at phase 1 treatment for trauma. The program ran for 8 weeks. Individuals attended 4 half days of group sessions per week and also one hour of one-to-one therapy per week.	N = 7	Age: Between 31 to 71 years old Gender: Female: N = 7 History of child maltreatment (sexual, physical or emotional abuse and/or neglect)	Interviews Constant comparative method	• Individuals felt that views and beliefs about themselves and the world changed e.g. they became less blaming of themselves • They felt they were able to connect with others in the group • Talking to others who had similar difficulties was helpful • The skills developed in the group helped with e.g. managing relationships and empowerment • The group helped them to feel more confident about exploring other resources or support after completing the group program
2	Tummala-Narra et al. 2012 Relational experiences of complex trauma survivors in treatment: Preliminary findings from a naturalistic study Psychological Trauma Theory Research Practice and Policy USA	To explore individual's experience of treatment with regards to the relational aspect e.g. with others and themselves	All of the individuals were receiving one-to-one psychotherapy and 15 individuals received trauma-focused group psychotherapy Those who received both interventions were interviewed after completing the group treatment. Those who only received individual therapy were interviewed between 8 – 16 months into treatment	N = 21	Age: Between 24- 62 years old Gender: Males: N = 3 Females: N = 18 Race/ethnic: White: N = 19 Asian American: N = 1 African American: N = 1 PTSD Complex trauma	Interviews Grounded theory	• Some of the individuals felt that they had difficulties trusting others • Treatment helped them to be more open with others and to put in place boundaries with others • Individuals became more compassionate towards themselves and experienced an improvement with regards to how they viewed themselves • Individuals were able to think more about their future • Exploring relationship difficulties with the therapist was helpful

3	Bermudez et al. 2013 A qualitative analysis of beginning mindfulness experiences for women with post-traumatic stress disorder and a history of intimate partner violence Complementary Therapies in Clinical Practice USA	To explore women's experiences of mindfulness-based stress reduction group intervention for PTSD (for women who experienced intimate partner violence)	Individuals participated in an 8 week program which occurred on a weekly basis for 2 ½ hours and a 6 hour retreat. Individuals were interviewed 4 times (before, at mid-point and after the group as well as 3 months after completing the group). Focus group also took place during a 9 month follow up.	N = 10	Age: Between 31 to 62 years old Gender: Females: N = 10 Race/ ethnic: African American: N = 9 Asian American: N = 1 Chronic trauma, including intimate partner violence and symptoms of PTSD	Interviews and a focus group Interpretative Phenomenological Analysis	• Some individuals found it difficult to use meditation at the start of the group however with time they were able to apply it better • Individuals in the group valued helping others • Individuals felt more relaxed when using meditation and found it helpful to focus on the here and now • The intervention helped them to be more aware of their emotions and to manage this better as well being more compassionate towards themselves • The intervention helped improve relationships and communications with others
4	**a.** Stige, Rosenvinge & Traeen (primary article) 2013 A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach Psychotherapy Research Norway	To explore individual's experiences of the stablisation group intervention	Individuals took part in a weekly group session over 17 weeks. They also received one-to-one therapy sessions. Individuals were interviewed after 3 months of completing the program	N = 13	Age: Between 18 – 60 years old M = 39 Gender: Females: N = 13 Human-inflicted trauma (childhood, adulthood or both) Trauma-related symptoms (PTSD & complex PTSD) All experienced multiple traumas	Interviews Hermeneutic-phenomenological approach	• Individuals were worried about what the group would be like before starting it e.g. if it would be demanding • Some felt that it could be challenging and exhausting in term of taking part in the group • Being in a group normalised some of their difficulties. They were also able to share or listen to other people's experiences, which made them feel validated and less isolated • They felt it helped them to understand better their symptoms of trauma

	b. Stige et al. 2013 Stories from the road of recovery- How adult, female survivors of childhood trauma experience ways to positive change Nordic Psychology Norway	To explore individuals' experience of recovery in those who have received treatment for trauma	Individuals took part in a stabilisation group intervention which occurred on a weekly basis for 17 sessions. Individuals also received one-to-one treatment. Interviews took place after individuals completed group (within 3 months)	N = 13	Age: Between 18 – 60 years old M = 39 Gender: Females: N = 13 Trauma-related symptoms All experienced multiple traumas (childhood, adulthood or both)	Interviews Hermeneutic-phenomenological approach	• The group helped individuals to understand better their difficulties and the symptoms they were experiencing. They felt a sense of empowerment. • Individuals felt more aware of their feelings (physical and emotional) and how they could make sense of this or manage this better • Individuals became more aware of the importance of self – care • Individuals felt more in control of their thoughts/ feelings and more able to make changes themselves
	c. Stige & Binder 2017 From painstaking work to a new way of meeting the world – trauma clients' experiences with skill training in a stabilisation group approach Psychotherapy Research Norway	To explore individual's experiences of the stabilisation group intervention and what impact it had on them after completing the group	Individuals took part in the stabilisation group intervention which involved 17 weekly group sessions (separate gender groups were offered). Participants also had individual treatment at the same time. Participants were interviewed twice- 3 months and also 11-13 months after completing the program	N = 13	Age: Between 18 and 60 years old M = 39 Gender: Females: N = 13 Human-inflicted trauma All experienced multiple traumas	Interviews Hermeneutic-phenomenological approach	• Main themes included: • Individuals willing to explore new ways of managing the symptoms of trauma • Learning new skills and having a better understanding of their difficulties was helpful in the group • Skills training led to new experiences or discoveries however it could take time and effort to get used to it • The new skills developed from the group helped them view their difficulties differently • The second interview showed that change occurred for individuals, where the skills they developed became automatic for them to use. • The skills developed helped individuals to feel more in the present moment and to feel more in control of their emotions and in managing or preparing for difficult situations in the future

	d. Stige, Binder & Veseth 2019 The role of therapy in personal recovery- Trauma clients' use of resources to continue positive processes following group therapy Qualitative Social Work Norway	To explore individual's experiences of recovery after completing the stabilisation group by looking at how they have continued to consolidate the change they experienced a year after the group intervention	Individuals were interviewed twice – this study looked at the second interview where they were interviewed a year after completing the group. Phase 1 stabilisation group intervention. 17 weekly sessions.	N = 13	Age: Between 18-60 years old Gender: Females: N = 13 Human-inflicted trauma	Interviews Hermeneutic-phenomenological approach	• Participants referred back to the resources and what they learnt in therapy to help them to continue with the progress they made • They were able to focus on their own strengths and apply the skills they learnt in their everyday life, which helped them with regards to their well-being e.g. cooking, dancing, nature. • Participants became more active in managing their well-being/ recovery. • The group helped them to find new ways of managing their difficulties as well as using their own strengths and resources.
5	Lawrence & Lee 2014 An exploration of people's experiences of compassion-focused therapy for trauma, using interpretative phenomenological analysis Clinical Psychology and Psychotherapy UK	To explore individual's experiences of compassion-focused therapy (CFT) in relation to trauma	There were 4 individuals who took part in a CFT group and 3 individuals who received CFT individually.	N = 7	Age: Between 30 to 54 years old Gender: Female: N = 5 Male: N = 2 History of traumatic experiences (from either childhood to adulthood experiences) PTSD	Interpretative Phenomenological Analysis	• Being critical towards themselves was a part of who they were as a person and was used as strategy to manage unpleasant feelings • It was difficult for some individuals to become compassionate towards themselves as this was an unfamiliar feeling for them • Being in a group helped normalize their difficulties and for individuals to become more compassionate towards themselves. They felt less alone • The therapeutic relationship with the therapist was important • Individuals became more hopeful about life and were more positive about life once they were able to become more compassionate towards themselves

6	Jindani & Khalsa 2015 A yoga intervention program for patients suffering from symptoms of posttraumatic stress disorder: A qualitative descriptive study The Journal of Alternatives and Complementary Medicine Canada	To explore individuals experiences of the trauma-sensitive Kudalini yoga program	Individuals took part in an 8 week kudalini yoga group, which ran on a weekly basis for 90 minutes.	N = 40	Age: Ranged from 18 to 63 years old Gender: Male: N = 9 Female: N = 31 PTSD Type of trauma experienced included sexual and emotional abuse, physical trauma (road traffic accident, illness)	Interviews Thematic analysis	• Individuals felt more emotionally connected with their mind and body • They were able to reflect more and felt more confident • They became more compassionate towards themselves with regards to their trauma • They felt more empowered and at peace within themselves • They felt that it was important to carry out the exercises at home as part of a routine. This helped them to feel better both emotionally and physically • They felt supported by the group
7	Myers, Lewis & Dutton 2015 Open mind, open hearts: An anthropological study of the therapeutics of meditation practice in the US Culture Medicine Psychiatry USA	To explore individuals experiences of meditation in relation to trauma	Individuals attended meditation training group. This consisted of 10-30 minutes of 'seated meditation'. They also looked at ways of managing anxiety.	N = 10	Age: Over the age of 18 years old Gender: Female: N = 10 Race/ethnic: "Mostly Caucasian" Trauma included sexual abuse, physical abuse, natural disasters, life threatening illness	Ethnographic fieldwork and interviews Thematic narrative analysis	• The group helped individuals to focus on the here and now • Meditation helped them to connect more with the mind and the body • Individuals developed more awareness in terms of how they were feeling physically • The group helped them to feel more connected with others • They felt more in control and were more compassionate towards themselves
8	Rhodes 2015 Claiming peaceful embodiment through yoga in the aftermath of trauma	To explore individuals experiences of yoga and the impact that had on them with regards to their trauma	Individuals took part in the 'Trauma Sensitive Yoga' group which occurred on a weekly basis for an hour.	N = 39	Age: M=41 years old; SD= 13 Gender: Female: N = 39 Race/ethnic: Black: N =4	Interviews Hermeneutic phenomenological method	• Individuals learnt to focus more on the present • It helped them to feel more in control and at peace within themselves • They noticed an improvement in their wellbeing, especially the connection between their mind and body

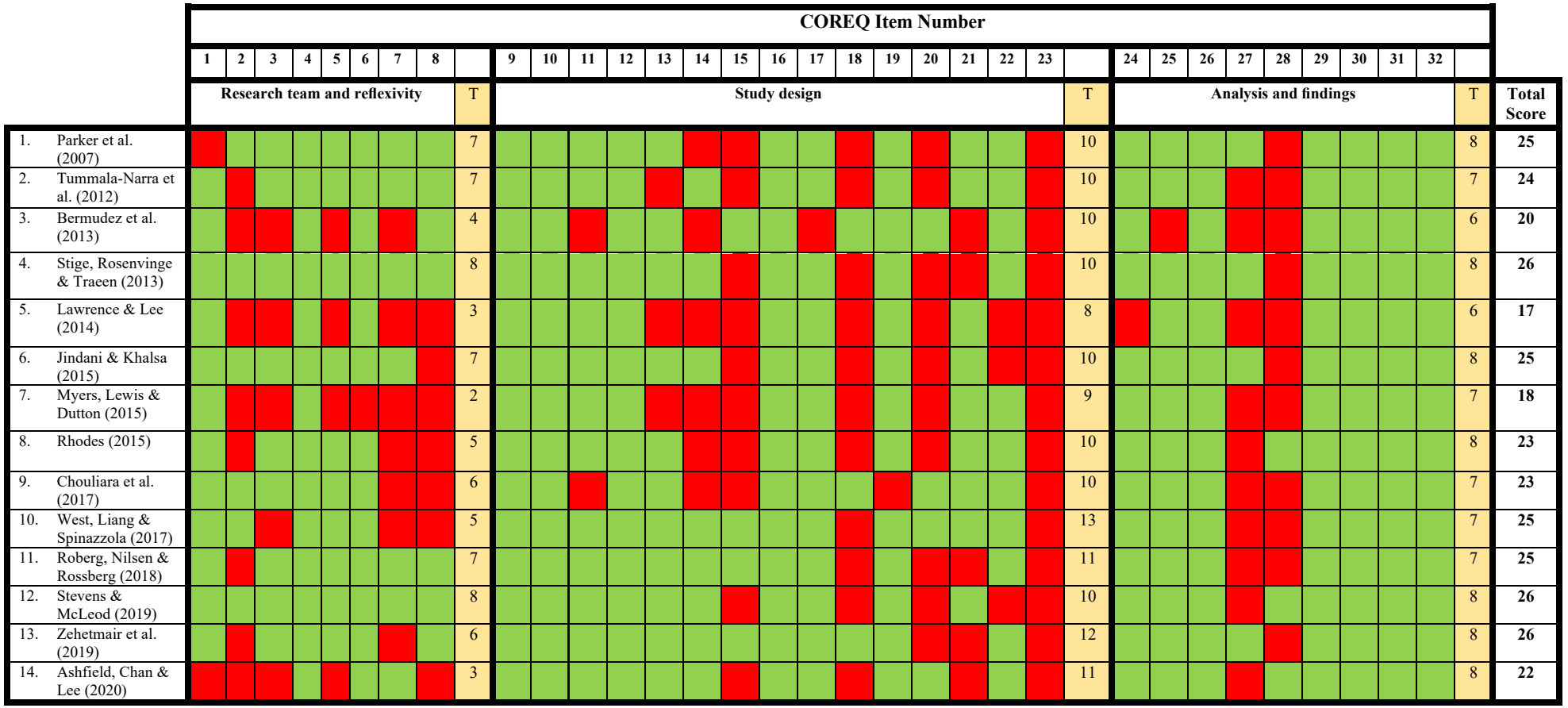
	Complementary Therapies in Clinical Practice USA				White: N = 30 Other: N = 2 Did not report: N = 3 PTSD Childhood maltreatment Some also experienced life threatening illnesses, accidents, assaults or witnessed violence		• They felt more hopeful about their future and were better with their self-care • They felt safe and supported by the yoga teacher • It was important to practice the skills out with the class to sustain the skills developed
9	Chouliara et al. 2017 Therapeutic change in group therapy for interpersonal trauma: A relational framework for research and clinical practice Journal of Interpersonal Violence UK	To explore patients and group facilitators experience of the group and the changes that occurred for them	Individuals took part in the 'Trauma Recovery and Empowerment Model' group. The group involved psychoeducation, developing cognitive restructuring and coping skills.	N = 16	Age: M= 41 years old Gender: Female: N = 16 Complex interpersonal trauma	Interviews Interpretative phenomenological analysis	• Those who completed the group felt that the group helped them to normalize their feelings. They felt that by talking about their difficulties, it helped them to bring closure and to move forward. • Those who started the group but stopped it, felt that it was not helpful having individuals with different needs in group. They experienced difficulties in trusting others and were worried about being judged.
10	West, Liang & Spinazzola 2017 Trauma sensitive yoga as a complementary treatment for posttraumatic stress disorder: A qualitative descriptive analysis	To explore individual's experiences of Trauma Sensitive Yoga (TSY) in relation to the treatment of chronic PTSD.	Individuals took part in a 10 week TSY program. This was used as complementary treatment. It ran on a weekly basis for an hour with a yoga teacher specialised in TSY.	N = 31	Age: Between ages of 18 – 58 years old Gender: Females: N = 31 Race/ ethnic: White/ Caucasian: N = 23 Black: N = 3	Interviews Content Analysis	• Five main themes were found: • Individuals became more grateful and compassionate towards themselves • individuals felt more connected within themselves and to others • Acceptance • Individuals felt more 'centred' and calm

	International Journal of Stress Management USA		Individuals received psychotherapy for a least 6 months before receiving TSY. Individuals were interviewed after they completed the TSY program.		Multiracial: N = 1 Hispanic/ Latina: N = 1 American Indian: N = 1 Did not respond: N = 2 PTSD (in relation to childhood trauma)		• They felt more in control, empowered and confident
11	Roberg, Nilsen & Rossberg 2018 How do men with severe sexual and physical childhood traumatization experience trauma-stabilizing group treatment? A quality study European Journal of Psychotraumatology Norway	To explore men's experiences of the trauma-stabilizing group treatment	Group intervention ran for 22 weeks on a weekly basis for 2 hours.	N = 5	Age: Between 29 and 64 years old Gender: Males: N = 5 Race/ethnic: Norwegian: N = 5 Complex PTSD Multiple trauma from childhood	Interviews Interpretative phenomenological analysis	• Individuals felt that it was important to feel safe in the group in order to open up and to share their experiences • Some individuals experienced social anxiety and symptoms of trauma e.g. flashbacks in the group • The group helped them to have a better understanding of their difficulties and strategies they could use to manage this • Individuals felt that group was not long enough (both in terms of length of time and number of sessions) • Individuals felt that it was helpful having only men in the group
12	Stevens & McLeod 2019 Yoga as an adjunct to trauma-focused counselling for survivors of sexual violence: A qualitative study British Journal of Guidance & Counselling UK	To explore individuals experiences of yoga (for those who experienced sexual violence)	Individual took part in the 10-week Forest yoga programme, where sessions lasted 90 minutes.	N = 5	Age: Ranged from 21 to 55 years old Gender: Female: N = 5 Race/ethnic: British: N = 4 Haitian: N = 1 Childhood sexual abuse or sexual violence	Interviews and follow up email Interpretative Phenomenological Analysis	• Being around others who had similar experiences helped individuals to feel less alone • They felt supported by others • It helped them to feel more confident within themselves and to speak to others in the group • They felt safe in the group • Individuals noticed that they became more focused and relaxed • Having the yoga teacher was helpful- some found it difficult to practice at home with this support

					Some experienced physical violence, domestic abuse and emotional abuse		• They became less critical of themselves • It helped them to feel more connected with the mind and the body
13	Zehetmair et al. 2019 Stabilizing techniques and guided imagery for traumatised male refugees in a German state registration and reception centre: a qualitative study on a psychotherapeutic group intervention Journal of Clinical Medicine Germany	To explore individual's experiences of group therapy which looked at stabilisation techniques and guided imagery	Interviews took place after the first, the fifth and two weeks after the last group session they attended. Group therapy occurred twice a week. The group focused on developing stabilisation techniques and guided imagery. The average number group sessions attended by the participants was 7.03 (SD = 8.56, range 1-40).	N = 30 Total interviews conducted: N = 50 First interview: N = 16 Second interview: N = 9 Follow up interview: N = 26 Participants who took part in all of the interviews: N = 5 Participant who took part in the first interview and follow up: N = 9 Participant who took part in the second interview and	Age: M = 25.83, SD = 6.8, range 18-42 Gender: Male: N = 30 Participants were refugees Origin: Sub-Saharan Africa: N=23 Middle East: N = 3 South Asia: N = 4 All spoke English for the interviews PTSD Trauma included torture, imprisonment, physical assault or seeing someone killed or injured.	Interviews Content analysis	• Four main themes were found, which looked at: • Motivation (they found it helpful going to the group) • their views of the groups (being with others helped normalised their difficulties, having support from therapists) • what they found helpful (finding ways to manage feelings and thoughts and developing confidence in interacting with others) • what they found difficult (concentrating or doing the techniques on their own, their surroundings making it harder for them to practice exercises).

				follow up: N = 2 Took part in in the first interview only: N = 2 Took part in in the second interview only: N = 1 Took part in in the follow up interview only: N = 10			
14	Ashfield, Chan & Lee 2020 Building ‘s compassionate armour’: The journey to develop strength and self-compassion in a group treatment for complex post-traumatic stress disorder Psychology and Psychotherapy: Theory, Research and Practice UK	To explore individuals experiences of group treatment and the impact it had on them	Individuals took part in the ‘Compassionate Resilience’ group The group involved psychoeducation, developing problem solving skills and carrying out compassion-based exercises	N = 11	Age: Between 22 to 62 years Gender: Female: N = 11 Race/ ethnic: White: N = 10 Mixed race: N = 1 Complex PTSD Complex trauma	Interviews Constructivist grounded theory	• Developed a ‘Journey of Change’ model • Individuals tended to blame themselves, were worried about being judged and felt alone before starting the group • They felt the group helped them to understand better their difficulties • They became more aware of their emotions and more compassionate towards themselves and to others • They felt safe in the group and more connected with others • It helped them to feel more empowered and improved their feelings of shame and self-care

Appendix 1.6: Ratings on the COREQ for the included studies



T – Total

Not reported

Reported

Appendix 1.7: Themes in the included studies

	Themes							
	Process of Change				Group Processes		Individual's Healing Process	
	Understanding Difficulties	Acceptance	Being in the Present Moment	Connection	Meeting Others	Therapeutic Relationship with Therapist/ Facilitator	Growth & Self-Development	Focus on the Future
1. Parker et al. (2007)	✓	✓	✓	✓	✓	✓	✓	
2. Tummala-Narra et al. (2012)	✓	✓		✓	✓		✓	✓
3. Bermudez et al. (2013)		✓	✓	✓	✓		✓	✓
4. a. Stige, Rosenvinge & Traeen (2013)	✓		✓	✓	✓	✓	✓	✓
b. Stige et al. (2013)	✓	✓	✓	✓	✓		✓	✓
c. Stige & Binder (2017)	✓	✓	✓		✓		✓	✓
d. Stige, Binder & Veseth (2019)	✓		✓	✓	✓		✓	✓
5. Lawrence & Lee (2014)	✓				✓	✓	✓	✓
6. Jindani & Khalsa (2015)	✓	✓	✓	✓	✓	✓	✓	
7. Myers, Lewis & Dutton (2015)		✓	✓	✓	✓		✓	
8. Rhodes (2015)		✓	✓	✓		✓	✓	✓
9. Chouliara et al. (2017)	✓			✓	✓		✓	
10. West, Liang & Spinazzola (2017)	✓	✓	✓	✓	✓		✓	✓
11. Roberg, Nilsen & Rossberg (2018)	✓		✓		✓	✓	✓	
12. Stevens & McLeod (2019)	✓	✓	✓	✓	✓	✓	✓	
13. Zehetmair et al. (2019)			✓	✓	✓	✓		✓
14. Ashfield, Chan & Lee (2020)	✓	✓		✓	✓	✓	✓	✓

Appendix 2.1:

Guidelines for the submission of the Journal of Cross-Cultural Psychology

(https://journals.sagepub.com/author-instructions/jcc [Accessed 13 February 2020]):

Manuscript Submission Guidelines:

Journal of Cross-Cultural Psychology (*JCCP*) publishes material in three categories: (1) regular, unsolicited manuscripts, (2) brief reports, and (3) special issues. Summary details of each category are as follows:

1.Regular, Unsolicited Manuscripts. This is *JCCP*'s main emphasis. See Aims and Scope for a detailed description of appropriate manuscripts.

Manuscripts should be submitted electronically to http://mc.manuscriptcentral.com/jccp. Authors will be required to set up an online account on the SageTrack system powered by ScholarOne. Manuscripts will be sent out anonymously for editorial evaluation. Obtaining permission for any quoted or reprinted material that requires permission is the responsibility of the author. Submission of a manuscript implies commitment to publish in the journal. Authors submitting manuscripts to the journal should not simultaneously submit them to another journal, nor should manuscripts have been published elsewhere in substantially similar form or with substantially similar content. Authors in doubt about what constitutes prior publication should consult the Editor.

Manuscript length should normally be 15 to 35 double-spaced, typewritten pages. Longer papers will be considered and published if they meet the above criteria. Manuscripts should be prepared according to the most recent edition of the American Psychological Association Publication Manual. Manuscripts are reviewed by the Editorial Advisory Board. Allow up to 3 months for a publication decision and up to 1 year for publication.

2. Brief Reports. Accepted Brief Reports should be no more than 10 double-spaced manuscript pages long, including title page, references and any tables.

3. Special Issues. An important part of *JCCP*'s publication policy is the periodic publication of special issues or special sections of regular issues. Current needs, emerging trends, and readership interest guide the publication of material in this category. Ideas or suggestions for special issues or special sections should be discussed with Walter J. Lonner (Walter.Lonner@wwu.edu), Founding and Special Issues Editor, or other members of the Editorial Advisory Board, especially current Editor, Deborah L. Best (best@wfu.edu).

Orcid

As part of our commitment to ensuring an ethical, transparent and fair peer review process SAGE is a supporting member of ORCID, the Open Researcher and Contributor ID. ORCID provides a unique and persistent digital identifier that distinguishes researchers from every other researcher, even those who share the same name, and, through integration in key research

workflows such as manuscript and grant submission, supports automated linkages between researchers and their professional activities, ensuring that their work is recognized.

The collection of ORCID iDs from corresponding authors is now part of the submission process of this journal. If you already have an ORCID iD you will be asked to associate that to your submission during the online submission process. We also strongly encourage all co-authors to link their ORCID ID to their accounts in our online peer review platforms. It takes seconds to do: click the link when prompted, sign into your ORCID account and our systems are automatically updated. Your ORCID iD will become part of your accepted publication's metadata, making your work attributable to you and only you. Your ORCID iD is published with your article so that fellow researchers reading your work can link to your ORCID profile and from there link to your other publications.

If you do not already have an ORCID iD please follow this link to create one or visit our ORCID homepage to learn more.

English language editing services

Authors seeking assistance with English language editing, translation, or figure and manuscript formatting to fit the journal's specifications should consider using the services offered by SAGE Language Services. Visit SAGE Language Services on our Journal Author Gateway for further information. Here is the link:

http://languageservices.sagepub.com/en/

If you or your funder wish your article to be freely available online to nonsubscribers immediately upon publication (gold open access), you can opt for it to be included in SAGE Choice, subject to the payment of a publication fee. The manuscript submission and peer review procedure is unchanged. On acceptance of your article, you will be asked to let SAGE know directly if you are choosing SAGE Choice. To check journal eligibility and the publication fee, please visit SAGE Choice. For more information on open access options and compliance at SAGE, including self/author archiving deposits (green open access) visit SAGE Publishing Policies on our Journal Author Gateway.

Appendix 2.2: Interview schedule

INTERVIEW SCHEDULE

Introduction

- Go through the Participant Information Sheet and check their understanding of the study
- Informed consent – Confidentiality and the limitations of it
  - Remind participants that they can take breaks, stop the interview and withdraw at any time
- If interpreters are used – inform participants what the interpreter's role is
- Collect demographic details:
  - Age
  - Ethnicity
  - Refugee or asylum seeker
  - What language they spoke (if not English)
  - How long they have been in the UK
  - What was the trauma experienced

Topic area

Experience of the group

- I was wondering if you could talk me through how you were referred to the group
  - *What led you to the group?*
  - *What was that like for you?*
  - *Where there any challenges or issues faced when attending the group? If so, what were they? If not, what did you think helped?*

Group

- What did you think of the group?
  - *What was helpful in the group?*
  - *What was unhelpful in the group?*
  - *What are your thoughts about the group being used for refugees and asylum seekers?*
    - *Did you benefit from the group?*
    - *What was it like being with other people in the group?*
  - *What impact did the group have on you?*
    - *What have you learned from being in the group?*
    - *Were there any changes in your symptoms?*
      - *If so, what were they? How did they change?*

After the group

- What are things like for you now after completing the group?
  - *Has your understanding of your difficulties changed since completing the group?*
    - *If so, how / if not, what do you think are the reasons for this?*
    - *How do you make sense of your difficulties now?*
    - *How do you cope with your difficulties now?*

- Can you tell me about any other challenges or issues you faced?
    - *Is there anything you would change about the group?*
        - *If so, what would that be?*

Ending

- Is there anything that you think is important which we haven't talked about?
- Do you have any questions that you would like to ask?

Prompts/ follow up questions:

- Can you tell me more about that?
- What did that mean for you?
- Could you give me an example?
- How did you feel about that?
- What did you think of that?
- What was that like?
- What did you do?

Appendix 2.3: Ethical approval

Research Ethics Committee approval

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

West of Scotland REC 5
West of Scotland Research Ethics Service
Ward 11, Dykebar Hospital
Grahamston Road
PAISLEY
PA2 7DE

Date 09 October 2019

Direct line 0141 314 0213
E-mail WoSREC5@ggc.scot.nhs.uk

Miss Nadia Hanif
NHS Highland, Drumossie Unit
New Craigs Hospital
6-16 Leachkin Road, Inverness
IV3 8NP

Dear Miss Hanif

Study title: **Exploring Refugees and Asylum Seekers experience of Group Work for Trauma - A Qualitative Study.**
REC reference: **19/WS/0141**
Protocol number: **N/A**
IRAS project ID: **261818**

Thank you for your email response of 4 October 2019. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 24 September 2019.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Participant consent form [Participant Consent Form]	2.0	03 October 2019
Participant information sheet (PIS) [Participant Information Sheet]	2.0	03 October 2019
Response to Additional Conditions Met		04 October 2019

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Interview schedules or topic guides for participants [Interview Schedule]	1.0	09 August 2019
IRAS Application Form [IRAS_Form_21082019]		21 August 2019
Letter from sponsor [Sponsor Letter - Page 1]	N/A	20 June 2019
Letters of invitation to participant [Information Leaflet for Participants]	1.0	09 August 2019
Participant consent form [Participant Consent Form]	2.0	03 October 2019

Participant information sheet (PIS) [Participant Information Sheet]	2.0	03 October 2019
Research protocol or project proposal [Research Protocol]	1.0	09 August 2019
Response to Additional Conditions Met		04 October 2019
Summary CV for Chief Investigator (CI) [CI CV - Nadia Hanif]	1.0	02 September 2019
Summary CV for supervisor (student research) [Research Supervisor's CV - Andrew Gumley]		

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

19/WS/0141 **Please quote this number on all correspondence**

Yours sincerely

Sharon Macgregor
REC Manager

Copy to: Dr Frances Hines, NHS Highlands

Lead Nation - Scotland: nhsg.NRSPCC@nhs.net

NHS Research & Development approval

Professor Angus Watson
Research & Development Director
NHS Highland Research & Development Office
Centre for Health Science
Old Perth Road
Inverness
IV2 3JH

Tel: 01463 255822
Fax: 01463 255838
E-mail: angus.watson@nhs.net

NHS Highland

05 November 2019

NHS Highland R&D ID: **HIGHLAND 1546**
NRSPCC ID: **NA**

Miss Nadia Hanif
NHS Highland,
Drumossie Unit
New Craigs Hospital
6-16 Leachkin Road
Inverness
IV3 8NP

Dear Miss Hanif,

Management Approval for Non-Commercial Research

I am pleased to tell you that you now have Management Approval for the research project entitled: **'Group Intervention for Complex Trauma in Refugees and Asylum Seekers' [Protocol V1 09/08/19].**

I acknowledge that:

- The project is sponsored by NHS Highland.
- The project has no external funding.
- Ethics approval for the project has been obtained from the West of Scotland Research Ethics Committee 5 (Reference Number: 19/WS/0141)
- The project has an Organisational Information Document signed 10/10/2019.

The following conditions apply:

- The responsibility for monitoring and auditing this project lies with NHS Highland.
- This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the UK Policy Framework for Health and Social Care Research (2018, V3.3 07/11/17, however prior written notice of audit will be given.

POSITIVE ABOUT DISABLED PEOPLE

Headquarters: Assynt House, Beechwood Park, INVERNESS IV2 3BW

Interim Chair: Professor Boyd Robertson
Chief Executive: Iain Stewart

- Any researchers coming into NHS Highland for the purposes of carrying out research with patients will require the submission of a Research Passport, Occupational Health approval and Letter of Access before starting the study at this site. Please contact a member of the RD&I Governance team at high-uhb.nhshighlandresearchpassports@nhs.net for further assistance, if this is required.
- The paperwork concerning all incidents, adverse events and serious adverse events, thought to be attributable to participant's involvement in this project should be notified to the NHS Highland R&D Governance team. Please email documents to RD&I Facilitator at High-UHB.RandD@nhs.net.
- You are reminded that all amendments (minor or substantial) to the protocol and associated study documents or to the REC application should be copied to the NHS Highland Research and Development Office to obtain a R&D amendment approval letter. Guidance can be found at https://www.nhsresearchscotland.org.uk/services/permissions-co-ordinating-centre/permissions
- If applicable, monthly recruitment rates should be notified to the NHS Highland Research and Development Office, detailing date of recruitment and the participant trial ID number. This should be done by e-mail on the first week of the following month, to Debbie McDonald, Data Manager (debbie.mcdonald@nhs.net). Please quote your RD&I Highland reference number (Highland 1546).
- Please report any other changes in resources used, or staff involved in the project, to the NHS Highland Research and Development Manager, Frances Hines (01463 255822, frances.hines@nhs.net).

Please quote your RD&I Highland reference number (Highland 1546) on all correspondence.

Yours sincerely,

Frances Hines
R&D Manager

cc n.hanif.1@research.gla.ac.uk

Appendix 2.4: Managerial approval

Letter of Access

Administrator: Mrs Elaine O'Neill
Telephone Number: 0141 314 4001
E-Mail: elaine.o'neill2@ggc.scot.
Website: www.nhsggc.org.uk/r&d

Research & Development
Ward 11 - Dykebar Hospital
Grahamston Road
Paisley PA2 7DE

Ms Nadia Hanif
The Anchor Centre
Festival Business Centre
150 Brand Street
Glasgow G51 1DH

Dear Ms N Hanif,

NHS to NHS - Letter of Access for Research

As an existing **NHS employee** you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through **NHS Greater Glasgow and Clyde** for the purpose and on the terms and conditions set out below. This right of access commences on **10/10/2019** and ends on **30/04/2020** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to **NHS Greater Glasgow and Clyde** premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through **NHS Greater Glasgow and Clyde** you will remain accountable to your employer **NHS Highland** but you are required to follow the reasonable instructions of your nominated manager **Dr Lisa Reynolds** in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with **NHS Greater Glasgow and Clyde** policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with **NHS Greater Glasgow and Clyde** in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on **NHS Greater Glasgow and Clyde** premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the Board via the **HR Departme**nt prior to commencing your research role at the Board.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

NHS Greater Glasgow and Clyde will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Mrs Elaine O'Neill
Senior Research Administrator

cc: **Shani Sellar (NHS Highland)**

NHS Greater Glasgow & Clyde Approval

Administrator: Mrs Elaine O'Neill
Telephone Number: 0141 314 4001
E-Mail: elaine.o'neill2@ggc.scot.nhs.uk
Website: https://www.nhsggc.org.uk/about-us/professional-support-sites/research-development/

Clinical Research & Development
Dykebar Hospital, Ward 11
Grahamston Road
Paisley, PA2 7DE
Scotland, UK

09 September 2019

Ms Nadia Hanif
The Anchor Centre
Festival Business Centre
150 Brand Street
Glasgow G51 1DH

NHS GG&C Board Approval

Dear Ms N Hanif,

Study Title:	Group Intervention for Complex Trauma in Refugees and Asylum Seekers
Principal Investigator:	Ms Nadia Hanif
GG&C HB site	NHS GG&C Specialist Trauma Service/The Anchor Centre
Sponsor	NHS Highland
R&D reference:	GN19MH405
REC reference:	19/WS/0141
Protocol no: (including version and date)	V1.0; 09/08/2019

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004

    a. During the life span of the study GGHB requires the following information relating to this site
        i. Notification of any potential serious breaches.
        ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
    a. First study participant should be recruited within 30 days of approval date.
    b. Recruitment Numbers on a monthly basis

NHS
Greater Glasgow and Clyde

c. Any change to local research team staff should be notified to R&D team
d. Any amendments – Substantial or Non Substantial
e. Notification of Trial/study end including final recruitment figures
f. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,

Mrs Elaine O'Neill
Senior Research Administrator

Cc: Frances Hines (NHS Highland)

Appendix 2.5: Information leaflet for participants

INFORMATION LEAFLET FOR PARTICIPANTS

Study title: Group Work for Trauma in Refugees and Asylum Seekers

You are invited to take part in a study that is taking place at NHS Greater Glasgow and Clyde Specialist Trauma Service, also known as The Anchor Centre.

We are interested in finding out more as to how the group has been for you and whether or not you have found it helpful or unhelpful in recovering from your trauma. We would therefore like to explore your experience of The Anchor Centre's group for trauma. This will help us to see how the intervention is working for you and if it meets the needs for asylum seekers and refugees.

The study will involve meeting with the researcher and the researcher asking questions about the intervention used in the group. An interpreter can be arranged for you if you require this. The interview will take place at The Anchor Centre and could take up to 60 – 90 minutes.

In terms of what will happen in the study, the clinicians at The Anchor Centre will let me know who would be interested in taking part in the study and a meeting will be arranged for the interview. All of the information collected in the study will be confidential. The interviews will be audio recorded. This is so that the researcher can use the information to analyse the data collected. You will be given a code number so that you cannot be identified. We may use quotations from your interview in the write up of the research project, but this will only be done with your consent. If you would like, we can send you a summary of the results of the study.

Taking part in the study will not cost participants anything. Participants will be reimbursed £5 to compensate for their time in taking part in the study.

If you have any questions, please contact Nadia Hanif, Trainee Clinical Psychologist, either by telephone on 01463 253697 or by email on n.hanif.1@research.gla.ac.uk.

Thank you for taking the time to read this.

Appendix 2.6: Participant information sheet

University of Glasgow
Institute of Health & Wellbeing

NHS Highland
NHS Greater Glasgow and Clyde

Group Work for Trauma in Refugees and Asylum Seekers

Main Researcher:
Nadia Hanif
Trainee Clinical Psychologist
n.hanif.1@research.gla.ac.uk

Address:
Institute of Health and Wellbeing
University of Glasgow
Administration Building, 1st floor
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH
Tel: 0141 211 0690/3927

This information sheet is designed to give information about this research study. It is important that anyone who might wish to take part is completely aware of what the study is about, what it involves, and the potential benefits and risks of taking part. This Information Sheet is yours to keep and you can show it to other people and talk about it with them if you wish. You can then decide if you would like to take part and if you do, you will be asked to sign a consent form.

This sheet goes into detail about all aspects of the study. *Please feel free to take breaks as needed and ask us if you have any questions.*

1. What is the purpose of the project?

There is a lack of research which looks into the experience of group interventions for refugees and asylum seekers who have experienced complex trauma. It is important to understand your experiences as a means of understanding how groups may help or hinder recovery from complex trauma. We would therefore like to explore your experience of The Anchor Centre's group for complex trauma. This will help us to see how the intervention is working for you and how it might be meeting the needs of asylum seekers and refugees.

2. Why have I been asked to participate?

You have been asked to participate because you receive services from The Glasgow Psychological Trauma Service (the Anchor) within NHS Greater Glasgow and Clyde.

3. Do I have to take part?

No. It is up to you to decide if you want to take part or not. If you decide "yes" you want to take part, you will be given this information sheet to keep and be asked to sign a consent

form. If you decide you don't want to take part that is absolutely fine and you don't need to tell us why. Your decision about whether or not to participate will have **no effect** on the care you receive from the NHS.

4. What if I decide to withdraw from the study?

You can withdraw from the study at any time. You do not have to provide a reason and if you withdraw it will not affect the care you receive. If you do withdraw, any personally identifiable information about you (e.g. your name, date of birth) will be destroyed. However, anonymised data already collected will be retained to ensure that the results of the research project can be measured properly. You should be aware that data collected up to the time that you withdraw will form part of the research project results.

5. Am I eligible for the study?

To take part in this study, you must currently be a service user within the Anchor. You also must be over 16 years old.

If English is not your first language then we will need to ensure that we have access to an appropriate interpreter for you.

You must also have participated in at least 4 sessions of the group intervention.

6. What will happen if I am eligible?

If you decide to take part in the study, a meeting will be arranged to take place at The Anchor Centre with the researcher, Nadia Hanif. At the meeting, we will go through this Participant Information Sheet and you will have the opportunity to ask any questions. If you decide to participate in the study, you will then be asked to complete a consent form before starting the interview.

7. What does the study involve?

The study will involve asking you questions about your experience of the group. This will be carried out by Nadia Hanif (Trainee Clinical Psychologist) at The Anchor Centre in Glasgow. The interview could take up to 60-90 minutes. If you would like to take part in the study and require an interpreter, this can be arranged for you.

8. What are the benefits and harms of taking part?

Potential Benefits:
There will be no direct benefits to you for taking part in the study. However, this study will improve our understanding of the group intervention. It will be an opportunity for you to tell us how the group has been for you and how it has or hasn't met your needs. It will also help us to explore any adaptions that could be made to the group.

Potential Harms:
There is a possibility that you may feel distressed or upset during the interview. You are welcome to take a break or stop the interview all together. Support from a clinician at The Anchor Centre can be provided if need be.

9. How will my data be kept confidential?

If you choose to take part, relevant members of your care team e.g. your GP will be informed. This is to ensure you are supported if you have any difficulties during or after the study. Only if you disclose information that indicates that you or others are at risk of serious harm would relevant information about you be disclosed, and only to a relevant person.

As part of this study, Nadia Hanif will receive supervision to ensure that our research is of high quality. This means that there may be some discussions between Nadia Hanif with academic and clinical supervisors, which will be done in a confidential manner, and no personal data relating to participants will be disclosed. All supervisors are bound by confidentiality through the General Data Protection Regulations.

10. What will happen to my data?

Why we keep data*:* The University of Glasgow uses personally-identifiable information to conduct research to improve health, care and services. As a publicly-funded organisation, we have to ensure that it is in the public interest when we use personally-identifiable information from people who have agreed to take part in research. This research will not use any personally identifiable information in the analysis or for publication.

The purpose of data collection is purely for the purpose of this research project and not to inform any external agency about your actions or opinions.

When we keep data:
If you do not wish to take part in the study after meeting with Nadia Hanif or if you are found not to be eligible, then your data will be securely destroyed in line with University of Glasgow guidelines. If you are eligible and agree to take part in the study, we will use your data in the ways needed to support the analysis and obtain findings for the research study. When the study is complete, we will delete any personal data which identifies you, including audio recordings. All other data will be retained in an anonymised format.

Managing data: NHS Highland is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. NHS Highland will keep non-identifiable information about you for 10 years after the study has finished.

Your data rights*:* Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the non-personal information about you that we have already collected. If you were to lose the capacity to consent to the study while it is still going on, you will be withdrawn from the study but we will keep non-personal

information about you collected before that point. To safeguard your rights, we will use no personally-identifiable information.

How we store the data: All information collected for the purposes of the study will be stored in locked cabinets or on password-protected computers in rooms with restricted access within study settings in NHS Highland and the University of Glasgow. This information, including any information stored on university computers, will be anonymized – which means no one would be able to tell the information came from you. The code which links you to the information will be held separately. All anonymised study data will be held in accordance with The General Data Protection Regulation (2018). The anonymised data will be stored in archiving facilities for 10 years as per University of Glasgow recommendations. After this period, further retention may be agreed or your data will be securely destroyed in accordance with the relevant standard procedures.

Data sharing: Your information might be shared with the study sponsor, NHS Highland, who monitor that the study is done properly and to carry out research supervision. Individuals from NHS Highland and regulatory organisations may look at the research records to check the accuracy of the research study.

The Anchor will use your name, CHI number and contact details to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. The Anchor will pass these details to NHS Highland along with the information collected from you. The only people who will have access to information that identifies you will be people who need to contact you to follow-up about the study or to audit the data collection process. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

11. Who has reviewed the study?

The study has been reviewed by NHS West of Scotland Research Ethics Committee, the University of Glasgow, and NHS Greater Glasgow and Clyde and NHS Highland Research and Development Departments.

12. What will happen if there is a problem or if I want to make a complaint?

If you have any concerns about the study, please contact the researcher in the first instance. If you wish to make a complaint, please contact Professor Andrew Gumley, Mental Health and Wellbeing, Gartnavel Royal Hospital, 1st Floor, Admin Building, University of Glasgow, Glasgow, G12 0HX or the Research and Development Department, NHS Greater Glasgow and Clyde on 0141 314 4001.

13. What will happen to the results of the research project?

The results of this project will form the basis of the thesis (a large scientific report) that Nadia Hanif will write as part of the Doctorate in Clinical Psychology at the University of Glasgow. This work will be published in an academic journal, presented at conferences, and other clinical forums. Any personally identifiable information that you provide will not be included

in any reports arising from this study (e.g. places, names). When the project is completed you will be provided with a summary of the results.

14. Will taking part in the study cost me anything?

No. You will be reimbursed £5 to compensate for the time you have given to take part in the study.

15. Who is organising and funding the study?

This study is part of a Doctorate in Clinical Psychology training and is not externally funded.

16. How to contact us

If you require any further information about the study please contact us.

Chief Investigator:
Nadia Hanif
Trainee Clinical Psychologist
n.hanif.1.@research.gla.ac.uk
Tel: 01463 253697

Academic Supervisor:
Professor Andrew Gumley
Professor of Psychological Therapy
andrew.gumley@glasgow.ac.uk
Tel: 0141 211 3939

Field Supervisor:
Dr Andy Siddaway
Clinical Psychologist
The Anchor Centre
andy.siddaway@ggc.scot.nhs.uk
Tel: 0141 303 8968

External contact option:
Professor Hamish McLeod
Professor of Clinical Psychology
Hamish.mcleod@glasgow.ac.uk
Tel: 0141 211 3922

Thank you for reading this information sheet

Appendix 2.7: Consent form

University of Glasgow
Institute of Health & Wellbeing

NHS Highland

NHS Greater Glasgow and Clyde

Group Work for Trauma in Refugees and Asylum Seekers

Name of Researcher(s): Nadia Hanif
Professor Andrew Gumley
Dr Andy Siddaway

CONSENT FORM

Please initial box

1. I confirm that I have read and understand the Participant Information Sheet Version 2.0 dated 03.10.19. ☐
2. I have had the opportunity to consider the information sheet, ask questions, and understand the answers that I have been given. ☐
3. I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights or services I receive being affected. ☐
4. I confirm that I allow members of my clinical team, including my GP, to be informed that I am taking part in this study. ☐
5. I agree that my name, contact details and data described in the information sheet will be kept for the purposes of this research study. ☐
6. I confirm that I agree to the way my data will be collected and processed and that data will be stored for up to 10 years in University archiving facilities in accordance with relevant Data Protection policies and regulations. ☐
7. I understand that all data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers. ☐

8. I understand that if I share information that causes concern for my safety or the safety of others, that the research team have a duty of care to tell other people involved in my care. ☐

9. I agree to the use of audio-recordings as described in the Participant Information Sheet and I understand that I can withdraw my consent for this data to be recorded at any time during the study. ☐

10. I understand that if I am not eligible to participate, withdraw from the study, or lose capacity to participate during the research, that my data collected up to that point will be retained and used for the remainder of the study. ☐

11. I agree that quotations from the interview, which will be anonymised, maybe used in the final report for the research. ☐

12. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	*Date*	*Signature*
_____	_____	_____
Name of Person Taking Consent	*Date*	*Signature*

Appendix 2.8: Recruitment procedure

The clinicians who facilitated the safety and stabilisation group screened potential participants. The group sessions ran once a week for a period of eight weeks.

Participants were included in the study if they had participated in at least four sessions of the safety and stabilisation group. This was so that they were able to talk about their experience of the group.

The researcher contacted the clinicians before the groups ended to check what languages were required for document translation purposes. The languages that were used included: English, Albanian, Arabic, Farsi, Kurdish Sorani, Swahili, Vietnamese and Kinyarwanda.

The researcher gave the clinicians a list of dates and times when they would be available to carry out the interviews. The participants had the PIS for at least 24 hours before a meeting was arranged.

Appendix 2.9: Example of transcript and initial coding

Themes	Transcript	Coding
Acceptance	**Were there any challenges or issues you faced when attending the group?** No, it was only the qualities, because we could learn a lot like accepting what happened to us	Accepting what happened
Self-talk	**What did you think of the group?** The group helped me accept what happened and they also made me realise that whatever I am thinking in the moment is just the past and that it helps me control myself. I'm able to talk to myself that whatever happened to me was in the past and that this is the present	Talk to self that what happened was in the past and this is the present
Self-love Lives are valued	**So how did it help you to control yourself?** They taught us self-love and that our lives are valued and they also taught us that what happened to us, even if there is something that makes you fear eh the moment that you're in, they gave us a scent and to help us to recall that this is the present that we are in, even if we are thinking about the past but we could recall that this is the scent and because of the scent it brings us in the present moment and we forget that the problems are in the past and they also taught us to breath and relax the muscle for us to feel good internally	Was taught self-love and their lives were valued
Techniques taught – scent		Use scent to help recall that this is the present
Techniques taught – breathing		Taught to breathe and relax the muscle in order to feel good internally
Techniques used to help with sleep	**It sounds like that was really helpful for you** It helped me a lot, and they taught us to also to meditate before sleeping and to relax the muscle, it will help us to sleep good. And they gave us these scent that we must put near the nostril. When we put it on the nostril, it helps you put your thoughts there and afterwards you find yourself sleepy. And also we discussed about it in the group and I found that we share the same experience about it	Meditate before sleeping and to relax the muscle Scent helps you to feel sleep
Sharing experiences in the group		Shared the same experience with others when discussing it in the group (meditate, scent for sleep)
Normalisation Qualities of the group facilitators Having a male facilitator was helpful	**What was it like being in the group with other people?** It helps a lot because we share our (thoughts and feelings) and you feel that you're relieved. We had two people that were supervising the group, two ladies that were listening a lot and they helped us tell what we had to tell. There were also a man that was there, who also was appointed at the group and it helped a lot	Share thoughts in the group Feel relieved Two ladies were listening a lot and helped say what we had to tell

Appendix 2.10:

Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist (Tong, Sainsbury & Craig, 2007)

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Interviewer/facilitator	Which author/s conducted the interview or focus group?	P58
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	P126-130 – Appendix 2.6 – student at the University of Glasgow
3. Occupation	What was their occupation at the time of the study?	P61– Trainee Clinical Psychologist
4. Gender	Was the researcher male or female?	P61
5. Experience and training	What experience or training did the researcher have?	P61– Training to be a Clinical Psychologist and has had experience working in Adult Mental Health Services
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	P61 - No
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	P126 - 130 – Appendix 2.6
8. Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	P61 – Research Reflexivity
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography,	P57 – Hermeneutic approach

	phenomenology, content analysis	
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	P58 – Research procedure
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	P58 & P133
12. Sample size	How many participants were in the study?	P59 – 7 participants
13. Non-participation	How many people refused to participate or dropped out? Reasons?	P59 – 4 participants did not attend the interview
Setting		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	P58 – The Anchor Centre
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	P58 – P59 - interpreters
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	P59- P60
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	P57 & P115 - 116 (Interview Schedule)
18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	P59
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	P60
20. Field notes	Were field notes made during and/or after the interview or focus group?	P58
21. Duration	What was the duration of the interviews or focus group?	P57
22. Data saturation	Was data saturation discussed?	P60 – P61 – Data analysis

23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	P61
Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	P61 – Researcher. Their supervisor crossed checked the data
25. Description of the coding tree	Did authors provide a description of the coding tree?	P60-61 and P134 (Appendix 2.9)
26. Derivation of themes	Were themes identified in advance or derived from the data?	P60-61
27. Software	What software, if applicable, was used to manage the data?	Not reported
28. Participant checking	Did participants provide feedback on the findings?	P61
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	P63 – P71(Results)
30. Data and findings consistent	Was there consistency between the data presented and the findings?	P63 – 71 (Results) P72 – 77 (Discussion)
31. Clarity of major themes	Were major themes clearly presented in the findings?	P62 - 71 (Results)
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	P62 – 71 (Results)

Appendix 2.11: Major research project proposal

Abstract

Background: Refugees and asylum seekers may experience complex post-traumatic stress disorder as a result of war, violence, torture and abuse. Treatment for this includes developing skills in regulating emotions, anxiety management and psycho-education, which can be carried out in a group setting. Group treatment can be effective however in refugees and asylum seekers there could be issues, such as, language barriers and cultural differences which could make their experience different from those in for example western cultures. More research is required looking in depth about the intervention being applied to refugees and asylum seekers.

Aims: To explore the experiences of refugees and asylum seekers interaction with a group intervention and what their experience of group intervention can reveal about the intervention being used.

Methods: Participants will be male refugees and asylum seekers service users from The Anchor Centre and who have participated in the psychoeducation group intervention. Semi-structured interviews will be carried out individually with the participants.

Applications: This study will give a voice to refugees and asylum seekers and will provide an exploration of how the intervention works for them and whether the intervention meets their needs.

Word Count: 189 words

Introduction

Refugees and asylum seekers may experience a number of traumatic events. Some of these events may include torture, violence, war, sexual, emotional and physical abuse (Lindert et al., 2016). These events can lead to complex post-traumatic stress disorder (cPTSD) which may require treatment (Robertson et al., 2013).

Treatment for cPTSD involves using a phased-based intervention approach (Cloitre et al., 2012). This involves three different phases (Herman, 1992). Phase 1 focuses on safety and stabilisation which looks at therapeutic relationships and developing skills in emotion regulation and psycho-education, phase 2 involves interventions to facilitate processing of traumatic memories and the final phase involves individuals reintegrating with others in their life (Cloitre et al., 2012).

There has been some recent research which has looked into psychological interventions in refugees and asylum seekers. These studies suggested that psychological interventions can be effective for the treatment of post-traumatic stress disorder (Thompson, Vidgen & Roberts, 2018; Crumlish & O'Rourke, 2010). However, the majority of these studies have focused predominantly on individual interventions rather than group interventions (Thompson, Vidgen & Roberts, 2018). A systematic review from Mahoney, Karatzias and Hutton (2019) showed that group treatment for cPTSD can be effective in treating symptoms of post-traumatic stress disorder. Group treatment may help individuals to feel less alone and may also offer peer support. Individuals could share ideas and help build up relationship and social skills. Further research is required looking into how group treatments work for individuals.

Research which has looked into individuals' experiences of group work has helped to give some understanding of what it is that makes group treatment effective, the factors associated with this and the change processes involved in group treatment. Some studies have shown that meeting and sharing with others who had similar experiences can be helpful as this reduces isolation (Stige, Rosenvinge & Tareen, 2013) and normalises their experiences (Robertson et al., 2013). Other studies have found that the therapeutic relationship can have an impact in how individuals engaged in treatment (Chouliara et al., 2017; Vincent et al., 2013). However more research is needed within this area especially in the context of cPTSD with refugees and asylum seekers. Refugees and asylum seekers are a heterogenous group who may have suffered from different types of trauma. There could be cultural differences in how trauma is viewed and shared as well as language differences. Interpreters may be used in treatment which could have an impact on their experiences. These factors need to be explored further.

Overall, there is limited research which looks into how interventions work for refugees and asylum seekers. Therefore, the aim of this study is to explore the experiences of refugees and asylum seekers interaction with a phase 1 group intervention. Exploring what the intervention does allows a deeper understanding of the complexity of the intervention and also the nature and the underlying mechanism of the intervention (Thirsk & Clark, 2017). Exploring this will allow a better understanding of not only the intervention itself but whether the intervention meets the needs of refugees and asylum seekers.

Research Questions

What can refugees and asylum seekers' experiences of and interactions with the psychoeducation group inform us about the intervention and its implementation?

Plan of Investigation

Participants:

The clinicians within NHS Greater Glasgow and Clyde Specialist Trauma Service, also known as The Anchor Centre, will screen their clients for possible participation in the research project from the phase-one psycho-educational group. The intervention looks at developing emotional regulation skills, anxiety management as well as social and relationships skills. It also provides psychoeducation in trauma. The intervention is intended to help individuals develop a better understanding of their difficulties in relation to trauma and to develop helpful coping strategies.

The group starts with around 15 members however it is anticipated that each group will have between 7 and 10 members who will complete the programme. The group will run once a week over a period of 9 weeks. Data will be collected once the group programme has been completed. Participants will be offered an honorarium of £5 for participating in the study.

Inclusion Criteria

Participants will be male refugees and asylum seekers who are service users at The Anchor Centre and have participated in at least 4 sessions of the phase one psycho-educational group. This is to ensure that they have had some experience of the group to be able to talk about it.

Recruitment Procedures

Clinicians will invite participants to the project by giving them a Participant Information Sheet at the group. This will be translated in their preferred language. At the review appointment, if potential participants express an interest in the project, a meeting will be arranged by the clinician for the interview with the researcher. The participants will have the Participant Information Sheet for more than 24 hours. When they meet with the researcher, they will go through the Participant Information Sheet and have the opportunity

to ask any questions. Once it is satisfied that the participants understood the study, informed consent will then be taken.

The researcher will check with the field supervisor as to what languages will need to be translated prior to the last group session to ensure that translation is completed in time for the interviews. The researcher will contact the Interpreting Service at NHS Greater Glasgow and Clyde where translations will be provided from them, which can take about 2-3 working days. The aim would be to recruit from two groups.

Design

A qualitative research design will be used where semi-structured interviews will be carried out by the researcher to gain detailed information about the intervention in relation to participants' experience of the group.

A hermeneutic approach will be used in the study. This approach will focus on how the intervention has helped refugees and asylum seekers by exploring the underlying mechanisms in the intervention and how change may have occurred in relation to the different components that may have been used in the intervention. It doesn't look into confirming what is already known about the intervention but what new knowledge or understanding of the intervention through the experience of refugees and asylum seekers can be learned about the intervention.

An interpreter may be used in the interviews. Some of the benefits of using an interpreter include interpreters helping to find culturally appropriate ways of asking questions but also being able to communicate the meaning of what was said (Bramberg & Dahlberg, 2013). There are various factors which need to be considered when involving interpreters. This includes interpreters' competence (Squires, 2008). Interpreters need to be able to work with both the participant and researcher and also be able to inform the

researcher the participants responses according to their understanding of the questions asked. This may add another layer of interpretation as the researcher may receive the interpreter's perception of what has been said (Temple, 2002). The researcher could therefore be distancing themselves away from what was originally said from the participant, which can affect the quality of the data collected. Moreover, it may be more difficult to ask probing questions when using interpreters (Bramberg & Dahlberg, 2013).

There were some thoughts about having the interpreters interview the participants however it was felt that this may not be feasible. This would need to involve training up interpreters about how to conduct research interviews. As well as this, using different interviewers could create more difficulties as each interviewer may have their own ways of communicating or interpreting the questions or the responses received from the participants. They may also vary in their understanding of the topic being explored. Therefore, it was felt that it would be best if the researcher carried out the interviews as they will have more control of the data collected and a professional interpreter who is employed by NHS interpreting service is used.

Research Procedures

Participants who meet the inclusion criteria and consented to take part in the study will be interviewed at The Anchor Centre. Prior to participation in the study, participants will be provided written informed consent. The interpreters will also complete a confidentiality form before commencing the interview.

The interview schedule will be developed using an inverted pyramid approach where questions will be broad to specific. Input by an expert from experience will be considered. The questions will be checked with the researcher's supervisors and with interpreters who will be interpreting for the participants. This is to ensure that the questions asked are appropriate and can be translated to give the same meaning as to what is being asked. It is not feasible to carry out a pilot study for the interview schedule as there is the potential for different languages being used for the interviews.

There could be risks that interpreters could take over the interview and affect the responses given by the participants. To ensure that this doesn't happen, it is important to be clear as to what the interpreter's role is and what is expected from them in the study. This can be done by meeting with the interpreter before the interview takes place and discuss with them their role, what the study is about and the interview schedule (Plumridge et al., 2012). As well as this, participants will need to be explained as to what the role of the interpreter is in the interview. This will be explained at the start of the interview. The interpreter will also be debriefed after the interview where reflections about the communication between the interpreter and the participant as well as with the researcher in the interview will occur.

Data Analysis:

The interviews will be audio recorded and will then be transcribed and anonymised by the researcher in English. A code will be given for each interview. English language will be used to analyse the data as this is the researcher's preferred language. It is recognised that this may add another layer of what was interpreted. However, if interpreters were asked to transcribe the interviews, there could be differences in how each interpreter does this as there could be potentially more than one language used in the study. Moreover, not all interpreters will be available for both interviewing and transcribing the data, which could mean that if different interpreters were used to transcribe the data, there could be another interpretation added and there could also be possibilities that the interpreter may not agree with what had been said or translated in the interview which would then add another layer of complexity. Moreover, interpreters may not have the skills to transcribe the data. Therefore, the researcher will transcribe all of the interviews so that there is consistency in the way that it has been transcribed.

Thematic analysis will be used to analyse the data. This was deemed a more appropriate analysis if interpreters are used, as themes and patterns of data are explored rather than, for example, Interpretative Phenomenological analysis which uses exact language to describe experiences. An inductive approach will

be used. The steps used by Braun and Clarke (2006) will be applied for the data analysis. Sections of the transcripts and the development of codes and themes will be cross checked with the research supervisor. A hermeneutic approach by Thirsk and Clark (2017) will be used in the analysis. This approach focuses on what can be learned about the intervention through refugees and asylum seekers experiences rather than how refugees and asylum seekers experienced the group intervention.

It would have been ideal to translate the Participant Information Sheet back to English to ensure accuracy of the translation however this would make the study financially infeasible.

The researcher will keep a reflective journal throughout the research process. This will help to manage and explore the researcher's experience of the research process as well as their views, what they have learnt and reflections on what the communication was like with participants and interpreters in the interviews. The researcher will also have reflective meetings with their supervisor.

Justification of sample size:

According to Braun and Clarke (2013), around 6-10 interviews will be required for thematic analysis to be used in a report which is around 10,000 words. It is important to be mindful that there could be some difficulties in terms of setting a fixed number of participants to be recruited as participants may have different views and there could be different themes with each interview.

Settings and Equipment

The research will take place at The Anchor Centre in Glasgow. The interviews will be recorded using a digital voice recorder and transcribed and stored on an encrypted laptop.

Health and Safety Issues

Researcher Safety Issues

Participants will be screened by a clinician from The Anchor Centre prior to taking part in the research. If a participant is deemed to be too vulnerable they will not be invited to take part in the research. This will be based on the clinician's clinical judgement at The Anchor Centre.

The researcher can seek support from both the academic and field supervisors as well as the university advisor if they experience any distress in the study.

Participant Safety Issues

There will be a named clinician available at all times whilst the interviews are taking place at The Anchor Centre. If participants experience any distress, they will be asked if they would like to take a break and/ or wish to stop the interview. If necessary, the researcher can seek assistance or support from the named clinician at The Anchor Centre when the interviews are being carried out. The interview will be stopped if there are any concerns about the participants health or well-being.

Interpreters will all be debriefed after each interview, where support can be put in place for them if necessary.

Please see Appendix 1 for the Health and Safety form.

Ethical Issues

Before carrying out the study, a 'NHS to NHS profoma' will be required to obtain a 'Letter of Access' as the researcher will require having NHS access out with their employing health board. Ethical approval will be obtained from NHS Research Ethics Committee as well as managerial approval from NHS Research and Development office.

Information about the study will be provided in a Participant Information Sheet. Participants will be given time to think about the research study. If they choose to participate in the study, they will be asked on the consent form if they have read and understood the Participant Information Sheet. Participants will be consenting to be interviewed for the study which will be recorded, to confidentiality and anonymity and having the right to withdraw. The consent form will also include details about the process in making complaint, the likelihood of distress and consent use of quotations, which will be anonymised. Participants will be given the opportunity to ask questions at any point in the interview and will be informed that participating in the research will be on a voluntarily basis. They will be informed that they can withdraw at any time without giving any reasons and that their health care at The Anchor Centre will not be affected by this. The findings will also be completely anonymous in the context of the study so that the participants identities are not disclosed. The researcher will also adhere to the BPS Code of Human Research Ethics (2014).

The information and the data collected from the study will be treated confidentially. The only form that will contain person identifiable information will be the participant's consent form as the participant's name and signature is required. These forms will be kept in a locked and secure location on NHS premises. All

electronic data will be password protected. The data will only be available to the researcher and the supervisors for this study.

Financial Issues

There will be costs involved in using the interpreter and in translating the Participant Information Sheet to the participants' preferred language. Please see Appendix 2 for further details.

Equipment and Stationary Costs

An encrypted laptop and a digital voice recorder will be borrowed from The University of Glasgow.

Timetable

Date	**Task**
February – April 2019	Ethics procedure
May 2019 – October 2019	Recruitment and data collection
October 2019 -December 2019	Data analysis and write up for the MRP
February 2020	Portfolio submitted
April 2020	Viva

Practical Applications

The study will give a voice to those who participated in the group and will allow an exploration of the intervention used for this client group.

References

Bramberg, E.B. & Dahlberg, K. (2013) Interpreters in cross-cultural interviews: A three-way coconstruction of data. *Qualitative Health Research*. 23 (2), 241-247. DOI: 10.1177/1049732312467705.

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*. 3 (2), 77-101. DOI: 10.1191/1478088706qp063oa.

Braun, V. & Clarke, V. (2013) *Successful qualitative research: A practical guide for beginners*. London: Sage.

British Psychological Society. (2014) *The Code of Human Research Ethics*. Available from https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014 [Accessed 9 January 2019].

Chouliara, Z., Karatzias, T., Gullone, A., Ferguson, S., Cosgrove, K. & Burke, C.D. (2017) Therapeutic change in group therapy for interpersonal trauma: A relational framework for research and clinical practice. *Journal of Interpersonal Violence*. 1-20. DOI: 10.1177/0886260517696860.

Cloitre, M., Courtois, C.A., Ford, J.D., Green, B.L., Alexander, P., Briere, J., Herman, J.L., Lanius, R., Stolbach, B.C., Spinazzola, J., Van der Kolk, B.A. & Van der Hart, O. (2012) *The ISTSS expert consensus*

treatment guidelines for complex PTSD in adults. Available from https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf [Accessed 6 August 2018].

Crumlish, N. & O'Rourke, K. (2010) A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. *The Journal of Nervous and Mental Disease*. 198 (4), 237–251. DOI: 10.1097/NMD.0b013e3181d61258.

Herman, J. L. (1992) *Trauma and recovery.* New York: Basic Books.

Lindert, J., Carta, M.G., Schafer, I. & Mollica, R.F. (2016) Refugees mental health – A public mental health challenge. *European Journal of Public Health*. 26 (3), 374-375. DOI: 10.1093/eurpub/ckw010.

Mahoney, A., Karatzias, T. & Hutton, P. (2019) A systematic review and meta-analysis of group treatments for adults with symptoms associated with complex post-traumatic stress disorder. *Journal of Affective Disorders*. 243, 305-321. DOI: 10.1016/j.jad.2018.09.059.

Plumridge, G., Redwood, S., Greenfield, S., Akhter, N., Chowdhury, R., Khalade, A. & Gill, P. (2012) Involving interpreters in research studies. *Journal of Health Services Research & Policy*. 17 (3), 190-192. DOI: 10.1258/jhsrp.2012.012003.

Robertson, M.E., Blumberg, J.M., Gratton, J.L., Walsh, E.G. & Kayal, H. (2013) A group-based approach to stabilisation and symptom management in a phased treatment model for refugees and asylum seekers. *European Journal of Psychotraumatology*. 4, 1- 8. DOI: 10.3402/ejpt.v4i0.21407.

Squires, A. (2008) Language barriers and qualitative nursing research: Methodological considerations. *International Nursing Review*. 55 (3), 265-273. DOI: 10.1111/j.1466-7657.2008.00652.x.

Stige, S.H., Rosenvinge, J.H. & Traeen, B. (2013) A meaningful struggle: Trauma clients' experiences with an inclusive stabilization group approach. *Psychotherapy Research*. 23 (4), 419-429. DOI: 10.1080/10503307.2013.778437.

Temple. B. (2002) Crossed wires: Interpreters, translators, and bilingual workers in cross-language research. *Qualitative Health Research.* 12 (6), 844-854. DOI: 10.1177/104973230201200610.

Thirsk, L. M. & Clark, A. M. (2017) Using qualitative research for complex interventions: The contributions of hermeneutics. *International Journal of Qualitative Methods*. 16, 1-10. DOI: 10.1177/1609406917721068.

Thompson, C.T., Vidgen, A. & Roberts, N.P. (2018) Psychological interventions for post-traumatic stress disorder in refugees and asylum seekers: A systematic review and meta-analysis. *Clinical Psychology Review.* 63, 66-79. DOI: 10.1016/j.cpr.2018.06.006.

Vincent, F., Jenkins, H., Larkin, M. & Clohessy, S. (2013) Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: A qualitative study. *Behavioural and Cognitive Psychotherapy*. 41 (5), 579-593. DOI: 10.1017/S1352465812000550.