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Charura, Divine (2024) Therapists' experience of working with refugees and asylum seekers who have been tortured: An interpretative phenomenological analysis. Psychological trauma : theory, research, practice and policy, 16 (Suppl3). S521-S531.

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Citation

Charura, D. (2024). Therapists' experience of working with refugees and asylum seekers who have been tortured: An interpretative phenomenological analysis. *Psychological Trauma: Theory, Research, Practice, and Policy.* Advance online publication. https://doi.org/10.1037/tra0001709

Therapists' experiences of working with refugees and asylum seekers who have been tortured: an interpretative phenomenological analysis

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Abstract

OBJECTIVE: The novel concept of 'the trauma therapists' journey' during their work with formerly tortured refugees and asylum seekers is introduced, mapped and explicated for a convenience sample of 10 psychological therapists/practitioners who work in the United Kingdom.

METHOD: This study operationalised semi-structured interviews that were focused on therapists' experiences of providing trauma psychotherapy to sanctuary seekers who presented to a range of psychological therapy services. The methods of interpretative phenomenological analysis were deemed appropriate for use to explore their experiences, thoughts and feelings.

RESULTS: Four superordinate themes were conceptualised, namely: (i) questioning self-preparedness; (ii) the challenge of trauma wrapped in complexity; (iii) psychological flexibility that arises from the therapist's role and internal conflict; and

(iv) personal impact. The empirical findings suggest that therapists who work with sanctuary seekers who have been tortured encounter a complex range of experiences. These include frequently finding themselves engaged in activities that go beyond and are in conflict with their expectations of their professional role, and, in many cases, this engagement results in vicarious trauma and burnout.

CONCLUSIONS: All practitioners communicated in some detail how their work with sanctuary seekers, who had experienced torture and presented with trauma, affected them to varying degrees. The research has led to recommendations, which include the prioritisation of self-care, multicultural competencies, continual development, and ensuring the availability of appropriate professional supervision support as part of ethical trauma practice.

Keywords: Therapist/Psychologist experiences, refugees/asylum seekers and torture, trauma

CLINICAL IMPACT STATEMENT: The clinical significance of the study includes its provision of in-depth insight into the lived experiences, complexities, challenges, and impact of trauma work on psychological practitioners who work with refugees and asylum seekers who have been tortured. Furthermore, the findings from this study have implications for future trauma practice and research, as they confirm the importance of incorporating self-care and continual personal and professional development of multicultural competencies into the therapists' practice. They also highlight that appropriate professional supervision and support must be provided as part of ethical trauma practice when therapists work with displaced individuals who present with experiences of torture and trauma.

Introduction

Over the last decade, there have been increases in the numbers of asylum seekers and refugees who seek shelter in different international regions due to their forced displacement as a result of persecution, conflict, violence and human rights violations (O'Brien & Charura, 2022). For instance, in 2021, numerous harrowing images were shown on media platforms of Afghan men, women and children queuing for days at Kabul airport in a bid to leave Afghanistan. Some of the scenes included people who were so desperate to escape their country that they were clinging to the undercarriage and landing gear of a US military C-17 jet. Other pictures showed 823 Afghan citizens on board a Boeing C-17 Globemaster cargo plane. In another example, the United Nations High Commissioner for Refugees (UNHCR) estimates that over four million people may flee from the instability in Ukraine and seek protection and support across the region, given the recent conflict with Russia (UNHCR, 2022). With continued political instability in the world, the number of people seeking refuge in other countries will continue to rise. It is evident that the numbers of refugees and asylum seekers are increasing globally and therefore serious attention must be paid to humanitarian, psychological service provision, and effective policy formulation.

This paper examines the lived experiences of therapists (practitioner psychologists, psychotherapists and counsellors) who work with refugees and asylum seekers who have experienced torture. After the researcher conducted semi-structured interviews with therapists who work with such sanctuary seekers, the themes presented in this paper were conceptualised through the application of interpretative phenomenological analysis (IPA) processes. These were used to relay the experiences of these therapists and the effects on them of working with survivors of torture (refugees and asylum seekers). The paper starts with a brief description of torture, its prevalence, and its importance in psychotraumatology and therapeutic practice. Background literature is reviewed regarding the needs of sanctuary seekers and the challenges that they and the therapists who work with them face. The aims of and methodological approach to this research are highlighted. The analysis of the findings and presentation of the conceptualised themes are outlined. Then, in the discussion, the findings are reviewed in terms of the therapists' experiences and the journeys that they take as they work with sanctuary seekers. The discussion highlights the complex nature of this journey, the ethical challenges the therapists face, and the professional developments they achieve along the way. In conclusion, the importance of continual professional development and the implications for future trauma research are highlighted.

Prevalence of torture and the needs of and challenges faced by sanctuary seekers

In their 2022-2025 *Healing and Strategy* report, the International Rehabilitation Council for Torture Victims highlighted that there were at least 140 countries where torture and ill-treatment continued despite the United Nations Convention against Torture having come into effect 35 years previously (International Rehabilitation

Council for Torture Victims, (IRCT), 2022). Campbell (2007) argued that many psychologists and therapists were hesitant to study torture and its psychological impacts because of the depth of trauma and complexity that sanctuary seekers are often presented with. Pope (2016), however, raised the important point that one of the primary principles for those working with the public is to ensure that they are safeguarded and protected; therefore, anyone who abuses their professional power, or engages in abusive practices such as torture, must be held to account for that abuse of power (Pope, 2016). Both the American Psychological Association (APA) and the British Psychological Society (BPS) have guidelines that prohibit the participation of psychologists in national security interrogations (APA, 2009; BPS, 2005), and the BPS has issued a declaration that guides its members concerning torture and other cruel, inhuman, or degrading treatment or punishment (BPS, 2005).

Refugees and asylum seekers have a wide range of needs. The processes of torture, trauma, and exile that many experience inevitably impact on their lives and disempower them personally and politically (Kenny et al., 2022; Satinsky et al., 2019). Many sanctuary seekers in the USA and Europe have experienced or witnessed torture, war, sexual violence, stress, trauma, multiple complex losses, and dislocation from social networks or families (Burnett & Peel, 2001; Satinsky et al., 2019). In addition to this, they also experience post-traumatic stress, generalised anxiety, depression, wounds of torture, destitution, and a lack of advocacy and legal representation (Burnett & Peel, 2001; Jackson, 2015; O'Brien & Charura, 2022; Satinsky et al., 2019). In 2017, the *European Journal of Psychotraumatology* published a special issue that was focused on traumatised refugees. It identified their needs and challenges in relation to mental health care (Knaevelsrud et al., 2017).

Other studies have shown that poly-traumatisation in asylum seekers is associated with complex post-traumatic stress disorder (CPTSD). One study in 2021, which was conducted through a London-based trauma-specialist service for asylum seekers, noted that CPTSD was prevalent in 66.23% of the asylum-seeking population (Jowett et al., 2021). Another study reported that 74.6% of asylum seekers who were living in a humanitarian setting in Africa met the criteria for diagnosis of CPTSD compared with 19.8% for PTSD and that there was no difference in the rates among men compared with women (Barbieri et al., 2023). Furthermore, the findings from this study suggested that both pre-migration factors (i.e., the early age at which the first trauma occurred), as well as post-migration stressors (i.e., experiences in the host country), were important predictors of CPTSD symptoms (Barbieri et al., 2023).

Psychosomatic aspects of trauma, which relate to how emotions become stored in the body, are also prevalent in sanctuary seekers. Some studies have noted that examples of somatic symptoms in sanctuary seekers include gastrointestinal, pain, fatigue, cardiopulmonary factors (Schlechter et al., 2023) and other patterns of somatic distress such as pain in the arms, legs, back or joints (McGrath et al., 2020). Thus, embodied trauma may include psychosomatic symptoms and states of dissociation, numbing and relational disconnection (O'Brien & Charura, 2022). For many of these people, the combination of these health and trauma challenges limits daily functioning, reduces the quality of their lives and contributes to their critical need to access health and welfare resources (Boyles, 2015; Kenny et al., 2022).

Several studies have addressed the physical and psychological effects of torture such as long-lasting headaches, hearing impairments, gastrointestinal distress, and joint and chronic pain. Such studies have identified that some of the most common psychological disorders and notable problems that follow torture include

neurocognitive disorders, depression, anxiety, PTSD, substance misuse, and personality changes (Board et al., 2021; Freedom From Torture, 2022; Moreno et al., 2006; O'Brien & Charura, 2022; Punamäki et al., 2010; Womersley & Kloetzer, 2018)Other mental health challenges are common among those who have been tortured, such as memory and concentration difficulties, lack of energy, sexual dysfunction, emotional dysregulation, irritability, loss of trust, insomnia, flashbacks, nightmares, phobias, affective disorders such as depression and anxiety, and other conditions such as psychosis (Board et al., 2021; Moreno et al., 2006; Schippert et al., 2021). The most common somatic consequences of torture are neuropsychological pathologies, broken bones, joint and muscle pain, headaches, dizziness, burns and hearing loss (Board et al., 2021; Moreno et al., 2006; Womersley & Kloetzer, 2018). Other research has shown that survivors of torture face psychosocial challenges and a lack of cultural understanding among practitioners who support them (Punamäki et al., 2010). Campbell (2007) highlighted the complexity of psychological assessment of torture victims and found that many studies had focused only on PTSD as the disorder that resulted from torture (Campbell, 2007; UNHCR, 2021). Thus, it is argued that the assessment and treatment of torture victims cannot be focused only on PTSD, nor is it justified to transpose treatments for other disorders directly to survivors of torture who fit the diagnostic criteria for those disorders (Campbell, 2007; Hinton & Lewis-Fernández, 2011; McGregor et al., 2015). This review of the literature defines and clarifies some of the issues that relate to sanctuary seekers who have been tortured and the components of their presentation for psychological treatment.

Challenges faced by practitioners who work with sanctuary seekers

Working with refugees and asylum seekers has its challenges. Firstly, it has been noted that there are ethical difficulties involved in working or conducting research with

this population. For example, research on their mental health, self-harm, sexual orientation or experiences of sexual violence carries high risks of stigmatisation or ostracism if identifying information is disclosed, particularly if their participation in such research is misconstrued. Thus, in cases in which participants are asked to provide narratives of their lived experiences as sanctuary seekers, protocols must be followed to ensure that strict confidentiality is upheld (Deps et al., 2022). With regard to therapeutic work with refugee children and their families, basic ethical principles such as autonomy, non-maleficence, beneficence and justice should be taken into consideration at every stage of offering support. For example, non-maleficence can be ensured by the involvement of therapists who can attain multicultural competence because they know the differences and similarities between their cultures and those of the sanctuary seekers they work with, and through working with interpreters (Atiyeh & Gray, 2022; Björn, 2005). Incompetence on a therapist's part can lead to temporal desynchrony in communication, a loss of verbal and non-verbal cues as well as detachment between client and therapist (Atiyeh & Gray, 2022; Björn, 2005). Working with sanctuary seekers presents other challenges such as limited training opportunities, the impact of therapists' biases and assumptions, rigidity in therapeutic approach and language barriers (Atiyeh & Gray, 2022). On the one hand, to be effective, therapeutic engagement requires that the therapist take a flexible approach. It is important to navigate fluid boundaries, advocate, demonstrate a welcoming and warm demeanour, facilitate acculturation, broach topics with cultural humility and honour cultural backgrounds. On the other hand, the therapist must collaborate with interdisciplinary teams, monitor and support their members, and accept their support, sharing consultations and critiques when necessary, to develop multicultural

competencies and the skills required to work ethically and effectively with sanctuary seekers (Atiyeh & Gray, 2022).

Several studies have highlighted some of the effects on practitioners of working with sanctuary seekers. These effects include the development of secondary traumatic stress, which results from knowledge about another individual's traumatic experience (Bride et al., 2004); and vicarious trauma (VT), which is the cumulative effect of working with traumatised individuals (Ebren et al., 2022). A cross-sectional survey that was conducted among 376 national staff who worked for 21 humanitarian aid agencies in Uganda showed that over 50% of these workers experienced five or more categories of traumatic events and that 68%, 53%, and 26% of respondents reported symptom levels that were associated with a high risk of depression, anxiety disorders and PTSD, respectively (Ager et al., 2012). A UNHCR staff well-being and mental health study showed that in a sample of 2,431 UNHCR staff members who worked with sanctuary seekers, the prevalence of emotional exhaustion and depersonalisation was 31% and 9%, respectively (UNHCR, 2016). A study by Denkinger (2018) of practitioners who worked with women and children who had experienced extreme violence from members of the "Islamic State" showed that 22.9% of the practitioners suffered secondary traumatisation and 8.6% showed severe symptom load (Denkinger et al., 2018). Factors that contributed to VT and burnout included personal histories of traumatic experiences or flight from danger, a high number of hours per week spent working in direct contact with refugees, workforce loss and staff turnover, as well as a preoccupied attachment style (Ager et al., 2012; Denkinger et al., 2018; Ebren et al., 2022). In contrast, factors that protected and provided resilience against the development of VT in practitioners who worked with sanctuary seekers were reported to include a secure attachment style, high levels of social and emotional

support, strong team cohesion, professional supervision support and reduced exposure to chronic stressors (Ager et al., 2012; Denkinger et al., 2018; Ebren et al., 2022). There is a paucity of studies that have focused specifically on the impact of working with sanctuary seekers and on the prevention of or treatment for secondary traumatisation among refugee service providers (Ebren et al., 2022).

Study aim

This study aimed to explore the lived experiences of therapists (practitioner psychologists and psychotherapists/counsellors) who worked with sanctuary seekers who had experienced torture. Table S1 shows how the research question was formulated.

Method

IPA was the chosen methodology for this study due to its grounding in an epistemological approach to inquiry and its focus on in-depth exploration of each participant's personal lived experience and elicitation of how they make sense of that personal experience (Smith et al., 2022). IPA draws on hermeneutic approaches, which provide opportunities for interpretative analysis that contextualises participants' accounts in terms of reflections and relevant theoretical material, thus making it possible to link the findings to the psychological literature (Smith et al., 2022).

IPA has three distinctive characteristics: it is idiographic, inductive and interrogative. The idiographic feature of IPA is its prescription of a process in which each case in turn undergoes detailed examination and deep analysis until a degree of closure is achieved (Smith et al., 2009). The inductive characteristic of IPA relates to its flexibility, which enables the use of techniques that allow the emergence of unanticipated topics or themes during the data analysis process. The assertion of Smith et al. (2009) on

the inductive nature of IPA informed the formulation of my research question, which aimed at the collection of expansive data. Finally, the interrogative feature of IPA relates to its ability to contribute to psychology through the interrogation of published research.

Recruitment and sample

I sent recruitment invitations that contained brief information on the study via email to organisations across the United Kingdom that offered therapeutic services to sanctuary seekers who had experienced torture in their home countries before they came to Europe. Ethical approval for this study was granted by Teesside University in North England.

The inclusion criteria required that participants were practitioner psychologists or psychotherapists with more than three years of post-qualification experience who had worked with refugees or asylum seekers who had suffered torture. Given these specialist requirements, only a small number of such practitioners were expected to be practising within the United Kingdom. A total of 10 such therapists (nine females, one male) were recruited.

Each therapist who was recruited was sent a participant ID number and a copy of the participant consent form for them to read through and bring to the interview or to send back to me ahead of the interview. The details of the participants are shown in Table 1.

Table 1 Participants' demographic details

Pseudonym	**P. No**	**Sex**	**Therapeutic orientation**	**Interest in psychotraumatology and**

				experience working with sanctuary seekers
Mary	1	F	Integrative	10 years – working with children
Paula	2	F	Integrative	15 years – working with families
Adele	3	F	Psychodynamic	16 years - working with adults
Silvia	4	F	Existential-humanistic	10 years -- working with adults
James	5	M	Integrative (relational)	15 years - working with adults
Rose	6	F	Integrative	15 years - working with adults
Mandy	7	F	Integrative	7 years - working with families
Philippa	8	F	Integrative	10 years - working with adults
Zhou	9	F	Integrative	5 years – working with women
Cleo	10	F	Integrative	5 years - working with adults

Trustworthiness and credibility of method

In line with IPA recommendations, all the interviews started with general questions such as: “Can you tell me how you came to start to work with refugees and asylum seekers?” These questions enabled respondents to settle into the interviews and to establish rapport and openness with the researcher, who then progressed gently to more specific questions such as: “What specific interventions do you use when working with trauma resulting from torture?”

I sent each participant their respective transcript, for confirmation that each transcript was an accurate representation of each interview. The participants all responded with confirmation of the accuracy of the content. A couple of them noted minor clarifications that related to grammatical inaccuracies, which I took on board and changed. All participants were also given the opportunity to debrief before they left the research setting.

Analysis and results

All 10 transcripts were analysed through the application of IPA guidelines. Each analysis followed the staged process that is outlined by Smith et al. (2022), which starts with analysis of one transcript and then repeats the procedure for each transcript. In the first edition of their work on IPA, Smith et al. (2009) highlighted the need to approach each case on its own merit and to do justice to its uniqueness, while also acknowledging the difficulty of bracketing the ideas that may have emerged from earlier transcripts. An iterative and inductive cycle was followed, and this involved close, line-by-line analysis of each participant's experiential narrative with identification of emergent themes within each case and consequently across participants. Triangulation was carried out at different time points during the analysis between the researcher and a research supervisor who had expertise in IPA to ensure validity (Yardley, 2008). Please see Table S3 for a summary of the analysis process. Smith et al. (2022) asserted that, because themes were recurrent, they embodied most of the participants speaking about their experiences in a similar way. Thus, they suggested that given the potentially large amount of data that could be generated through IPA, the analysis and write-up could be performed at a group level. They argued that this required the summarisation, condensation and illustration of main themes and shared experiences.

Through IPA's sensitivity and depth of analysis, four superordinate themes were conceptualised, which were: (i) questioning self-preparedness; (ii) the challenge of trauma wrapped in complexity; (iii) psychological flexibility arising from the role and internal conflict; and (iv) personal impact. Table 2 lists the superordinate and subordinate themes.

Table 2 Superordinate and subordinate themes

	Superordinate theme	**Subordinate themes**
1.	Questioning self-preparedness	i. Self-questioning and self-evaluation of skills
		ii. Self-re-evaluation and re-learning of skills
2.	Challenged by trauma wrapped in the complexity of the therapeutic work	i. Barriers experienced before engaging in trauma therapy
		ii. Feeling personally challenged by the nature of presenting complex trauma and working with trauma across cultures
3.	Flexibility arising from role and internal conflict	i. Enmeshment of personal and professional roles resulting in working outside the boundary of role
4.	Personal impact	i. Reappraisal of life perspective
		ii. Undesirable feelings
		iii. Heightened awareness of the possibility of VT and embrace of self-care

The four themes were framed within the analysis of this research as a metaphor that could be encapsulated as *'the therapist's journey'*. The empirical findings suggest that therapists who work with formerly tortured sanctuary seekers encounter a complex range of experiences.

Questioning self-preparedness

The superordinate theme of questioning self-preparedness was conceptualised following assertions by every interviewee of how they experienced the work with sanctuary seekers. All participants shared their feelings regarding how they questioned themselves as they started work with these clients because they realised how much they needed to learn, and how long it would take to understand the work, despite being experienced in working with trauma with other client groups. James stated:

> *… although I had worked with quite severely traumatised people, I hadn't worked with survivors of torture […] to actually do the work I would say it took me… [mmm]… probably at least 12 months before I could really begin to understand the work. (James: lines 26–44)*

Silvia said:

> *…and when I started, I wasn't drawn to the money but the need … the great need… yet I kept thinking 'What can I offer these people?' (Silvia: 73–76)*

Self-questioning and self-evaluation of skills

All the participants in some way referred to a process in which they thought at the start of the work with this client group that they could sufficiently transfer the skills that they had attained previously during work with other forms of trauma. However,

the questioning of their capacity as therapists and feelings of doubt about how prepared they were to support sanctuary seekers was a feature in every participant's experience. Mandy and Silvia, for example, shared their reasons for taking up the work. They acknowledged how their own histories and parallel experiences of torture and trauma in their narratives informed their curiosity and questions about what they could offer.

> *I have a family history of people being tortured and killed! I ask myself if I can help these people who have been tortured and suffered* (Mandy: 27–29)
>
> *Here it's not just torture survivors we see but it's torture survivors who have made a huge trip. I mean I have been through a lot of trauma myself and have worked through all that and wondered if I could offer something* (Silvia: 73–76)

Self-re-evaluation and re-learning of skills

During analysis of the transcripts, it was evident that all the therapists had gone through similar processes as they began their work with sanctuary seekers who had been tortured. First, they had all acknowledged the process of accepting their self-questioning or feelings of non-preparedness in their first year of practice. Through this process, they had identified over time what they needed to learn or change and how they would do it. Most participants noted that they had found a human-rights-based approach and that a humanistic-based, trauma-informed, flexible, practically orientated and transcultural perspective was most useful. For example, Rose, whose original training was in psychoanalysis, stated:

> *In working with those so traumatised, then a rigid model certainly in my experience, wasn't helpful, that's when I did my diploma in trauma. I wanted something very practical, as well as wanted to understand the physiology of it all* (Rose: 262–264)

Most of the therapists outlined what they meant by practical and helpful skills. These included engagement in practical tasks, such as writing support reports to the government departments that processed the sanctuary seekers' legal status, or writing reports to medical professionals regarding the psychological impact of the torture injuries that the individuals had experienced. For some, this practical help included attending legal appointments or visiting their client if they were in hospital.

> *… So, in working with them I …, in trying to just meet their needs and with this client group there are so many practical things and not working in a centre… for example… I also have to do the casework, I have to do all the leg work because I actually work in isolation with my clients …* (Cleo: 111–120)

Once therapists had gone through this process of self-questioning, evaluating, and learning other modalities that they felt might fit, they re-evaluated their practice and relearned new skills in line with the continued challenges of the work.

Silvia referred to the process of re-evaluation through hindsight reflection:

> *But I think so much of what I have learnt about the impact of torture on refugees … I have learnt as I have worked here. I don't think I came in with great strong ideas … but even then, I had to drop my approach a few times and consider other effective ways of working* (Silvia: 56–57)

Others noted what they had learnt as helpful, specifically in relation to clients who had been tortured.

> *I think providing a loving and accepting relationship to somebody who has been tortured and who finds it so difficult to trust … in an unconditional way … and when that is done over a period of time as well, can be very healing (Paula: 330–339)*
>
> *I think one of the things that is really important when working with survivors of torture is to create a sense in the room for the client that you can bear it, that you have a lot of familiarity of that work … for example, saying 'did they keep*

you naked?' … and you can see a client's eyes weirdly light up like - ah - she knows (Rose: 649-651)

Whilst the therapists noted the importance of helpful skills, such as these, the second superordinate theme that emerged from the research was the challenge of working with the trauma that sanctuary seekers who had been tortured presented with.

Challenged by trauma wrapped in the complexity of the therapeutic work

Through the analysis, the concept emerged that all the participants experienced challenges in their work. These are presented in this paper through the subordinate themes of (i) barriers that had been experienced before engagement in trauma therapy and (ii) feeling personally challenged by the nature of the presenting complex trauma and working with trauma across cultures.

Barriers experienced by sanctuary seekers before engagement in trauma therapy

Most participants named the factors that are encapsulated here as barriers that had existed before sanctuary seekers enganged with trauma therapy. It was noted during the analysis that amongst all the participants, these barriers could be categorised into two main groups: psychosocial factors and legal processes for asylum seekers. The excerpts that follow are representative of what emerged. Mandy noted the psychosocial barriers:

I worry about how the impact of the refugee and asylum-seeking processes slows down the healing and it continues to distress them. Well, they can't improve because they are still frightened, worried and socially unstable (Mandy: 83–90)

Adele, who had stated that she worked mainly from a psychodynamic perspective, acknowledged the difficulty in working from a purely psychodynamic framework: she

said that it was difficult because of the factors she identified that impacted the therapeutic process.

> *I mean I haven't had many people who I could really do 'psychotherapy' with. To do with linking up history between the past and the present because so much of the external world impinges all the time* (Adele: 98–100)

What was evident in every interview was that at some point in their journeys, every one of the participants had felt challenged by the intensity of the experiences and trauma that clients presented with. This was relayed in the subordinate theme that follows.

Feeling personally challenged by the nature of the presenting complex trauma and working with trauma across cultures

This theme emerged in all the interviews. The participants all described how the nature of the narratives they heard was emotionally challenging to bear. The quotes that follow offer evidence for this.

> *So, in his home country, the client was taken to prison and tortured and eventually he went to [X} [names country]. An attempt was made to deport him … and then while awaiting deportation, he was sexually attacked by a security guard at 'X' airport here in Europe. And he got compensation which is quite rare from X [names particular department]. They said, 'We'll give you this money as long as you don't tell anyone else'. So, imagine that's on top of all the torture he had got in his home country. It's heart-breaking (Philippa: 187–192)*

Mary relayed her sad feelings about the burden of proof that many refugees and asylum seekers are asked to provide "evidence" for their asylum claim:

> *The Home Office system is such that you used to have to prove it! … for example, that you were raped ….! On top of the psychological scars … have to prove physical ones too. I think it was barbaric to ask for that proof. To*

have to prove that it happened and not be believed is yet another trauma on top of trauma. It's difficult stuff - difficult stuff! (Mary: 264–270)

The aspect of hearing the trauma in detail and depth also contributed to this sub-theme of feeling personally challenged by the nature of the trauma's complexity. Excerpts from James' and Adele's narratives highlight the nature of trauma that the therapists listened to:

What had happened was he was suspended by his ankles and he was dropped headfirst onto the concrete and both his medical legal reports and therapy were central to describing the first time this happened to him. When I asked him to tell me what had happened, he said the first time it happened he said to me [pause] 'That was when my soul fell out!', and it really struck me because he was very clear about it (James: 118-123)

One little girl had been imprisoned with her father and her father was tortured in front of her, he had been hung upside-down and had nasty things put onto the genitals … so for her it was trauma watching her dad being tortured - yeah (Adele: 358–359)

It also emerged that the experience of working with such a diverse group brought challenges about working across cultures. James' narrative regarding working with difference encapsulates the experiences that other participants shared, and it includes an appreciation of the use of an interpreter.

… well most of my clients don't speak enough English to work without an interpreter. So, I see the task there is starting to build a trusting safe but also what I would call an intercultural encounter and so I can't leave my white middle-class privileged background out of the room. That is what I am. They can't leave out their culture that they come from so I see that the really important thing is about meeting or encountering (James: 244-250).

Psychological flexibility arising from role and internal conflict

Over time, as they worked on therapeutic engagement with these sanctuary seekers, the therapists developed some psychological flexibility and openness to the use of models that could be helpful. In all the interviews it was evident that therapists at times stepped out of their role as therapists to engage in behaviours or actions that seemed more personal than those that are usually within the boundaries of a counselling psychologist or psychotherapist.

Enmeshment of personal and professional roles resulting in working outside the boundary of role

This enmeshment of roles was evident through the analysis of different transcripts. The quote below shows this sub-theme:

> *For example, not so long ago one client used to walk here and had no shoes, and I had some money and I bought for her and her child some shoes. They never knew because [the shoes] were given through the organisation as a donation* (Philippa: 145–148)

Adele's and Paula's quotes clearly evidence ways in which these therapists worked that were outside the boundaries of both the therapy room and of their roles as therapists, even though in the context of the narrative, their actions seemed justified.

> *I actually did something utterly outside the box … I stayed over one night and 9 PM, …she was under the bed [having a psychotic episode] and the crisis emergency [mental health] team wouldn't come and I thought I can't leave her, two kids of this age - they were about five and nine at the time - in the house with her in a state… so I dealt with things in the morning* (Adele: 224–229)

> *And I found that these adolescent boys were far better if they were just doing something creative as well. So, one had decided that he would draw on the walls of my therapy room. Whilst he was doing it, he told me all about the torture that happened to him … we cleaned the wall later* (Paula; 222–236)

Personal impact

Hearing narratives of torture, trauma and injustice undoubtedly had a significant impact on the lives of these therapists. They heard intricate details of torture including rape, degradation and beatings, and descriptions of the witnessing of family members being raped or killed. In line with this, it has been asserted that one of the risks of exposure to trauma work is VT, which involves personal and relational changes that trauma workers experience due to their cumulative and empathic engagement with those who present for support with trauma (McCann & Pearlman, 1990). Several studies have highlighted the prevalence of VT, which has impacts on the trauma workers' intimate relationships, and causes long-term transformations of their cognitive schemas in relation to their perceptions, beliefs and expectations of themselves, others and the world (Babiker & Abdalla, 2021; Rizkalla & Segal, 2020).

Reappraisal of life perspective

Quotes below from Sylvia and Rose are representative of comments in all the interviews, in which participants spoke about a reappraisal and shift in their life perspectives. Their thoughts ranged from feelings of uncertainty or privilege to a sense that continuation of the work was not sustainable.

> *It has definitely changed my worldview, I don't feel so safe in the world, but I think that's kind of realistic. A lot of safety I had before was quite false because things can change in hearing these narratives of torture and trauma* (Sylvia: 342–344)

> *I think one of the most important ways is that I have never felt that I have had such a sort of life perspective on how lucky I am that's with me most of the time and that's quite a gift really. It's that, I don't think I ever forget - [pause] - that even if it's a beautiful cup of coffee it might be my last* (Rose: 439-444)

In line with these perspective shifts, all the study participants shared feelings that emerged for them. These are encapsulated in the subordinate theme of 'undesirable feelings'.

Undesirable feelings

On analysis, it was evident that the therapists' 'undesirable' feelings came in reaction to the work. As therapists themselves, most participants were able to recognise their own feelings or the source of the feelings. Zhou's and James' comments are representative of those of the other participants:

> *Yeah, so hearing so many horrific stories with people who have been through really horrifying things … there is something about that which kind of encroaches upon me. I feel quite protective of my own life* (Zhou: 213–226)
>
> *I engaged with this client … at that level … and I suddenly started to experience nightmares!! [sighs]* (James: 530-534)

It was evident that all the participants were aware of this cost of caring and made contingencies for it in the form of self-care plans.

Heightened awareness of the possibility of VT and embrace of self-care

James' and Mary's narratives are representative of the majority of participants' explanations that showed a heightened awareness of the possibility that they might experience VT and their consequent embrace of self-care. They stated the following:

> *In the training part of my job, I very quickly worked out that without paying attention to what's generally called self-care, people get swamped, overwhelmed, overburdened … burnt out … umm … traumatised secondarily … I worked with another counselling psychologist who couldn't understand why they were sat at the desk crying their eyes out because they had no conceptualisation whatsoever. It takes on a life inside yourself* (James: 469–482)

> *… umm [laughs] … I remember sitting with one mum and she suddenly screamed and was seeing people coming out of this cupboard, so much so that I went, and I checked the cupboard … which was silly… really, well, it wasn't silly for her, but I suddenly thought … oh god what if there is somebody in the cupboard? … but that's a knock-on effect* (Mary: 77–80)

In relation to the importance of self-care, all the participants spoke about their own ways of coping with the inevitable impact of the work. They explained how they ensured that they debriefed to be able to function outside their work and to keep doing the work. They drew on relationships, family members' hobbies and activities to manage the work.

> *I do take self-care seriously and I do ordinary things. I enjoy gardening, I enjoy music, and seeing friends and I do make sure that I maintain those things* (Paula: 290–291).

Without exception, the participants spoke of their heightened awareness of VT. They either knew someone who had experienced VT or had experienced some symptoms themselves, which they knew were related to their work and thus self-care was recognised as important by all the participants.

Discussion

This study found that therapists who were experienced in working with clients/patients who presented with psychological trauma questioned their preparation level once they began work with formerly tortured and traumatised sanctuary seekers. The subordinate themes revealed that therapists travel a journey that involves self-questioning and self-evaluation regarding their skills, the unlearning and re-learning of new skills, and further self-re-evaluation because of the intensity of the work. There is a dearth of literature that has denoted this process and this study has produced some

ideas regarding the process of therapists' journeys of integration. More research is needed as some of the themes that are conceptualised in this paper could inform future research questions in this area.

Rihacek, Danelova and Cermak (2012) identified phases of therapists' journeys to integration and development, which are characterised by a loosening in therapists' adherence to their orientation of training. This relaxation is a result of growing confidence and a decline in pervasive anxiety, which together result in intuitive integration. They draw on Rønnestad and Skovholt's (2003) ideas, which state that therapists in their novice professional phase shift from confirmation-seeking through a phase of disillusionment to exploration of other possibilities, which develop with an increasing sense of the complexity of the psychotherapeutic process.

Although the therapists who worked with sanctuary seekers and who participated in this study were not novices, it could be argued that the process of engaging with this intense trauma work brought a realisation and questioning of their preparedness for the depth of challenges they would face in the work. Their questioning of their skills and of their readiness to engage with sanctuary seekers who have experienced torture and trauma highlights the developmental gaps that must be filled in order to work ethically and effectively. A similar conceptualisation was given by Rønnestad and Skovholt (2003) in a process termed "shedding and adding at the conceptual and behavioural level" (p. 17). This explanation mirrors the descriptions given by the participants as they realised that some of their home modalities or skills were not sufficient for the work and that they needed to find other ways of working (Rønnestad & Skovholt, 2003). Rihacek et al. (2012) argued that such modifications of therapists' approaches were interlinked with the therapists' development, clinical experience, and

world views (Rihacek et al., 2012). Psychologists working with sanctuary seekers who have been tortured face a diverse range of challenges that include multifactorial clinical presentations and diverse psychosocial, cultural and political factors, some of which may be unfamiliar and challenge the psychologists at both professional and personal levels (Board et al., 2021; Posselt et al., 2019).

The majority of therapists who took part in this study expected PTSD to be the foremost diagnostic presentation that would be associated with the sanctuary seekers. This is in line with the findings of other studies (Board et al., 2021; Hernandez-Wolfe et al., 2015; Posselt et al., 2019; Steel et al., 2009). However, other authors have challenged this focus on the development of psychopathology. They state that it fails to illuminate broader psychosocial factors and the compounding complexity of psychological functioning that follows torture, trauma and the asylum-seeking journey (Boyles, 2015; Campbell, 2007; Freedom From Torture, 2022; Hinton & Lewis-Fernández, 2011; Womersley & Kloetzer, 2018). Refugees and asylum seekers, rather than leaving behind their trauma, continue to experience psychological and embodied trauma even when they are in the host country (O'Brien & Charura, 2022). Therefore, given the challenges identified in this research, it is clear that the expectations and experiences of sanctuary seekers are complex and not just psychological. Thus, any psychotherapeutic interventions that are offered to this client group or policies that are formulated must respond effectively to the bio-psycho-social-spiritual and sexual trauma that sanctuary seekers experience (O'Brien & Charura, 2022).

All participants in the research identified the challenges that arose due to differences in cross-cultural understanding of health and language difficulties with sanctuary

seekers. These difficulties made it hard for the therapists to communicate regarding physical and psychological health. Nonetheless, it was noted that working with interpreters could help to mitigate some of the communication challenges in the therapeutic arena. This has also been reported in the literature (Tribe & Lane, 2009; Wenk-Ansohn & Gurris, 2011). However, it has been pointed out that most training and indeed cross-cultural models that are adopted by professionals who work with trauma do not target the processes and dynamics of working with translators, nor do they offer opportunities for trainees to work in ways that enable the development of cross-cultural competencies (Boyles, 2015; Tribe & Lane, 2009; Wenk-Ansohn & Gurris, 2011). Thus, the skills required to actualise cultural competency are not illuminated, nor is it shown how cultural competency is achieved, nor is there any explanation of the dynamics that are embedded in the therapeutic process. The delivery of culturally competent practice by practitioners and therapists calls for more than understanding and knowledge of the dynamics and stages involved; it must also include an understanding of the meaning of trauma, health and well-being from each client's cultural perspective. Other research has shown that survivors of torture have experienced psychosocial challenges and a lack of cultural understanding, and thus ethnocultural discordance (Punamäki et al., 2010). Ethnocultural discordance is defined as the alienation and lack of being understood that refugees and asylum seekers feel because their cultures and ethnicities are different from those of the majority and to those of the therapists who try to help them.

The case for a new ethics paradigm

There are major implications for practice in the discussion of the conceptualised experiential themes of therapists stepping outside their roles and their reflections on 'enmeshment'. Enmeshment with the client's process can be a potentially disastrous

psychological feature of the relationship. Several studies have argued that psychologists and other practitioners can play a vital role in advocating for sanctuary seekers (Ecklund & Johnson, 2007; Hernandez-Wolfe et al., 2015; Raghavan, 2019; Rees et al., 2007). However, these studies also caution that practitioners should consider their engagements thoughtfully as they may become overwhelmed, with the consequence that they may further disempower the client and face conflicts within their work with sanctuary seekers (Ecklund & Johnson, 2007; Hernandez-Wolfe et al., 2015; Posselt et al., 2019; Raghavan, 2019; Rees et al., 2007).

The references to a therapist who secretly purchased shoes for clients, and to another who allowed some young clients to draw on the therapy room wall to permit them to talk about their trauma, warrant further discussion. In my reflections, this brought into focus the ethical dilemmas and moral challenges that these therapists faced and raised for consideration the importance of adherence to ethical and professional guidelines within their field of work (BPS, 2021). Iqbal (2015) asserted that the purpose of ethics was to advise towards high professional standards and thereby enable psychologists to set up structures for their work, which should be in place to resolve problems should they arise. It was clear from this research that the experience of working with sanctuary seekers who had been tortured led to the therapists' reappraisal of their worldviews. This included re-evaluation of their sense of personal purpose and life's meaning, and they continued to adapt both of these factors throughout their work journeys. From this research it was clear that therapeutic work with refugees by clinicians in different services illuminates the tensions between upholding traditional ethical values that emphasise the strict application of the principle of non-maleficence - "do no harm"; and the practical challenges of engaging with the needs and complex presentations of this vulnerable group. Some refugee scholars

have performed research studies and put forward an argument for a new ethics paradigm for those who work with forced migrants. Such a paradigm would promote flexibility, ethical and ecological thinking, as well as the importance of committing to principles of social change (Dehghan & Wilson, 2019; Seagle et al., 2020; Matos et al., 2023).

Implications for clinical practice in working with traumatised sanctuary seekers

In brief, I summarise the implications of this study for clinical practice as therapists must be aware of: the importance of self-care and the risks of developing VT (Iqbal, 2015); the importance of building multicultural competencies in practice, which has been widely addressed by other researchers (Hinton & Lewis-Fernández, 2011; Iqbal, 2015; Raghavan, 2019; Tribe & Lane, 2009); and paying attention and offering appropriate supervision and support to the development of the integrative journey of therapists who work with trauma (Posselt et al., 2019; Rihacek et al., 2012; Rønnestad & Skovholt, 2003; Wenk-Ansohn & Gurris, 2011).

Importance of self-care

The impact of listening to traumatic experiences can manifest for counselling psychologists/therapists as experiences of symptoms of post-traumatic stress. This situation has long been identified as VT (McCann & Pearlman, 1990) or compassion fatigue (Figley, 2002). Barrington and Shakespeare-Finch (2013) examined the lived experiences of 17 clinical professionals who worked with sanctuary seekers. Their analysis of their data showed that the entire sample reported symptoms of VT (Barrington & Shakespeare-Finch, 2013).

In a recent systematic review of studies of secondary trauma and related concepts among psychologists, Pellegrini, Moore and Murphy (2022) reported the importance

of balance between nourishment and the depletion that is caused by work with trauma in different contexts. They relayed how some practitioners felt that working with individuals who presented with trauma was “a privilege” and/ or “humbling” (p.382). This could be argued to indicate vicarious resilience (VR), which is a fairly new concept that is based on research by Hernandez, Gengsei and Engstrom (2007) with practitioners who have worked with victims of political violence. They asserted that, similar to VT, VR could be seen as a natural process that could occur in practitioners who worked in the field of trauma (Hernández et al., 2007; Posselt et al., 2019). In response, Iqbal (2015) stated that “although not all practitioners that work with trauma will develop vicarious traumatisation, all are potentially at risk” (p.49). She argued that VT could be prevented, addressed, and overcome through education, appropriate supervision and support structures that should be in place to resolve problems should they arise (Iqbal, 2015).

Summary of the journey

Analysis of all the themes has revealed that the conceptualised journey that therapists take as they work with formerly tortured sanctuary seekers is not typically a simple progression along a linear trajectory of realising a limitation in their skills and then developing them accordingly. Rather it is a complex, dynamic, twisted journey that involves advances, impasses, learning, development and growth. Even after the therapist has gained substantial experience and has integrated different modalities and transcultural skills, the challenge of self-questioning, being impacted by the depth of trauma narratives and acknowledging the importance of self-care is an ongoing process.

Future research and limitations

Groups of professionals, such as psychiatrists who practise as consultant medical psychotherapists and social workers trained in various forms of psychological therapy, were excluded from the study. Future research that includes these groups and is performed on a larger scale and employs a range of methodologies that could offer different experiences and insights on the subject matter. Secondly, the client's voice is missing; qualitative research on refugees and asylum seekers' experiences of therapy would provide the opportunity to triangulate the findings of this study and to explore links to the development of policies and practices that could enhance the support that is offered to sanctuary seekers who present with trauma. Furthermore, a comparative study that explores both clients' and psychologists' or practitioners' experiences is also recommended for future research.

Conclusion

The findings of this study have highlighted that therapy with sanctuary seekers involves more than just sitting in a room with a client. That the consideration of moral and ethical positions is an essential aspect of the role of counselling psychologists regarding human rights abuses and torture. The complex nature of the work and the time required to develop the specialist skills that practitioner psychologists and other psychotherapists require, warrants consideration of how services can recruit and support those interested in the work.

The findings offer several distinctive contributions to the field of psychotraumatology research policy and practice. They emphasise the similarity of therapists' experiences of working specifically with sanctuary seekers who have been tortured. Furthermore, they offer a practice-based perspective which leads to my recommendation that

therapists place uppermost the importance of incorporating self-care, continually engaging in the development of one's multicultural competencies and accessing appropriate professional supervision support as part of ethical trauma practice.

Acknowledgements: I would like to thank Dr Sue Becker for her supervisory support with this project and for her feedback on earlier versions of this work. I would also like to thank Professor Colin Lago and Ms Anne Burghgraef for their continued encouragement in my work with refugees and asylum seekers. I am thankful to all the participants and the agnecies that supported me and continue to support me in research with sanctuary seekers and displaced people.

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