City Research Online

City, University of London Institutional Repository

Citation: Miqdadi, D. (2015). "It's Tough but it's Worth it": Psychosocial Counsellors' Experience of Working with Iraqi Refugees in Jordan: An Interpretative Phenomenological Analysis. (Unpublished Doctoral thesis, City University London)

This is the accepted version of the paper.

This version of the publication may differ from the final published version.

Permanent repository link: https://openaccess.city.ac.uk/id/eprint/12477/

Link to published version:

Copyright: City Research Online aims to make research outputs of City, University of London available to a wider audience. Copyright and Moral Rights remain with the author(s) and/or copyright holders. URLs from City Research Online may be freely distributed and linked to.

Reuse: Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge. Provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.

City Research Online: http://openaccess.city.ac.uk/ publications@city.ac.uk

“It’s Tough but it’s Worth it”: Psychosocial Counsellors’ Experience of Working with Iraqi Refugees in Jordan: An Interpretative Phenomenological Analysis

Dina Miqdadi

Doctor of Psychology Portfolio

City University, London

Department of Psychology

April 2015

CONTENTS

PAGE

ACKNOWLEDGEMENTS viii

CITY UNIVERISTY DECLARATION ix

PREFACE x

SECTION A: RESEARCH STUDY 1

ABSTRACT 2

LIST OF ABBREVIATIONS 3

CHAPTER 1: LITERATURE REVIEW 4

Defining People Living in Exile 4

Background Information 6

Provision of Mental Health Care for Refugees 9

Political, Environmental and Societal Factors Influencing Refugee Mental Health 12

Refugee Resiliency 15

The Psychosocial Needs of Iraqis in Jordan 16

Obstacles to Utilising Clinical-Based Services in Jordan 19

Provision of Mental Health Care in Jordan 21

How Could These Factors Impact Psychosocial Counsellors in Jordan? 22

Negative Aspects of Trauma Work 23

Positive Aspects of Trauma Work 43

Simultaneous Positive and Negative Effects 45

Methodological Issues 46

Argument for the Current Study 48

Aim and Research Questions 49

CHAPTER 2: METHOD 51

Rationale for Conducting a Qualitative Study 51

IPA 51

Research Paradigm and Epistemological Reflexivity 53

Rationale for Choosing IPA 54

Limitations of IPA 56

IPA as Opposed to Other Qualitative Methodologies 56

Reflexivity 57

Procedure 61

Ethical Considerations 64

Data Collection 66

Analytical Strategy 70

Quality Issues 72

Limitations of the Research Study 74

CHAPTER 3: ANALYSIS 76

Introduction to the Master Themes 76

Master Theme 1: The Effects of Sociopolitical and Socioeconomic Factors 79

"There's Nothing You Can Do" 79

"You Feel Like a Little Child" 82

"Just Picking up the Pieces" 85

Emotional Burden 87

Master Theme 2: Enriching and Motivating Aspects of Their Roles 93

"Psychological Value" 93

Increased Commitment 97

"There's Always a Way Back to Life" 99

"There's Something Special About the World" 101

Master Theme 3: Coping with the Distressing Aspects of Their Roles 103

Self-Care 104

"It's Tough but It's Worth It" 106

Summary 110

CHAPTER 4: DISCUSSION 112

Linking Previous Literature to the Findings of This Study 112

Conclusion 124

Methodological Limitations 125

Future Research 126

Implications for Psychosocial Service Providers and Supervisors in Jordan 127

Personal Reflexivity 128

REFERENCES 131

APPENDICES 154

A: Invitation to Participate 155

B: Explanatory Statement 156

C: Informed Consent Form 158

D: Confidentiality Agreement on the Use of Audiotapes 161

E: Interview Schedule 162

F: Debriefing for Participants 163

G: Vignettes 164

H: Visual Presentation of Vignettes 166

I: Email to Participants 167

J: Summary of Results 168

L–Q: Audit Trail 171

SECTION C: MANUSCRIPT 185

Abstract 186

Past Literature on the Impact of Trauma Work 187

Method 190

Findings 192

Discussion 199

Implications 201

Limitations and future directions 202

Conclusion 203

References 204

LIST OF TABLES

Table 1: Themes 78

LIST OF FIGURES

Figure 1: Visual Representation of Themes 77

ACKNOWLEDGEMENTS

I would like to thank all the psychosocial counsellors who participated in my pilot and research study. Without their participation, this study would not have been possible. I would also like to thank them for sharing their personal experiences with me to help others working in this field. My deepest gratitude goes to my parents, for their constant encouragement and undying support; my family and friends, for their patience and understanding; and, in particular, my husband for tirelessly supporting me throughout this journey.

CITY UNIVERSITY DECLARATION

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

PREFACE

The central purpose of this research study is to gain a deeper understanding of the experience of psychosocial counsellors working with Iraqi refugees in Jordan. By raising awareness of the factors that effect counsellors and their practice, the aim is to inform organisations, trainers, and supervisors about how best to prepare and support psychosocial counsellors in order to benefit them and their clients.

The deciding factor in my choice of research subject emerged from my personal experience of working with Iraqi refugees in London. During the formation of this research study I was volunteering as a counselling psychologist in training with a charity that works with people living in exile in the UK. Being an Arabic speaker, I worked with refugees and asylum seekers from the Middle East and North Africa to overcome their language barriers with English-speaking therapists. Due to the nature of world politics at that time, most of my clients were Iraqi refugees or asylum seekers from the Iraq War.

My clients had experienced multiple traumas and losses before and after exile. My experience of working with them made me feel underqualified to work with people who had experienced multiple traumas and also rather burned out from dealing with the emotional nature of the many difficult cases I had worked with. After my contract with my placement ended, to process the emotional content of my experience I decided to take a break from trauma work until I felt ready to go back to working in this field.

This experience made me reflect on the various aspects involved in working with this client group. The first aspect was that the organisational structure was directly influenced by funding restrictions. This made me reflect on the ethical dilemmas that might need to be worked through when limited funding restricts access to treatment. The second aspect was that the clients' basic needs, in their view, outweighed their psychological needs. This made

me question the balance of the objective versus subjective worldview when working with refugees. Keeping an eye on the field in Jordan, which I will be joining soon, I also wondered about the experience of counsellors who work within Jordan's unique sociopolitical cultural climate. A personal experience in 2008 had attuned me to the severity of the situation. I had been asked to manage a caseload of 40 Iraqis at a time when I had had no clinical training. This experience made me reflect on the situation in Jordan and drove me to study for a Professional Doctorate in Counselling Psychology abroad. However, I kept in mind that many people do not have the opportunity or financial ability to do so.

I chose to conduct this study primarily to aid my own understanding of a field that I have my own assumptions about and in which I anticipated some of the difficulties that counsellors might face. However, more research in this area identified that of concern are the moral dilemmas in the provision of counselling for Iraqi refugees in Jordan. During Gilbert's (2009) experience of working with international nongovernmental organisations (INGOs) in Jordan, she reflected on some of the moral dilemmas she encountered when speaking to counsellors working in this field. The author proposed that further research is needed in this area, as the effects on counsellors working with this new population of Iraqis had yet to be examined.

Thus, the aim of this study is to explore the lived experience of counsellors, including some of the challenges they face, taking into account the sociopolitical climate they work in and what it is like to work within such a situation. The aim of the study is to explore this area, but the work could also help to inform supervision and training.

The thesis consists of three main sections, each concentrating on a different area related to refugee trauma. The first section is an exploratory research study, which focuses on the experience of psychosocial counsellors working with Iraqi refugees in Jordan. The second section presents a case study focusing on a Sudanese asylum seeker struggling with insomnia.

Finally, the third section presents a manuscript prepared for the *Middle East Journal of Positive Psychology*.

Section A: Research Study

The research study was carried out in response to a gap identified in the literature. Other than Gilbert's (2009) study, no known study has focused on the experience of this population. The present study aimed to explore the perception of six psychosocial counsellors working in Jordan using interpretative phenomenological analysis (IPA). The findings of the study highlighted the positive and negative aspects of their work, as well as some of the difficulties they face. The implications for psychosocial service providers are presented.

Section B: Professional Practice

The case study presented in this thesis focuses on working with an asylum seeker suffering from insomnia. The case focuses on the relationship between guilt and shame and the participant's sleep disturbances. A relational psychodynamic approach was used to help the client connect his posttraumatic experiences with his insomnia (Adshead, 2000; Herman, 2001). I chose to present this work because I found that it was a key learning experience, personally and professionally. It aims to demonstrate my clinical skills and my ability to integrate theory into practice.

Section C: Manuscript

This section presents a manuscript for the *Middle East Journal of Positive Psychology*. The article presents the findings of this study, which include the positive and negative impacts of working with Iraqi refugees in Jordan. I chose this particular journal in order to support emerging research in the Middle East and to promote the inclusion of

empowerment in trauma research. Other journals considered for this manuscript were: (1) *Intervention, the Journal of Mental Health and Psychosocial Support in Conflict Affected Areas*, which is aimed at service providers who work with similar populations to those found in this research study; and (2) the *European Journal of Psychotraumatology*, to reach a wider population and contribute to the new thematic cluster, resilience and trauma.

Epistemological Position

As a researcher I place myself within an interpretivist/constructionist paradigm. Such paradigms are focused on subjectivity and intersubjectivity as an alternative to the positivist naturalist paradigms. They emphasise that reality is socially and intersubjectively constructed (Guba & Lincoln, 1994) and that truth or reality can only be derived or understood through dialogue.

As a practitioner I work within a relational psychodynamic model (Mitchell, 1988), which proposes that reality is mutually constructed through dialogue. This relates to the notion that truth or reality can only be derived through dialogue in the interpretivist/ constructionist paradigm. In contrast to traditional psychoanalytic theory, this model does not view resistance as the client's disagreement with the practitioner's expertise. Instead, it suggests that resistance stems from the practitioner's inability to understand the client's reality, which in turn impedes the client's ability to trust the therapeutic space as a place to reflect on his or her experiences (Stolorow & Atwood, 1992).

This model does not propose that the therapist is the expert in the client's life, but that the therapist is an expert in Western psychological theories that are presented to the client as one way of understanding experience; in turn, the client might or might not find them related or beneficial to his or her experience. Additionally, rather than proposing set interventions, this model suggests that the guiding principle of the relationship is the driving force for

change. As such, the flexibility to use different tools or interventions is accepted and their benefit is mutually constructed with the client according to the client's individual experiences.

Therefore, I view my epistemological positions as a researcher and as a practitioner as overlapping, wherein similarities and differences exist between them. In the literature a tension exists between a phenomenological research approach and a psychodynamic therapy approach. However, I do not consider that there is an issue in holding different epistemologies; as Cooper and McLeod (2007) suggest in their pluralistic framework, it need not be a problem. As suggested by the authors' framework, I hold an *and* position instead of an *either/or* position. This is because I view human experience as being so vastly complex that it cannot be boxed into a single approach: different approaches can help different people at different times. Finally, from my personal perspective, the notion that more than 400 types of therapy exist (Norcross, 2005) suggests that different people have found different types of therapy helpful at some point in their lives. Each type of therapy has been relevant to at least one individual; therefore, that individual experience cannot be rejected on the basis of it not being applicable to others.

Personal Reflections

The central theme of this thesis is working with asylum seekers and refugees. I have found the processes of carrying out the research study, reflecting on my case study, and writing a manuscript for a relevant journal to be valuable for my personal and professional development. From a personal point of view, offering therapeutic services to refugees, making inquiries into the experience of others working with refugees, and being a third-generation refugee myself have been valuable experiences. These experiences have taught me a lot about myself and about my assumptions about the world. They have also highlighted my

own limitations in professional practice and helped me identify the importance of self-awareness and the utilisation of professional support in working with this client group. I feel that my perspective has expanded enormously throughout the few years that I have been focusing on this area, which has had a significant positive impact on my personal and professional life.

SECTION A: RESEARCH STUDY

"It's Tough but it's Worth it": Psychosocial Counsellors' Experience of Working with Iraqi Refugees in Jordan: An Interpretative Phenomenological Analysis

Supervised by: Dr Cristina Boserman

ABSTRACT

This research study focused on exploring the experiences of psychosocial counsellors who were working with Iraqis who had fled to Jordan after the 2003 regime change. The extensive research on the effects of trauma work on therapists has been focused on the negative effects of trauma work and is mostly quantitative. Research into the experience of psychosocial counsellors in Jordan is largely absent from the established literature. Utilising an interpretative phenomenological analysis, the current study explored the lived experiences of six psychosocial counsellors in Jordan in some depth. The three master themes that were identified were: (1) the impact of sociopolitical and socioeconomic factors; (2) enriching and motivating aspects of their roles; and (3) coping with the distressing aspects of their roles. The results of this study support previous research in the sense that secondary traumatic stress and vicarious trauma symptoms were found to be a part of the participants' experiences. The study also supports newly emerging research that suggests that the negative and positive effects of trauma work with individuals affected by political violence are a simultaneous part of counsellors' experiences. The reciprocal nature of trauma work is also discussed. Rich descriptions of the participants' experiences are presented and discussed. Implications for psychosocial service providers and supervisors are considered, along with limitations of the research study and directions for future research.

LIST OF ABBREVIATIONS

APA: American Psychological Society

CF: Compassion fatigue

CSDT: Constructivist self-development theory

CT: Countertransference

CVS Consultants (CC): Consultancy Services to the Voluntary and Statutory Sector

FAFO: The FAFO Norwegian Research Foundation (Forskningsstiftelsen)

IASC: Inter-Agency Standing Committee

IDP: Internally displaced person

INGO: International nongovernmental organisation

IOM: International Organisation for Migration

IPA: Interpretative phenomenological analysis

MRCF: Migrant and Refugees Community Forum

PTG: Posttraumatic growth

PTSD: Posttraumatic stress disorder

STS: Secondary traumatic stress

UN: United Nations

UNHCR: United Nations High Commissioner For Refugees

VR: Vicarious resilience

VT: Vicarious trauma

WHO: World Health Organization

WHO-AIMS: World Health Organization Assessment Instrument for Mental Health Systems

CHAPTER 1: LITERATURE REVIEW

Numerous studies have consistently shown that listening to the trauma narratives of clients has significant personal and professional impacts on therapists (Adams & Riggs, 2008; Arnold, Calhoun, Tedeschi, & Canns, 2005; Arvay & Uhelmann, 1996; Astin, 1997; Beaton & Murphy, 1995; Bride, 2004; Meldrum, King, & Spooner, 2002; Wee & Myers, 1997). People living in exile experience various complexities and stressors, and this has been shown to have a profound impact on therapists (Munday, 2009). Therefore, a breadth of literature can be drawn upon to explore the impact of providing psychological therapy on psychosocial counsellors working with Iraqi refugees in Jordan.

Defining People Living in Exile

The two terms used to describe people who have fled their countries to host countries that are signatories to the 1951 refugee convention are *asylum seekers* and *refugees*. In Jordan, the term *guest status* is used to identify people who have fled their countries to Jordan. These three terms are used throughout the literature review, depending on the legal status of the research participants.

Refugee

A refugee as classified by the United Nations in 1951 is someone who is:

> Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such

> events, is unable or, owing to such fear, is unwilling to return to it. (UN General Assembly, 1951, p.152)

Asylum Seeker

According to the United Nations High Commissioner For Refugees (UNHCR, 2006), an asylum seeker is:

> An individual who is seeking international protection in countries with individualised procedures. An asylum seeker is someone whose claim has not yet been finally decided on by the country in which he or she has submitted it. Not every asylum seeker will ultimately be recognised as a refugee, but every refugee is initially an asylum seeker. (UNHCR, 2006, p.4)

Guest Status

Jordan has not signed the 1951 UN Refugee Convention. Therefore, the Jordanian government views all Iraqis who do not have a residence permit and who enter Jordan on a visit permit as *guests*. This term is an Arabic custom but is not legally binding. Those who overstay their visit permits due to the instability in Iraq remain illegally in Jordan and live in fear of being deported (World Health Organization Assessment Instrument for Mental Health Systems, WHO-AIMS, 2011). Because most of the relevant research reported in the literature has been conducted in Western countries that are signatories of the 1951 UN Refugee Convention, the terms refugees and asylum seekers are frequently used in this review.

Background Information

Jordan

Jordan is a Middle Eastern country with a relatively small population of 6 million. UN-Habitat (2012) reported that the capital city of Jordan, Amman, currently hosts the highest number of refugees in any city in the world: one in every four residents is a refugee. Jordan is situated in the middle of the region and plays a significant role. It receives sizeable numbers of refugees due to its geographical position. Jordan's first major influx of refugees took place during the Palestinian flight in 1948, and it is estimated that 42% of Palestinian refugees living in the Middle East reside in Jordan.

The second major influx of refugees took place after the regime change in Iraq in 2003, when many members of the Iraqi urban middle class relocated to Jordan to escape political violence. The FAFO Norwegian Research Foundation (2007) carried out a national survey of Iraqis in Jordan and found that there were around 500,000 displaced Iraqis living in Jordan. The majority of these people originated from urban areas in central Iraq (primarily Baghdad) and belonged to the educated middle class. The report found that 23% arrived before 2003 and 77% arrived in 2003 or afterwards, with migration peaking in 2005 and 2006.

Jordanian people's reactions to the arrival of Iraqis has been mixed. Initially, the spirit of Arab brotherhood and the strong historical ties between the people of Iraq and of Jordan compelled Jordanians to be hospitable. However, later the Jordanians blamed the Iraqis for inflation, housing shortages, high food prices, and job scarcity (Fagen, 2009). This frustration was expressed not only in public discourse, but also in sporadic violence against Iraqis (Ibrahim & DeBartolo, 2007). Jordan has a persistent lack of economic and natural resources and relies heavily on international aid. Therefore, it responded to the major influx of Iraqi

refugees by tightening border controls, discouraging assimilation, seeking international aid, and insisting on third-country resettlement or deportation (Fagen, 2009).

The third major influx of refugees took place in 2011 after the Syrian Civil War erupted. It is estimated that 600,000 Syrian refugees currently reside in Jordan (UNHCR, 2014). However, the Syrian refugee crisis, with its unique set of concerns, is beyond the realm of this study.

Iraqi Migration to Jordan

The regime change in 2003, and the fighting between coalition forces and former regime loyalists that followed, instigated the movement of Iraqis. The major influx of Iraqis occurred in 2006, when 168 mosques were hit over a period of two days. This development led to an ethnic war, whereby cities were quickly segregated into Shiite and Sunni regions and innocent citizens were kidnapped, tortured, or killed because they belonged to one branch of Islam or the other. In addition, thousands of homes were bombed or set on fire. These are two of the major causes of migration, although the Iraqi population faced various additional issues (FAFO, 2007).

The UNHCR (2012) reported that due to vigorous security checks, the chances of resettlement from Jordan to a third country have been poor and for those who are accepted for resettlement, it can take up to a year for them to leave. The UNHCR (2012) stated that those who chose to leave Jordan to return to Iraq did so largely because of their deteriorating living conditions in exile, rather than because they felt that life in Iraq had returned to normality.

Iraqis Legal Status in Jordan

Jordan is not a signatory to the 1951 UN Refugee Convention; therefore, it is not under any legal obligation to recognise or confer refugee status (WHO-AIMS, 2011). Although the Jordanian authorities and civil society are sensitive to the issues of refugees and human rights, Iraqis in Jordan are viewed as guests. Under the conditions of this status, Iraqis are not allowed to work and their rights to health and education are only granted by special dispensation of the state.

In 1998 a Memorandum of Understanding signed by the UNHCR and the Jordanian Government outlined the major principles of international protection. This specified that authorised asylum seekers waiting for refugee status may stay in Jordan for a maximum of six months (International Organisation for Migration, IOM, 2008). During this period, a durable solution has to be found. As this status precludes access to opportunities to find legal work, local integration has become an unlikely solution. Thus, due to their illegal status, when Iraqis do manage to find a job it is usually illegal and underpaid. The majority of Iraqis in Jordan live in rented homes and an increasing number of Iraqi families are having to share apartments or rooms because this is all they can afford.

FAFO (2007) stated that in 2006 there were 450,000 to 500,000 Iraqis living in Jordan. As going back to Iraq is not an option for most of these people because of the continued violence, the alternative is seeking asylum in other countries. Up until now, reallocations from low- and middle-income countries have taken a long time and successful cases of reallocation have been limited (UNHCR, 2012). This led to IOM (2008) describing Iraqi guests in Jordan as stuck in a limbo. IOM (2008) reported that 21% of Iraqis living in Jordan have been "severely traumatised" by attacks on themselves or on their families in Iraq. The magnitude of the issue has created a sense of urgency in Jordan to investigate the needs of Iraqis.

Provision of Mental Health Care for Refugees

A review of previous literature on refugees and asylum seekers identified that *trauma* is the main word used to describe their experience. The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) defines trauma as:

> Exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual: directly experiences the traumatic event; witnesses the traumatic event in person; learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related). (APA, 2013, p.271)

Briere and Scott (2006, p.4) suggested a broader definition of trauma, defining an event as being traumatic “if it is extremely upsetting and at least temporarily overwhelms the individual’s internal resources”. However, according to the DSM-5, experiencing such events can lead to two types of disorders: (1) acute stress disorder, which is usually resolved within a month; or (2) posttraumatic stress disorder (PTSD), which is considered a chronic condition with symptoms such as intrusive recollection, persistent avoidance, marked alterations in arousal and reactivity, and negative alterations in cognitions and mood associated with the traumatic event (APA, 2013).

Many have argued that PTSD is a Western notion that is not universally adaptable (Baldachin, 2010) and that the symptoms previously described in the DSM-IV are not necessarily applicable across cultures (Bracken, Giller, & Summerfield, 1995). From this, the

DSM-5 acknowledged culture-related diagnostic issues in the diagnosis of PTSD and added that the presence of social support is a protective factor.

PTSD as a Western Concept

The Western biomedical model became the dominant belief system in the treatment of mental health issues only in the 19th century. Summerfield (2000) argued that before the development of psychology as a discipline, the distress caused by war was predominantly considered as spiritual or religious rather than medical or psychological, and rituals intended to help fighters returning from combat reintegrate into communal life have existed for centuries.

PTSD is a relatively new way of viewing trauma. It was conceptualised in the United States (US) in the 1980s as a tool to understand the problems faced by American veterans after serving in the Vietnam War and help ease their psychological distress (Bracken, Giller, & Summerfield, 1995). Because they were being treated after the traumatic event had taken place, the word *post* was used. However, for the majority of refugees and asylum seekers, the trauma does not end when they flee their countries; rather, it continues. Unlike the American veterans, who could return to a situation of relative “normality”, the majority of refugees who are experiencing a social crisis cannot do this (Honwana, 2001).

PTSD in the Refugee Population

The validity of the concept of PTSD for refugees and asylum seekers has not yet been established (Hinton, 2011; Hopkins, Seltzer, & Avigaad, 2005; Nicholl & Thompson, 2004; Summerfield, 2001). Pupavac (2001) argued that PTSD is relied upon to label people affected by political violence; therefore, psychological treatment is geared towards recovery from PTSD. Lipson (1993) suggested that because refugees experience a range of difficulties and

subsequently diverse reactions, it is important to assess them for specific symptoms of PTSD and other psychiatric illnesses. This is to identify whether the symptoms are being confused with other symptoms, such as grieving for the losses of family, country, and lifestyle, and depression associated with downward social status and the inability to find work. Woodcock (1997) similarly argued that the majority of refugees and asylum seekers experience multiple losses that can lead to complicated grief, violations of human rights, forcible uprooting, suicidal ideation, depression, mistrust, feelings of exclusion, and survival guilt. Furthermore, Summerfield (1996) argued that symptoms of PTSD might mean different things for different people. For example, Summerfield (1996) described the cultural differences between intrusive dreams as follows: “for one person, recurring violent nightmares might be an irrelevance, revealed only by direct questioning; to another, they may indicate a need to visit a health clinic; to a third, they might represent a helpful message from his/her ancestors” (Summerfield, 1996, p.13).

PTSD in the Middle East

Shoeb, Weinstein, and Mollica (2007) reviewed studies on trauma in the Middle East, and found that despite the severity of the reported traumas, the rates of PTSD were neither high nor universal. They found that several factors, along with a network of healing, provided protection from adverse psychological consequences. These factors were family ties; social support; and religious faith, which offered consolation and comfort; a sense of commitment to a political cause; and the belief that their struggles are not personal but communal.

The aim is not to discredit PTSD or other notions devised by Western research, but to integrate Western concepts devised from the biomedical model with other social and traditional notions of mental health. By being aware of the origins of paradigms and popular ideas in the literature, a more mindful and integrated approach can be deduced, which can

then be reflected in working with non-Western populations afflicted by war (Honwana, 2001).

Research has shown that political, environmental and societal factors have an impact on an individual's development and mental health (Tamminen, 2006). Therefore, psychosocial interventions, defined as "actions that seek to address the interplay of social conditions and psychological well-being" (Ager & Loughry, 2011, p.362), were introduced as an alternative to the PTSD framework that previously conceptualised the provision of mental health in the refugee population.

Political, Environmental and Societal Factors Influencing Refugee Mental Health

Papadopoulos (2007) argued that it must be emphasised that not all refugees and asylum seekers need psychological treatment, even if they have experienced traumatic events. Additionally, the Migrant and Refugees Community Forum and the Consultancy Services to the Voluntary & Statutory Sector (MRCF & CC, 2002) argued that "the refugee experience is not, in itself, pathological; there should be no automatic assumption that the refugee experience leads to mental health problems" (p.15).

Research has shown that refugees tend to experience psychological distress due to the sociocultural and sociopolitical nature of their life experiences (Jamil et al., 2002; Weine, Vojvoda, Becker, McGlashan, Hodzic, & Laub, 1998). The term *refugee trauma* is used to describe the multifaceted experience of people who have fled their country due to political violence. Papadopoulos (2007) stated that refugee trauma is a complex term that differs for each refugee, depending on their individual experience, legal status, resiliency, intactness of community support, coping mechanisms, access to basic needs, and the extent to which their psychological immune system has been damaged.

Mann and Fazil (2006) reviewed the literature to highlight the factors that increase the vulnerability of asylum seekers and refugees to mental health issues. The following factors emerged: human rights abuses; the experience of escape; the loss of family, friends, country, culture, and profession; the loss of socioeconomic status; unemployment; insecurity/instability; unmet expectations; poverty and hardship; language difficulties; and racism and stigmatisation. Therefore, attending to those needs might reduce vulnerability to mental illnesses.

To distinguish between the different types of traumas this population experiences, Gonsalves (1992) examined the refugee process and proposed that there are three phases: preflight, flight, and resettlement. Gonsalves suggested that trauma can occur during any of these phases. McColl and Johnson (2006) also stated that traumas can occur during either the premigration or postmigration phases. Thus, therapeutic interventions should not be made on the assumption that the client is suffering from premigration traumas; rather, it is necessary to identify at which stage the traumatic event causing the distress occurred. Miller (1999) provided a similar argument and mentioned that research has shown that a substantial amount of distress reported by this population is not related to experiencing violent events but instead is due to exile-related stressors, such as:

> The loss of one’s community and social network, the loss of important life projects, changes in socioeconomic status and related concerns about economic survival, the loss of meaningful structure and activity in daily life, and the loss of meaningful social roles. (Miller, 1999, p.283)

The Inter-Agency Standing Committee’s (IASC, 2007) guidelines on mental health and psychosocial support in emergency settings suggested that the mental health and

psychosocial problems of refugees and asylum seekers are highly correlated. The guidelines include integrating support systems; providing basic services and security; promoting community and family support; focused, nonspecialised support; and specialised services. Additionally, Alayarian (2007) stated that it is important to address the basic needs of refugees and asylum seekers in conjunction with their psychological needs.

Tyrer and Bajaj's (2005) approach, termed nidotherapy, is to alleviate a client's mental health issues by helping the client change their environment; that is, cultivate employment opportunities or reestablish social connections. This suggests that the mental health distress experienced by Iraqi refugees in Jordan could be eased by establishing programmes to alleviate the socioeconomic stress they are suffering due to lack of status, lack of employment opportunities, limited access to services and community outreach, and lack of adequate health care (Duncan, Schiesher, & Khalil, 2007).

This can be related to Herman's (2001) three-stage model of trauma recovery: establishing safety, remembering and mourning, and reconnection. Herman (2001) suggested that these phases are nonlinear and serve as guidelines only. The first stage is described as establishing client safety and stabilisation. Thus, if basic needs are not met and the legal status of a client is not clear, the goals of the first stage of the model might be difficult to achieve.

Similarly, McKinney (2007) suggested that an important aspect of recovery is a client rebuilding their life. However, this can take years if a client's basic needs are not met, they do not have a legal status, the threat of deportation is imminent, or they are awaiting resettlement. In addition, Jaganjac (2004) stated that "attention needs to be focused on improving objective reality and safety, otherwise medical therapy is not going to work" (2004, p.34). This could also be related to Maslow's hierarchy of needs and Max Neef's

models of the scale of human development (Heylighen, 1992), which suggest that basic needs (physiological and safety) need to be fulfilled before other needs can be attended to.

Gorst-Unsworth and Goldenberg (1998) compared the influence of trauma-related factors and social factors on psychological distress. Using various measures previously employed in trauma research, they assessed 84 male Iraqi refugees for psychological morbidity, adverse events, and level of social support. They defined mental health issues within two domains: (1) symptoms of PTSD and major depression; and (2) attitudinal change towards religion, politics, and family. They found that social factors in exile, in particular the level of affective social support (close intimate support provided by family and friends), was more significant than the severity of trauma or torture in determining the severity of PTSD and depressive reactions. The authors suggested that the significance of affective support on psychological morbidity should direct organisations to prioritise family reunions over professional input.

Refugee Resiliency

Woodcock (1997) stated that refugees are survivors of hostile events who embody emotional resiliency in the face of overwhelmingly adverse odds. Rolf, Masten, Cicchetti, Neuchterlein, and Weintraub (1990) described the distinctive aspects of emotional resiliency as follows: the presence of self-esteem; secure relationships; the capability to interact positively and deal with the presence of ongoing stress; processing events in a meaningful way; and having the capability to integrate a stressful event into a personal belief system.

However, for some refugees this type of emotional resiliency becomes compromised and vulnerability is indicated when the above-mentioned aspects are absent. In these cases, the experience of trauma might have impaired the survivors' capability to access their personal, social, and cultural forms of resiliency (Woodcock, 1997). Hence, Balchin (2010)

suggested that before providing psychological therapy, humanitarian responders ought to reestablish and reinforce community structures, meanings, and networks; these serve as protective influences for individuals experiencing trauma and enable individuals to cope by using their own community support systems. Mann and Fazil (2006) suggested that a large amount of distress is reported due to postexile stressors rather than preexile events; accordingly, Tribe and Patel (2007) have recommended that community interventions might serve this client population more effectively than clinical-based services.

The Psychosocial Needs of Iraqis in Jordan

CDC-Mercy Corps (2007, as cited in Al-Qdah & Lacroix, 2010) interviewed 372 Iraqis to identify the needs of Iraqi asylum seekers in Amman and make recommendations for policy-makers and services. They found that 77% of the Iraqis surveyed expressed suffering from one or more psychological or emotional issues. Forty-two per cent reported suffering from anxiety and depression, 22.4% reported that they were struggling with stress related to their economic and social conditions, 20.3% reported feeling sadness and emotional instability, 8.7% stated that they struggled with feelings of fear and insecurity, and 6.6% said they felt isolated.

A study conducted by Bader, Sinha, and Leigh (2009) focused on the general and mental health needs of Iraqis in Jordan. By conducting interviews and administrating questionnaires to 664 Iraqi care-seekers from seven clinics, they found that 49% of the respondents required mental health services but only 5% had gained access to them. The respondents reported that stress, violence, displacement, or the death of a family member were the precipitating reasons for needing mental health services. The authors did not examine the reasons why the Iraqis had not accessed mental health services. However, they described anecdotally that some of the respondents were not aware that mental health

services were available at the clinics, while others expressed frustration with the bureaucratic administrative procedures they needed to follow to gain access to such services. In addition, it was suggested that the low percentage of Iraqis accessing treatment might be due to the lack of mental health providers, psychiatric facilities, and training in counselling and psychological treatment (Bader et al., 2009).

The authors suggested that the need for mental health was self-reported; no determination was made by interviewer judgment or clinician diagnosis. However, the interview questions are not available in the study, which makes it difficult to ascertain how the need for mental health services was defined by the study and the participants. Additionally, the need for mental health services included needing a mental health service for themselves and needing one for a member of their household. No statistic is provided to differentiate between a respondent's own need and the perceived need of a family member.

The authors suggested that stress (65%) was the dominant reason for needing psychological services. However, the study did not define stress. Previously mentioned studies have suggested that among the factors that contribute to increased uneasiness and stress among displaced Iraqis in host countries are the inability to gain employment or secure housing within the host country; the inability to fulfil basic needs; dwindling financial resources; and insecure legal status. Thus, whether psychological services could ease the stress experienced by the participants in this study is difficult to determine from the results.

The study found that the duration of residence in Jordan was positively correlated with the need for mental health services. Those reporting a need for mental health services had an average length of stay in Jordan of 4.2±3.8 years, compared with an average length of 3.3±3.2 years for those who did not report a need. Thus, the authors suggested that the longer an Iraqi guest remains in Jordan, the greater their need for mental health services will be.

Related to this notion, Sundram and Loi (2012) suggested that asylum seekers are already vulnerable to mental illnesses because of the traumatic history and social stressors they have experienced; hence, protracted refugee determination is often profoundly distressing for them. Some develop a clinical syndrome that the authors identified as *protracted asylum seeker syndrome*. The characteristics of the syndrome include fluctuating mood; poor concentration and attention; irritability; recurrent intrusive thoughts about the refugee determination process; and overwhelming feelings of hopelessness and powerlessness.

Laban, Gernaat, Komproe, Schreuder, and De Jong (2004) had previously suggested similar findings. They investigated the impact of lengthy asylum procedures on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. The authors measured psychiatric (DSM-IV) disorders with the Composite International Diagnostic Interview. This instrument is designed for the assessment of mental disorders according to the definitions and criteria of ICD-10 and DSM-IV.

The results of the prevalence rates of psychiatric disorders showed that the Iraqi asylum seekers who had undergone lengthy procedures (more than two years) had higher rates of psychiatric disorders (66.2%) than Iraqis who had just arrived in the Netherlands (42%). The two groups differed in a variety of risk factors but it appeared that a lengthy asylum procedure was the most important of those.

Mental health issues were defined using the biomedical model and only factored in symptoms of psychiatric disorders according to the definitions and criteria of ICD-10 and DSM-IV. The authors’ findings indicated that anxiety, depressive, and somatoform disorders were significantly higher in the group with lengthy asylum procedures. These findings are in line with other studies’ findings that conveyed these symptoms as common, natural, and

normal worries that people living in exile experience, which might be believed to be symptoms of a psychiatric disorder.

For example, Laban, Gernaat, Komproe, Van der Tweel, and De Jong (2005) conducted a more recent study on postmigration living problems and psychiatric disorders among Iraqi refugees in the Netherlands. They identified five clusters that were significantly related to psychopathology: (1) family-related issues, such as missing the family and worrying about family members in Iraq; (2) discrimination; (3) issues directly related to the asylum procedure, such as fear of being sent home; (4) socioeconomic living conditions, especially financial problems and housing problems; and (5) socioreligious aspects, such as a lack of contact with people of the same religion. As Jordan is a predominately Sunni Muslim country, and a small percentage of the population is Christian (similar to the Iraqi population), issues of religion did not come up in studies conducted in Jordan. However, it is important to note that 18% of Iraqis in Jordan are Shi'a Muslims, who might be discriminated against in a predominantly Sunni population (FAFO, 2007).

In summary, the literature on Iraqis in Jordan (Bader et al., 2009; Duncan, Schiesher, & Khalil, 2007; FAFO, 2007; IOM, 2008) suggested that Iraqis who have fled to Jordan are experiencing distress due to preexile and postexile stressors, which include: attacks on themselves or their families; lack of legal status; lack of employment opportunities; lack of adequate health care; bereavement; limited access to services and community outreach; and unmet psychosocial support needs. Additionally, they might be affected by lengthy asylum procedures, which they may find distressing.

Obstacles to Utilising Clinical-Based Services in Jordan

Various studies have shown that refugees usually have high rates of somatisation, which is when psychological distress is manifested as physical symptoms in the absence of a

biomedical disease (Cheung, 1993). Tribe (1999) said that refugees might feel it is safer to present a physical symptom than to talk about the immense emotional pain they feel. Hence, this could hinder their access to mental health services.

Shoeb et al. (2007) found several commonly mentioned indicators of distress in an Iraqi refugee population. These included somatic terms that encompassed various symptoms related to mental health issues, such as feeling a constriction in the chest; a choking sensation; poor concentration; headaches; muscle aches; breathlessness; dizziness; numbness; poor appetite; a lack of initiative; sleep problems; tiredness; the heart being squeezed; irritability; nervousness; and a lack of patience.

In Jordan, IOM (2008) found that 45.9% of its sample disclosed somatic complaints. In response to this, the International Medical Corps facilitated the integration of mental health into primary health care in Jordan by offering a training course for public and private-sector general practitioners in order to improve their ability to identify, manage, and refer people with mental health conditions for more specialised treatment (IOM, 2008).

Furthermore, Iraqis traditionally seek the help of religious leaders in trying times and might not present themselves to mental health services. This is because usually, Muslims feel that God keeps a close watch over them, that everything happens for a reason, and that their struggles attest their faith in God (Shoeb et al., 2007). Additionally, family elders usually help individuals to overcome adverse circumstances. However, the support of religious leaders and family elders might be lost through forced migration, separation, and death. Thus, because they might expect the same guidance they received from religious leaders and family elders to be provided by psychosocial counsellors, they might not benefit from formal mental health services.

Finally, Ciftci (2012) suggested that a stigma against mental health services is a major barrier in Muslim and Arab countries. Because of this stigma, Arabs tend to underutilise

mental health services and hold negative attitudes towards formal mental health services. Arabs feel that mental illnesses cover only psychotic behaviour and mental retardation, and usually label minor psychiatric issues, such as anxiety and depression, as medical illnesses. Therefore, it can be construed that distressed Iraqis in Jordan might not present themselves to mental health services due to fear of stigma, because they view their psychological distress as a physical illness, or because they rely on their faith and religious leaders to overcome their struggles. If they do access mental health services due to referrals from general health practitioners or the inability to access religious leaders they trust, they might not trust the processes relayed by mental health professionals to overcome their psychological distress.

Provision of Mental Health Care in Jordan

The massive influx of Iraqis into Jordan placed an immense strain on the already underresourced mental health sector. WHO-AIMS (2011) reported that there were 61 psychiatrists, 221 nurses, 15 psychologists, 17 social workers, and 5 occupational therapists in Jordan. The mental health system in Jordan is based on the biomedical model and has a hierarchal system in which psychiatrists lead treatment plans. This has prompted a consortium of international organisations to establish programmes and employ and train psychosocial counsellors to implement psychosocial interventions. Some examples are as follows.

- Care International provided psychosocial counselling and rehabilitation activities.
- Mercy Corps offered basic counselling through a Community Development Centre.
- World Vision provided basic counselling to the Iraqi community.

- International Medical Corps offered training on mental health for general health practitioners.

Jordan, a low- and middle-income country, has limited and stretched resources. Horn and Strang (2008) suggested that Jordan was facing difficulties in implementing the IASC guidelines even though substantial international funding had been provided. They suggested that it was difficult to implement the guidelines for the following reasons. Firstly, Jordan did not have a previously established mental health system, which hindered referrals to specialised services. Secondly, because of Iraqis' lack of legal status, they were scattered in urban areas and many were not able to leave their homes due to fear of deportation, which made community outreach programmes difficult to apply. Thirdly, donors' enthusiasm to help Iraqis led to many agencies entering the field with little capacity and little attention paid to Iraqis' needs, so "programmes often seemed not to be planned on the basis of reliable information or population based needs assessments, but were, to a large extent, donor driven. In this context, it was extremely difficult for the guidelines to be implemented objectively" (Horn & Strang, 2008, p.293). The aforementioned factors and obstacles led organisations to provide clinical-based interventions for Iraqis in Jordan – the setting in which the psychosocial counsellors who participated in this study are working.

How Could These Factors Impact Psychosocial Counsellors in Jordan?

When the Iraqi crisis began, the provision of psychosocial counselling was relatively new in Jordan. Therefore, the challenges that psychosocial counsellors might be facing is largely unknown. Iraqis in Jordan suffer from significant stressors, such as unemployment; social disruption and isolation from family; lengthy asylum procedures; and a history of experiencing or witnessing torture, persecution, and severe trauma. Such complexities could have a profound effect on the psychosocial counsellors working with them. In the previous

literature, several terms describe the effects of therapeutic work with individuals who have experienced trauma. These terms can be utilised to gain an understanding of the potential impact on psychosocial counsellors working with Iraqi refugees in Jordan.

The terms include *burnout* (Maslach, 1982), *secondary traumatic stress* (STS) (Figley, 1999), *compassion fatigue* (CF) (Joinson, 1992), *vicarious trauma* (VT) (McCann & Pearlman, 1990), *posttraumatic growth* (PTG) (Tedeschi & Calhoun, 1995) and *vicarious resilience* (VR) (Hernandez, Gangsei, & Engstrom, 2007). They describe different aspects of working with clients who have experienced trauma, although they vary in their theoretical basis and focus.

Negative Aspects of Trauma Work

Burnout

The term burnout is well established in the literature and is accepted worldwide. Schaufeli, Leiter, and Maslach (2009) stated that various definitions of burnout have been provided in the literature since its conception in 1974 by Freudenberger, who described it as gradual emotional depletion, loss of motivation, and reduced commitment. Pines and Aronson (1988) defined burnout as a state of mental, physical, and emotional exhaustion that is "caused by long-term involvement in emotionally demanding situations" (p.9). Maslach and Jackson (1986, as cited in Maslach, Jackson, & Leiter, 1996, p.4) defined it as "a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with people in some capacity".

Kahill (1988) identified five categories of symptoms associated with burnout: physical, emotional, behavioural, work-related, and interpersonal. The physical symptoms include fatigue, specific somatic problems, and general physical depletion. The emotional symptoms include irritability, anxiety, depression, guilt, and a sense of hopelessness. The

behavioural symptoms include aggression, pessimism, defensiveness, cynicism, and substance abuse. The work-related symptoms include leaving the job, poor work performance, and absenteeism. Lastly, the interpersonal symptoms included withdrawal from clients and colleagues.

In the literature, burnout is identified through symptoms and can be experienced by anyone working with people (Maslach, 1982). The Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981, 1986; Maslach, Jackson, & Leiter, 1996) was designed to assess emotional exhaustion, depersonalisation, and reduced personal accomplishment and is the most widely used instrument to measure burnout (Schaufeli et al., 2009). Burnout is identified as a potentially harmful effect on therapists working with trauma, but it is not specified as a distinctive effect of therapeutic work with clients.

Pross (2006) suggested that burnout is common in health-care systems and therapists working exclusively with refugees. As psychosocial counsellors in Jordan are full-time employees in organisations that provide psychosocial interventions, it could be construed that they are exclusively working with refugees. An unpublished study carried out by Salahat (2009), who utilised the MBI, found that eight out of ten counsellors in the primary organisation working with Iraqis in Jordan were experiencing burnout.

Countertransference

Since Freud coined the term countertransference, it has been understood in various ways and assigned many definitions. However, in the scope of therapeutic work, countertransference is the therapist's response to a client. In the context of trauma work, Pearlman and Saakvitne (1995) defined it as "(1) the affective, ideational and physical responses a therapist has to her/his client, his clinical material, transference, and reenactments, and (2) the therapist's conscious and unconscious defences against the affects,

intrapsychic conflicts and associations aroused by the former" (Pearlman & Saakvitne, 1995, p.23).

Countertransference occurs with all client groups and is considered to be an important diagnostic tool. However, how a therapist reacts to or utilises it determines whether it is a positive or negative experience. For example, in the context of trauma work, Chu (1988) suggested that a therapist might avoid speaking about the trauma for fear of reexperiencing a countertransferential reaction. Kinzie (2001) suggested that therapists who work with refugees need to hear and believe the extreme stories they present, be consistent over time, be able to provide long-term therapy, and have the ability to receive what their clients need to give. This notion is related to the *testimony method* (Lira & Weinstein, 1983), wherein clients tell their life stories, including the traumatic experiences, and then the narrative is reflected in a written document. Thus, therapists partake in the journey of recalling traumatic events. Because therapists working with refugees are continuously subjected to traumatic material, they might become emotionally affected by the stories they hear from their clients.

The three most widely used terms in the literature to describe the inherent risk of exposure to trauma on helping professionals are STS, CF and VT. Although these terms are specific to trauma work, they are not unique to therapists; the various studies conducted on these terms included social workers (Adams, Matto, & Harrington, 2001; Bride, 2007; Cunningham, 2003), relief aid workers (Musa & Hamid, 2008; Shah, Garland, & Katz, 2007) and psychiatrists (Boscarino, Adams, & Figley, 2010).

STS and CF

Figley (1999) defined STS as:

> the natural, consequent behaviours and emotions resulting from knowledge about a traumatising event experience by a significant other. It is the stress resulting from helping, or wanting to help, a traumatised or suffering person (Figley, 1999, p.10)

Figley (1999) related STS to the DSM-IV (APA, 2000) definition of PTSD, in which it is suggested that STS is equivalent to PTSD. Therefore, the definition of STS is, like burnout, symptom-based. STS is measured by the Secondary Traumatic Stress Scale (STSS), a 17-item instrument designed to measure intrusion, arousal, and avoidance symptoms (Bride, Robinson, Yegidis, & Figley, 2003).

The development of the definition of STS was influenced by the following inclusion criteria for PTSD. The DSM-IV (APA, 2000) states that PTSD is "the development of characteristic symptoms following [...] learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates" (p.425). The DSM-IV's recognition that the development of symptoms can occur through *learning* about traumatic events experienced by a close associate has been the main criteria for defining STS (Figley, 1995).

Joinson (1992) coined the term CF for the nursing profession. Figley (2002) developed this further, describing CF as:

> A state of tension and preoccupation in the traumatised patients caused by re-experiencing the traumatic events, the avoidance/numbing of reminders, and persistent arousal (e.g. anxiety) associated with the patient. It is a function of bearing witness to the suffering of others. (Figley, 2002, p.1435)

McCann and Saakvitne (1995) highlighted that within the literature, CF is also known as secondary traumatisation, STS disorder and VT. Figley (1995) suggested that STS could

be defined as CF and that the terms STS and CF are used interchangeably within the literature. The Professional Quality of Life (ProQOL) is the current self-test measure of CF and was developed based on Figley's (1995) Compassion Fatigue Self Test. CF in ProQOL is split into two parts: burnout and STS. Thus, STS is viewed as a part of CF, and CF is viewed as a combination of burnout and STS (Stamm, 2010). Therapists working with refugees might experience symptoms of STS and CF due to the nature of their clients' stories. Woodcock (1995) stated that therapists might find it difficult to absorb the horror of what refugees and asylum seekers have endured, which could ultimately negatively affect them. Additionally, as some refugees struggle with symptoms of PTSD, therapists working with them could be experiencing STS symptoms.

VT

VT is a psychological term used to refer to the changes in individuals that can occur when they are repeatedly and indirectly exposed to traumatic material. The term, coined by McCann and Pearlman (1990), is the most widely used in the literature on trauma work. Pearlman and Saakvitne (1995) defined it as "the inner transformation that occurs in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995, p.31). Laidig, Brady, and Guy (1999) stated that it could result in changes to a therapist's cognitive schemas and belief systems, as well as affecting the therapist's sense of identity, worldview, spirituality, levels of tolerance, and interpersonal relationships. As therapists working with refugees in low- and middle-income countries are usually full-time employees in their respective organisations, they may be at risk of VT due to being continuously subjected to traumatic material.

McCann and Pearlman (1992) developed the constructivist self-development theory (CSDT) to provide an understanding of the VT factors that could cause changes in the therapist's internal world. The authors suggested that CSDT explains the psychological,

interpersonal, and transpersonal impact of trauma and provides a framework that describes the impact of trauma work on the therapist.

Trippany, White Kress, and Wilcoxon (2004) proposed that the basis of the theory is that an individual's construction of reality occurs through the development of perceptions or cognitive schemas that enable an individual to understand their life experiences. McCann and Pearlman (1990) elaborated on this by stating that each person's subjective experience of a traumatic event is influenced by a complex interplay between the individual, the event, and the wider context. Thus, CSDT proposes that when therapists are exposed to client-presented traumatic material, they develop new perceptions as a normal adaptive strategy. The vicarious reaction of each therapist is based on the individual characteristics of the therapist, the traumatic material presented, and the wider context of the event (Trippany et al., 2004). Furthermore, Pearlman and McKay (2008) proposed that these changes have the potential to affect every area of the therapist's life and could be permanent, as each traumatic event the therapist encounters could reinforce these changes in cognitive schemas.

Differences Among STS, VT and CT

Arvay (2001) provided an overview of research findings on STS and suggested that counsellors working with people who have experienced trauma are vulnerable and at risk of experiencing trauma symptoms themselves. Arvay (2001, as cited in Courtois, 1988, p.1) proposed that PTSD is "contagious". From the research findings, Arvay (2001) suggested that VT and STS are the same phenomenon.

However, Jenkins, and Baird (2002) stated that there are differences between STS and VT. They stated that the main difference is in how clients' traumatic material is assimilated. In STS therapists develop symptoms of PTSD, whereas in VT therapists experience changes in their worldviews, schemas, and relationships, as presented by the CSDT. Additionally, VT

reactions are related to specific traumatic client experiences and are similar to the changes their clients experience, whereas the symptoms of STS might not be similar to what the client is actually experiencing, even though they are a product of the client's experiences.

Way, VanDeusen, Matin, Applegate, and Jandle (2004) suggested that the constructs of VT, STS, and countertransference have features that overlap and can have an interactional effect. Countertransference, is theoretically linked to VT and STS. Pearlman and Saakvitne (1995) suggested that countertransference is "temporally or temporarily linked to a particular period, event, or issue in the therapy or in the therapist's inner or external life as it interacts with the therapy" (Pearlman & Saakvitne, 1995, p.33). This suggests that countertransference is linked to a particular moment in time, whereas STS and VT occur in a time and place beyond the therapeutic relationship; that is, in the therapist's wider professional and personal life.

Sabin-Farrell and Turpin (2003) suggested that the process of countertransference might result in CF. As a client describes the details of the trauma, the therapist can experience parallel states of grief, fear, and helplessness, and when these reactions become repetitive, intrusive, and disruptive, CF might manifest in the therapist. Additionally, Wilson and Lindy (1994) argued that unacknowledged countertransference reactions could make the therapist vulnerable to experiencing VT. Similarly, VT creates changes in the self of the therapist; as the contemporary definition of countertransference describes reactions being determined by the self, VT invariably shapes countertransference. Hesse (2002) argued that "reactions to secondary trauma that are manifested in sessions as countertransference pose a serious ethical dilemma for therapists as clients can actually be harmed or possibly even re-traumatised by such reactions" (Hesse, 2002, p.303).

In summary, the two most widely used terms to describe the effect on therapists providing trauma therapy are STS and VT. Jenkins and Baird (2002) described the difference

between STS and VT in terms of how the traumatic material of clients is assimilated. In STS, therapists develop symptoms of PTSD, whereas in VT, therapists experience changes in their worldviews, schemas, and relationships that are similar to the changes their clients have experienced. Burnout and CF are terms that are also used to describe the effects therapists experience from their work. However, Sabin-Farrel and Turpin (2003) argued that burnout and CF can be experienced with other client groups; thus, STS and VT are unique experiences that occur in therapists providing therapy for people who have experienced trauma. Not only do refugees have a high incidence of exposure to trauma, but also their recovery is complicated by loss of social connections, loss of family support, lack of legal status, and the inability to work. Thus, they might be frustrated by the impact of the political climate on their own and their family’s future and might not feel that counselling is a sustainable solution to their problems. This might result in mental health providers feeling helpless, powerless, and frustrated, which could subject them to the negative impact of working with refugees.

Gilbert (2009) discussed the impact of trauma work on counsellors in Jordan in relation to her observations and discussions with counsellors working within INGOs. The author found that counsellors were experiencing ethical dilemmas influenced by limited resources, a lack of training, and the complexity of cases. She also found that the counsellors had feelings of acute powerlessness because their resources were extremely limited and they felt that they needed to be providing *sympathetic listening* rather than counselling (Gilbert, 2009). Counsellors also found it difficult to cope with the stress of dealing with clients’ anger and frustration with the system and their own feelings of helplessness amid the complexity of cases and severity of trauma.

Implications of VT and STS

VT. Pearlman and Saakvitne (1995) suggested that, as proposed in CSDT, five components of an individual's self might be impacted by exposure to trauma. These components are: (1) frame of reference; (2) self-capacities; (3) ego resources; (4) psychological needs and cognitive schemas; and (5) memory and perception. They suggested that frame of reference refers to how individuals view and understand themselves and the world, identity, and spirituality. From this point of view they suggested that any changes to a therapist's frame of reference might be distressing and could have an impact on the developing therapeutic relationship.

The second aspect, self-capacities, is defined as the "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection and positive self-esteem" (Pearlman and Saakvitne, 1995, p.64). Ego resources refers to an individual's resources of introspection, personal growth, and empathy, and their ability to establish mature relationships and boundaries, interpersonally connect with others, and meet their psychological needs. Finally, Trippany et al. (2004) suggested that psychological needs and cognitive schemas relate to an individual's safety needs, trust and esteem needs, intimacy needs, and control needs. These psychological needs provide some understanding of and prevention of VT.

Safety needs. A sense of security is the basis of safety needs. According to Trippany et al. (2004), with regard to a client's traumatic material, a therapist experiencing VT might start feeling that he or she is not protected from real or imagined threats to their personal safety. Pearlman (1995) suggested that higher levels of fearfulness and vulnerability might manifest in the disruption of safety needs. This occurs when a therapist starts fearing for their own safety and the safety of their family, and they might become hypervigilant in relation to cues of threat.

Trust and esteem needs. According to Trippany et al. (2004), the CSDT proposes that all individuals have an innate need to trust their own perceptions and beliefs and to trust significant others’ ability to meet their own emotional, psychological, and physical needs. Pearlman and Saakvitne (1995, as cited in Trippany et al., 2004, p.71) describe this as a “healthy dependency”. They suggested that inherent trust needs to be found in a therapist for them to be vulnerable to this aspect of VT. For example, in relation to trusting his or her own perceptions and beliefs, if a therapist holds a strong belief that a mother cannot hurt her child, they might be surprised to hear about a client’s experience of being sexually abused by his or her mother, which might lead the therapist to question their other strong beliefs about the world. This is in contrast to a therapist who has an understanding that sometimes, for various reasons, mothers might hurt their children.

Esteem needs (Pearlman, 1995) relate to a therapist’s vulnerability to self-doubt in the sense of questioning their own judgment and their ability to work with and help clients. If the therapist’s perception of this ability is negatively affected, this might affect their self-confidence and how they value themselves.

Intimacy needs. Trippany et al. (2004) illustrated how VT can disrupt a person’s need to feel connected to themselves and others. This disruption is expressed by withdrawing from others or by becoming overly dependent on significant others and experiencing an inability to spend time alone.

Control needs. Trippany et al. (2004) related control needs to self-management, suggesting that when a therapist feels they have lost a sense of control, this can lead to distress. The sense of control can be disrupted by intrusive verbal, imagery, bodily, affect, and interpersonal memory recalls that develop in the therapist due to empathically engaging with a client while hearing descriptions of the client’s memories of traumatic events.

Because those memories can be emotionally distressing, a therapist might turn to numbing, denial, or avoidance to alleviate the emotional impact. The final component of an individual's self is memory and perception; when a therapist's memories are affected by VT, they can become fragmented and disjointed, or recalled without emotion.

Pearlman (1996) suggested that VT has 10 components; that is, self-safety, other's safety, self-trust, other trusts, self-esteem, other esteem, self-intimacy, other intimacy, self-control and other control. The Trauma Symptom Inventory (TSI) Belief Scale measures these components. In summary, the CSDT's five inherent needs provide an understanding of how VT can negatively influence a therapist's view of self and their worldview and highlights how extensive these changes can be.

STS. Figley (1995) described STS symptoms as resembling those of PTSD. Brady, Guy, Poelstra, and Brokaw (1999) found that the experiences of secondary trauma were similar to those of direct trauma victims. Furthermore, Steed and Downing (1998) suggested that posttraumatic symptoms are risk factors for the development of mental health problems, including depression and anxiety disorders. Therefore, as with the symptoms of PTSD, if the symptoms of STS are unacknowledged, therapists might internalise them and use maladaptive coping strategies, such as avoidance and numbing, to alleviate their symptoms.

Therapists working with refugees are repeatedly exposed to clients dealing with issues such as abuses of human rights; the loss of family, friends, country, culture, and profession; unemployment; traumatic experiences; insecurity/instability; and racism and stigmatisation. Therefore, such issues might have a negative effect on therapists' view of themselves and on their worldview. This could lead them to use maladaptive strategies, such as avoidance and numbing, which might cause disruptions in their personal relationships.

Implications of VT for Clients

Stamm, Varra, Pearlman, and Giller (2002) suggested that VT has been associated with increased sick leave, lower morale, and lower productivity. Motta, Joseph, Rose, Suozzi, and Liederman (1997) highlighted that VT can occur at lower levels of intensity in therapists than in clients who have experienced direct trauma. Lerias and Byrne (2003) stated that this might result in chronic, milder distress. As a result, VT can go undetected because the individual is still able to function relatively well. Saakvitne and Pearlman (1996) argued that this can result in ethical issues regarding the quality of treatment a client receives.

Research suggested that therapists experiencing VT are at a higher risk of making poor professional judgments than those who are not affected (Munroe, 1999; Pearlman & Saakvitne, 1995; Williams & Sommer, 1995). Hesse (2002) provided examples of poor judgments, which included misdiagnosis, clinical error, and poor treatment planning, including (but not limited to) the overmedication and inappropriate hospitalisation of patients.

Hesse (2002) further argued that disruptions in cognitive schemas might result in the therapist avoiding and withdrawing (e.g., forgetting appointments, abandonment, and unreturned phone calls) and thereby becoming unable to maintain therapeutic boundaries. Hesse (2002) also stated that the most damaging implication for clients is if a therapist blames the client for their own experience of trauma as a form of denial and views the client as manipulative. Herman (2001) suggested that disruption in esteem needs in therapists might lead them to doubt their skills and lose sight of their clients' strengths and progress. In addition, Munroe (1999) suggested that therapists might collude with the client to avoid traumatic material or become intrusive when exploring traumatic memories.

Predictor Variables of VT

The nature of trauma work is predictive of the likelihood of experiencing negative symptoms. The nature of the work refers to the nature of the clientele and specific facts about the traumatic event, supervision, and organisational climate, which includes the organisational setting and bureaucratic constraints.

Nature of the Clients and Specific Facts About the Traumatic Event

James and Gilliand (2001) suggested that trauma could include childhood physical and sexual abuse, domestic violence, sexual assault, and naturally occurring disasters. Johnson and Hunter (1997) found that the facts about the traumatic event generate different emotional burdens among therapists. They utilised the MBI and found that sexual assault counsellors scored higher on emotional exhaustion than counsellors working in other areas.

In addition, Cunningham (1999) highlighted that when the trauma is inflicted by another human being it is much more devastating, perhaps due to the disruption it causes in the therapist's existing trust (Courtois, 1988; Herman, 1992; Janoff-Bulman, 1992; McCann and Pearlman, 1990). Smith, Kleijin, Trijsburg, and Hutschemaekers (2007) found that therapists who were working with refugees experienced higher levels of emotional burden from the stories they had heard than therapists working with veterans of WWII.

Schauben and Frazier (1995) assessed the effects on counsellors of working with survivors of sexual violence. They found that therapists who had a larger number of survivor clients in their caseload were correlated with more disruptions in their beliefs and schemas, along with PTSD symptoms and a higher probability of experiencing VT. Brady et al. (1999), Chrestman (1999), Cunningham (1999), Kassam-Adams (1995), and Pearlman and MacIan (1993) found that therapists who work primarily with trauma clients experience more VT than therapists who have only a few clients who have experienced trauma.

Devilly, Wright, and Varker (2009) suggested that work-related stressors, such as burnout and experience in the field, were the best predictors of therapist distress. This was contrary to past research, which had suggested that exposure to client traumatic material predicted affect of STS and VT. Steed and Bickell (2001) explained these differences in results in terms of the definition of exposure to traumatic material; that is, the number of hours per week, the number of clients, and how long a therapist has been involved in trauma work. However, Baird and Jenkins (2003) and Brandon (2000) found no link between time spent working in trauma therapy and experience of VT.

Supervision

Sabin-Farrell and Turpin (2003) found that the quantity and quality of supervision is associated with VT. Ullman and Townsend (2007) found that VT was related to poor supervision. Sommer (2008) argued that counsellor educators have an ethical responsibility to train counsellors and supervisors to identify and alleviate VT. Schauben and Frazier (1995) and Trippany et al. (2004) encouraged supervision practices that support awareness of VT. Harrison and Westwood (2009) proposed that supervision could be a predictor and a protective variable of VT. They cite Walker (2004, p.179), stating that "ensuring early recognition and response […] [acts] as a protection against burnout and consequent damage to the therapist and to their client". In contrast, Ben-Porat and Itzhaky (2011) found no correlation between supervision satisfaction and secondary traumatisation and burnout.

Pearlman and Saakvitne (1995) noted four components of effective supervision for trauma counsellors: a strong theoretical grounding in trauma therapy; an awareness of the conscious and unconscious aspects of trauma work; a mutually respectful interpersonal climate; and an educational aspect that addresses VT. In addition to Pearlman and Saakvitne's (1995) suggestion that a mutually respectful interpersonal climate is integral to

supervision, other studies have found similar results (Bernard & Goodyear, 2004; Bradley & Ladany, 2001; Holloway, 1995; Nelson, Gray, Friedlander, Ladany, & Walker, 2001). Furthermore, McCann and Pearlman (1990) argued that a therapist needs to engage in a process of integrating and transforming the traumatic experience, in the same way a client does during therapy, to negate maladaptive coping strategies, such as numbing and avoidance.

Organisational Climate

Herman (2001) proposed that for therapists to work effectively they need support as much as a trauma survivor needs support to heal. Pearlman and Saakvitne (1995) argued that organisations with therapists experiencing VT are affected by increased illness and absenteeism, a reduction in motivation and productivity, violations of ethics or boundaries, a higher staff turnover, and a decrease in morale. Thus, organisations need to be involved in the reduction of VT to protect the health of the therapists and the clients they serve.

Bell, Kulkarni, and Dalton (2003) discussed the organisational prevention of VT in social workers. They argued that organisations should promote an organisational culture that fosters an atmosphere of understanding the negative effects of working with trauma and supporting workers to alleviate those effects. Catherall (1995) stated that organisational culture includes the assumptions, values, norms, and behaviours of an organisation's members. This includes whether or not an organisation acknowledges the existence of VT, STS, and CF as natural responses to the client's traumatic material, which might contribute considerably to the therapist's ability to manage and cope with the symptoms and to seek help in doing so.

Furthermore, Yessen (1995) argued that organisations must help develop and provide workers with opportunities for self-care; that is, allowing holidays, varying caseloads, and

allowing time for self-care activities. Carroll, Gilroy, and Murra (1999) suggested that self-care includes "interpersonal work, interpersonal support, professional development, and physical and recreational activities" (p.135). The authors suggested that to maintain self-care, clinicians benefit from clarifying their view of themselves as adults in their personal lives and as clinicians in their professional lives. Additionally, they argued that seeking and receiving help from their social support network is of special importance. Attending continuing education workshops, receiving support from colleagues and supervisors, and spending time on personal hobbies and activities provides clinicians with a route to protect themselves from the harm of working with severe trauma.

Bell et al. (2003) also stated that organisations should implement supervision practices that allow each individual worker to feel safe enough to express fears, concerns, and inadequacies. Organisations should also provide safe and comfortable work environments, trauma-specific education, group support, and resources for self-care. The authors concluded that if organisations serving clients who have experienced trauma do not consider these measures, their workers will be more prone to experiences of VT.

In support of previous research, a recent research study conducted by Choi (2011) examined the influence of organisation characteristics and their impact on STS in social workers. The author measured STS by using the STSS and looking at work conditions (direct and nondirect client hours and supervision) and organisational support (sociopolitical support, access to strategic information, access to resources, and organisational culture). In addition, the author controlled for demographic and individual characteristics (age, years of experience with trauma cases, trauma history, salary, gender, and race/ethnicity). The author found that the social workers who had access to strategic information and support from colleagues, supervisors, and work teams experienced lower levels of STS.

Finally, research into a therapist’s own trauma history and vulnerability to VT has been covered extensively in the literature (Battley, 1996; Kassam-Adams, 1995; Pearlman & MacIan, 1995; Trippany, Wilcoxon, Allen, & Satcher, 2003). Figley (1995) suggested that therapists with personal trauma histories are at risk of developing trauma symptoms when working in trauma therapy. However, since the conception of VT, the research findings have been inconsistent.

Protective Practices

Harrison and Westwood (2009) argued that although various studies have discussed the protective practices of VT (Coster & Schwebel, 1997; Ladany, Friedlander, & Nelson, 2005; Walker, 2004), only a limited amount of specific research has been conducted into these practices. The authors, therefore, conducted a qualitative study to explore the protective practices that therapists working with clients experiencing trauma most utilise, and found nine major themes, which they termed *countering isolation*. These themes were: developing mindful self-awareness; consciously expanding perspectives to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries; honouring limits; exquisite empathy; professional satisfaction; and creating meaning.

The participants described that they countered isolation through actively pursuing professional support. Thereby, Harrison and Westwood (2009) suggested that supervision, training, professional development, and organisational support were vital for the participants to mitigate the risks of VT. In addition, the participants stated that social support, as described by Lucero (2002), was essential to mediate the effects of VT.

In support of previous research (Brady et al., 1999; Pearlman, 1995; Trippany et al., 2004) the participants also described that cultivating a spiritual connection was important in their line of work. Based on the participants’ descriptions, the authors concluded that:

> Spiritual interconnection reinforces their positive disposition and renews their conviction that: (a) people are resilient and can heal; (b) growth can occur in the wake of trauma; (c) life is about more than suffering; (d) their professional efforts are meaningful; and (e) they are not solely responsible in their efforts to heal trauma. (Harrison & Westwood, 2009, p.209)

Ringenbach (2009) supported this notion by examining the meditation practices of counsellors and their experiences of burnout, CF, self-compassion and compassion satisfaction. The study found that counsellors scored lower on burnout and CF and higher on compassion satisfaction and self-compassion if they practised meditation and valued experiences in a nonjudgmental way, accepting rather than avoiding their negative affective experiences. Additionally, Hudek (2007) suggested that a method of mitigating and alleviating VT symptoms is focusing; that is, directing conscious, acceptant attention to one's feelings. Pearlman and Caringi (2009) supported this practice by suggesting that the process of preventing VT and STS involves active engagement.

Finally, the participants in Harrison and Westwood's (2009) study described that they consciously expanded their perspectives and were actively optimistic about embracing the complexity of their work by challenging themselves and reminding themselves "that positive growth does not diminish or efface agonising pain; rather, pain and positive transformation coexist" (Harrison and Westwood, 2009, p.210).

Harrison and Westwood's (2009) study also suggested that holistic self-care, meaning caring for all parts of the self, was integral in preventing VT. Self-care constitutes various facets, including taking care of one's physical, emotional, mental, and spiritual health. The integrity of self-care for therapists working with traumatic material has been covered extensively in the literature (Maschi & Brown, 2010; Pearlman, 1995; Pross, 2006; Tiegreen

& Newman, 2009). Figley (2002) argued that CF occurs due to the therapist's lack of self-care.

The authors also suggested that to maintain firm interpersonal boundaries, therapists need to be aware of and acknowledge their own limits, including their own vulnerability to VT, and recognise that as therapists they are not responsible for making changes in clients' lives. However, these boundaries remain permeable, allowing the therapist to experience intimate connections without losing a personal perspective (Harrison and Westwood, 2009).

The authors further suggested that therapists who are attentive to their own subjective world, and recognise when a client's story resonates with their personal history and brings up their own material, ought to seek supervision or personal therapy. This will help them distinguish between their own worldview and that of their client, while managing their own, individual emotions (Harrison & Westwood, 2009).

Previous research suggested that empathic engagement was a risk factor (Hamilton, 2007). However, Harrison and Westwood (2009) found that it was a protective factor for their participants. The difference seemed to be that when therapists maintained clear boundaries and honoured their limits, while remaining open to establishing deep and intimate therapeutic alliances, they mitigated the experience of VT and enhanced their professional satisfaction. This suggests that empathic engagement alone could be a risk factor for VT, but combining it with clear boundaries might turn it into a protective factor (Harrison & Westwood, 2009). Pearlman (1995, as cited in Wilcox, 2011) provided a description of this process: "when we are receptive, it is easier to care, and to enter into a genuine reciprocal relationship with our clients. Just as we feel their pain more acutely, we appreciate their strengths more directly. We experience the human potential in a deeply heartfelt way" (Wilcox, 2011, p.1).

Harrison and Westwood (2009) recognised that creating meaning is one way of

mitigating VT. The conclusions of Briere and Jordan (2004) and Van der Kolk and McFarlane (1996) paralleled these results. They found that "the process of making meaning beyond concrete events helps to contextualise and reduce the threat of trauma" (Van der Kolk & McFarlane, 1996, p.213). To verify the effect of sense of coherence on psychological distress and trauma in a group of helpers and social workers in Palestine, Veronese, Fiore, Castiglioni, Kawaja, and Said (2012) utilised the Sense of Coherence (SOC-29) Scale, the Impact of Events (IES) Scale and the General Health Questionnaire (GHQ). The authors found that participants who created meaning reported less psychological distress from direct and indirect war-related traumas.

To date, the extensive research on the phenomenon of the vicarious impact of client stories on the professionals who work with them has been predominantly analysed through the concepts of VT, STS, and CF. The positive processes, or changes, that therapists could experience when working with trauma clients are recognised in the literature; however, they are mostly given less emphasis than the negative effects.

Increasing importance has recently been placed on resiliency and the transformation of negative to positive experiences (Pearlman & Carnigi, 2009; Satkunanayagam, Tunariu, & Tribe, 2010; Stamm & Figley, 2009; Stamm, Figley, & Figley, 2010). Pearlman, who conceptualised VT, also developed the concept of vicarious transformation. Pearlman and Saakvitne (1996) recognised that VT can be transformed and suggested that "the client's courage and determination may inspire us to press forward in our own continuing personal growth" (Pearlman & Saakvitne, 1995, p.404). However, although that concept was recognised, the majority of the research continued to focus on conceptualising VT because VT was still in its infancy.

Although refugees experience various complexities that incite feelings of helplessness and powerlessness, they also embody emotional resiliency in the face of adverse conditions.

Previous research has shown that because of this, therapists are positively impacted by their work, which motivates them to continue working in this field.

Previous literature has shown that therapists originally enter the field due to the following: experiencing cultural or social marginalisation; enduring painful childhood experiences; developing a high degree of psychological mindedness; serving as a confidant to others; needing to help others; engaging in personal therapy; or needing intellectual stimulation and intimacy (Farber, Manevich, Metzger, & Saypol, 2005). However, they continue working in the field due to experiencing attachment; intimacy; connection and care; privilege; pride; and behavioural change and progress (McCann, 2010).

Positive Aspects of Trauma Work

PTG

Tedeschi and Calhoun (1995) coined the term PTG in reference to individuals who have experienced growth after a traumatic event. Fosse (2005, as cited in Taylor, 2011) suggested that PTG includes "a shift in perception, knowledge and skill, bringing about positive changes in relationships, self-perception, and attitudes to life, including philosophical/spiritual changes" (Taylor, 2011, p.32).

Arnold et al. (2005) related PTG to therapists' experience of working with trauma. They argued that the literature has underestimated the rewards of working with people who have survived trauma. In their study they described PTG as psychological growth that occurs in therapists after vicarious exposure to traumatic material. They interviewed 21 therapists who had worked with survivors of sexual abuse. They found that for 18 of the therapists, permanent, positive changes had occurred in their worldviews and beliefs. They reported that the therapists experienced "a deeper, more nuanced understanding of the entire spectrum of human behaviour [...] their faith had grown deeper as a result of trauma work and this change

in self-perception had made life seem more precious and inspired them to live fuller, richer lives" (Arnold et al., 2005, pp.257-258).

Compassion Satisfaction

Compassion satisfaction relates to the pleasure an individual derives from their work. The ProQOL (Stamm, 2010) measures compassion satisfaction as well as CF and burnout. Sabin-Farrell and Turpin (2003) suggested that compassion satisfaction has been excluded from many studies that investigate trauma work. However, a study conducted by Raphael, Singh, Bradbury and Lambert (1983) found that 33 out of 95 disaster workers derived personal satisfaction from their work.

VR

The concept of VR, introduced by Hernandez et al. (2007), is concerned with the influence on therapists of witnessing their clients' resilience through adversity. Masten and Coatsworth (1998) described resilience in an individual as being inferred from their pattern of positive adaptation to challenges based on a past or present adversity. This newly emerging term, which was conceptualised by therapists working with torture survivors in the US, also focuses on the positive vicarious impact of empathically engaging with clients' traumatic material.

Hernandez et al. (2007) defined VR as "a unique and positive effect that transforms therapists in response to client trauma survivors' own resiliency. In other words, it refers to the transformations in the therapists' inner experience resulting from empathetic engagement with the client's trauma material" (Hernandez et al., 2007, p.237). Thereby, they argued that VR could be a unique consequence of trauma work. They also suggested that the process of VR is a "common and natural phenomenon illuminating further the complex potential of

therapeutic work both to fatigue and to heal" (Hernandez et al., 2007, p.237).

Engstrom, Hernandez, and Gangsei (2008) interviewed 11 mental health providers involved in the area of torture treatment to support their concept by conceptualising its difference from PTG. Using grounded theory to analyse their data, they found that VR differs from PTG in the sense that VR does not necessarily lead to psychological growth, but is focused on the influence of a client's resiliency on the therapist's resiliency.

The main themes relating to VR are: (1) reflecting on human beings' capacity to heal; (2) reaffirming the value of therapy; (3) regaining hope; (4) reassessing the dimensions of one's own problems; (5) understanding and valuing the spiritual dimensions of healing; (6) discovering the power of community healing; and (7) making the professional and public aware of the impact and multiple dimensions of violence by writing and participating in public speaking forums (Hernandez, Gangsei, & Engstrom, 2010, p.73).

Engstrom et al. (2008) explained that VR bears some similarity to PTG. Like PTG, VR asserts that one's spirituality, personal strength, and outlook on life can be enriched as a consequence of trauma. The authors argued that the difference is that research on PTG is mostly concerned with the transformation of clients and focuses on the growth, rather than the resiliency, that stems from traumatic material.

Simultaneous Positive and Negative Effects

Arnold et al. (2005) focused on the positive and negative experiences of therapists working with clients who have experienced trauma. The study utilised semistructured interviews to investigate therapists' experiences. They found that a large majority of the therapists interviewed described having simultaneous negative and positive experiences through their work. The authors concluded that, in order to help therapists view themselves, their clients, and their work in new and empowering ways, "a more inclusive, less

pathologising conceptualisation of trauma work" needs to be adopted (Arnold et al., 2005, p.260). Johnson (2010) argued that the literature is missing a narrative of how therapists thrive on trauma work. The author supported the emerging research on the positive aspects of trauma work, and concluded that the field needs to include the potential of thriving as well as suffering in trauma work (Johnson, 2010).

This notion was also supported by Satkunanayagam et al. (2010), who explored the experience of mental health professionals working with survivors of trauma in Sri Lanka. In addition, the authors found that the participants they interviewed had gone through personal changes because of their work. However, the authors found that the trauma work, as well as having a negative impact on the participants, simultaneously changed them in a positive way; the participants felt that they had grown personally and professionally because of their work. This was in contrast to the majority of research in the field.

Methodological Issues

Research into the impact of trauma work on therapists has been extensive and various methodological issues have been addressed. In particular, several overlapping and interrelated concepts were found in the literature, and different instruments and methods have been used to understand and measure those concepts (Stamm, 1997). Stamm (1997) argued that there is no consistently used term regarding the impact on therapists who are exposed to traumatic material. This creates challenges in comparing and critiquing the empirical evidence and determining which construct or set of experiences is being referred to.

The existing literature predominantly employs quantitative methodologies and, on the whole, focuses on the negative impact of trauma work. Sabin-Farrell and Turpin (2003) argued that more qualitative research, rather than predefined categories, is needed to understand the real experiences of therapists. Kadambi and Ennis (2004) concluded that to

date, research in this area has been restricted by a lack of baseline data and divergent and contradictory results. Additionally, the focus in the literature varies among populations of social workers, relief workers, psychiatrists, and therapists, where each role has distinctive features.

As shown in the literature review, the studies conducted in this research area utilise different definitions of the negative and positive effects of trauma work, with a significant focus on the negative impact. This invariably results in a diverse theoretical basis and research focus, which influences the choice of instruments to measure the impact. Various instruments have been developed to measure the impact of trauma work, which makes it difficult to compare studies (Kadambi & Ennis, 2004). Meichenbaum (2007) listed some of the instruments that have been used to measure the impact of trauma work:

- MBI
- Professional Quality of Life Scale (PSS-SR)
- Traumatic Stress Inventory (TSI-BSL)
- Traumatic Stress Inventory Life Event Questionnaire (LEQ)
- Secondary Trauma Questionnaire
- Self-report Posttraumatic Stress Scale (PSS-SR)
- IES
- Trauma Symptom Checklist-40
- Symptom Checklist-90 (Revised SCL-90-R)
- Brief Symptom Inventory

Pearlman and Saakvitne (1995) suggested that a phenomenological approach could overcome the limitation caused by the various instruments used to measure the impact of trauma work. Implementing a phenomenological approach would allow flexibility and openness in understanding an individual's meaning of their experience. Additionally, it

would alleviate the limitation caused by predetermined concepts. As the distinctive features of therapists working with refugees cannot be predetermined by past research conducted on therapists working with other client groups, research into the refugee population might provide different results.

Argument for the Current Study

Out of the seven terms described throughout the review, only VR was conceptualised by investigating the experience of therapists working with refugees. Thus, the literature on the effect of refugee trauma on the therapist remains in its infancy. This suggests that more attention needs to be paid to the experience of therapists working with refugees. In the literature there is extensive support for trauma work having an impact on therapists (Figley, 1999; Hernandez et al., 2007; Pearlman & Saakvitne, 1995). However, although the existing research has explored the effects of providing therapy for individuals who have experienced trauma, most of that research has been quantitative in nature (Sabin-Farrell & Turpin, 2003). An IPA approach, which aims to explore the experiences of the participants, could contribute more to the understanding of the impact that working with refugees has on therapists. The decision to utilise an IPA approach is discussed further in Chapter 2: Method.

The UNHCR global trends report (2011) stated that by 2010, 43.7 million people worldwide had been forcibly displaced by conflict. This was the highest number reported in the past 15 years. The UNHCR also found that most refugees were migrating to low- and middle-income countries, fewer refugees were returning home than in past years, and fewer still were finding places of resettlement in Western countries. Studies that have used an IPA approach to explore the experiences of therapists working with refugees have been conducted in Western countries (Munday, 2009). Therefore, therapists in low- and middle-income countries with different experiences should be taken into account.

A search for existing literature indicated that, so far, there are no known published studies applying an IPA approach to exploring the experience of psychosocial counsellors working with Iraqi refugees in Jordan.

Aim and Research Questions

The aim of the current study was to gain an in-depth understanding of the experience of psychosocial counsellors working with Iraqi refugees in Jordan, using an IPA approach (Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2008). The focus of the interview was determined by the areas connected to the available literature on the experience of therapists working with trauma and refugees; and the sociopolitical and socioeconomic climates of Jordan and Iraq. These unique features might provide different results from the ones suggested in the literature.

The psychosocial counsellors were asked open-ended questions to allow them to describe their experiences flexibly and focus on the most pertinent issues that concerned them. Questions broadly relating to the issues of VT, VR, compassion satisfaction, STS, PTG, and self-care were included. In addition, questions were included that aimed to consider whether a client’s social, economic, and political concerns influenced the participants’ work. Prompter questions were developed in advance to provide direction if the interviewee could not provide sufficiently detailed answers.

The main research question, therefore, was:

How do psychosocial counsellors describe their experience of working with Iraqi refugees in Jordan?

Related to this main research question, the following areas of interest were explored:

1. How the participants describe their work with Iraqi refugees.

2. Whether the current sociopolitical climates in Jordan and Iraq influence their work.
3. In what ways their work challenges or rewards them.
4. Whether the work has changed the way they view themselves, the world, and how others view them.
5. How they care for themselves while doing this work.

CHAPTER 2: METHOD

Rationale for Conducting a Qualitative Study

This study employed a qualitative method because (1) past research utilised predesigned questionnaires to measure the impact of trauma work, which do not encompass the whole experiences of therapists; (2) the only study carried out to explore the experience of counsellors in Jordan utilised observations and reflections from counsellors; (3) the research study is not intended to test a hypothesis; and (4) the study aims to gain a rich and full picture of the participants’ experiences in Jordan.

IPA

Theoretical Underpinning of IPA

IPA is an experiential qualitative approach developed by Jonathan A. Smith. It aims to explore individual personal experiences. The three key areas of the philosophy of knowledge that have informed IPA are phenomenology (Husserl, 1931), hermeneutics (Ricoeur, 1978), and idiography (Thomae, 1999). This section will briefly discuss these philosophies and explain their connections to IPA. For a more detailed discussion, see Smith et al. (2009).

Phenomenology. Phenomenology is the name given to the historical movement in philosophy in the early 1900s by Edmund Husserl (1859–1938), which was then developed further by Martin Heidegger and followers. It is a discipline that studies human experience and the structures of consciousness that are experienced from a first-person point of view (Laverty, 2003). Essentially, phenomenology is the study of phenomena: the way we experience things, how things appear to us, and the meanings we give to our experiences. IPA is phenomenological in the sense that it is interested in exploring individuals’ perceptions of their experiences, rather than relaying an objective record of those

experiences. IPA considers that this is achieved through hermeneutics, the theory of interpretation (Smith et al., 2009).

Hermeneutics. Hermeneutics was originally based on the interpretations of spiritual texts, and was defined by Ricoeur (1978, p.141) as "the theory of the operation of understanding in relation to the interpretation of text". Heidegger introduced hermeneutic phenomenology, which proposed that phenomenology is partly interested in something that is disguised, where meaning is hidden and is brought to light through the adoption of deep reflection and interpretation (Smith et al., 2009). This is achieved within the IPA approach through what is referred to by Smith and Osborn (2008) as a double hermeneutics process, whereby the researcher tries to make sense of the participant trying to make sense of their world.

As such, this theory acknowledges the complexity of the relationship between interpreter and interpreted. Access to the individual's experience is complicated by the researcher's own assumptions. Therefore, IPA emphasises the importance of the researcher's awareness of his or her own bias and preconceptions and acknowledges their influence throughout the research process (Smith et al., 2009).

Smith et al. (2009) suggested that the researcher needs to be able to *bracket* his or her own assumptions, which means being able to put aside personal experiences that create biases and assumptions so they are able to listen attentively to the participant's own experience through a different lens. This does not mean one is able to achieve objectivity, but that researchers need to be able to reflect in a reflexive manner on how their assumptions and biases might have affected the data.

As the interviews were conducted in Arabic and were then translated into English, a third hermeneutic process took place: the translator is trying to make sense of the narrative taking place between researcher and participant, who are trying to make sense of the

participant's world. This added to the complexity of the relationship between interpreter and interpreted, because a third person, who was not present at the interviews, was trying to make sense of an audiotape and translate it into a different language. This process is explored further under the heading 'Data Collection'.

Idiography. Allport (1937) introduced the term *idiography* to psychology. This approach focuses on unique individual experience and behaviour (Thomae, 1999). IPA studies are embedded in idiographic designs because they are concerned with investigating in detail how lived experience is understood from the perspective of a specific group of people, in a specific context (Smith et al., 2009). Hence, IPA is different from traditional nomothetic approaches, which focus on the generalisability of findings.

In summary, Kvale (1996) described IPA as "a phenomenological perspective including a focus on the life world, an openness to the experience of the subject, a primacy of precise description, attempts to bracket foreknowledge, and a search for invariant essential meanings in the description" (p.38).

Research Paradigm and Epistemological Reflexivity

In this section I will discuss my philosophical locations, particularly research paradigms, and reflect on my epistemological position.

Research Paradigm

Patton (1990) stated that a research paradigm is, in essence, the way a researcher views the world. Patton (1990) highlighted that by pinpointing the researcher's mindset and location in a particular paradigm, it is simpler to identify how the researcher came to make the methodological choices in a particular study.

Through the review of my own beliefs, my view of the world and my mindset, while

considering the research question I placed myself within an interpretivist/constructionist paradigm. Such paradigms are focused on subjectivity and intersubjectivity as an alternative to the positivist naturalist paradigms. Spiegelberg (1972) argued that the positivist and naturalist view of seeing objects in the world as being separate from subjectivity and our perception of them restricts us from gaining a wider and deeper understanding of a phenomenon.

These paradigms assert that reality is socially and intersubjectively constructed (Guba & Lincoln, 1994) and that truth or reality can only be derived and understood through dialogue. Interpretations of such dialogue are based within a particular moment and context. Voce (2004, p.2) described an interpretive paradigmatic view of the world as “complex and dynamic and constructed, interpreted and experienced by people in their interactions with each other and with wider social systems”.

Epistemological Reflexivity

Epistemology is a study that is concerned with knowledge; that is, what knowledge is, how it is acquired and how we know what we know. In essence it acknowledges whether something can be known and how the reality of the world can be described and explained. Holding an interpretivist/social constructionist standpoint, I view reality as perceptual in terms of how it is constructed by individual subjectivity that is mediated socially and culturally. Thus, there is no singular external reality. This is aligned with the aim of the study, which is not to find one singular reality but to find commonalities between the various subjective realities of the participants within the social and cultural context they live in.

Rationale for Choosing IPA

This research study has focused on examining the lived experiences of psychosocial

counsellors working in Jordan with Iraqis who have fled there since 2003. Smith et al. (2009) suggested that IPA is a valuable tool for examining professionals' perspectives. It attempts to offer new and different perspectives on a phenomenon by learning from those who are experiencing it instead of using predetermined notions in existing literature or theories based on different contexts.

The participants in this research study are underrepresented in the literature and the concepts relating to their experiences are based upon predetermined notions within differing contexts. Therefore, the use of IPA is congruent with the objective of examining a new phenomenon from the participant's perspective. Additionally, the idiographic nature of IPA fits with the objective of this research: to study a small group within a specific context.

The research design also employed an IPA approach. This approach is congruent with my beliefs about the nature of reality (social constructionist and interpretivist standpoints) and acknowledges my preconceived ideas, based on my life experiences, which were the driving force for conducting this study. I am a researcher working in a therapeutic capacity with Iraqis in the UK. As I am Jordanian and I have also worked in Jordan as a counsellor, I held my own assumptions about the participants' experiences. As Willig (2008) suggested, direct access to participants' perspectives is realistically unobtainable; hence, the process of accessing a participant's inner world is interpretive. In this sense, the researcher's perspective within the research process can be acknowledged. IPA allows for introspection and self-reflection and acknowledges that assumptions will be present. This acknowledgement permits some reflection on my individual responses to the data and emphasises the need to recognise and manage my personal subjectivity.

Finally, in this study I investigated the participants' perceptions of the world they live in within a set time. Hence, the experience of counsellors might change as their sociopolitical and cultural realities change. Therefore, what might have been their "reality" at the time of

the interviews could be different on the present day, which fits in with my epistemological standpoint.

Limitations of IPA

The first concern about the use of IPA is the role of language. The IPA approach aims to understand the lived experiences of research participants through the first-hand accounts of the participants themselves. This is mostly achieved through verbal semistructured interviews that are transcribed into text. Social constructionists argue that language constructs rather than describes reality. Therefore, it could be inferred that interview transcripts tell us more about the way an individual talks about a particular experience than about the experience itself (Willig, 2001). Although IPA acknowledges that an individual's pure experience is inaccessible, it opposes the view of people as being only discursive agents (Eatough & Smith, 2006). Smith and Osborn (2008) acknowledge that individuals might find it difficult to express or describe their thoughts and feelings through language, but emphasise that the researcher should uncover what is not being said by asking questions about what is not being said and by analysing what is being said.

Finally, the role of reflexivity poses a limitation to IPA. Although reflexivity is highly regarded as integral to the application of IPA, it is not theorised. Thus, it iterates the importance of the researcher's perspective but does not provide a way to integrate this insight into the research process, as it does not provide a way to show how the researchers' own assumptions are implicated in the analysis (Willig, 2001). Smith and Osborn (2008) argued that IPA is an approach rather than a strict method, which allows the researcher flexibility.

IPA as Opposed to Other Qualitative Methodologies

In addition to IPA, there are several other qualitative methods that can be considered

when conducting qualitative research. The first method, grounded theory (Glaser & Straus, 1967), is usually considered because it bears similarities to IPA. However, because the aim of this research study is to examine the lived experiences of psychosocial counsellors and to gain an understanding of their perspectives, grounded theory was ruled out on the basis that its particular focus is theory construction and the social processes that account for the phenomenon (Willig, 2001).

The second method, discourse analysis (Burman & Parker, 1993), was also ruled out because this is concerned with the role of language in the construction of social reality (Willig, 2008). Since this research study is focused on a detailed understanding of a specific lived experience, it contrasts with discourse analysis’s goal of understanding how individuals use language.

Finally, narrative analysis (Clandinin & Connelly, 2000) is usually considered when conducting qualitative research. Murray (2008) defined narrative analysis as being concerned with understanding the relationships between individuals’ experiences and their social framework. Although narrative analysis also bears similarities to IPA, it was deemed inappropriate for my research because it was focused on the narratives people construct to bring order and meaning to their world, while IPA is focused on the interpretation of the participants’ narratives in order to gain understanding of how they perceive those experiences (Smith et al., 2009).

Reflexivity

As previously mentioned, it is crucial to be aware of how personal experiences influence assumptions and biases. By being aware of our own biases it is somewhat easier to be aware of how they might affect the research process, including creating an interview schedule, interviewing participants, and analysing the data.

Our own experiences usually provide us with the drive to conduct particular studies, and my personal experiences were at the forefront of why I wanted to specifically research this area. In the early stages of my research study I became aware of how my own assumptions were already influencing the path of the study in the way I initially constructed my interview schedule.

Having worked within the mental health field in Jordan, having worked with Iraqi refugees in the UK and having had various informal conversations with people in different sections of the mental health field in Jordan, I have constructed a reality in my own mind. In reviewing my questions I needed to continuously remind myself that what is true for me might not be true for someone else, and by looking only at what is true to me I am narrowing my access to the potential depth of my participants’ experiences.

Before starting my training as a counselling psychologist I worked within the mental health field in Jordan and observed various unethical practices taking place. However, I did not have the capability or knowledge to challenge them. I was asked to practise out of the limits of my competence and on several occasions felt I had to turn down jobs. This experience made me aware that there is a great need for professional psychologists in Jordan and that I would need to pursue further training if I wanted to work in the field with my ethical values embedded in not causing harm to clients.

Unfortunately, the practice of gaining further training abroad and turning down jobs is not realistic for most people in Jordan. Therefore, I perceived that some counsellors might be practising out of the limits of their competence, either consciously or unconsciously, due to lack of training. Others might want to gain further training but are unable to, which could create ethical dilemmas for them. This assumption arose from my own experience of realising I was practising outside the limits of my competence, and going through the difficult process of making a decision to leave my social support system to gain a degree in the UK

that was unavailable in Jordan.

After conducting my interviews and analysing my data I recognised that this assumption might have been presumptuous. In other words, gaining further training outside of Jordan does not necessarily mean I will be better informed on how to work with clients in Jordan than people who do not take this path. I noticed that some of the research participants could have benefited from understanding some concepts I was aware of because of my training; however, at the same time they had a better understanding of concepts that I had not been exposed to.

Before the interviews I reflected on how the participants might view me. I wondered if they might see me be as being different or more privileged due to being a Westernised Arab who has a Western education; therefore, they could perceive that I might not understand what they are experiencing and what it is really like to work as a counsellor in Jordan. During my first interview I noticed that because of that assumption I was trying to show the participant that I understood what he was saying instead of inquiring further to gain a deeper understanding of his experience.

In my work with Iraqi refugees within a charity organisation in the UK, the issue of funding was at the forefront of most of the ethical dilemmas I was faced with. I found the lack of funds frustrating and stressful, as I wanted to offer a service to people who really needed it but was unable to, either for their basic needs or their psychological needs. For example, to maintain funding the service limited the number of sessions provided. Because Jordan is a third-world country that has limited resources and is funded by Western organisations, I assumed that counsellors working there face similar issues, which might influence their experiences of working with Iraqis in Jordan. I found this assumption to be correct, but I needed to distinguish between how it made me feel and how the participants actually felt about it.

In addition to the fact that the funding comes from Western organisations, I realised that I might be viewed as Western. This might lead to counsellors omitting frustrations or feeling that I have more power than I actually do. I experienced the assumption of power with some participants when I conducted an IPA study for my master's degree that explored how Iraqi refugees made the decision to come to Jordan. I found that some participants viewed me as having the power to make changes in areas I could not influence, such as in the legal field.

Fine (1992) suggested that researchers want their work to make a difference, benefit participants and pursue social transformation. This motivation was true for me as a researcher; however, I needed to be aware of the limits to the changes I could achieve. Bourdeau (2000) suggested that qualitative research should address power issues in the researcher/participant relationship. Punch (1994) suggested that to mitigate power issues the researcher should be clear about his or her role in the interaction with participants. To alleviate power issues, at the beginning of my interviews I explained to the participants the aim of my research study and my role as a researcher, which is to understand their experiences as psychosocial counsellors in Jordan.

I attempted continuous introspective reflection during and after the interviews to maintain an awareness of, and process, my own psychological states. I chose to write up process notes after each interview to elucidate how I might have influenced the interviews. I also reflected on how the interviews had influenced me or brought up presumptions. This was to be aware of my own subjectivity to minimise its influence on how I analysed and interpreted the data and how I approached the next interview.

Finally, as much as I, as a researcher, worked towards utilising methods to bracket my assumptions, I acknowledge and recognise that I do have my blind spots. The results of the study are based on my interpretations of what the participants willingly shared with me (Field & Morse, 1992). This study does not claim to represent "the only truth", and it does not

propose that a consensus has been reached to describe the experience of the research participants. In contrast, it proposes that there are possible other truths, and that the findings represent only a step towards shedding light on and deepening our understanding of this specific group.

Procedure

In this section the methods of defining the sampling, data collection and the process of creating an interview schedule will be discussed.

Recruitment

Following ethical approval from City University, a purposeful sampling procedure was used to recruit participants. At the time of recruitment I was living in London, while my target participants were living in Jordan. I chose to conduct my study and recruit participants in Jordan because I sought to gain insight into an underexplored population. To gather a sample of participants, I used professional networks to access counsellors who work with Iraqis in Jordan. At first, I identified the organisations that were offering supervision to their psychosocial counsellors. This was achieved by telephoning the organisations I had in mind. Organisations that did not provide supervision were excluded. I then sent an email to the relevant INGOs and NGOs providing psychosocial counselling services to Iraqis who had fled to Jordan (see Appendix A). The explanatory statement (Appendix B) and consent form (Appendix C) were attached. Because the mental health field is small in Jordan, I have not included the names of the organisations in order to maintain the anonymity of my participants.

Participant Inclusion and Exclusion Criteria

Smith (2003) suggested that to obtain a homogenous sample, it is possible to state specific requirements about the participants to be involved. The inclusion criteria specified that all participants should be counsellors, with any qualifications or experience, who were currently working with Iraqis in Jordan. All participants had to give full informed consent and had to be in supervision. As support services are not readily available in Jordan, the inclusion criterion of being in supervision was deemed necessary for the participants to ensure that they had access to professional support.

During the recruitment phase I received replies from five caseworkers from the identified organisations, even though the email included the words "counsellor" and "therapeutically working with". The five caseworkers were excluded from the study. An explanation as to why they were excluded from the research was sent to each of them. From personal experience I was aware that there could be misunderstandings; therefore, before setting a date for an interview I checked whether potential participants were providing counselling for Iraqis or working with Iraqis in another capacity The fact that I received replies from a number of caseworkers, and the implications for people working with Iraqis and for Iraqis themselves, will be discussed further in the discussion chapter.

Defining the Sample

The aim of the study was to explore the experience of people working in a therapeutic capacity with Iraqis who had fled to Jordan. One of the difficulties I faced in defining the sample was using a term to define my research participants. Gilbert (2009) argued that terms to define psychological work are used loosely in Jordan and there are no real definitions of what the terms used actually mean. For example, an individual labelled as a counsellor might be working in a different capacity and might have different training from another person

labelled in the same way. In this study the term *psychosocial counsellor* was used because that is how the research participants are defined in the organisation they work for. All the participants have undertaken the same training within the organisation in order to implement psychosocial counselling.

In order to define the client population they work with, this study has used the terms *Iraqis in Jordan*, *Iraqis who have fled*, *Iraqi refugees*, and just *Iraqis* to describe individuals who have fled Iraq due to the consequences of the 2003 regime change. The term refugee is not consistently used because of the different forms of legal status Iraqis hold in Jordan. When the word refugee is used, this does not confer refugee status, but rather describes someone who is seeking refuge (safety) in Jordan. The terms asylum seeker and guests are not used either, because some of the clients participants worked with were given residency before the Jordanian borders became overburdened with the huge influx of Iraqis in 2006; since that time, permits have not been as readily available as they had been before.

The Sample

IPA does not set a number of participants for sample size, because it is mostly concerned with data that provides enough richness to examine the similarities and differences between cases (Smith, 2003). Therefore, Smith and Osborn (2008) recommended five to six participants as a sample size for a student using IPA. As the present research was a small-scale study with limited resources, a small sample size of six participants took part in the study. These six participants were recruited from one organisation that adopted the international psychosocial model. This was because they represented a homogeneous sample through their training (for vignettes about the participants, see Appendixes G & H). Participants were recruited through word of mouth through their colleagues or managers. Once prospective participants made contact with me, the criteria for eligibility were checked.

After the participants confirmed that they had read the consent form and information sheet, written consent to take part was obtained. After that, arrangements were made to carry out the interviews at a place that was convenient for the participants. All the interviews took place at the participants’ place of work.

Ethical Considerations

The City University Ethics Committee granted ethics approval.

To check who I needed to contact to gain ethics approval in Jordan, I first called the Jordanian Psychological Association. They informed me that because I was exploring the experience of participants who were not vulnerable, because I was not using any instruments (which would infer cultural issues), and because I had already gained ethical approval from my university’s research committee, I did not need further ethics approval. With that information in mind, I decided to look through the literature and check what ethical considerations I needed to keep in mind when carrying out research in a low- and middle-income country.

Caballero (2002) cited the US National Bioethics Advisory Commission (NBAC), which provided seven basic principles that should be followed by investigators conducting human research in low- and middle-income countries. The seven basic principles, which are followed in this research study, are as follows:

- The research plan must receive prior review by an independent ethics review committee.
- Efforts must be made to minimise the risk to research participants.
- The research must involve a reasonable risk-benefit ratio.
- Adequate plans for the care and compensation of participants for injuries directly related to the research must be presented.

- Individual informed consent must be obtained from all participants.
- All participants must receive equal consideration and care.
- There must be an equitable distribution of the burdens and the benefits of the research.

In addition, Caballero (2002) suggested that the study must address a problem of importance for the local population and thus must have the potential to benefit from it.

Informed Consent

A copy of the informed consent was sent to the participants before the interview date and participants signed the form before the interview began. The consent form explained that the participation in the study was voluntary and that participants were able to withdraw from the research study at any time during the research process. It also explained that if this were to happen, all the information they had provided would be deleted immediately. The consent form also asked for the participants' permission for the interview to be audiotaped and translated (see Appendix C).

Confidentiality and Anonymity

Coding the interview recordings and transcripts protected the anonymity of the participants. To ensure that confidentiality was not breached, permission from the participants was obtained to use quotes from the transcripts to illustrate the findings of the study.

Potential Distress

Orb, Eisenhauer, and Wynaden (2001) recommend that the researcher should consider the potential harm for research participants in qualitative research. As the focus of this study is on the experiences of counsellors working with individuals who had experienced trauma,

the intentions of the research study, including the discussion of trauma-related content, was described in the invitations to participate. To protect the participants from potential harm it was compulsory for them to be in supervision, and it was clearly highlighted in the explanatory statement and consent form that they could withdraw from the research study at any point before, during, or after the interviews (see Appendixes B & C). Each interview was followed by time to debrief (Appendix F) and the researcher encouraged further questions about the research study. In respect to discussing trauma-related content, to protect myself as a researcher my experience of the research process was supervised and I used personal therapy when I felt it would be beneficial or necessary.

Data Collection

Semistructured interviews were used to collect data. Smith and Osborn (2008) stated that the goal of the interview is to see the phenomena being studied from the participant's point of view; the participant shapes the course of the interview rather than merely responding to set questions. The interviews were conducted in Arabic, which is the researcher's and the participants' first language. The interviews were collaboratively translated into English by using back-translation (Su & Parham, 2002) and decentring (Werner & Campbell, 1970) to ensure valid translation.

Although these two methods are used to ensure the validity of instruments, I also found them to be useful in translating my interviews. Back-translation means using two bilingual translators, one to translate the Arabic text into English, and the other to translate the text back into Arabic to see if it is equivalent to the original text. By utilising a translator in this study, a third hermeneutic process took place; therefore, decentring was carried out to minimise the meaning lost during the direct translation. Decentring is a method used to eliminate linguistic and cultural differences, as some words or terms may not be found in the

translated language. For this process, I listened to each interview while reading the transcribed and translated text and checked the meaning with my bilingual colleagues. Various discussions took place about how they would define Arabic terms in English and I checked whether they matched the translations I had used.

This process highlighted how much meaning could be lost through direct translation and how my own assumptions about the participants’ lived experiences had influenced the translation. I found the method of decentring with the aid of bilingual colleagues extremely useful, although at times it was challenging to reach an agreement on the essence of what was being said by the participants in Arabic and finding words to describe it in English that did not result in losing meaning.

Creating an Interview Schedule

A semistructured interview schedule was created and used as a guide during the interview process. The nature of the semistructured interviews allows flexibility within the interview so that the researcher is able to follow a train of thought and explore it further, rather than sticking to a script that could hinder the participants’ own process. Smith (2003) suggested that this allows the researcher to establish a connection with the participant and explore the concerns of the participants to provide richer information from the participants’ perspectives.

Several issues were considered when I was developing my interview schedule. Smith et al. (2009) suggested all questions needed to be open-ended to refrain from leading the participant in a particular direction and allow the participant to provide in-depth answers. It is also suggested that difficult or personal questions are best held back until later in the interview to allow time to build a rapport with the interviewee. Therefore, factual points or

questions that are descriptive in nature are best used as opening questions (Smith et al., 2009).

When I began developing the interview schedule I was aware that my assumptions were at the forefront of my mind, and my own disappointments in the mental health system in Jordan were hindering me from taking a step back and looking at the participants’ experiences as separate from my own view of Jordan and my own experiences of working with refugees in the UK. Thus, my research supervisor and I agreed that my questions were leading and focusing on parts of individual experiences, rather than looking at the experience as a whole.

To move from a narrow view to a whole view of individual experiences in this particular field, I needed to acknowledge and set aside my assumptions and try to be able to bracket my assumptions. This process was also important in the interview process (Smith et al., 2009). Experiencing the difficulty of doing this while developing questions set me up for what it might be like for me to do the interviews.

My study focused on hot cognition (Smith, 2010); that is, examining strong emotions connected to current issues that might have been arising for the participants at the time. Therefore, my questions were centred on the participants’ experiences of current issues related to providing therapeutic services for Iraqis in Jordan. After reviewing my questions several times with my research supervisor and conducting a pilot study, I chose to use the interview schedule found in Appendix E.

Interviews

The interviews lasted from approximately 40 minutes to one hour. Each interview was audio-taped. The interview process was explained in the information sheet provided before the participants gave written consent. Each participant was given the time to ask any

remaining questions before they signed the consent form and the interview began. To build a rapport, the interviews began with general questions about the participants' work experience and their day-to-day activities.

The interview commenced with a broad, open-ended question that focused on what it meant to the participant to be working with the Iraqi community. This was followed by prompts about how it made the participant feel to be doing this type of work, and then follow-up questions such as reflective statements to further explore their experiences; for example, "So it means a lot to you?" The questions then moved on to how, if at all, the current sociopolitical atmosphere in Jordan and Iraq had influenced their work, what difficulties they might have been facing and what rewards they might have been gaining, and how they managed any difficulties that might have arisen. Before ending the interviews, the participants were given the opportunity to add anything about their experience that the researcher might have missed out or not asked about.

At the end of each interview, the participants were given the opportunity to debrief and were again invited to ask any questions. Following this, the participants had approximately two months after the interview to withdraw their approval for the data to be used. The interviews were then translated and transcribed.

Transcription

The interviews were transcribed in chronological order and were given numbers to identify the participants. As Smith (2003) suggested, the transcription of the interviews included false starts, pauses, laughter and any other features that were worth recording. Any identifying details, such as the names of organisations and colleagues, were disguised or changed.

The interviews were translated and transcribed by a third party, and the participants agreed to this (Appendix C). To ensure that meaning was not lost or altered I listened to and read the transcriptions several times. Additionally, the recording was continuously played back while working with the transcripts during the analysis of the text.

Analytical Strategy

Data was analysed using IPA (Smith & Osborn, 2008). A bottom-up approach was used to identify the emergence of themes that described the meanings that psychosocial counsellors assigned to their experience of working with Iraqis in Jordan. In addition to looking at shared themes, diverging themes were considered to offer further insight into the meanings attached to their experiences.

The interview transcripts were analysed with reference to the different stages outlined by Smith et al. (2009). Following an idiographic approach to the analysis, the transcripts were analysed individually and simultaneously. To clarify the analytical strategy, a step-by-step audit trail is included in the Appendix (see Appendixes L–Q). An extract from the transcript of the first participant (Farah) is used to illustrate this process. The same extract from the transcript is presented for each stage of the analysis to enable the reader to follow the steps taken.

At the first stage of the analysis, each transcript was read while listening to the audio-recording of the interview (see Appendix L for an extract from Farah’s transcript). The second stage included noting down descriptive comments on the data using the right-hand margin of the text (see Appendix M for a sample of the first stage of the analysis) At the third stage of the analysis, emergent themes were developed (see Appendix N for a sample of the second stage of the analysis). This process generated themes inferred from the participants’

dialogue, which were then recorded as codes in a table for each transcript (See Appendix O for a sample initial list of themes) (Smith et al., 2009).

The fourth stage of the analysis, described as structuring the analysis, involved making connections among the codes and clustering those with shared meanings for each transcript (See appendix P for an example of clustered codes) (Smith et al., 2009). At this stage, patterns across cases start to emerge, and the task of combining them under sub and master themes to illustrate the participants' experience begins to structure the analysis.

However, Smith and Eatough (2007) argued that the analysis does not necessarily end at this point; it continues to extend during the writing up phase because "when one sees the extracts again within the unfolding narrative, often one is prompted to extend the analytic commentary on them. This is consonant with the processual, creative feature of qualitative psychology" (Smith & Eatough, 2007, p.76). At the initial stages of the analysis I found this process to be stressful; because I felt I needed to keep on reevaluating my analysis, I originally thought that my analysis was superficial. However, after reading Smith and Eatough's (2007) commentary on this aspect of the analysis, I recognised that it was a natural part of the process.

The fifth stage involved constructing a thematic table, which included quotes from the participants to illustrate each theme. The main themes were then selected based on their relevance to the research question and their richness (see Appendix Q for an extract from the master table of themes from the group).

Finally, quotes from the participants' transcripts were provided in the analysis as evidence of the themes being discussed. Because a number of quotes represented each theme, a process of selecting which quotes to use in the text took place rather than simply providing a list of quotes. The quotes chosen to be presented in the text were selected for a number of reasons: (1) they captured the essence of what was being said and portrayed the theme better

than other quotes; (2) they illuminated the participants' experiences; (3) they provided a strong metaphor; and (4) if more than one quote from the same participant could have represented what was being said, the richest or most metaphorical one was chosen.

Quality Issues

To ensure the quality of the research study, I followed Elliott, Fischer, and Rennie's (1999) suggestion for the evaluation of qualitative research. They stated that researchers should disclose their own values and assumptions and provide vignettes of specific participants to show the relevance of using those individuals. The authors also suggested that researchers should provide the reader with examples of the data to (1) reveal analytic procedures; and (2) communicate whether the study aims to provide a general understanding of phenomena or examine a specific case.

Yardley's (2007) suggestions of four principles of assessing the quality of qualitative research throughout the process were followed. These are: sensitivity to context; commitment; rigour; transparency and coherence; and impact and importance. A summary of each principle will be discussed to portray how they were followed in the study.

Sensitivity to Context

Yardley (2007) proposed that sensitivity to context is exhibited through indicating awareness of existing theory and linking views to existing literature. Additionally, it is suggested that the researcher needs to maintain an awareness of how the participants' language, social interactions, and culture might have an impact on their beliefs and expectations and how those might in turn have an impact on, or be reflected in, the results. This suggestion is demonstrated in 'Reflexivity' in the discussion section.

Commitment, Rigour, Transparency, and Coherence

Commitment and rigour relate to: in-depth engagement with the research question; developing sufficient proficiency in the utilised methodology; thorough data collection; and through interpretations. Transparency (also referred to as reflexivity) and coherence add clarity by providing details of the processes (intentions, assumptions, and actions) that lead to the arguments presented, including full accounts of the methods and representation of data where applicable; that is, without compromising anonymity. These recommendations were followed and are made clearly visible throughout the study.

Impact and Importance

Impact and importance refers to whether the research study presents the reader with useful or important information that makes a difference. This research study was focused on a population in Jordan, a country where there is a dearth of such publications. WHO (2011) conducted a search in PubMed in December 2010 utilising the following keywords: Jordan, mental health, psychiatry and psychosocial. They found that Jordan has produced only 25 publications in the past five years.

This study focuses on enhancing the understanding of the experience of a specific population in Jordan that has been absent in the literature. This population has had an influence on the mental health needs of a client population that has been affected by political violence and is experiencing mental health difficulties (Bader et al., 2009). It is hoped that this study can provide relevant information that could enhance support for psychosocial counsellors in Jordan. Furthermore, Luck (2012) reported that UN officials estimated that more than 140,000 individuals from Syria have already crossed the border into Jordan to flee the ongoing political violence. This study might help address potential challenges faced if a necessity emerges for an increased number of psychosocial counsellors in the country.

Limitations of the Research Study

One criterion for counsellors participating in the study was that they needed to be in supervision. This was deemed important because no public support systems are available in Jordan. This criterion excluded counsellors who were not in supervision and might have been working with minimal professional support. While the law in the UK and the US states that therapists need to be in supervision when working with clients, no such laws exist in Jordan; therefore, counsellors are not protected within organisations. Gilbert (2009) supported this notion; she observed that there was no systematic supervision system in the INGO she discussed. The supervision that is available is mostly used to discuss practical issues, rather than the emotional responses of counsellors towards their work.

Therefore, due to the criteria of this research, the study does not reflect the general experience in Jordan and should be viewed as such. The findings reflect the experience of counsellors who have been in the field for more than six months, are in supervision, and have had training on trauma therapy. Counsellors in Jordan with a different background might describe a different experience. Additionally, the interviews took place within the organisation that the counsellors were employed by. This could have hindered the counsellors from discussing organisational issues. Although the interviews took place within a secluded area behind a closed door, because they had been recruited through their managers they might have felt that they could not discuss such issues.

In addition, Morrison (2007) suggested that therapists who are significantly affected by trauma work leave the field; therefore, this study focused on counsellors who were still in the field and might have been able to transform their VT reactions. Finally, the psychosocial counsellors who opted to take part in the study might be aware of and able to identify and acknowledge the difficulties they face in their work. However, psychosocial counsellors who

did not volunteer to take part might have chosen not to volunteer to avoid discussing their experience, which is an aspect of STS.

CHAPTER 3: ANALYSIS

Introduction to the Master Themes

Following the analytic process, three master themes emerged from the participants' narratives. The three interconnected master themes are: (1) the impact of sociopolitical and socioeconomic factors; (2) enriching and motivating aspects of their roles; and (3) coping with the distressing aspects of their roles. The themes are summarised in table 1 and a visual representation is presented in figure 1.

The first master theme, the effects of sociopolitical and socioeconomic factors, describes several ways in which sociopolitical and socioeconomic factors have an impact on the participants. The first subtheme, "there's nothing you can do", focuses on the helplessness that the participants feel due to working with clients whose basic needs are not being met. The second subtheme, "you feel like a little child", represents the powerlessness that the participants feel as a result of working with Iraqis who have no legal status in Jordan. The third subtheme, "just picking up the pieces", illustrates the impact of the ongoing violence in Iraq on the participants. In the fourth subtheme, emotional burden, the participants describe how the various client stories that they hear affect them.

In the second master theme, enriching and motivating aspects of their roles, the participants describe the positive impact of working with this client group. In the first subtheme, "psychological value", the participants describe how working with this client group enriched them in various ways. In the second subtheme, increased commitment, the participants talk about how they became more committed to this client group due to witnessing the challenges that their clients face. The third subtheme, "there's always a way back to life", describes the change in self-concept that the participants experienced because

of working with this client group. In the fourth subtheme, “there’s something special about the world”, the participants describe how working with Iraqis changed their perceptions about the world.

In the third master theme, coping with the distressing aspects of their roles, the participants describe how they cope with the difficult aspects of their work. In the first subtheme, self-care, the participants express how they try to integrate self-care into their lives to manage the challenges that they face. In the second subtheme, “it’s tough but it’s worth it”, they describe how the positive aspects of working with this client group help them cope with the challenging aspects of the work.

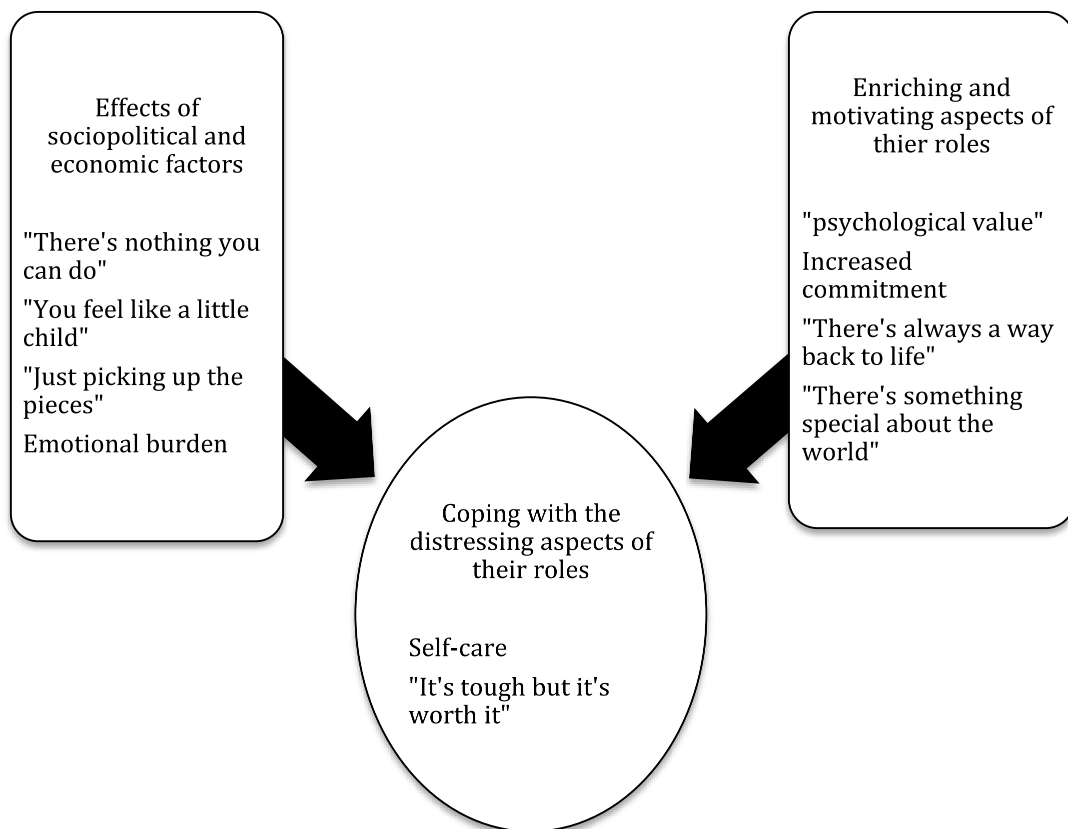


Figure 1. Visual Representation of Themes

Master themes	Subthemes
Effects of sociopolitical and socioeconomic factors	"There's nothing you can do"
	"You feel like a little child"
	"Just picking up the pieces"
	Emotional burden
Enriching and motivating aspects of their roles	"Psychological value"
	Increased commitment
	"There's always a way back to life"
	"There's something special about the world"
Coping with the distressing aspects of their roles	Self-care
	"It's tough but it's worth it"

Table 1: Themes

In the following section the themes are discussed further. Descriptions provided by the participants are supported by quotes extracted from the transcripts. Commas are used to represent natural pauses and longer pauses are indicated by brackets. Bracketed words clarify words that lose their meaning when translated from Arabic into English. To avoid changing the text itself, brackets have been used to stay close to the text while clarifying the meaning for the reader. To safeguard the participants' anonymity, their names have been altered.

Master Theme 1: The Effects of Sociopolitical and Socioeconomic Factors

Participants described the challenges that they faced due to working within the sociopolitical and socioeconomic factors affecting the Iraqi community. They spoke about different influences, such as basic needs not being fulfilled, a lack of legal status, and ongoing violence, which evoked feelings of helplessness, powerlessness, and perplexity. The participants also discussed how the stories that they heard from their clients affected them.

"There's Nothing You Can Do"

Many of the counsellors described incidents when they felt helpless in front of clients who were experiencing a lack of basic needs. Farah describes her experience of this issue in the following way:

> It is very difficult for you to start building on something if these people don't even have the basic needs, considering Maslow's hierarchy of needs their spirit and morale are very important but you have to provide them with their basic needs first so that they can benefit from our help more. Farah.5.136

Farah refers to Maslow's hierarchy of needs in the sense that she believes that if her clients' basic needs are not met then they cannot focus on their emotional needs. In turn, this makes it difficult for her to offer psychological therapy. Sara depicts a similar experience in the following statement:

> For more than one case, there is nothing that you can do, they tell you that they don't have enough to eat, or "I have no house, what can you do for me? You're going to

talk to me? OK, but you cannot help me by talking to me. This isn't the time for talking; talking is a secondary need right now". Sara. 7.209

Sara's statement suggests that the clients themselves highlight the significance of the problem. The client's statement that "talking is a secondary need right now" suggests that talking is important to the client, but it is not possible to attend to their emotional needs without first meeting their physical needs. This suggests that there might be a discrepancy in the referral system, where clients who need to be referred to centres that provide basic needs, such as food and shelter, are being referred to centres that provide psychological therapies. Sara's statement "there is nothing you can do" suggests a feeling of helplessness when faced with such clients; she finds herself unable to do anything to help. Hussam also speaks about this issue and provides a solution by saying:

> They need their basic needs to be fulfilled. We have to have a referring system to more than one institute where we can refer to provide them with basic needs and when things become more stable you will notice that he will get better emotionally. Hussam. 8.242

Hussam's statement implies that he feels that some of his clients would have less need for psychological help if their basic needs were met, as they are struggling with a physical need that affects them psychologically. Hussam's statement describes that there is no comprehensive referral system and that assessments might not consider clients' basic needs before their psychological needs.

Hussam's statement also suggests that he attempted to remedy this issue by trying to refer his clients to an institute that his organisation has on file. This organisation might have been unable to take in more people to support at the time when Hussam referred his client.

Lubna also speaks about this issue, providing an example of how when she tried to help her client, financial issues kept hindering her treatment plan.

> I've worked with some clients where for example a client I worked with had a son who was becoming aggressive at school and one of the reasons behind this is because his parents and four brothers and sisters live in one room, this boy didn't have anywhere to vent his anger and frustration. However, each suggestion I made required money, not that I suggested anything expensive, just something basic such as a football, but they couldn't afford one. The dad would laugh and say "I can barely afford to feed my children bread, I don't have time or money for that". I mean, things I suggested, it really makes you feel like, I don't know what to do. Lubna. 9.259

Lubna's expression "I don't know what to do" suggests a feeling of helplessness when faced with clients who have financial struggles. Walid also describes this issue by explaining that he feels that the basic needs provided by supporting organisations are not enough:

> Most families are offered 220 JDs a month – that is nothing! They can't live properly off that, so yes there is a system but it's not enough, because living costs are still rising and it doesn't cover rent for proper accommodation where the parents and children are not living in the same room! Walid. 6.187

Walid's perspective outlines that even though there is a referral system, the services clients are being referred to are not offering them enough.

"You Feel Like a Little Child"

The participants expressed feelings of helplessness, frustration and powerlessness in respect to their clients' lack of legal status. Ghada and Hussam express feelings of frustration and helplessness that stemmed from the fact that Jordan views their clients as guests rather than as refugees with rights. Ghada speaks about this difficulty by saying:

> Our work is very complicated and complex and interconnected, and they still have hope for settlement. They do not consider Jordan their home; they consider it merely as a stopping station, which isn't easy to mend. Ghada. 3.74

Ghada describes how her clients' hopes for resettlement make it challenging for her to work within a situation "which isn't easy to mend". It appears from her statement that her clients "still have hope for a settlement", but Ghada herself does not have much hope that they will be resettled. This suggests that her treatment goal could be to help her clients accept that resettlement might not be a viable option for a long period of time, as is the case in Jordan (UNHCR, 2012). Hussam describes feeling helpless in the face of his clients being in Jordan temporarily, explaining that:

> They are here temporarily in hope of being granted settlement rights. You know they have no employment rights in Jordan, which puts them under a lot of pressure because they spend all day at home just thinking about everything, which puts them under a lot of stress, I feel helpless, I provide psychological help but I also want an

> environment that helps the work that I do, sometimes the environment frustrates them and depresses them, all of this affects me and my job. Hussam.6.184

In addition to feeling helpless, Hussam also appears to feel frustrated (“I also want an environment that helps”) by the lack of legal status of his clients, and is affected (“all of this affects me”) by his feeling of powerlessness to change the environment his clients live in. Sara also describes this challenging aspect of her work, explaining:

> Sometimes the UN would ruin our work with some piece of news and we have to start building all over again, so that is a challenge, they had hope and then it was taken away at once. Sara.11.330

Sara’s description of how the UN would “ruin our work” implies that she views the UN as an entity that has the power to destroy the work she has done. The power the UN appears to have over the clients’ lives is illustrated in a powerful metaphor by Farah, who says:

> You just get frustrated, because you would work with a client for three or four months and you cannot believe it when they finally manage to get on their feet and getting better, then suddenly it all gets torn down. You feel like a little child that was building things up, then someone comes and tears everything down. Farah. 5.169

Farah viewing herself as a child can be compared with the perceived power that the UN has over her clients’ psychological wellbeing. The statement “you feel like a little child” highlights how powerless she feels when one of her clients is denied resettlement. Walid

provides another metaphor of how it feels when the UN makes an unfavourable resettlement decision.

> I mean it is like you building a house and having someone tear it down for you, that is how you feel. Walid. 8.273

His description of feeling like someone has torn down what he had built up provides further insight into how the counsellors feel when their clients are denied resettlement. They perceive their work as helping people to rebuild their lives, and in one instant a decision by the UN can make them feel they have lost all the progress that they had made with their clients.

Lubna expresses her anger and frustration at the lack of legal status for Iraqis in Jordan, while describing her understanding of the system's limitations:

> Just the fact that Jordan sees my clients as guests, it's ridiculous to me, they can't go back and nor can they go forward because resettlement is so difficult and they can't integrate, I mean, what options do they have? It makes their life so difficult, I mean it makes me angry at times, but I also know we're so underresourced and our own population can barely live off the resources of the country so I understand it but I guess it's another obstacle for people who don't need any more obstacles, they've been through enough, so yeah it's hard and it's frustrating to want to help people but having your hands tied. It makes me feel helpless and I just want to shout at people who make those decisions. You know, can't you see what you're doing to people who just want to live their life? Lubna. 4.109

Lubna liberally expresses her anger and frustration with the difficulties she faces due to “having your hands tied” when working with this client group. Even though she is aware of the financial restraints the Jordanian government is facing, the feeling that her clients need more support rather than more obstacles seems to frustrate her.

“Just Picking up the Pieces”

Sara, Lubna and Hussam express how they view the ongoing violence in Iraq and the important role it plays in how they perceive their work. Sara describes her feeling of helplessness in the following way:

> It challenges me in so many ways to find the good on days when I feel like there’s no point, it’s just one war after the other and from this work I see the devastating effects it has on human life, and it does make me sometimes wonder like who am I kidding, I should be at the other end, stopping those wars, rather than sitting here and just picking up the pieces, so I guess I mean it challenges me because it makes me feel helpless at times and that’s a difficult feeling to shake off. Sara. 10.293

Sara’s feelings of helplessness seem to stem from her awareness of her inability to stop what is causing her clients to seek the service she offers. This makes her wonder whether she is in the right position to help people: “there’s no point”. Saying “who am I kidding?” implies that sometimes she finds her job futile and feels sceptical about her work: she cannot control what is causing her clients to struggle, but is merely “sitting here and just picking up the pieces”. This statement expresses her frustration with the continuing violence in the world and her feelings of helplessness because she cannot contribute to stopping what is causing her

clients' need for psychological treatment. Her words "sitting here" also express her feeling of helplessness, as sitting symbolises not doing anything to make a difference.

Lubna describes how the ongoing violence in Iraq makes her work challenging for her and makes her feel incapable when one of her clients is directly affected by it. She explains that:

> When we work very hard and something happens in Iraq, for example an explosion in Iraq that kills the patient's brother, father or son etc. then it triggers a relapse in the progress we were making, and he goes through the posttrauma syndrome again. The first time it happened I was speechless at first I felt this incredible heavy feeling, like I didn't know what to say, completely incapable of knowing what to do next, it still creeps up when I'm faced with a situation like that but I just put that feeling aside as best as I can and have to think we can still move forward, because if I just look at the client and say "I don't how you can get over this", because that's what I initially thought, then what good am I as a counsellor? Lubna. 5.153

In this account Lubna's expression "completely incapable of knowing what to do next" signifies experiencing a feeling of helplessness and an inability to know how to influence a situation. However, she is mobilised to provide help to her clients, as implied by her awareness of her feelings and her ability to put them aside and reframe her thought processes from not knowing what to do to thinking "we can still move forward". In addition, her awareness that her role as a counsellor is to provide help musters her ability to set her assumptions aside ("I don't how you can get over this"), a notion referred to as *bracketing* (Spinelli, 2005), and engage with her clients.

Hussam also speaks about how the ongoing violence in Iraq is a struggle for him and his clients. He says that:

> The violence is continuing in Iraq, and most of my clients still have families there, and you know it feels for me like they're here but their hearts are still there, and it's a struggle between wanting to move forward but being unable to 'cause a part of them is still in danger, so it's tough, it makes me wonder I mean what is my role here, am I doing anything and can I do anything? Hussam. 7.192

Hussam's question, "Can I do anything?" in relation to how he feels about the ongoing violence describes him trying to make meaning of his role as a counsellor who is working with clients who have unmet safety needs: "a part of them is still in danger". His words also describe an awareness that if his clients are not feeling secure, and their families are still in danger, what he is doing might not actually be helpful and he might not really be able to do anything to help.

This theme encompassed three sociopolitical elements that influenced participants' ability to feel capable of helping their clients. These are the fulfilment of basic needs, legal status, and ongoing violence. The themes challenged the participants and evoked feelings of anger, frustration, powerlessness, and helplessness. The next subtheme focuses on the emotional burden that participants experience because of the stories they hear and how that burden affects some of their personal relationships.

Emotional Burden

All the participants described how the various stories that they heard from their clients affected them emotionally. The participants expressed feelings of shock and concern at the

unfairness and injustice that their clients had endured. They also expressed feelings of heaviness, power imbalance, incomprehensiveness, and a lingering emotional burden caused by the stories that they heard from their clients.

Sara describes the impact of hearing her clients' stories at first hand and her struggle to become more aware of the reality of what had happened within the Iraqi community. She said:

> The work isn't easy, and erm, the stories that we hear in the job aren't very easy to listen to, and it is completely different when you hear these stories directly from the source rather than listening to them on the news, I mean, things you cannot imagine, this definitely affects me. Sara. 9.278

Sara's extract describes her experience of becoming empathetically engaged with her clients and realising the difference between hearing the stories from them and watching something on the news, which might have distanced her from the feelings associated with it. By saying "things you cannot imagine" it seems that she has come face to face with realities that she had never imagined could exist in the world, and that this has had an emotional impact on her.

Lubna expressed how hearing her clients' stories affected her motivation as a counsellor:

> It doesn't feel good when you listen to how people are being treated unjustly and this affects my drive for sure. Lubna. 12.393

Lubna's view of how her clients are being treated unjustly and how this affects her morale suggests that she faces an emotional struggle after hearing her clients' experiences.

Expressing that “it doesn’t feel good” elaborates a negative impact on her emotional wellbeing. Farah also depicts this by expressing her frustration with the world and questioning why her clients have experienced what they have experienced.

> You wonder what is going on in the world; why has it become like this? It is really unfair. Farah. 4.125

Farah’s expression “wondering what is going on in the world” suggests that she thinks about her clients’ experiences and feels they have been treated unfairly. Farah also talks about how some of her clients’ stories play on her mind and make her wonder about the world she lives in.

> Till now I wondered how some people can bear hurting others. Is it possible that some people can hurt others like this? And I wonder what wrong did the children, who are 12 years old, for them to suffer like this and lose loved ones? Farah. 5.136

Farah’s statement describes how she tries to find reasons for events that take place in the world to make meaning of what she is faced with. This can be inferred from her saying “I wonder what wrong did the children, who are 12 years old, do”. However, in this case it seems that she cannot find meaning (“till now I wonder”) in the suffering of 12-year-olds in the Iraqi community. This suggests a lingering, “till now”, emotional struggle of trying to comprehend and make meaning of what she had witnessed from working with this client group.

Hussam illustrates the emotional burden he feels by talking about the incomprehensible process of a downward spiral that some Iraqis have experienced. He says:

> Each in his own house with his car at his disposal and suddenly they lost everything, their money and their houses due to explosions and had to move, in addition, they thought they were going to be settled down and nationalised in Jordan, then 5–6 years later they were still not granted settlements in Jordan and they spent all their money, it's incomprehensible. Hussam. 6.190

Hussam talks about the process that some Iraqis had been through while explaining that he cannot comprehend the magnitude of it: "it's incomprehensible". This suggests that what he has heard from his clients has played on his mind and that he still finds it difficult to understand how such a series of events could occur. Walid describes how he feels due to frequently working with "difficult cases" in this client group. He says:

> The cases we deal with are often difficult cases such as rape, kidnapping, and torture. It needs a lot of effort on your part to deal with these people, you sometimes feel it is draining… this is a heavy burden on our shoulders. I mean, you are dealing with people who have been through a lot, so you hear all sorts of stories and it affects us personally… I hear a lot of horror stories from my clients, which you can consider as one of the difficulties or challenges we face at the job, as you know we are human after all, so sometimes hearing about the torture and the misery that they went through makes me, myself, have nightmares as well from all the stories we heard. This is one of the challenges of working with victims of war. Walid. 8.244

Walid's statements, such as "it needs a lot of effort", "sometimes I feel it is draining" and "this is a heavy burden on our shoulders" describes the emotional burden he might have

experienced from listening to the first-hand accounts of people who have experienced severe trauma. Additionally, Walid talks about experiencing STS symptoms (having nightmares) in relation to working with victims of war.

Ghada describes the burden she feels due to the fact that some of her clients are unable to work or cannot find work, even though they are searching for a job. She explains:

> I have a degree and he has a degree, but he is looking for a job and cannot find one or isn't allowed to work. This all adds to the burden. A lot of clients tell me that they would be much better off if they could work, at least it would get their minds off things. They do not know how they will be able to manage or feed their kids. Ghada. 7.216

Her statement describes her feeling that the situation is not fair; even though she and her client both have degrees ("I have a degree and he has a degree"), she can work while her client cannot. Her statement suggests that she struggles with this unfairness when she sees how much it affects her clients.

The extracts have described how, by listening to and thinking about their clients' life stories, the participants have developed a sense of disbelief about what has happened to their clients. This has made them question the world that they live in, including the unfairness of their clients' situations. This affects the participants emotionally in various ways, such as draining them and reducing their drive to continue working in this field.

Two of the participants talked about disruptions in their personal relationships that were caused by hearing about the experiences that their clients had gone through. Schauben and Frazier (1995) proposed that when an individual's affect tolerance is exceeded, that individual might draw upon protective defences. In Farah and Lubna's experience, this

included displacement of anger, irritability, and distancing.

Farah describes her experience of distancing by relating how she finds it difficult to empathise with her friends after working with this client group. She says:

> Now, whenever I listen to my friends' problems I cannot really sympathise with them because they seem so silly to me in comparison with what I hear in the job. Farah. 13.385

Her statement suggests that her affect tolerance has been exceeded through her experience of empathically engaging with clients who have experienced traumatic events. She might dismiss her friends' emotional needs ("they seem so silly") because she feels she cannot handle taking on their emotional needs in addition to those of her clients.

Lubna expresses a similar experience by describing how she displaces her anger onto people who are close to her:

> Another important thing that has changed about me is that I take out my anger at people who are close to me, which isn't a good thing. Lubna. 14.427

Lubna seems to have displaced her frustration and anger at the system, which is discussed under the subtheme "you feel like a little child", onto her family and friends. Her statement that this "isn't a good thing" suggests she is aware that her defence mechanism is not helpful but is still struggling with it.

Master Theme 2: Enriching and Motivating Aspects of Their Roles

This master theme focuses on the participants’ views on the enriching and motivating aspects of working with this client group. The four subthemes are as follows: “psychological value”, increased commitment, “there’s always a way back to life”, and “there’s something special about the world”.

“Psychological Value”

Throughout the interviews, the research participants described how working with this client group enriched their lives in various ways. When asked what their job meant to them, all the participants described what they personally gained from working with Iraqis in Jordan. What they gained was attached to psychological rewards, accompanied by positive feelings such as pride, privilege, connecting at an authentic level, achievement, and recognition.

Walid illustrates this by describing that the main factor driving him to continue his work is his sense of achievement from helping the Iraqi community. He says:

> It means a lot to me because it is humanitarian work and when you work in this field you feel that you have achieved a lot… the feeling that you are helping out this segment of people is the most rewarding feeling, otherwise I would be looking for another job. Walid. 1.18

His statement “otherwise I would be looking for another job” provides a potent understanding of the significance of feeling that he is influencing his client group in a positive way. Walid also speaks of the personal reward he gains and the sense of pride he feels about helping Iraqis rebuild their lives. He says:

> It is a rewarding feeling when you know that you have helped these people get back on track and continue on the path that they used to lead and they can continue building on this and go on with their lives, you feel proud. Walid. 2.72

The sense of rebuilding what has been taken away from their clients seems to be an important factor for the participants. Sara also emphasises this by saying:

> I mean you can work in anything you want in life, but when you work with people, you are working with their emotions and history as well, and in this line of work, when you feel like you have helped renovate and rebuild these people's lives, regardless of the fact that it is your job and that you need to do it, it feels great. Sara. 4.105

Sara's positive feelings seem to be attributed to giving herself as a person rather than as an employee who is merely doing a job. This seems to touch upon her humanity; she feels like a person helping another and achieving a connection, rather than someone who is just fulfilling a professional role. Hussam touches upon this experience as well, saying:

> I have found myself and my role and I feel very satisfied doing it and dealing with the human element, I mean we are humans as well and I feel rewarded helping people from drowning… Nothing rewards you like knowing that you have achieved something, even if you have earned a 100 million, nothing rewards you like feeling like you've accomplished something. Hussam. 8.253

By relating to himself as being human, Hussan seems to signify that in his role he has found himself and is able to connect with others authentically. This describes a quite profound experience for him. Additionally, the intrinsic reward of feeling he had accomplished something meaningful rather than materialistic ("earned a 100 million dollars") is a crucial part of Hussan's experience as a counsellor.

Ghada describes how tangible results are a fundamental aspect of feeling psychologically rewarded. She emphasises this by saying:

> When I see tangible results to my work I feel rewarded. I sometimes hear from my clients that they reconnected with their old friends, or made some new contacts in Jordan, or started going to centres that help them or that I helped them with their fear of leaving the house or that I have helped rid them of their nightmares. We can write books on all of this, but each and every time that you hear something like that it is as though you have gotten a gift, it is very psychologically and personally rewarding for me… It has psychological value for me, when I see that the client was destroyed emotionally and is now getting back to his life. Ghada. 9.266

Ghada's description of feeling as though she has received a gift every time she sees clients rebuilding their lives portrays how receiving intrinsic rewards (the feeling of influencing someone's life in a positive way) can feel like receiving a tangible reward, such as a gift. Farah also describes psychological reward from the same perspective. She says:

> 3 days before he travelled he called me and thanked me for the work that I have done.... These are small things but they mean a lot to me. The work we do is very

> important and we serve these people who need our help, I get to provide a humanitarian service and help people who really need my help. Farah. 7.208

Here, Farah's experience of seeing how her clients are benefiting from the work she does has made her aware of the integrity of the service she provides. Her expression "these are small things but they mean a lot to me" signifies that although her clients' gratitude might seem like a minimal gesture, it is an experience that is profound for her. Additionally, the sense of privilege ("I get to provide") and the opportunity to help her clients are important aspects of her work.

Lubna describes her feeling of reward from a different perspective. Her ability to hold her clients' pain personally rewards her. She describes this by saying:

> It means a lot to me, it really made me feel like I was helping people even though, I mean, their stories are heartbreaking, and there is nothing I could do to change that, but just being there and sharing those stories and holding my clients through the horrors they have witnessed… I'm not sure what it is but there's something about that, that when you leave a session you just breathe out and feel somehow blessed and lucky to be able to sit there and do that type of work. Lubna. 2.51

In Lubna's statement, in contrast to the other participants it was not the goal of her work that personally rewarded her, but the journey. Lubna's extract describes that the sense of privilege ("just being there and sharing those stories") she has from "being" with clients and "holding" them through difficult emotions is valuable for her.

The participants expressed a sense of achievement, pride, privilege, integrity, and recognition that their jobs provided meaning for them on a fundamental level. Gaining these

things perhaps precludes the sense of helplessness, powerlessness, and emotional burden that counsellors might feel from working with this client group.

Increased Commitment

The participants described how witnessing the issues that the Iraqi community were dealing with in Jordan and becoming more aware of the help they need made them feel more committed to offering psychological services. Lubna talks about how she feels her role in making a difference in her clients’ lives is important. From her experience as a counsellor she knows that the service she offers is limited, so without her there would be a lack of services to help her clients. She says:

> I feel my job is very important, because I feel if we don’t provide them with this service then they would not find it anywhere else. Lubna. 10.312

Ghada also emphasises this commitment:

> This time around I wanted to work with them because I realised how much they’ve been through and how much they need help and I wanted to help them. Ghada. 8.233

Ghada chose this line of work because she realised through her previous experience of working as an animator with Iraqi children that the Iraqi community truly need the help she offers. This describes a personal choice and suggests that by becoming aware of this client group’s struggles, Ghada felt a sense of commitment to helping them.

Farah also describes how her work increased her commitment to helping people and how important it is. She says:

> A lot of things changed about me. Personally I like doing psychological work more, I like to help people out more, I can now see how important psychological work is in Jordan and in the Arab world…. and you can feel with them and you will want to help them as much as you can. Farah. 11.338

The emphasis on the fact that she gets to help people who really need her help suggests that Farah feels that the Iraqi community certainly benefit from the services she offers, which enhances her commitment to the client group. Farah also describes another aspect of her increased commitment to this client group in the following statement:

> Some say they deserve what happened to them, but after my work with them my beliefs changed. At first people would criticise them whenever I mentioned that I was going to be working with them, but after my work with them I started believing in their cause, defending them and fighting for them because they had no fault in what happened to them, I mean they had nothing to do with what happened, they just woke up one day and saw that even neighbours had turned on each other, I believe that we have to stand with them and help them. They need our help. We can’t wash our hands clean from their cause and call them liars, I mean some people are really suffering and need our help. Farah. 6.190

Farah describes that her negative attitude towards the Iraqi community changed once she started working with them in a therapeutic capacity: “after my work with them my beliefs changed”. Her experience of working with them gave her a different perspective and motivated her to try to change other people’s perceptions. She describes this by saying: “I

started believing in their cause, defending them and fighting for them".

The extracts describing how the participants wanted to help their clients illustrate how the participants' commitment to this client group increased after working with them. Farah's extract portrays how she took this a step further and started advocating, helping others to understand what she had understood and gained from working with the Iraqi community.

"There's Always a Way Back to Life"

All of the participants talked about how their role as counsellors working with Iraqis had changed their self-concept. Specifically, witnessing their clients' strength in the face of adversity helped them acquire a similar trait. This change might illustrate what Hernandez et al. (2007) coined VR.

Ghada describes how witnessing her client's strength in the face of adversity taught her something and influenced her perception of persistence through hardship. She says:

> I mean, you work with people on a very very deep level, in a way I haven't with other client groups and I guess this work makes me a better therapist because of the depth of the work. Nothing scares you any more, 'cause I've seen hell and have come back, so it teaches you that there's always a way back to life. Ghada. 14.440

Ghada's extract describes how her clients' resilience has influenced her own, even though she has not gone through the same experiences they have. Witnessing their reaction to adversity has influenced her perception of how she presumes she would react to adversity if she encountered it. Her statement that "this work makes a better therapist" suggests that how she views herself as a therapist has changed. Expressing that fearlessness makes her a better therapist implies that she feels that her fears have held her back as a therapist. This could be

also be inferred from her statement that she has seen hell and come back, a possible indication that she experienced VT during her work but has overcome it. This suggests that she might have experienced vicarious transformation.

Farah describes her experience of change in relation to what she has learned about her own resilience. She says:

> It has taught me so many things, like the fact that no matter how difficult things get, you can still stand on your feet and get through them and live… these people have gone through, like torture, and you see how easy the things you go through are. You start to look at the bigger picture and realise how petty some of your problems are in comparison to the hardships that they have faced, these people have rebuilt themselves after having their whole life collapse, which isn't easy at all… They taught me how to be strong and patient and how small things aren't worth worrying about…now I see how some people really suffered and when you help them, this affects your personality and your beliefs and the way you speak. Farah. 13.404

Farah describes how she now views herself as someone who can pass through difficult experiences, also suggesting an experience of VR. It seems that her experience has made her realise that if her clients can survive the experiences they have been through then she can survive what she has to face. She also seems to have reflected on the issues within her personal life and realised that she can survive them and does not need to worry about them, which influences her perception of her capacity to overcome her own problems.

Lubna's description of the change she experienced combines patience and strength as two characteristics that have become prominent for her.

> I can withstand more, and I am more patient now that I’ve seen all the problems these people are going through, which aren’t easy at all. Lubna. 10.303

The participants’ capacity to endure hardship appears to have increased through their work. Sara illustrates this by saying:

> I guess it gives you a type of strength by seeing the clients’ strength. Sara. 6.188

Connecting her experience of gaining strength with that of seeing her clients’ strength suggests that her perception of her ability to face adversity has changed because of viewing her clients’ resilience.

“There’s Something Special About the World”

The experience of becoming more aware and viewing the world from a different perspective emerged as a significant theme in various parts of the interviews. The participants described changes in their worldviews and how those changes altered them. Sara attributes the new strength she has gained to her client work and states that it has given new meaning to her life. She emphasises this by saying:

> You realise there’s something special about the world that I never saw before but being in this position I could see it, it changes you. Sara. 12.374

What seems to be her experience of VR appears to drive her to continue with her work: it gives her a feeling that she does not encounter in other places. Her description that her work enables her to see “something special” in the world that she couldn’t see before

further emphasises an experience of VR. Additionally, her description of how it was her clients' strength that made her realise there is something special about the world suggests she has experienced a positive change in her worldview. While talking about the positive aspects of the job, Walid also describes how his perception of the world has changed:

> Sometimes you are used to seeing things in a certain way, whereas in the real world, I mean the world has different dimensions and erm… you can view it in different dimensions with this newfound view. This job, it has made me a lot wiser, it made me view life with more wisdom, it adds a lot of experiences and adds a lot of things and you view things in different dimensions which weren't available to you before. Walid. 2.60

Farah describes her experience of altering her view on the world by discussing how seeing something on the news is not the same as working with Iraqis affected by trauma first hand. She emphasises how this experience influenced her in a positive way:

> When you deal with the people personally it is very different, you touch them (emotionally) and interact with them and feel what they feel, erm, then you start to view things completely differently, you aren't just watching the news, you are listening to people tell you about their experience and the, the torture they went through first hand, so this causes you to become more compassionate. Farah.11.333

Farah's expression of seeing things completely differently when working first-hand with the Iraqi community illustrates how the work increased her awareness of the Iraqi community's struggle. Her empathic engagement with the client group, "you touch them

(emotionally) and interact with them and feel what they feel", also seems to have transformed her perception of the world: "you see things completely differently".

Farah's statement also suggests that she felt distant from what was happening to the Iraqis before she started working with them: she says "you are not just watching the news". Working with this client group and empathically engaging with their stories of trauma increased her motivation to help and become more compassionate: "you will want to help them as much as you can". This change, as Engstrom et al. (2008) suggest, is an aspect of VR.

Participants described the changes they experienced in terms of how they viewed themselves and the world after working therapeutically with Iraqis. Their descriptions of VR highlight the reciprocal process that seems to take place when working with this client group. By becoming more aware of how the war affected the Iraqis, the counsellors wanted to help even more and give more of themselves to their clients.

This section has explored how empathic engagement with victims of war positively transformed the participants and changed their self-concepts and worldviews. The VR attributed to those changes seems to have strengthened the participants' professional motivation, made them perceive their own problems as more manageable, motivated them to advocate for their client group, and made them feel stronger and more able to endure hardship.

Master Theme 3: Coping with the Distressing Aspects of Their Roles

This theme describes how the participants cope with the challenging aspects of working with this client group. The first subtheme, self-care, focuses on the integrity and integration of self-care into their lives. The second subtheme, "it's tough but it's worth it", provides the participants' descriptions of how the positive aspects of their work override the

difficulties they face because of working with this client group.

Self-Care

The participants describe the different ways in which they include self-care in their lives. Farah explains how she tries to implement interpersonal work and include recreational activities in her life:

> I usually try not to let it affect my personal life as much as I can. I try to separate my personal from my professional life, I try to leave what happens at work at work and leave what happens in home at home. I'm always busy and every month I arrange something with my friends from school and university and so during the weekend I meet up with my friends, I go on trips, anything to get out of the working mood. Farah. 14.422

Farah's description of how she tries not to let the work affect her personal life illustrates that she is aware that she needs to implement interpersonal work in her everyday life. However, she says "I try" three times, which suggests that she has difficulty with separating her professional life from her personal life. Farah describes how she also utilises recreational activities to take her mind off her work. Although she is aware of self-care techniques, implementing them seems to be a struggle for her.

Lubna talks about using interpersonal work, interpersonal support and recreational activities as methods of self-care:

> I do simple things like not thinking about my job at home and trying not to imagine the stories that I hear, I listen and process but I do not allow myself to drift away in

my imagination and let it get to my heart. For me, I think that talking to my family and friends is also a method of self-care to me, I vent out to people who are close to me. I also try to go out every weekend and have fun. Lubna. 12.365

Lubna’s extract describes her struggle with intrusive imagery: “trying not to imagine”. However, the statement “I listen and I process but I do not allow myself to drift away in my imagination and let it get to my heart” shows she creates boundaries, which suggests she is aware of the importance of processing difficult emotions that her clients’ stories evoke in her. Her utilisation of her social support network and working towards including recreational activities into her life shows that even though she seems to struggle with intrusive imagery she utilises methods of self-care to minimise the effect.

Walid describes how using professional support when he experienced symptoms of STS helped him to overcome the experience and provided him with an understanding of the importance of gaining professional support:

I talked to someone and discussed what happened. We started connecting the sessions that I had with the nightmares that I got. This helped me, because sometimes when you talk about things, it helps, and this is part of the self-care process, to share this with someone with experience and he can help you with his information and his expertise. Walid. 9.270

Hussam describes how he has gained the ability to separate his personal life from his professional life, discussing how he has different roles inside and outside his work as a counsellor:

> I have the ability to separate my personal life from my professional life. When I am at work I am Hussam the counsellor, when I leave work, I am only Hussam, so I have the ability to practise my social role normally because as you know I have a different role at work than I do with my father or so, that is for sure, here, I am Hussam the counsellor, there I am Hussam the son, so I can separate both things and I can maintain a normal lifestyle without changing my relationships with the people around me […] I have the ability to separate both things, thank God. Hussam. 11.342

In the extract above, Hussam describes how at work he is Hussam the counsellor, while at home he is Hussam the son. It seems that he views himself as fulfilling different roles and is aware of the differences between each role. He uses "Hussam the son" as an example, placing himself in the child's position. It seems that he is aware that he does not consistently need to be in a helping position because of his professional role and is able to be in a reverse role outside of his professional life.

His words "thank God" could be inferred as the phrase Muslims often use to reflect God's presence in their life. However, Hussam's body language at the time of the interview is what prompted the addition of this statement into the analysis. Hussam looked up and smiled, as if saying "thank you, God", rather than "thanks to God" (the common statement that Muslims use in their everyday language). This describes Hussam's awareness of the potential harm of not being able to implement interpersonal work in his life and the fact that he is grateful for being capable of separating his professional life from his personal life.

"It's Tough but It's Worth It"

This theme describes how the positive aspects of the participants' roles helps them cope with the distressing aspects of those roles. The participants were asked how hard or easy

they find their work, and the question generated conflicting views. This might suggest they feel ambivalent about the work that they do. Alternatively, a fluctuation between describing working with this client group in one way or the other could be perceived as the process of simultaneously experiencing VR, VT and STS.

Lubna clarifies why she doesn't find it either difficult or easy by saying:

> Before, I couldn't really believe that people were capable of evil, but now I am exposed to more things and I see more types of people and how they think, I also see how strong some people are, having to go through things like this and still manage… especially when you are dealing with the victims and seeing how hurt they are and how much they miss their children and spouses, some lose their husbands for no reason, and you start to see how strong the ladies who lost their husbands or children are and sometimes don't even know where they are. Lubna. 5.155

Lubna's experience suggests that the resilience she has witnessed in her clients is the element that counterbalances the difficulties she faces. Sara emphasises this further by saying:

> It's neither, it's both, the difficulty in it as I mentioned earlier is the aspects neither I nor our clients can control, that's what makes it difficult, the helplessness, that's the difficult part…I wouldn't say it's easy but the support and the humanitarian part of it and the depth of it is what keeps me going so it makes it easier to keep going forward but no, it's not easy, it's tough but it's worth it. Sara. 10.314

Sara’s statement that “it’s worth it” suggests that the humanitarian aspect and the depth of the work makes the pain she might feel from working with this client group worth enduring. Ghada also highlights how the humanitarian side of the work and the intrinsic rewards of recognition are what keep her going, regardless of the frustration she feels from the emotionally challenging stories she hears from her clients.

> Sometimes I get frustrated with the work that I do and all the stories I hear, but the humanitarian side is what always keeps me going and rewards me, or when they see me and thank me, that also feels good. Ghada. 8.247

Farah provides a similar statement to explain her own experience of how it feels to do this type of work:

> The work has two sides to it; it is very important to me as it offers great services to Iraqis, but at the same time it is very demanding and tiring… sometimes I feel that I am always uptight and cannot handle listening to people complain about small things. On the other hand, however, it makes you more compassionate towards people and adds to your humanitarian side. Farah. 4.120

The fact that Farah is able to offer services that help Iraqis seems to be a positive aspect for her. However, she also stresses that the work is very demanding and tiring, and she does sometimes feel overwhelmed; she “cannot handle listening to people complain about small things”. However, it seems that offering this service is important to her despite the negative aspects.

The participants reflect on the struggles they experience while working with Iraqis in Jordan, which make the work challenging for them. However, they also reflect on what keeps them doing the work they do, such as the resilience they witness in their clients, the depth of the work, and the intrinsic rewards that they gain. Ghada emphasises this by saying:

> Even though it’s heartbreaking, something pulls you to keep on doing it. It’s the strength that you witness every day and the motivation to rebuild their lives, and just by seeing some of my clients who have lost everything, they still come in week after week wanting to find their way back and not giving up. It amazes me and I appreciate that they allow me to be a part of it, I mean to walk with them through the maze… there are days when I think, why am I doing this work? It literally on some days tears your heart apart but on others you see that strength and resilience and you think, this is why I do this work. Ghada. 6.181

Ghada’s expression that the work “on some days tears your heart apart but on others you see that strength and resilience” suggests that, as Engstrom, et al. (2008) have stated, VR is a process rather than an end result, in which VT and VR can occur simultaneously. Hussam depicts a similar notion in the following extract:

> I mean I sometimes walk out of sessions feeling like, wow that person just elevated me in a way I never imagined, but of course I sometimes walk out and feel like hiding and not facing the world, but on other days the world can look so beautiful when one of my clients overcomes something incredible. Hussam. 12.376

The differences in Hussam's experiences portray difficult and rewarding aspects of working with this client group. All the participants talk about the difficulties and complexities of the work, but they also talk about the positive aspects that balance these difficulties. For Sara, what seems to be her experience of VR is what drives her to continue doing her work as it gives her a feeling that she does not experience in other places.

This is highlighted by Hussam, who says:

> It is rewarding in spite of the pain. Hussam. 12.359

Summary

The analysis section explored three master themes: (1) the effects of sociopolitical and socioeconomic factors; (2) the enriching and motivating aspects of their roles; and (3) coping with the distressing aspects of their roles. The first master theme described how the counsellors were challenged by their clients' unmet basic needs, their lack of legal status, the ongoing violence in Iraq, and the stories their clients told them. These challenges involved feelings of helplessness, powerlessness, perplexity, unfairness, injustice, and a lingering emotional burden. Two of the research participants also described how the stories they hear when working with this client group resulted in disruptions in their personal relationships in the form of displacing anger and distancing.

The second master theme, enriching and motivating aspects of their roles, described the positive aspects of the participants' work and the way in which it motivated them to continue working with this client group. This included feelings of pride, achievement, and recognition. Witnessing their clients' difficulties increased the counsellors' commitment to the work. Additionally, they described positive changes in their self-concept and worldview.

The final theme, coping with the distressing aspects of their roles, described how the participants struggled with and benefited from self-care. The participants described interpersonal work as one of the main elements of self-care; one participant described her struggle in implementing it while others talked about how grateful they are that they are able to achieve separation from their professional lives in their personal lives. The participants also spoke about how interpersonal and professional support are essential to enable them to cope with the distressing aspects of their work. Finally, the participants reflected on the positive and negative aspects of their work and how they cope with the difficult aspects of the work through the positive aspects.

Although the three master themes discussed have distinct qualities, they also hold particular interrelating and shared concerns. Each theme tries to capture the essence of what is being described, but similarities are found across them. The two master themes – effects of sociopolitical and socioeconomic factors and enriching and motivating aspects of their roles – illustrate how working with this client group changed and influenced the counsellors as individuals in negative and positive ways. The third master theme, coping with the distressing aspects of their roles, highlights how the participants use various methods of self-care to cope with the emotional burden they experience. In addition, in "it's tough but it's worth it" it illustrates how the positive aspects of working with this client group motivate the participants to continue in their roles in spite of the challenges.

The themes also brought out a reciprocal pattern of interconnectedness and a reciprocal process, where participants perceived themselves as playing an active role in their field. In particular, participants appeared to feel constantly affected by their clients and in turn they perceived themselves as actively affecting and changing their own environments in a negative or positive way.

CHAPTER 4: DISCUSSION

The current study set out to explore the experience of counsellors working with Iraqis who have fled to Jordan. Three master themes emerged from the participants' narratives: the effects of sociopolitical and socioeconomic factors; enriching and motivating aspects of their roles; and coping with the distressing aspects of their roles. The aim of this section is to discuss, summarise and integrate the findings of the study by (1) considering and linking previous literature to the findings of this study; (2) providing a critical evaluation of the study by discussing its limitations, including researcher bias and methodological limitations; (3) discussing the implications of the research; and (4) suggesting directions for future research.

Linking Previous Literature to the Findings of This Study

Because this was a small-scale study the findings of the study cannot be generalised. Therefore, the aim of this section is to relate the findings of the study to existing literature.

Effects of Sociopolitical and Socioeconomic Factors

"There's nothing you can do": the importance of working within a system to meet client needs. The study found that the participants felt helpless, powerless and perplexed when faced with their clients' experiences of their objective reality. Participants spoke of their ability to provide psychological therapy being affected by their clients' unmet basic needs. Several of the counsellors provided examples of situations when a client rejected talk therapy or could not carry out set tasks because the client felt it was more important to attend to their basic needs than to their emotional needs. They also provided examples of clients who could not attend to their own or their family's emotional needs because their basic needs had not been fulfilled.

Farah mentioned Maslow’s hierarchy of needs (physiological needs, safety needs, love and belonging, esteem, and self-actualisation) as a way of explaining how she viewed this challenge. She suggested, as Maslow suggested, that an individual’s most basic level of needs must be met before they can focus on secondary needs and that if basic physiological and safety needs are not met, the individual experiences anxiety and fear. Criticisms do exist of Maslow’s hierarchy of needs (Heylighen, 1992); in particular, The Max Neef Model of Human Development Scale views needs as interrelated and interactive rather than existing in a hierarchal order. However, both models consider the basic needs of subsistence and survival to be the most essential and agree that anxiety and fear result if those needs are unmet.

Farah’s and Sara’s clients seemed to view their emotional needs as secondary. In addition, Hussam viewed emotional needs as being interrelated with basic needs. Wherein, he suggested that if the clients’ basic needs were met then their emotional health would simultaneously improve.

Alayarian (2007) suggested that, for effective therapy to take place, clients’ practical concerns, such as basic needs, need to be addressed alongside the therapeutic treatment. This suggestion is also supported by the Inter-Agency Standing Committee guidelines on mental health and psychosocial support in emergency settings (IASC, 2007). The guidelines placed basic services and security, including food and shelter, as the main need for people in emergency settings. They also suggested that in emergency settings mental health and psychosocial problems are highly correlated.

The IASC guidelines were presented in 2007 and the interviews took place in 2012.. From Hussam’s extract, it appears that collaboration between agencies remains insufficient, as he mentions that the organisation he works for needs more than one organisation that they

can refer their clients to for basic needs. Walid suggested that the financial help his place of employment is receiving is not enough to promote psychosocial wellbeing.

The participants revealed that they felt helpless when faced with clients who were struggling to fulfil basic needs. Herman (2001) suggested that the process of countertransference could explain the helplessness that therapists feel. However, the participants also felt that their skills as counsellors could not help clients who were encountering those difficulties. The participants' experiences suggest that they feel they cannot help their clients to alleviate the feelings of anxiety associated with meeting their basic needs without the help of other organisations.

Hussam expressed the need for environmental change to improve his clients' mental health by saying: "I provide psychological help but I also want an environment that helps the work that I do". This notion of the effect of environmental change on mental health is linked to Tyrer and Bajaj's (2005) approach, termed *nidotherapy*. They suggested that helping a client change their environment can alleviate mental health issues. However, they were referring to environmental changes that a therapist can change; whereas the research participants of this study feel powerless to alter their clients' environment.

Jordan is a low- and middle-income country that has limited and strained resources. It seems that implementing the IASC guidelines to improve the Iraqis' environment has been difficult in practice; Walid said "yes there is a system but it's not enough". Although international funding had been provided, a referral system to support the Iraqis' needs might have been difficult to employ. Horn and Strang (2008) suggested that implementing such a system is difficult in a country that does not have previously established mental health services and can take some time to accomplish.

Horn and Strang (2008) discussed those difficulties in their case study that focused on the implementation of the IASC guidelines in Jordan. They presented two significant

obstacles. Firstly, due to their location and lack of legal status, the Iraqis are scattered in urban areas and many do not leave their homes out of fear of deportation. Therefore, community outreach programmes were difficult to apply. Secondly, due to the enthusiasm of donors to help Iraqis, many agencies entered the field with little capacity and without paying attention to the Iraqis' needs: "Programmes often seem not to be planned on the basis of reliable information or population based needs assessments, but are, to a large extent, donor driven. In this context, it is extremely difficult for the guidelines to be implemented objectively" (Horn & Strang, 2008, p.293).

"You feel like a little child": the impact of legal status on providing psychological treatment. Schauben and Frazier (1995) explained that the institutional barriers within the legal system that clients have to navigate could be stressful and frustrating for the therapist. Similarly, the participants of this study spoke about the interconnectedness of their clients' mental health, resettlement issues and integration needs. They spoke about how those issues affected them as counsellors by causing feelings of helplessness, powerlessness, frustration and anger. Hussam expressed his feelings of helplessness, powerlessness and frustration when seeing the effects on his clients of the Jordanian government viewing them as guests. Lubna, Farah, and Sara spoke about the negative effects of resettlement decisions on their clients' mental health.

Previous research suggested that asylum seekers, who are more similar to the status of guest than of refugee with regard to unemployment rights and an uncertain future, suffer from mental health difficulties related to their social issues (Summerfield, 1999). As previously mentioned, Laban (2004) found that Iraqi asylum seekers who had to undergo lengthy asylum procedures (more than two years) were particularly vulnerable to mental health issues (Laban, 2004). Bader et al. (2009) presented similar findings; their study found that the length of period of residence in Jordan was positively correlated with the need for mental

health services. Furthermore, Sundram and Loi (2012) supported this by identifying protracted asylum seeker syndrome.

Farah and Walid spoke about their feelings of powerlessness when their clients were denied resettlement. The participants described feeling as if an external entity had destroyed what they had built up with their clients. McKinney (2007) explained that rebuilding is an integral aspect of therapeutic work with survivors of political violence. It seems that, for the counsellors, rebuilding is challenging when their clients are waiting for, or are denied, resettlement. This can make them feel powerless when providing therapeutic services, as expressed by Walid, who said: “I mean it is like you building a house and having someone tear it down for you, that is how you feel”.

The impact of counselling in the face of sociopolitical and socioeconomic factors could also be discussed from an alternative point of view. From the counsellors’ perspective, there seems to be a discrepancy between the psychological treatment they are offering their clients and what some of their clients need; that is, help with practical issues, such as basic needs and gaining legal status.

The surge of financial assistance for INGOs and NGOs to provide psychological treatment in Jordan for the huge number of Iraqis who fled there was the result of various studies that indicated a significant number of Iraqis were traumatised. IOM (2008) reported that 21% of Iraqis in Jordan were severely traumatised, while CDC – Mercy Corps (2007) reported that 77% of Iraqis surveyed reported suffering from one or more psychological or emotional issues. Bader et al. (2009) reported that 49% of Iraqis in Jordan needed mental health services. In contrast, Duncan et al. (2007) found that the main issues Iraqis faced were lack of status, lack of employment opportunities, limited access to services and community outreach, lack of adequate health care, and unmet psychosocial support needs. Bader et al. (2009), by interviewing Iraqis, found that the reasons for needing mental health services

included violence, stress, displacement, the death of a family member, family disputes, and unemployment or poverty.

The results of the studies portrayed a need for mental health services. However, other issues, such as political, socioeconomic, and social needs, also must be addressed. Ghada said: "They do not consider Jordan their home; they consider it merely as a stopping station, which isn't easy to mend". Pupavac (2001) argued that the psychosocial model assumes that conflict produces mass trauma and that various personal, political, and social factors that influence whether an individual experiences trauma need to be addressed. The participants' frustrations also relate to Hernandez et al.'s (2010) findings from a study of therapists working with clients who have experienced political violence. The study suggested that therapists experienced frustration because they were aware of the limitations of psychological therapy to address the vast traumas their clients were experiencing.

"Just picking up the pieces": reflecting on their impact as counsellors in the face of ongoing violence. Sara, Lubna, and Hussam expressed feelings of helplessness in the face of the ongoing violence in Iraq: in their work with their clients and in how it reflected on their impact as counsellors. Hussam questioned whether his counselling skills could benefit clients who were still feeling unsafe because they perceived their families to still be in danger. Hussam's thoughts on the importance of establishing safety as part of the recovery process is linked to Herman's (2001) three stages of trauma recovery. As previously mentioned, Herman (2001) suggested that establishing physical and emotional safety is one of the phases of recovery. This concept relates to Hussam's reflection on the impact he could have on recovery if his clients were not able to establish safety.

Sara explored the meaning of working with clients affected by wars. She wondered whether being a counsellor was her "place to be", rather than advocating for preventing wars. Her perception corresponds with Hussam's opinion on the importance of establishing safety.

Lubna explored her experience of being faced with the death of her client's family members in Iraq and how when hearing such difficult stories she has to bracket her assumption that the events are impossible to cope with in order to continue to be able to engage with her clients. She relates the notion of bracketing to her role as a counsellor, in the sense that without the ability to bracket in the face of extreme adversity and expressed her assumptions to her clients, her impact as a counsellor would be weakened.

The participants' reflections on their impact as counsellors in the face of ongoing violence could be explored within Herman's model of recovery. As mentioned previously, the three phases of recovery that Herman suggested are safety, mourning and remembrance, and reconnecting (Herman, 2001). In the case of ongoing violence, it seems that the participants could perceive the goals of establishing safety and remembrance and mourning as unattainable, because further loss remains a possibility.

Emotional burden. McKinney (2007) suggested that an integral part of recovery for clients is to have their story witnessed; that is, listened to. The author stated that it is essential for therapists working with refugees and asylum seekers to endure the emotional burden that accompanies hearing the stories of this client population. In this study the participants expressed the notion of emotional burden in relation to the stories that they had heard from their clients and voiced feelings of shock and concern about the unfairness and injustice that their clients had endured. They also expressed feelings of heaviness, power imbalance, incomprehensiveness, and a lingering emotional burden that stemmed from the realities they had to face through their client's stories.

Smith et al.'s (2007) study relates to this notion. The authors utilised the STRess Appraisal Inventory (STRAIN) to measure the emotional burden experienced by therapists working with veterans of WWII and with refugees. They found that the therapists who were working with refugees experienced higher levels of emotional burden from the stories that

they heard than the therapists working with veterans of WWII. Woodcock (1995) also suggested that it could be difficult for therapists working with refugees and asylum seekers to contemplate the horror of what their clients have endured. The findings of the present research study relate to Woodcock's (1995) study in the sense that Hussam found it difficult to contemplate what his clients endured: "it's incomprehensible". Additionally, similar to Figley's (1995) findings that experiencing STS is a natural consequence of working with trauma, Walid experienced symptoms of STS: hearing what his clients have experienced "makes me, myself, have nightmares as well from all the stories we heard".

Schauben and Frazier (1995) suggested that when a therapist feels overwhelmed and their affect tolerance is exceeded, they might rely on defence mechanisms as a coping strategy. Similarly, two of the participants of the present study spoke about how their work affected their personal relationships in a negative way. Farah described how she can no longer sympathise with her friends' problems; it seems that she cannot tolerate further emotional burdens and that to protect herself she perceives them as "silly problems" (Shauben & Frazier, 1995). Trippany et al. (2004) described a symptom of VT as the disruption of ego resources; that is, an individual's ability to interpersonally connect with others and meet their psychological needs, in which Lubna described how she displaces her anger onto significant others as a direct consequence of working with this client group. Thus, it seems that Farah and Lubna are both experiencing symptoms of VT.

Farah and Lubna described difficulties in implementing self-care, which might be the cause of their symptoms of VT. This notion is linked to Pross (2006) and Harrison and Westwood (2009), who suggested that self-care is a protective factor for VT. However, other research participants might have chosen not to speak about the disruptions in their personal lives during the interviews. Therefore, it is important to note that this is purely an

interpretation. Although the symptoms of VT were described in this theme, the same participants also discussed positive aspects of their work.

Enriching and Motivating Aspects of Their Roles

"Psychological value". The participants described gaining psychological value from their work with this client population. The positive feelings of pride, achievement, and recognition they gained from their client work as expressed in the interviews alleviated negative ones, such as helplessness, and drove them to continue with this work. This experience of positive feelings could be related to compassion satisfaction. Although no known study has focused on the factors motivating mental health providers to work with asylum seekers and refugees who are survivors of political violence, the findings of this study can be related to the motivating factors that drive therapists to work within this profession.

Farber et al.'s (2005) and McCann's (2010) findings link to the results of this study. The need to help others for intellectual stimulation (Walid), valuing connection (Hussam), pride and progress (Ghada and Walid), and feeling privileged to work on an authentic level (Lubna and Sara) are factors that were expressed by the research participants as valuable in their line of work. This was highlighted by some of the participants, who expressed that without the rewarding factors they mentioned they would be seeking another line of work.

Increased commitment. The research participants expressed their increased commitment to helping this client group as an outcome of working directly with them. By working with Iraqis who had fled to Jordan, the research participants became more aware of the issues and difficulties that their client population were facing. This awareness seems to have increased their commitment to helping them, and advocating for their cause.

This notion is similar to the concept of VR. Engstrom et al. (2008) related VR to therapists being more committed to their work, reaffirming the value of therapy, and having

an enhanced understanding of, and advocating for, the population they work with. Farah described how after working with Iraqis she realised how important psychological services are in the region, hence reaffirming the value of therapy. Farah also described how after working with this client group she understood how much they were struggling and started advocating for them.

Positive changes in self-concept and worldview. The research participants in this study expressed how witnessing their clients' strength affected them in a positive way. This notion might also be related to VR. The main themes relating to VR are: (1) reflecting on human beings' capacity to heal; (2) reaffirming the value of therapy; (3) regaining hope; (4) reassessing the dimensions of one's own problems; (5) understanding and valuing spiritual dimensions of healing; (6) discovering the power of community healing; and (7) making the professional and lay public aware of the impact and multiple dimensions of violence by writing and participating in public speaking forums (Hernandez et al., 2010, p.73). The various changes that the participants described bear similarities to the concept of VR.

Although during the interviews the researcher did not directly ask the research participants if they had experienced any positive changes, most of the participants spoke about them. They described how witnessing their clients' strength made them view themselves as being more capable of overcoming adversity, changed how they viewed their own problems, and gave themselves a sense of strength as well. Additionally, the participants expressed how, through their work, they had started viewing the world differently. Sara spoke about how she saw something special about the world after witnessing the resilience of her clients and Walid spoke about how his work allowed him to look at different dimensions of the world that had not been available to him previously, which in turn made him wiser. Finally, Farah expressed how working first hand with her clients allowed her to view her world from a different perspective, which made her more compassionate.

Coping with the Distressing Aspects of Their Roles

Self-care. The research participants expressed the importance of self-care in working with this client group. The self-care practices they employed were interpersonal work, interpersonal support, and physical and recreational activities. The participants expressed how implementing those practices protected them from the distressing effects of working with trauma and alleviated the emotional burden they felt. Lubna and Walid spoke about experiencing intrusive imagery and dreams. Walid said that processing his dreams with his supervisor was integral to connecting the dreams with his work and understanding why he was experiencing them, and that as a result of this understanding he no longer experienced intrusive dreams. Lubna explained how she tries to manage intrusive thoughts at home by processing them and being aware of the distressing effects of internalising them.

The participants who spoke about self-care described how interpersonal work, meaning separating themselves from their work at home, was integral for them. Hussam spoke about how he has been able to achieve that separation, while Lubna and Farah spoke about their struggle to achieve it.

The emotional cost of the helping professions is well documented in the literature (Meldrum et al., 2002). In Figley's (2002) study of therapists working with people with chronic illnesses, he highlighted the integrity of self-care practices. Figley argued that CF is a result of lack of self-care and highlighted that social support in the form of varied relationships that take the therapists out of the therapist role, and interpersonal work are essential. Killian (2008) explored CF, burnout and self-care in clinicians working with trauma survivors and suggested that self-care was an important aspect of compassion satisfaction. Pros (2006) and Harrison and Westwood (2009) explored the preventive and protective factors of VT. These authors also suggested that self-care is an important way of preventing VT.

The findings of this study are linked to the literature and suggest that the research participants perceive self-care as an important part of their work. While some participants seemed to have integrated and maintained self-care practices, others seemed to be struggling to do so. By looking at the brief history presented in Appendix G, it is possible to argue that the research participants who have more experience (Hussam and Walid) are more able to utilise self-care practices than the participants who have less experience (Lubna and Farrah); therefore, they are less prone to VT symptoms (Pearlman & MacIan, 1995). However, research on level of experience and experience of VT produced contradictory results in the literature. Bober and Regehr (2006) found that the greater number of years of experience a therapist has, the more prone he or she is to have disruptive beliefs with regard to intimacy with others. However, as this is a small-scale study, this finding cannot be generalised.

“It’s tough but it’s worth it”. Throughout the interviews the participants described experiencing distressing and enriching experiences simultaneously through their work with Iraqis who had fled to Jordan. In the participants’ extracts the symptoms of VT as well as VR are apparent. For example, Farah described experiencing disruptions in her personal relationships but also described that she had gained a new positive outlook on life and on overcoming adversity from witnessing her clients’ resilience.

Lubna also described disruptions in her personal relationships due to displacing her anger onto significant others. Although she continued to express that she was aware that her displacement was harmful, she had also tried to implement practices of self-care to minimise that harm. Additionally, Walid described how he had experienced intrusive dreams and how, with awareness and access to professional support, he had been able to process them and prevent further dreams about that specific client issue. Figley (2002) discussed this notion and suggested that STS is a natural consequence of working with trauma, adding that it is not necessarily a problem if it is acknowledged and worked through.

The participants’ extracts suggest that they have an awareness of the harmful and positive aspects of working with this client group and appear to be able to utilise professional support to cope with the harmful effects. They also display an awareness of the importance of self-care practices and professional support in managing these effects. If this study had used quantitative measures for VT or STS, some of the participants would have results indicating that they were experiencing VT or STS. The qualitative nature of the study illustrated that, although some of the participants have or are experiencing symptoms of VT and STS, they are also experiencing facets of VR. Additionally, from their extracts it seems that preventing symptoms of VT and STS is a process and participants’ active engagement in preventing them is integral (Pearlman & Caringi, 2009).

Hernandez et al. (2010) and Arnold et al. (2005) suggested that simultaneous experiences of negative and positive effects of working with survivors of political violence overlap. They argued that the stressful and harmful effects of trauma work dominate the literature. Although it is not to be implied that the negative effects are to be ignored or thought of as less significant, to empower therapists the authors suggested an integrated model of training and supervision is needed in the field.

Conclusion

The results of this research study highlight the difficulties that counsellors face in the sociopolitical climate in Jordan and Iraq, which relate to the lack of resources for Iraqi guests, their legal status, and safety in Iraq. In turn, this has affected the counsellors, making them reflect on their impact as counsellors in the face of ongoing violence, the impact of legal status on psychological treatment, and the importance of working within a comprehensive system to be able to better meet their clients’ needs.

This study also found that the participants were experiencing an emotional burden from witnessing and listening to client stories, which had a negative impact on them. However, it was also found that the counsellors were experiencing a positive impact of their work in the form of intrinsic rewards, which they described as alleviating the negative impact or helping them cope with the harmful effects. The participants also discussed how they implemented or tried to implement self-care practices to alleviate and manage the harmful effects of working with this client group.

The impact of working with this client group was found to have increased the participants' commitment to the group. The participants in this research study described the reciprocal and overlapping nature of working therapeutically with survivors of political violence in Jordan. Hernandez et al. (2010) suggested that reciprocity is central to, and must be appreciated in, trauma work; "reciprocity opens up the possibility of appreciating, attending to, and making meaning out of the process whereby therapists themselves may heal, learn, and change with clients" (Hernandez et al., 2010, p.74). In addition to Hernandez et al.'s (2010) concept of VR, the results of this study in the context of the positive impacts of trauma work are linked to other newly emerging research, including Arnold et al. (2005), Jenmorri (2006), and Linley and Joseph (2007).

In summary, the research findings of this study are similar to previous literature on VT, STS, and VR. However, it differs in the sense that the participants' experiences seem to embody the three concepts together, rather than separately.

Methodological Limitations

Due to the exploratory and interpretive nature of this research study, reflecting on methodology is integral. First and foremost, the results of this study were significantly shaped by the research questions chosen by the interviewer, which were initially formed from

personal experience. Although measures were taken to minimise researcher bias in creating the interview schedule, through research supervision and a pilot study, ultimately researcher bias cannot be fully eliminated. Therefore, it is important that other researchers replicate this study.

Additionally, due to the double hermeneutic nature of IPA, the results are also based on "the researcher trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2008, p.51). To minimise the interpretative bias in this study by checking the validity of the study, an email was sent to each participant to check if they agreed with the emerging themes. The qualitative nature of this study and its small sample size prevents generalisation of the data, although the current findings might benefit individuals working in the field by providing an understanding of the experience of a small number of psychosocial counsellors.

Although the findings identified several consistent themes among the participants, divergent themes emerged within Lubna's account, which were related to pay. This theme emerged from the question: "In what ways does your work reward you"? Lubna felt that the pay she received was not enough and that the organisation could reward her with better pay. Although the question did not specify the type of reward they received from their work, five of the participants understood it from the perspective of personal rewards and only Lubna understood it in the sense of financial reward. Because Lubna was the youngest participant with the least work experience, her pay might have been less than the other participants and might not match the time and effort she puts into the organisation.

Future Research

The study's epistemological stance stated that reality changes over time. As the interviews took place in April 2012, the participants' experience of working with Iraqis at the

time of the interviews may have changed over time. Therefore, this study does not suggest that the participants' experiences are stagnant. As such, longitudinal studies might be helpful to explore the difference of experience over time.

Finally, the number of caseworkers (as discussed in the methodology section) who replied to volunteer to participate in this research study was alarming, as it seems that the definition of counselling and therapeutic work is not clearly defined in Jordan (Gilbert, 2009). The implications of this misunderstanding might be harmful for clients and service providers. If service providers believe that they are providing therapeutic work (without training), the challenges that they might encounter in that work could be damaging for their self-esteem and their professional self-identity, because they might not have the necessary skills to overcome them. Additionally, if service providers are relaying to their clients that they are offering therapeutic services, but in reality do not know what therapy is, it might be harmful for clients. However, this is just the researcher's assumption and it may or may not be the case. Therefore, further research is deemed essential to understand caseworkers' assumptions of what therapeutic work consists of and how it affects them and their clients.

Implications for Psychosocial Service Providers and Supervisors in Jordan

The findings of the research study suggest that the psychosocial counsellors were negatively affected by the legal and social status of their clients. As previously mentioned, Schauben and Frazier (1995) have suggested that the legal system that clients must navigate is frustrating for therapists. This study proposes that organisations working with clients who are affected by legal and social issues need to be aware of the effect this might have on their counsellors and provide support to identify, acknowledge and alleviate these negative affects (Bell et al., 2003).

Baker (2012) emphasised the need to integrate graduate-level courses in trauma therapy to make students aware of the symptoms of VT. However, in addition and in support of Hernandez et al.'s (2010) integrative framework model, this study suggests that trauma therapy training should include all the overlapping concepts that make up the experience of working with trauma. To best prepare counsellors, this study proposes that supervision practices need to help counsellors identify and acknowledge the distressing and enriching effects of working with this client group.

Furthermore, similar to Bell et al. (2003), this study suggests that organisations should implement supervision practices that provide the space for counsellors to express fears and inadequacies. In addition, supervision practices should also provide the space to enrich counsellors by cultivating an awareness of VR in their supervision practices. Similar to Hernandez et al.'s (2010) findings, this study found that the negative and positive effects of trauma work could be simultaneous. Therefore, this study suggests that supervisors can help therapists construct a positive narrative about their work despite the exposure to trauma and integrate that narrative into their sense of self and assumption about the world.

Personal Reflexivity

When I started thinking about exploring this research area, I was an outsider holding the assumption that the lack of resources and formal training in Jordan must mean I would find that participants were really struggling with working with this client group. I did not expect to find that they were positively affected by their work. My assumptions and biases were challenged throughout the interview and analysis stages, and I was pleasantly surprised to find out that this was not the case.

During my work with refugees and asylum seekers, I noticed an experience of VR. At the time I was not aware of the term and found it frustrating that I could not find anything in

the literature that described my experience. After several months I did come across it and was surprised that it was still being conceptualised. When I interviewed my research participants I was not expecting to find that they had had similar positive experiences. Perhaps this is because I was focusing on finding faults in the system.

Throughout the research process, I reflected on the use of the words *positive* and *negative*, especially the word negative. My reflection was based on Hussam's experience of STS symptoms, and whether he would label experiencing these as negative or as part of the process. Additionally, I wondered if therapists working with trauma perceived such experiences as negative or as experiences that enhanced their self-awareness. Because I did not have answers to these questions, I maintained the use of the words positive and negative in the write up, but felt that further research needed to be conducted to understand how therapists themselves perceive such experiences. During the analytical process of reading the transcripts I found that I could have asked more exploratory questions. This is only my second IPA study; therefore, my interview skills are still developing. However, I found it rather frustrating to see that I could have explored certain areas in more depth. Ultimately, this has potentially affected the emerging themes and results of the study.

In addition to the influence of my interviewing skills on the results of the study, the way the participants might have perceived me had an effect as well. As previously mentioned, the fact that the interviews took place within the organisation played a role in what the participants might have felt was appropriate to discuss. For example, if the participants had an issue with the organisation that inhibited them in discussions with their manager, they might have felt that they could not discuss it with me out of fear that their confidentiality would be broken. Confidentiality issues were discussed with one of the participants, who explained that another researcher had broken confidentiality; the participant wanted assurance that I would not do the same. This attuned me to the mistrust that some of

the participants might have. Finally, because I am female, male participants might have underplayed some of the difficulties they had encountered, because typically in the Arab culture males do not discuss personal issues with females.

Furthermore, as mentioned previously, the absence of the experience of other counsellors who were not recruited might have affected the results of the study. During the initial stages of recruitment, some of the organisations I contacted did not respond and others told me that they would not like their therapists to be interviewed. One specifically told me that the reason for this is that they have been misrepresented in the past. Although I assured anonymity and confidentiality, the organisation did not respond, which might have been because they perceived that I would misuse the data. This construed a significant limitation for my study, because the therapists who were not contacted might have related a different experience.

At the time of recruitment I was living in London; therefore, I did not have many personal or professional relationships in the field in Jordan. When I moved back to Jordan in the final stages of my research study, I started developing relationships with people in the field. During this time I met some ex-employees of several different organisations, who spoke to me about the relevant ethical issues. This included having to see up to eight or ten clients a day and supervisors breaking confidentiality. This was purely anecdotal and the information was gained from people who had been employed by organisations other than the one in my research study. Although they asked me to include the information in my study, it has not been added to the main body of the research. However, further exploration of these issues remains necessary.

REFERENCES

Adams, K. B., Matto, H. C., & Harrington, D. (2001). The Traumatic Stress Institute Belief Scale as a measure of vicarious trauma in a national sample of clinical social workers. *Families in Society: The Journal of Contemporary Human Services*, *82*(4), 363–371.

Adams, K. B., & Riggs, S. A. (2008). An explanatory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology*, *2*(1), 26–34.

Ager, A., & Loughry, M. (2001). *The refugee experience: A psychosocial training module*. Oxford: Refugee Studies Centre.

Alayarian, A. (2007). *Resilience, suffering, and creativity*. London: Karnac Books.

Allport, G. W. (1937). *Personality: A psychological interpretation*. New York: Holt.

Al-Qdah, T., & Lacroix, M. (2010). Iraqi refugees in Jordan: Lessons for practice with refugees globally. *International Social Work*, *54*(4), 521–534.

American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revised). Washington, DC: Author.

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

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology*, *45*, 239–263.

Arvay, M. J. (2001). Secondary traumatic stress among trauma counsellors: What does the research say? *International Journal for the Advancement of Counselling*, *23*(4), 283–293.

Arvay, M. J., & Uhlemann, M. R. (1996). Counsellor stress in the field of trauma: A preliminary study. *Canadian Journal of Counselling*, *30*, 193–210.

Astin, M. C. (1997). Traumatic therapy: How helping rape victims affects me as a therapist. In M. Hill (Ed.), *More than a mirror: How clients influence therapists’ lives* (pp. 101–109). Binghamton, NY: Haworth.

Bader, F., Sinha, R., & Leigh, J. (2009). Psychosocial health in displaced Iraqi care-seekers in non-governmental organisation clinics in Amman, Jordan: An unmet need. *Prehospital and Disaster Medicine*, *24*(4), 312–320.

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatisation, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, *18*(1), 71–86.

Baker, A. A. (2012). Training the resilient psychotherapist: what graduate students need to know about vicarious traumatisation. *Journal of Social, Behavioral, and Health Sciences*, *6*(1), 1–12.

Baldachin, J. (2010). *The problematic nature of using Western treatments for PTSD in non-Western settings and a discussion of culturally sensitive interventions*. Columbia University, New York.

Battley, S. L. (1996). Vicarious traumatisation: The effects on psychotherapists of working with trauma victims. In S. J. Gamble & J. Munroe (Eds.), *Trauma’s impact on helpers: Research handbook* (pp. 3–4).

Beaton, R. D., & Murphy, S. A. (1995). Working with people in crisis: Research implications. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder* (pp. 51–81). New York: Brunner/Mazel.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organisational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Services*, *84*(4), 463–470.

Ben-Porat, A., & Itzhaky, H. (2011). The contribution of training and supervision to perceived role competence, secondary traumatisation, and burnout among domestic

violence therapists. *The Clinical Supervisor*, *30*(1), 95–108.

Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.). New York: Pearson.

Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, *6*(1), 1–9.

Boscarino, J. A., Adams, R. E., & Figley, C. R. (2010). Secondary trauma issues for Psychiatrists. *Psychiatric Times*, *27*(11), 24–26. Retrieved from http://www.psychiatrictimes.com/ptsd/content/article/10168/1727522

Bourdeau, B. (2000). Dual relationships in qualitative research. *The Qualitative Report*, *4*(3/4). Retrieved from http://www.nova.edu/ssss/QR/QR4-3/bourdeau.html

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

Bradley, L. J., & Ladany, N. (Eds.). (2001). *Counsellor supervision: Principles, process and practice* (3rd ed.). Philadelphia: Brunner-Rutledge.

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatisation, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, *30*(4), 386–393.

Brandon, J. H. (2000). Working models of self and other in adult attachment and vicarious traumatisation. *Dissertation Abstracts International: Section B: The Sciences & Engineering*, *60*(10-B), 5219.

Bride, B. E. (2004). The impact of providing psychosocial services to traumatised populations. *Stress, Trauma, and Crisis: An International Journal*, *7*(1), 29–46.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work*, *52*(1), 63–70.

Bride, B. E, Robinson, M. M., Yegidis, B., & Figley, C. R. (2003). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*, *13*, 1–16.

Briere, J., & Jordan, C. E. (2004). Violence against women: Outcome complexity and implications for treatment. *Journal of Interpersonal Violence*, *19*(11), 1252–1276.

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Thousand Oaks, CA: Sage Publications.

Burman, E., & Parker, I. (1993). *Discourse analytic research*. London: Routledge.

Caballero, B. (2002). Ethical issues for collaborative research in developing countries. *American Journal of Clinical Nutrition*, *76*(4), 717–720.

Carroll, L., Gilroy, P. J., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. *Women & Therapy*, *22*(2), 133–143.

Catherall, D. (1995). Coping with secondary traumatic stress: the importance of the professional peer group. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 80–92). Lutherville, MD: Sidran.

CDC - Mercy Corps (2007). *East Amman survey of Iraqis*. Amman: CDC & Mercy Corps.

Cheung P. (1993). Somatization as a presentation in depression and post-traumatic stress disorder among Cambodian refugees. *Australian and New Zealand Journal of Psychiatry*, *27*(3), 422–428.

Choi, G. Y. (2011). Organisational impact on the secondary traumatic stress of social workers assisting family violence or sexual assault survivors. *Administration in Social Work*, *35*(3), 225–242.

Chrestman, K. R. (1999). Secondary exposure to trauma and self-reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (2nd ed., pp. 29–36). Lutherville, MD: Sidran.

Chu, J. (1988). Ten traps for therapists in the treatment of trauma survivors. *Dissociation*, *1*(4), 24–31.

Ciftci, A., Jones, N., & Corrigan, P. W. (2012). Mental health stigma in the Muslim community. *Journal of Muslim Mental Health*, *7*(1), 17–32.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass.

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

Coster, J. S., & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice*, *28*(1), 5–13.

Courtois, C. A. (1988). *Healing the incest wound: Adult survivors in therapy*. New York: Basic Books.

Cunningham, M. (1996). *Vicarious traumatisation: Impact of trauma work on the clinician.* (Unpublished doctoral dissertation). Adelphi University: School of Social Work.

Cunningham, M. (1999). The impact of sexual abuse treatment on the social work clinician. *Child and Adolescent Social Work Journal*, *16*(4), 277–290.

Cunningham, M. (2003). Impact of trauma work on social work clinicians: Empirical findings. *Social Work*, *48*(4), 451–459.

Devilly, G., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *The Australian and New Zealand Journal of Psychiatry*, *43*(4), 373–385.

Duncan, J., Schiesher, D., & Khalil, A. (2007). *Iraqi asylum seekers in Jordan: A report of the ICMC-USCCB mission to assess the protection needs of Iraqi asylum seekers in Jordan*. Retrieved from http://www.aina.org/reports/iasij.pdf

Eatough, V., & Smith, J. A. (2006). I was like a wild wild person: Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology*, *97*, 483–498.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, *38*(3), 215–29.

Engstrom, D., Hernandez, P., & Ganagsei, D. (2008). Vicarious resilience: A qualitative investigation into its description. *Traumatology*, *14*(3), 13–21.

FAFO. (2007). *Iraqis in Jordan: Their number and characteristics*. Retrieved from http://www.dos.gov.jo/dos_home_a/main/Analasis_Reports/Iraqis%20in%20Jordan/Iraqis%20in%20Jordan.pdf

Fagen, P. (2009). *Iraqi refugees: Seeking stability in Syria and Jordan*. Institute for the Study of International Migration, Georgetown University. Retrieved from http://isim.georgetown.edu/Publications/PatPubs/Iraqi%20Refugees.pdf

Farber, B. A., Manevich, I., Metzger, J., & Saypol, E. (2005). Choosing psychotherapy as a career: Why did we cross that road? *Journal of Clinical Psychology*, *61*(8), 1009–1031.

Field, P. A., & Morse, J. M. (1992). *Nursing research: The application of qualitative approaches*. London: Chapman & Hall.

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised.* New York: Brunner/Mazel.

Figley, C. R. (1999). Compassion fatigue: Towards a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 3–28). Lutherville, MD: Sidran.

Figley, C. R. (2002). Compassion fatigue and the psychotherapist’s chronic lack of self-care. *Journal of Clinical Psychology*, *58*(11), 1433–1441.

Fine, M. (1992). Passion, politics, and power: Feminist research possibilities. In M. Fine (Ed.), *Disruptive voices: The possibility of feminist research* (pp. 205–231). Ann Arbor, MI: University of Michigan Press.

Fosse, M. (2005). Post-traumatic growth: the transformative potential of cancer. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *66*(3-B), 1716.

Freudenberger, H. J. (1974). Staff burnout. *Journal of Social Issues*, *30*, 159–165.

Gilbert, J. (2009). Power and ethics in psychosocial counselling: Reflections on the experience of an international NGO providing services for Iraqi refugees in Jordan. *Intervention*, *7*, 50–60.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.

Gonsalves, C. (1992). Psychological stages of the refugee process: A model for therapeutic interventions. *Professional Psychology: Research and Practice*, *23*(5), 382–289.

Gorst-Unsworth, C., & Goldenberg, E. (1998). Psychological sequelae of torture and organized violence suffered by refugees from Iraq: Trauma-related factors compared with social factors in exile. *British Journal of Psychiatry*, *172*, 90–94.

Guba, E., & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105–117). Sage Publications.

Hamilton, M. (2007). *What school leaders need to know about secondary traumatic stress*. Retrieved from http://beyond-balance.com/documents/leaders_article.pdf

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatisation of mental health therapists: Identifying protective practices. *Psychotherapy*, *46*(2), 203–219.

Herman, J. (2001). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror.* New York: Basic Books.

Hernandez, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies*, *29*(10), 67–83.

Hernandez, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process*, *46*(2), 229–241.

Hesse, A. R. (2002). Secondary trauma: How affecting with trauma survivors affects therapists. *Clinical Social Work Journal*, *30*(3), 293–308.

Heylighen, F. (1992). *A cognitive-systemic reconstruction of Maslow's theory of self-actualisation*. Retrieved from http://pespmc1.vub.ac.be/Papers/Maslow.pdf

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

Holloway, E. L. (1995). *Clinical supervision: A systems approach.* Thousand Oaks, CA: Sage Publications.

Honwana, A. (2001). *Discussion guide 4: Non-Western concepts of mental health, the refugee experience – psychosocial training module* (pp. 103–119). Oxford: Refugee Studies Centre.

Hopkins, B. W., Seltzer, A., & Avigaad, J. (2005). *NICE PTSD guidelines – not easily applicable to refugees*. Retrieved from http://www.bmj.com/cgi/eletters/330/7499/1038

Horn, R., & Strang, A. (2008). A Jordanian case study: The implementation of the IASC guidelines on mental health and psychosocial support in emergency settings. *Intervention*, *6*, 291–293. Retrieved from http://sustainabledevelopment.un.org/content/documents/745habitat.pdf

Hudek, C. (2007). Dealing with vicarious traumatisation in the context of global fear. *The Folio*, 95–101. Retrieved from http://www.focusing.org/folio/Vol20No12007/12_DealingWith_R.pdf

Husserl, E. (1931). *Ideas: General introduction to pure phenomenology* (3rd ed., G. W. Boyce, Trans.). London, UK: Allen & Unwin; New York, NY: Macmillan. (Original work published 1913).

Ibrahim, S., & DeBartolo, D. (2007). *The Iraq war’s impact on growth and inflation in Jordan*. Retrieved from http://iraqslogger.powweb.com/downloads/cssjordan_report.pdf

Inter-Agency Standing Committee (IASC). (2007). *IASC guidelines on mental health and psychosocial support in emergency settings,* Geneva: IASC. Retrieved from http://www.humanitarianinfor.org/iasc/contents/products

IOM. (2008). *Assessment on psychosocial needs of Iraqis displaced in Jordan and Lebanon*. Retrieved from http://www.iom.int/jahia/webdav/shared/shared/mainsite/published_docs/brochures_and_info_sheets/report_psy_assessment.pdf

Jaganjac, N. (2004). Europe and Central Asia: Profile of mental health. In The World Bank, *Health, Nutrition and Population (HNP) Report: Mental Health and the Post Conflict Development and Mental Health 135 Global*.

Jamil, H., Hakim-Larson, J., Farrag, M., Kafaji, T., Duqum, I., & Jamil, L. H. (2002). A retrospective study of Arab American mental health clients: Trauma and the Iraqi refugees. *American Journal of Orthopsychiatry*, *72*(3), 355–361.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma.* New York: The Free Press.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: a validation study. *Journal of Traumatic Stress*, *15*(5), 423–432.

Jenmorri, K. (2006). Of rainbows and tears: exploring hope and despair in trauma therapy. *Child and Youth Care Forum*, *35*(1), 41–55.

Johnson, A. B. (2010). *A resistance to joy: Living alternative narratives of trauma work*. (Doctoral thesis, Trinity Western University). Retrieved from http://www2.twu.ca/cpsy/assets/studenttheses/johnsonangelab.pdf

Johnson, C. N. E., & Hunter, M. (1997). Vicarious traumatisation in counsellors working in the New South Wales Sexual Assault Service: An exploratory study. *Work and Stress*, *11*, 319–328.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, *22*(4), 116–121.

Kadambi, M. A., & Ennis, L. P. (2004). Reconsidering vicarious trauma: A review of the literature and its limitations. *Journal of Trauma Practice*, *3*(2), 1–21.

Kahill, S. (1988). Symptoms of professional burnout: A review of the empirical evidence. *Canadian Psychology*, *29*(3), 284–297.

Kassam-Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. Hudnall Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (pp. 37–47). Lutherville, Maryland: Sidran Press.

Killian, K. D. (2008). Helping till it hurts? A multidimensional study of compassion satisfaction, fatigue, burnout and self-care in clinicians working with trauma survivors. *Traumatology*, *14*(2), 41.

Kinzie, D. (2001). Psychotherapy for massively traumatised refugees: The therapist variable. *American Journal of Psychotherapy*, *55*(4), 475–490.

Kvale, S. (1996). *Interviews. An introduction to qualitative research interviewing*. CA: Sage.

Laban, C. J., Gernaat, H. B., Komproe, I. H., Schreuders, G. A., & De Jong, J. T. (2004). Impact of a long asylum procedure on the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. *The Journal of Nervous and Mental Disease*, *192*(12), 843–852.

Laban, C. J., Gernaat, H. B., Komproe, I. H., van der Tweel, I., & De Jong, J. T. (2005). Postmigration living problems and common psychiatric disorders in Iraqi asylum seekers in the Netherlands. *The Journal of Nervous and Mental Disease*, *193*(12), 825–832.

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Critical events in psychotherapy supervision: An interpersonal approach*. Washington, DC: American Psychological Association.

Laidig, J., Brady, J., & Guy, J. D. (1999). Vicarious traumatisation, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, *30*(4), 386–393.

Laverty, S. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, *2*(3).

Lerias, D., & Byrne, M. (2003). Vicarious traumatisation: symptoms and predictors. *Stress and Health*, *19*, 129–138.

Linley, P. A., & Joseph, S. (2006). Positive and negative aspects of disaster work. *Journal of Loss and Trauma*, *11*, 229–245.

Linley, P. A., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology*, *26*, 385–403.

Linley, P. A., Joseph, S., & Loumidis, K. (2005). Trauma work, sense of coherence, and positive and negative changes in therapists. *Psychotherapy and Psychosomatics*, *74*(3), 185–188.

Lipson, J. G. (1993). Afghan refugees in California: mental health issues. *Issues in Mental Health Nursing*, *14*(4), 411–423.

Lira, E., & Weinstein, E. (1983). The testimony of political repression as a therapeutic

instrument. *American Journal of Orthopsychiatry*, *53*(1), 43–51.

Lucero, M. (2002). *Secondary traumatic stress disorder in therapists: Factors associated with resilience* (Unpublished doctoral dissertation, Hofstra University).

Luck, T. (2012). Number of Syrians in Jordan 'tops 140,000'. *The Jordan Times*. Retrieved from http://jordantimes.com/number-of-syrians-in-jordan-tops-140000

Mann, C., & Fazil, Q. (2006). Mental illness in asylum seekers and refugees. *Primary Care Mental Health*, *4*(1), 57–66.

Maschi, T., & Brown, D. (2010). Professional self-care and prevention of secondary trauma. In N. B. Webb (Ed.), *Helping bereaved children: A handbook for practitioners* (4th ed., pp. 325–355). New York: Guilford Press.

Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice Hall.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, *2*(2), 99–113.

Maslach, C., & Jackson, S. E. (1986). *Maslach burnout inventory manual* (3rd ed.). Palo Alto, CA: Consulting Psychologists Press.

Maslach, C., Jackson, S. E., & Leiter, M. (1996). Maslach burnout inventory. In C. P. Zalaquett & R. J. Wood (Eds.), *Evaluating stress: A book of resources* (3rd ed., pp. 191–218).

Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist*, *53*(2), 205–220.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatisation: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(2), 131–149.

McCann, I. L., & Pearlman, L. A. (1992). Constructivist self-development theory: A

theoretical framework for assessing and treating traumatised college students. *Journal of American College Health*, *40*(1), 189–196.

McCann, I. L., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatisation and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatised* (pp. 150–177). New York: Brunner/Mazel.

McCann, L., & Pearlman, L. A. (1991). Vicarious traumatisation: The emotional costs of working with survivors. *Treating Abuse Today*, *3*(5), 28–31.

McCann, P. F. (2010). *Motivational factors and frameworks for counsellors and psychotherapists* (Unpublished doctoral dissertation, University of Toronto). Retrieved from https://tspace.library.utoronto.ca/bitstream/1807/26374/1/McCann_Paul_201011_EdD_thesis[1].pdf

McColl, H., & Johnson, S. (2006). Characteristics and needs of asylum seekers and refugees in contact with London community mental health teams. *Social Psychiatry & Psychiatric Epidemiology*, *41*(10), 789–795.

McKinney, K. (2007). Breaking the conspiracy of silence: testimony, traumatic, memory, and psychotherapy with survivors of political violence, *Ethos*, *35*(3), 265–299. Retrieved from http://www.duke.edu/~sll11/McKinney.pdf

Meichenbaum, D. (2007). *Self-care for trauma psychotherapists and caregivers: individual, social, and organisational interventions*. Retrieved from http://www.melissainstitute.org/documents/Meichenbaum_SelfCare_11thconf.pdf

Meldrum, L., King, R., & Spooner, D. (2002). Compassion fatigue in community mental health case managers. In C. R. Figley (Ed.), *Treating compassion fatigue*. NY: Brunner/Rutledge.

Migrant and Refugees Community Forum and CVS Consultants (MRCF & CC). (2002). *A shattered world: The mental health needs of refugees and newly arrived communities*. London: Author. Retrieved from http://www.maternityaction.org.uk/sitebuildercontent/sitebuilderfiles/ashatteredworld.pdf

Miller, K. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychology*, *29*(4), 283–306.

Mollica, R. (2011). *Textbook of global mental health: Trauma and recovery, a companion guide for field and clinical care of traumatized people worldwide*. Harvard Program in Refugee Trauma [e-book]. Retrieved from http://www.hprt-cambridge.org

Morrison, Z. (2007). *Feeling heavy: Vicarious trauma and other issues facing those who work in the sexual assault field* (ACSSA Wrap No.4). Melbourne: Australian Institute of Family Studies.

Motta, R., Joseph, J., Rose, R., Suozzi, J., & Leiderman, L. (1997). Secondary trauma: Assessing intergenerational transmission of war experiences with a modified Stroop procedure. *Journal of Clinical Psychology*, *53*(8), 895–903.

Munday, A. M. (2009). *Clinical psychologists' experience of working with refugees* (Doctoral thesis, University of Birmingham). Retrieved from http://etheses.bham.ac.uk/710/1/Munday10ClinPsyD1.pdf

Munroe, J. F. (1999). Ethical issues associated with secondary trauma in therapists. In B. H. Stamm (Ed.). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed.). Lutherville, MD: Sidran.

Murray, M. (2008). Narrative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 11–132). London: Sage Publications Ltd.

Musa, S. A., & Hamid, A. R. (2008). Psychological problems among aid workers operating

in Darfur. *Social Behaviour and Personality*, *36*(3), 407–416.

Nelson, M. L., Friedlander, M. L., Gray, L. A., Ladany, N., & Walker, J. A. (2001). Toward relationship-centered supervision: Reply to Veach (2001) and Ellis (2001). *Journal of Counselling Psychology*, *48*(4), 407–409.

Nicholl, C., & Thompson, A. (2004). The psychological treatment of post traumatic stress disorder (PTSD) in adult refugees: A review of the current state of psychological therapies. *Journal of Mental Health*, *13*(4), 351–362.

Norcross, J. C. (2005). A primer on psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds), *Handbook of psychotherapy integration*. New York: Oxford University

Orb, A., Eisenhauer, L., & Wynaden, D., (2001). Ethics in qualitative research. *Journal of Nursing Scholarship*, *33*(1), 93–96.

Papadopoulos, R. K. (2007). Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy, Counselling & Health*, *9*(3), 301–312.

Patton, M. (1990). *Qualitative evaluation and research methods*. Newbury Park: Sage.

Pearlman, L. A. (1996). Psychometric review of the TSI Belief Scale, revision. In B. H. Stamm (Ed.), *Measurement of stress, trauma and adaptation*. Lutherville, MD: Sidran Press.

Pearlman, L. A. (1998). Trauma and the self: A theoretical and clinical perspective. *Journal of Emotional Abuse*, *1*(1), 7–25.

Pearlman, L. A., & Caringi, J. (2009). Living and working self-reflectively to address vicarious trauma. In C. A. Courtois & J. Ford (Eds.), *Treating complex traumatic stress disorder: An evidence-based guide* (pp. 202–224). New York: Guildford Press.

Pearlman, L. A., & MacIan, P. S. (1993). Vicarious traumatisation among trauma therapists: Empirical findings on self-care. *Traumatic Stress Points: News for the International Society for Traumatic Stress Studies*, *7*(3).

Pearlman, L. A., & MacIan, P. S. (1995). Vicarious traumatisation: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, *26*(6), 558–565.

Pearlmann, L. A., & McKay, L. (2008). *Understanding and coping with vicarious trauma: Online training module*. Pasadena, CA: Headington Institute.

Pearlman, L. A. & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatisation in psychotherapy with incest survivors*. New York: W.W. Norton & Company.

Pines, A., & Aronson, E. (1988). *Career burnout: Causes and cures*. New York: The Free Press.

Pross, C. (2006). Burnout, vicarious traumatisation and its prevention. *Torture*, *16*, 1–9. Retrieved from http://www.irct.org/Files/Filer/TortureJournal/16_1_2006/page_1–9.pdf

Punch, M. (1994). Politics and ethics in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research*. Newbury Park. CA: Sage.

Pupavac, V. (2001). Therapeutic governance: The politics of psychosocial intervention and trauma risk management. *Disasters*, *25*(4), 358–372.

Raphael, B., Singh, B., Bradbury, L., & Lambert, F. (1983). Who helps the helpers? The effects of a disaster on the rescue workers. *Omega*, *14*(1), 9–20.

Ricoeur, P. (1978). The task of hermeneutics. In M. Murray (Ed.), *Heidegger and modern philosophy: Critical essays* (pp. 141–160). New Haven, CT: Yale University Press.

Ringenbach, R. T. (2009). *A comparison between counsellors who practice meditation and those who do not on compassion fatigue, compassion satisfaction, burnout and self-*

compassion. The University of Akron. Retrieved from http://etd.ohiolink.edu/send-pdf.cgi/Ringenbach%20Ron%20T.pdf?akron1239650446

Rolf, J., Masten, A. S., Cicchetti, D., Neuchterlein, K. H., & Weintraub, S. (1990). *Risk and protective factors in the development of psychopathology*. Cambridge University Press.

Saakvitne, K. W., & Pearlman, L.A. (1996). *Transforming the pain: A workbook on vicarious traumatisation.* London: W. W. Norton & Co.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatisation: Implications for the mental health of health workers? *Clinical Psychology Review*, *23*(3), 449–480.

Salahat, M. (2009). *Burnout and secondary traumatic stress in counsellors working with victims of torture*. Unpublished manuscript.

Satkunanayagam, K., Tunariu, A., & Tribe, R. (2010). A qualitative exploration of mental health professionals’ experience of working with survivors of trauma in Sri Lanka. *International Journal of Culture and Mental Health*, *3*(5), 43–51.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: the effects on female counsellors of working with sexual violence victims. *Psychology of Women Quarterly*, *19*(1), 49–64.

Schaufeli, W., Leiter, M., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International*, *14*(3), 204–220.

Shah, S. A., Garland, E., & Katz, C. (2007). Secondary traumatic stress: Prevalence in humanitarian aid workers in India. *Traumatology*, *13*(1), 59–70.

Shoeb, M., Weinstein, H., & Mollica, R. (2007). The Harvard trauma questionnaire: Adapting a cross-cultural instrument for measuring torture, trauma and posttraumatic stress disorder in Iraqi refugees. *International Journal of Social Psychiatry*, *53*(5), 447–463.

Smith, A. J., Kleijn, W. C., Trijsburg, R. W., & Hutschemaekers G. J. (2007). How therapists

cope with clients' traumatic experiences. *Torture*, *17*(3), 203–215.

Smith, J. A. (Ed.). (2003). *Qualitative psychology: A practical research guide to research methods*. London: Sage.

Smith, J. A. (2010). *Interpretative phenomenological analysis*. Retrieved from http://www.cmpcp.ac.uk/JASSlides.pdf

Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. In A. Coyle & E. Lyons (Eds.), *Analysing qualitative data in psychology: A practical & comparative guide* (pp. 35–50). London: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, method, and research*. London: Sage.

Smith, J., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. London: Sage.

Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counsellor preparation. *Counsellor Education and Supervision*, *48*(1), 61.

Spiegelberg, H. (1972). *Phenomenology in psychology and psychiatry: A historical introduction*. Evanston, IL: North Western University Press.

Spinelli, E. (2005). *The interpreted world: An introduction to phenomenological psychology*. London: Sage.

Stamm, B. H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly*, *8*(2). Retrieved from http://www.dartmouth.edu/dms/ptsd/RQ_Spring_1997.html

Stamm, B. H. (2010). *The concise ProQOL manual*. Poctello, ID: ProQOL.org. Retrieved from http://proqol.org/uploads/ProQOL_Concise_2ndEd_12-2010.pdf

Stamm, B. H., & Figley, C. R. (2009). *Advances in the theory of compassion, satisfaction and fatigue and its measurement with the ProQOL 5*. Atlanta, GA: International Society for Traumatic Stress Studies.

Stamm, B. H., Figley, C. R., & Figley, K. R. (2010). *Provider resiliency: A train-the-trainer mini course on compassion satisfaction and compassion fatigue*. Montreal, Quebec, Canada: International Society for Traumatic Stress Studies.

Stamm, B. H., Varra, E. M., Pearlman, L. A., & Giller, E. (2002). *The helper's power to heal and to be hurt—or helped—by trying*. Washington, DC: Register Report: A Publication of the National Register of Health Service Providers in Psychology.

Steed, L., & Bickell, J. (2001). Trauma and the therapist: The experience of therapists working with perpetrators of sexual abuse. *The Australasian Journal of Disaster and Trauma Studies.* Retrieved from http://www.massey.ac.nz/%7Etrauma/issues/2001-1/steed.htm

Steed, L. G., & Downing, R. (1998). A phenomenological study of vicarious traumatisation amongst psychologists and professional counsellors working in the field of sexual abuse/assault. *The Australasian Journal of Disaster and Trauma Studies.* Retrieved from http://www.massey.ac.nz/~trauma/issues/1998-2.steed.htm

Su, C. T., & Parham, L. D. (2002). Generating a valid questionnaire translation for cross-cultural use. *American Journal of Occupational Therapy*, *56*(5), 581–585.

Summerfield, D. (1996). *The impact of war and atrocity on civilian populations: basic principles for NGO intervention and a critique of psychosocial trauma projects* (Relief and Rehabilitation Network Paper 14). London: Overseas Development Institute.

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

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

Sundram, S., & Loi, S. (2012, May 23). Long waits for refugee status lead to new mental health syndrome. *The Conversation*. Retrieved from

http://theconversation.com/long-waits-for-refugee-status-lead-to-new-mental-health-syndrome-7165

Tamminen, T. (2006). How does culture promote the early development of identity? *Infant Mental Health Journal*, *27*(6), 603–605. doi:10.1002/imhj.20109

Taylor, S. (2011). *Out of the darkness: From turmoil to transformation*. London: Hay House UK Ltd.

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering.* Thousand Oaks, CA: Sage.

Thomae, H. (1999). The nomothetic-idiographic issue: Some roots and recent trends. *International Journal of Group Tensions*, *28*(1), 187–215.

Tiegreen, S., & Newman, E. (2009). Review of leaving it at the office: A guide to psychotherapist self-care. *Journal of Trauma & Dissociation*, *10*, 120–122.

Tribe, R. (1999). Therapeutic work with refugees living in exile: observations on clinical practice. *Counselling Psychology Quarterly*, *12*(3), 233–243.

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

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counsellors should know when working with trauma survivors. *Journal of Counselling and Development*, *82*(1), 31–37.

Trippany, R. L., Wilcoxon, S. A., & Satcher, J. F. (2003). Factors influencing vicarious trauma for therapists of survivors of sexual victimisation. *Journal of Trauma Practice*, *2*, 47–60.

Tyrer, P., & Bajaj, P. (2005). Nidotherapy: Making the environment do the therapeutic work. *Advances in Psychiatric Treatment*, *11*, 232.

Ullman, S. E., & Townsend, S. M. (2007). Barriers to working with sexual assault survivors: A qualitative study of rape crisis center workers. *Violence Against Women*, *13*(4), 412–443.

UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, Volume 189, p. 137. Retrieved from http://www.unhcr.org/refworld/docid/3be01b964.html

UN-Habitat. (2012). *The state of the world's cities in 2012/2013*. Retrieved from http://mirror.unhabitat.org/pmss/listItemDetails.aspx?publicationID=3387

UNHCR. (2006). *Master glossary of terms*. Retrieved from http://www.unhcr.org/refworld/docid/42ce7d444.html

UNHCR. (2011). *Year of crises*. Retrieved from http://www.unhcr.org/4fd6f87f9.html

UNHCR. (2012). *UNHCR global appeal 2012-13*. Retrieved from http://www.unhcr.org/ga12/index.xml

UNHCR. (2014). *Registration trends for Syrians*. Retrieved from

https://data.unhcr.org/ Van Der Kolk, B. A., & McFarlane, A. C. (1996). The black hole of trauma. In B. A. van der Kolk, A. C. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 5–23). New York: Guilford Press.

Veronese, G., Fiore, F., Castiglioni, M., Kawaja, H., & Said, M. (2012). Can sense of coherence moderate traumatic reactions? A cross-sectional study of Palestinian helpers operating in war contexts. *British Journal of Social Work*, 1–16. Retrieved from http://bjsw.oxfordjournals.org/content/early/2012/02/20/bjsw.bcs005.full.pdf?keytype=ref&ijkey=o4WI5F6aeXDdGk1

Voce, A. (2004). *Introduction to research paradigms*. Retrieved from http://www.scribd.com/doc/78832156/Introduction-to-Research-Paradigms.

Walker, M., (2004). Supervising practitioners working with survivors of childhood abuse: Counter transference, secondary traumatisation and terror. *Psychodynamic Practice*, *10*, 173–193.

Way, I. D., VanDeusen, K., Martin, K. M., Applegate, B., & Jandle, D. (2004). Vicarious trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual offenders. *Journal of Interpersonal Violence*, *19*(1) 49–71.

Wee, D., & Myers, D. (1997). Disaster mental health: Impact on workers. In K. Johnson (Ed.), *Trauma in the lives of children*. Hunter House Press: Alameda, California.

Weine, S. M., Vojvoda, D., Becker, D. F., McGlashan, T. H., Hodzic, E., & Laub, D. (1998). PTSD symptoms in Bosnian refugees one year after the resettlement in the United States. *American Journal of Psychiatry*, *155*(4), 562–564.

Werner, O., & Campbell, D. T. (1970). Translation, wording through interpreters, and the problem of decentering. In R. Naroll & R. Cohen (Eds.), *A handbook method in cultural anthropology* (pp. 398–420). New York: Natural History Press.

WHO-AIMS. (2011). *WHO-AIMS report on mental health system in Jordan*. Retrieved from http://www.who.int/mental_health/evidence/mh_aims_report_jordan_jan_2011_en.pdf

Wilcox, P. (2011). *Vicarious transformation*. Retrieved from http://traumatreatment.blogspot.com/2011/10/vicarious-transformation.html

Williams, M. B., & Sommer, J. F. (1995). Self-care and the vulnerable therapist. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators.* Lutherville, MD: Sidran.

Willig, C. (2001). *Qualitative research in psychology: A practical guide to theory and method*. Buckingham: Oxford University Press.

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Maidenhead: McGraw Hill Open University Press.

Wilson, J. P., & Lindy, J. D. (1994). *Countertransference in the treatment of PTSD.* New York: Guildford Press.

Woodcock, J. (1995). Family therapy and human rights: working with refugees. *Mental Health Nursing*, *15*(5), 20–22.

Woodcock, J. (1997). Group work with refugees and asylum seekers. In T. Mistry & A. Brown (Eds.), *Race and group work* (pp. 254–277). London: Whiting and Birch.

Yardley, L. (2007). Demonstrating validity in qualitative research. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. London Sage.

Yessen, J. (1995). Preventing secondary traumatic disorder. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder* (pp. 178–208). New York: Brunner/Mazel.

APPENDICES

APPENDIX A

Invitation to Participate

To whom it may concern

I am writing to invite psychosocial counsellors working within ___________to participate in a research study being conducted by Ms. Dina Miqdadi.

Participation in the study involves taking part in an interview that would last approximately 1 hour. The interview will be focused on your experience of working therapeutically with clients who may have experienced trauma. This would be an opportunity for you to reflect on your experiences and any personal changes you may have experienced in your line of work.

This study requires you to be in supervision and have worked therapeutically with this client group for more than six months.

Please do not hesitate to contact me at dina.miqdadi.1@city.ac.uk for further information.

Thank you for your time and consideration in participating in the present study.

Sincerely,

Dina Miqdadi

Counselling Psychology Trainee

APPENDIX B

Explanatory Statement

Research Title: Exploring the experience of counsellors working with Iraqis who have fled to Jordan

Researcher: Dina Miqdadi, Counselling Psychologist in Training, 3rd year

Research Supervisor: Cristina Boserman, Counselling Psychology Department, City University

This sheet provides information about the project to help you understand what it is about, why it is being conducted and what your involvement will be. This information will help you to make an informed decision about whether you would like to participate in this research study.

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

You have been chosen to participate in this study because you have been working therapeutically with Iraqi refugees in Jordan. The aim of this study is to explore your experience of working with this client group. The method of collecting data is through one semistructured interview. The interview will consist of questions related to your experience. The length of each interview is up to the participant and it could last up to 1 hour. Each interview will be audiotaped and translated/transcribed by a third party.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time.

All the information collected in this study will be kept strictly confidential. Only the researcher, translator and transcriber will listen to the audiotapes that will be erased after the analysis. Transcripts of the audiotapes will be kept securely until the completion of the research project. The audiotapes and transcripts will be coded in numbers to eliminate any identifying data of the participant.

The results of this research will be used for my dissertation to complete my Professional Doctorate Degree in Counselling Psychology at City University.

If you need further information you are welcome to contact me at any time at 0795534426 (Jordan) or send me an email at dina.miqdadi.1@city.ac.uk. Alternatively, you may contact my supervisor, Cristina Boserman, Cristina.Boserman.1@city.ac.uk, Department of Psychology, City University, Northampton Square, LND, EC1V 0HB.

If you do not wish to participate in this research study. I would like to thank you for taking the time to read this explanatory statement.

Sincerely,

Dina Miqdadi

Counselling Psychology Trainee

APPENDIX C

Informed Consent Form

Name of researcher: Dina Miqdadi, Counselling Psychologist Trainee, 3rd year

Position: Student

Programme: Professional Doctorate in Counselling Psychology

Research supervisor: Cristina Boserman, Counselling Psychology Department, City University.

Title of research:

Exploring the experience of psychosocial counsellors working with Iraqi refugees in Jordan

- I agree to take part in the above-mentioned research project. I have had the project explained to me, and I have read the Explanatory Statement, which I may keep for my records.
- I understand that agreeing to take part means that I am willing to:
    - be interviewed by the researcher;
    - allow the interview to be audio-taped; and
    - allow the audiotape to be translated and transcribed by a third party.
- This information will be held and processed for the following purpose:

To explore the experience of psychosocial counsellors working with Iraqi refugees in Jordan.

- I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.
- I understand that the transcription of the interviews will be coded to protect my identity from being made public.
- I understand that I need to be in supervision to take part in this. I give consent to and understand that the results of this research study may be published.
- I agree to City University recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.
- I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.
- I agree to be contacted when the researcher completes the analysis to provide feedback on the results of the research study.

Name of participant: ....(please print)

Signature: ....……

Date: ....

Name of researcher:…..(please print)

Signature...

Date:..

APPENDIX D

Confidentiality Agreement on the Use of Audiotapes

This agreement is written to clarify the confidentiality conditions on the use of audiotapes by Dina Miqdadi for the purpose of psychological research.

I______________________ give Dina Miqdadi permission to tape the research interview on conditions that:

- My permission may be withdrawn at any time. In this case my recording will be immediately erased.
- I agree with the tapes being translated and transcribed by a third party.
- The tape will be stored under secure conditions and destroyed at the appropriate conclusion of their use.

This agreement is subject to the Code of Conduct and Ethical Principles of the British Psychological Society.

I have read and understood the above conditions and agree to their implementation.

Signed (research participant) ___________________ Date ______________

Name (block capitals)____

Signed (researcher) ___________________________Date______________

APPENDIX E

Interview Schedule

How do psychosocial counsellors experience working with Iraqi refugees in Jordan?

1. How would you describe your work with Iraqi refugees? *How do you feel about your work? What does it mean to you to work with this community?*
2. Do you feel, if at all, that the current sociopolitical climate in Jordan might influence your work as a therapist? *In what way? Could you give me an example?*
3. Do you feel, if at all, that the current sociopolitical climate in Iraq might influence your work? *In what way? Could you give me an example?*
4. In what ways does your work challenge you?
5. In what ways does your work reward you?
6. How easy/difficult is it to work with this client group? *If difficult, what makes it difficult? What would need to change to make it easier? If easy, what makes it easy?*
7. In what way, if at all, has this work changed the way you view yourself?
8. In what way, if at all, has this work changed the way you view the world?
9. In what way, if at all, has this work changed the way others see you?
10. In which ways do you care for yourself? *What do you find most helpful? In what way?*
11. Is there anything I have not asked you about that you would like to add?

APPENDIX F

Debriefing for Participants

I would like to thank you again for volunteering your time to participate in this research study. The aim of this research study is to gain a deeper understanding of psychosocial counsellors' experience of working with Iraqi refugees in Jordan. Your contribution to this study is of great value. It is hoped that this study will allow professionals to gain understanding of your experience of providing therapeutic services for Iraqi refugees in Jordan. This in turn, may be used in conducting training for and supervising psychosocial counsellors in Jordan.

If you have any questions regarding the research or should wish to withdraw your consent to participate at any time, you may contact me directly on [redacted] or [redacted] If you decide to withdraw from the research, the recording of your interview and any transcripts will be destroyed.

If you have any issues or concerns about the research or the conduct of the interview, which you do not wish to share with me, you may contact my supervisor:

Cristina Boserman, [redacted] Department of Psychology, City University, Northampton Square, LND, EC1V 0HB.

If you would like to receive a copy of the results of this research for your interest, please leave me your postal address and I will send you the information when the research is completed.

APPENDIX G

Vignettes

Lubna

Lubna is a 25-year-old psychosocial counsellor. She has been working with Iraqi refugees for nine months. She has a BA degree in psychology from a Jordanian university and is now thinking about applying for a master's. She received training on trauma treatment within the organisation. Prior to working with Iraqi refugees she worked in a care home for disabled children as an assistant.

Hussam

Hussam is a 34-year-old psychosocial counsellor. He has been working with Iraqi refugees for 18 months. He has a BA degree in psychology from a Jordanian university. He received training on trauma treatment within the organisation. Prior to working within his organisation, he worked as a counsellor with another NGO, working with individuals affected by domestic violence.

Walid

Walid is a 45-year-old psychosocial counsellor. He has been working within his organisation for about two years. He has a BA and master's degree in psychology from an Iraqi university. He migrated to Jordan during the 1994 Gulf War. Prior to working within his current role, he worked as a counsellor with another NGO in Jordan. He received training on trauma treatment within the organisation.

Ghada

Ghada is a 30-year-old psychosocial counsellor. She has been working with Iraqi refugees for six months. She has a BA in psychology and is currently working towards a master’s degree in psychological counselling. Prior to working with Iraqi refugees as a counsellor she worked as an animator with Iraqi children. She received training on trauma treatment within the organisation.

Farah

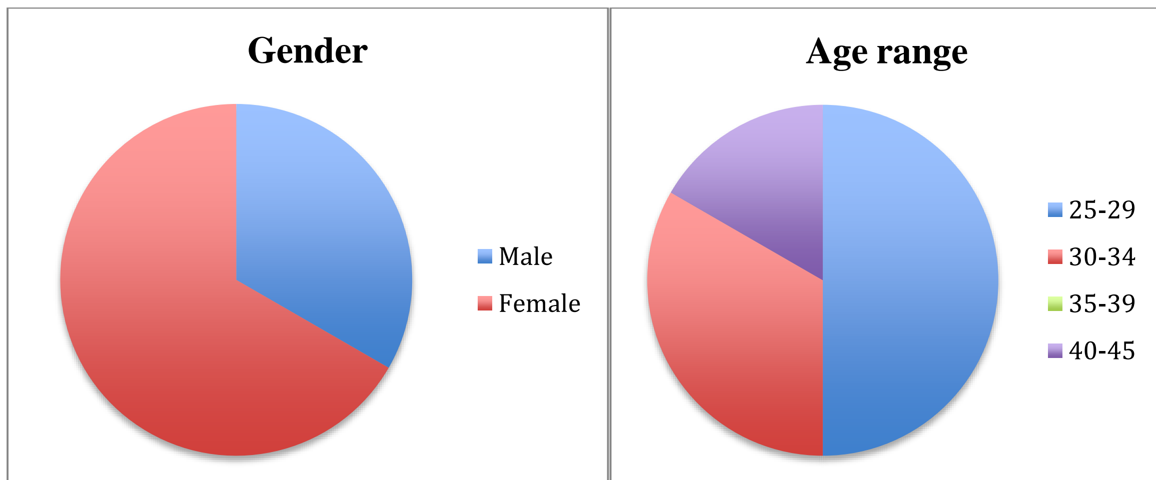
Farah is a 26-year-old psychosocial counsellor. She has been working with Iraqi refugees for nine months. She has a BA in psychology and is also currently working towards a master’s degree in psychological counselling. Prior to working with Iraqi refugees she also worked as an assistant in a care home for mentally and physically disabled children. She received training on trauma treatment within the organisation.

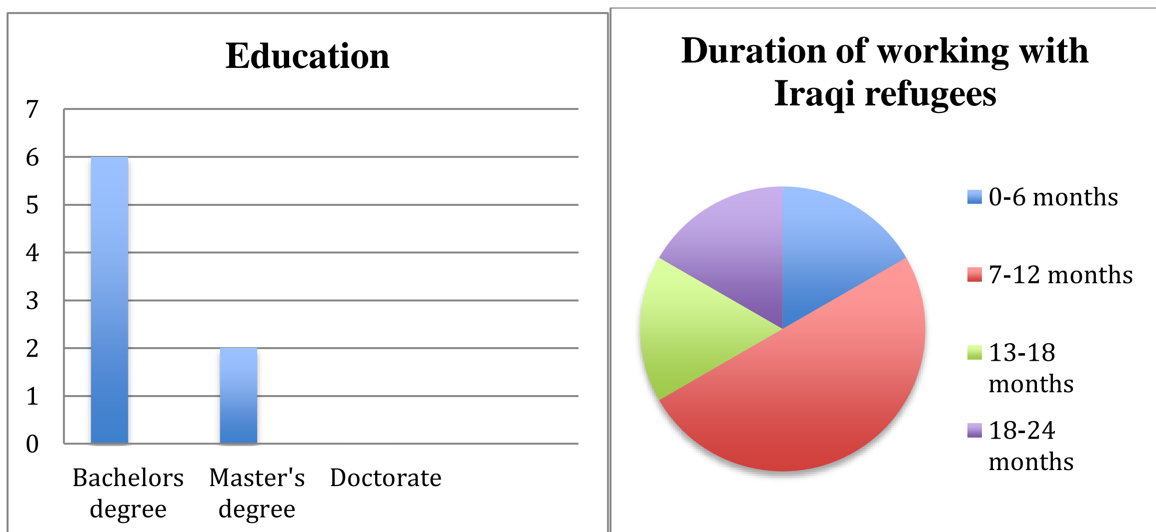
Sara

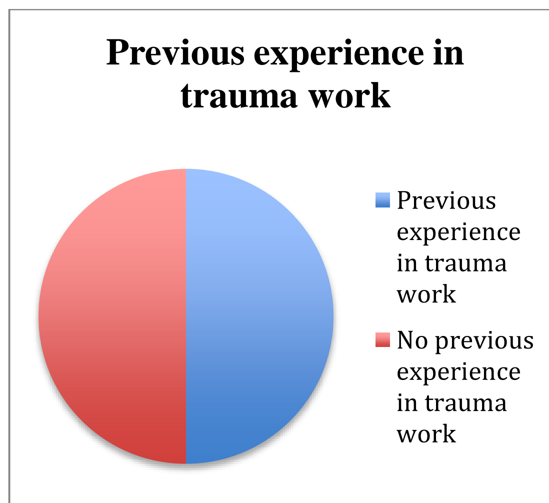
Sara is a 31-year-old psychosocial counsellor. She has been working with Iraqi refugees for seven months. She has a BA degree in psychology and a master’s in psychological counselling. Prior to working with Iraqis she was working as counsellor in an NGO. She also received trauma training within the organisation.

APPENDIX H

Visual Presentation of Vignettes







APPENDIX I

Email to Participants

Dear

I would like to thank you again for participating in this research study. Your contribution has been of great value. As discussed during the interview, I am contacting you to share with you the results of the study to get your feedback.

I have attached a summary of the results for you to read through. Please let me know whether all the findings apply to you. If you do not agree with any of my findings or if you would like to comment on any of the themes please feel free to do so!

Again the results are how I interpreted what you and the rest of the participants said. If you do not agree with any of the interpretations or feel like any do not apply to you, please let me know, as this would allow me to include any necessary corrections.

Thank you again for your participation – without you this study would have not been possible.

I look forward to hearing from you.

Best wishes,
Dina Miqdadi

APPENDIX J

Summary of Results

This research study set out to understand your experience of working with Iraqis who have fled to Jordan. Therefore, the results should illustrate how you viewed your experience during the interviews.

The results of the study found three themes: Effects of sociopolitical and socioeconomic factors, enriching and motivating aspects, and coping with the distressing aspects.

Master themes	Subthemes
Effects of sociopolitical and socioeconomic factors	“There’s nothing you can do”
	“You feel like a little child”
	“Just picking up the pieces”
	Emotional burden
Enriching and motivating aspects	“Psychological value”
	Increased commitment
	“There’s always a way back to life”
	“There’s something special about the world”
Coping with the distressing aspects	Self-care
	“It’s tough but it’s worth it”

The first master theme, effects of sociopolitical and socioeconomic factors, contains four subthemes. The first subtheme, “there’s nothing you can do”, focuses on the challenges that you discussed about working with clients who have a lack of basic needs. The second subtheme, “You feel like a little child”, focuses on the challenge of working with Iraqis who have no legal status in Jordan, and the third subtheme, “just picking up the pieces”, focuses on the impact of ongoing violence on your work. These realities seemed to make you feel helpless, powerless, and perplexed. The analysis also suggested that you felt emotionally burdened by your work from the stories that you hear from your clients. This included an expression of unfairness, injustice, heaviness, power imbalance, incomprehensiveness, and a lingering emotional burden. I also found that some of you felt that you could not attend to your family’s or friends’ emotional needs.

The second master theme, enriching and motivating aspects, includes four subthemes that describe enriching and motivating aspects of your work. The four subthemes are: “psychological value”, “there’s always a way back to life”, “there’s something special about the world”, and increased commitment. These themes described the positive aspects that you described encountering from working with Iraqis. This included feelings of pride, recognition, and achievement. It also portrays how it seemed to me that from witnessing your clients’ strength your perception of yourself and how you perceive problems in your own lives changed. Positive changes in worldview applies to some of you who felt that your view of the world changed though this work by increasing your awareness of the struggles that the Iraqi community are experiencing and by realising that there is more to the world from witnessing your clients’ resiliency and strength, which opened up for you different ways to view the world you live in.

The third master theme, coping with the distressing aspects of their roles, focuses on

two subthemes: self-care and "it's tough but it's worth it", which describe the factors that help you cope within your roles. Self-care illustrated how you described that self-care was important to you and how you actively tried to implement it in your life. The last subtheme, "it's tough but it's worth it", portrays how it seemed to me that working with the Iraqi community is neither easy nor difficult, but the ease of it or the challenging aspects of it are relative. Meaning, you experience negative and positive aspects of the work at the same time. That is, even if it is draining, you experience compassion and are positively affected by the strength of your clients.

Including the themes discussed above I found that the experience of your work is reciprocal, meaning that the work continuously affects you, which in turn affects how you perceive your clients, and affects your personal relationships.

APPENDIX L: AUDIT TRAIL

Extract from Transcript (Farah)

I: How did this job change the way you view yourself, if at all?

P1: It reflected on me and how well I can handle the small problems that I deal with and how I can help these people as much as I can. A lot of things changed about me personally, I like doing psychological work more and I like to help people out more. I can now see how important psychological work is in Jordan and in the Arab world; I use to think my major was unimportant and useless and that we didn't have much work, but now I see how important and valuable it is and how much people seek it out and need it.

I: So this job has increased, not your love, but your belief in this job?

P1: Yes it has restored my faith in the profession and I can now see how important this work is and how much it changes people's lives.

I: How did this job change the way that you view the world, if at all?

P1: It changed it a lot, till now I wonder how some people can bear hurting others, is it possible that some people can hurt others like this? And I wonder what wrong did the children who are 12 years old do for them to suffer like this and lose loved ones. These things affected me a lot and changed my beliefs… Sometimes we make excuses for people when they do things, but there is no excuse for the torture and the mistreatment that is going on, especially when you are dealing with the victims and seeing how hurt they are…you wonder what is going on to the world, why has it become like this? It is really unfair.

I: You mentioned that a lot of your beliefs have changed; can you give me an example of how they have changed, if you can think of one?

P1: Sometimes I guess we judge people, hear a lot from the people around you about Iraqis, some feel sorry for them, some say they deserve what happened to them, but after my work with them my beliefs changed, at first people would criticise them whenever I mentioned that I was going to be working with them, but after my work with them I started believing in their cause defending them and fighting for them because they had no fault in what happened to them, they had nothing to do with what happened, they just woke up one day and saw that even neighbours have turned on each other. I believe that we have to stand with them and help them, they need our help, we can't wash our hands clean from their cause and call them liars, and some people are really suffering and need our help.

I: And how did your job change the way people view you?

P1: I think that this experience has made me a stronger person. In Jordan, we do not hear stories like this because we are a stable country, but now I see how some people really suffered and when you help them, this affects your personality and your beliefs and the way you speak. Yes, a lot of things have changed in me, even the way that I deal with friends from university and school. Now, whenever I listen to my friends' problems I cannot really sympathise with them because they seem so silly to me in comparison with what I hear in the job.

APPENDIX M

Extract from First Stage of Analysis (Farah)

Original transcript	Exploratory comments
I: How did this job change the way you view yourself, if at all?	
P1: It reflected on me and how well I can handle the small problems that I deal with and how I can help these people as much as I can.	*Reflected on how she can deal with the small problems.* *As much as she can – she might feel there’s a limit to what she can do to help.*
A lot of things changed about me personally, I like doing psychological work more and I like to help people out more.	*Likes psychological work more, likes to help people more. She didn’t like her work before? Or appreciates it more now?*
I can now see how important psychological work is in Jordan and in the Arab world;	*Sees that psychological work is important in Jordan and the Arab world.*
I use to think my major was unimportant and useless and that we didn’t have much work,	*Thought her major was useless, unimportant. This work might be helping her feel important.*
but now I see how important and valuable it is and how much people seek it out and need it.	*Her work is valuable.* *A lot of people are seeking help and seem to need it.*
I: So this job has increased, not your love, but your belief in this job?	

P1: Yes it has restored my faith in the profession and I can now see how important this work is and how much it changes people’s lives.	*Restored her faith in the profession.* *Sees the effectiveness of the work.*
I: How did this job change the way that you view the world, if at all?	
P1: It changed it a lot, till now I wonder how some people can bear hurting others, is it possible that some people can hurt others like this? And I wonder what wrong did the children who are 12 years old do for them to suffer like this and lose loved ones. These things affected me a lot and changed my beliefs… Sometimes we make excuses for people when they do things, but there is no excuse for the torture and the mistreatment that is going on, especially when you are dealing with the victims and seeing how hurt they are…you wonder what is going on to the world, why has it become like this? It is	*Feels a lot has changed in her.* *Trying to make sense of the world in relation to the stories she has heard from clients (till now I wonder).* *Sees the world differently in the sense of wondering how people can commit such atrocities.* *Felt affected by the stories she has heard and changed her beliefs.* *No excuses for torture and mistreatment.* *Perhaps before she felt that excuses could be made for people to hurt each other, but in this case she does not feel anything could justify what is happening to the Iraqi population.*

really unfair. I: You mentioned that a lot of your beliefs have changed; can you give me an example of how they have changed, if you can think of one? P1: Sometimes I guess we judge people hear a lot from the people around you about Iraqis, some feel sorry for them, some say they deserve what happened to them, but after my work with them my beliefs changed, at first people would criticise them whenever I mentioned that I was going to be working with them, but after my work with them I started believing in their cause defending them and fighting for them because they had no fault in what happened to them, they had nothing to do with what happened, they just woke up one day and saw that even neighbours have turned on each other. I believe that we have to stand with them and help them, they need our help, we	*Wonders what's happening in the world, feels it is unfair. Perhaps she had a previous belief that ultimately the world is fair?* *Judged Iraqis in the past; she was influenced by people around her.* *Changed her previous judgments about the Iraqi community.* *After working with her clients she started believing, defending and fighting for them.* *After hearing their stories she now believes that people need to stand with Iraqis and help them.*

can’t wash our hands clean from their cause and call them liars, and some people are really suffering and need our help. I: And how did your job change the way people view you? P1: I think that this experience has made me a stronger person. In Jordan, we do not hear stories like this because we are a stable country, but now I see how some people really suffered and when you help them, this affects your personality and your beliefs and the way you speak. Yes, a lot of things have changed in me, even the way that I deal with friends from university and school. Now, whenever I listen to my friends’ problems I cannot really sympathise with them because they seem so silly to me in comparison with what I hear in the job.	*Feels her clients genuinely need help.* *People are suffering and need our help.* *Her work made her a stronger person.* *Living in a stable country never subjected her to suffering similar to what the Iraqi community has suffered.* *Saw how people really suffered; her work made her more aware.* *Helping them changed her personality, beliefs and the way she speaks and how she deals with her friends.* *Feels a lot has changed in her.* *Feels she cannot sympathise with her friends’ problems when she compares them to her clients’ problems.* *Feels everyday problems are silly.*

APPENDIX N

Extract from Second Stage of Analysis (Farah)

Emergent themes	Original transcript	Exploratory comments
	I: How did this job change the way you view yourself, if at all?	
Increased self-awareness	P1: It reflected on me and how well I can handle the small problems that I deal with and how I can help these	*Reflected on how she can deal with the small problems. As much as she can – she might feel there’s a limit to what she can do to help.*
Change	people as much as I can. A lot of things changed about me personally, I like doing psychological work more and	*Likes psychological work more, likes to help people more. She didn’t like her work before? Or appreciates it more now?*
Influencing clients influenced her commitment	I like to help people out more. I can now see how important psychological work is in Jordan and in the Arab	*Sees that psychological work is important in Jordan and the Arab world.*
	world; I use to think my major was unimportant and	*Thought her major was useless, unimportant. This work might be helping her feel important.*
Relationship between value of work and motivation to work	useless and that we didn’t have much work, but now I see how important and valuable it is and how much people	*Her work is valuable.* *A lot of people are seeking help and seem to need it.*

Restored faith in profession Change Making sense of the world Hearing traumatic stories changed her beliefs about her clients Perception of world affairs changed	seek it out and need it. I: So this job has increased, not your love, but your belief in this job? P1: Yes it has restored my faith in the profession and I can now see how important this work is and how much it changes people’s lives. I: How did this job change the way that you view the world, if at all? P1: It changed it a lot, till now I wonder how some people can bear hurting others, is it possible that some people can hurt others like this? And I wonder what wrong did the children who are 12 years old do for them to suffer like this and lose loved ones. These things affected me a lot and changed my beliefs… Sometimes we make excuses for people when they do things, but there is no	*Restored her faith in the profession.* *Sees the effectiveness of the work.* *Feels a lot has changed in her.* *Trying to make sense of the world in relation to the stories she has heard from clients (till now I wonder).* *Sees the world differently in the sense of wondering how people can commit such atrocities.* *Felt affected by the stories she has heard and changed her beliefs.* *No excuses for torture and mistreatment.* *Perhaps before she felt that excuses could be made for people to hurt each other, but in this case she does not feel anything could justify what is happening to the Iraqi population.*

Wonders about the state of the world Unfairness Changed her beliefs about the Iraqi community Started believing in their cause	excuse for the torture and the mistreatment that is going on, especially when you are dealing with the victims and seeing how hurt they are…you wonder what is going on to the world, why has it become like this? It is really unfair. I: You mentioned that a lot of your beliefs have changed; can you give me an example of how they have changed, if you can think of one? P1: Sometimes I guess we judge people hear a lot from the people around you about Iraqis, some feel sorry for them, some say they deserve what happened to them, but after my work with them my beliefs changed, at first people would criticise them whenever I mentioned that I was going to be working with them, but after my work with them I started believing in their cause defending	*Wonders what's happening in the world, feels it is unfair. Perhaps she had a previous belief that ultimately the world is fair?* *Judged Iraqis in the past; she was influenced by people around her.* *Changed her previous judgments about the Iraqi community.* *After working with her clients she started believing, defending and fighting for them.* *After hearing their stories she now believes that people*

Advocating for client population	them and fighting for them because they had no fault in what happened to them, they had nothing to do with what happened, they just woke up one day and saw that even neighbours have turned on each other. I believe that we have to stand with them and help them, they need our help, we can’t wash our hands clean from their cause and call them liars, and some people are really suffering and need our help.	*need to stand with Iraqis and help them.* *Feels her clients genuinely need help.* *People are suffering and need our help.*
Changed self-concept Gained strength (Positive change) Hearing her clients’ stories changed her drastically	I: And how did your job change the way people view you? P1: I think that this experience has made me a stronger person. In Jordan, we do not hear stories like this because we are a stable country, but now I see how some people really suffered and when you help them, this affects your personality and your beliefs and the way you speak. Yes,	*Her work made her a stronger person.* *Living in a stable country never subjected her to suffering similar to what the Iraqi community has suffered.* *Saw how people really suffered; her work made her more aware.* *Helping them changed her personality, beliefs and the way she speaks and how she deals with her friends.* *Feels a lot has changed in her.* *Feels she cannot sympathise with her friends’ problems when she compares them to her clients’ problems.*

Changed her relationships (negatively)	a lot of things have changed in me, even the way that I deal with friends from university and school. Now, whenever I listen to my friends’ problems I cannot really sympathise with them because they seem so silly to me in comparison with what I hear in the job.	*Feels everyday problems are silly.*

APPENDIX O

Initial List of Themes from Extract

Increased self-awareness

Change

Influencing clients influenced her commitment

Relationship between value of work and motivation to work

Restored faith in profession

Change

Making sense of the world

Hearing traumatic stories changed her beliefs about her clients

Perception of world affairs changed

Wonders about the state of the world

Unfairness

Changed her beliefs about the Iraqi community

Started believing in their cause

Advocating for client population

Changed self-concept

Gained strength

(Positive change)

Hearing her clients' stories changed her drastically

Changed her relationships (negatively)

APPENDIX P

Clustered Codes

Change

Influencing clients influenced her commitment

Relationship between value of work and motivation to work

Restored faith in profession

Changed her beliefs about the Iraqi community

Started believing in their cause

Advocating for client population

Hearing traumatic stories changed her beliefs about her clients

Making sense of the world

Perception of world affairs changed

Wonders about the state of the world

Unfairness

Increased self-awareness

Changed self-concept

Gained strength

(Positive change)

Hearing her clients’ stories changed her drastically

Changed her relationships (negatively)

APPENDIX Q

Extract from Master Table of Themes from the Group

Theme	Page.Line
Effects of sociopolitical and socioeconomic factors	
"There's nothing you can do"	
Farah: don't even have the basic needs.	
Sara: For more than one case, there is nothing that you can do	5.138
Hussam: They need their basic needs to be fulfilled	7.209
Lubna: I can barely afford to feed my children bread	8.242
Walid: there is a system but it's not enough	5.169
	9.259
"You feel like a little child"	
Farah: You feel like a little child that was building things up.	5.136
Ghada: and they still have hope for settlement	3.74
Hussam: I provide psychological help but I also want an environment that helps the work that I do	6.184
Sara: they had hope and then it was taken away at once	11.330
Walid: having someone tear it down for you, that is how you feel	8.273
Lubna: and it's frustrating to want to help people but having your hands tied	4.109
"Just picking up the pieces"	
Sara: *rather than sitting here and just picking up the pieces*	10.293
Lubna: *it triggers a relapse in the progress we were making*	5.153
Hussam: *wanting to move forward but being unable to 'cause a part of them is still in danger*	7.192
Emotional burden	
Farah: *Till now I wonder how some people can bear hurting others. It is really unfair*	7.208
Sara: things you cannot imagine, this definitely affects me	4.125
Lubna: people are being treated unjustly and this affects my drive for sure	9.278
Hussam: it's incomprehensible	12.393
Walid: I hear a lot of horror stories from my clients, which you can consider as one	6.190
of the difficulties or challenges we face	8.244
Ghada: This all adds to the burden	7.216

SECTION C: MANUSCRIPT

"It's Tough but it's Worth it": Psychosocial Counsellors' Experience of Working with Iraqi Refugees in Jordan

Abstract

At the time this study was conducted, the provision of psychosocial counselling for Iraqi refugees in Jordan was relatively new and the literature that was available portrayed psychosocial counsellors as struggling with numerous challenges. This study set out to gain a deeper understanding of their experiences by utilising a qualitative approach with an exploratory design. Six psychosocial counsellors were interviewed in Jordan and the data was analysed by taking an interpretative phenomenological approach. Three themes emerged from the data; namely: the effects of sociopolitical and socioeconomic factors, enriching and motivating aspects of their roles, and coping with the distressing aspects of their roles. The psychosocial counsellors brought forth the challenges they were experiencing as a result of the sociopolitical and socioeconomic factors their clients were struggling with in Jordan. However, they also brought to light positive aspects of their work that helped them remain motivated in spite of the numerous complexities they faced on a daily basis. The findings of this study contribute to understanding a newly evolving but rapidly expanding field in Jordan by illuminating the challenges experienced by the psychosocial counsellors and the lessons learned from those challenges. The limitations of the study and directions for future research are subsequently discussed.

Keywords: Iraqi refugees, psychosocial counselling, Jordan.

FAFO (2007), stated that 450,000 – 500,000 Iraqis migrated to Jordan after the 2003 regime change in Iraq. As no capacity existed in the field of trauma studies and psychosocial support in emergency and displacement in Jordan (IOM, 2008), several organisations

conducted research studies on the needs of Iraqis (Bader, Sinha, & Leigh, 2009; CDC-Mercy Corps, 2007; Duncan, Schiesher, & Khalil, 2007; FAFO, 2007; IOM, 2008). The results suggested that Iraqis who had fled to Jordan were experiencing distress due to the following: attacks on themselves or on their families; lack of legal status; lack of employment opportunities; lack of adequate health care; bereavement; limited access to services and community outreach; and unmet psychosocial support needs. The International Organisation for Migration (IOM; 2008) found that 21% of Iraqis in Jordan were "severely traumatised" by attacks on themselves or their families. These findings prompted a group of organisations to establish and implement programmes specifically designed to help Iraqis with their psychosocial needs (WHO-AIMS, 2011).

The majority of trauma research in Jordan has been based on the needs of Iraqis; however, little research has focused on the impact of trauma work on the counsellors who work with this group. The only known study that discussed the experiences of psychosocial counsellors working with Iraqis in Jordan (Gilbert, 2009) suggested that they struggled with feelings of acute powerlessness because of extremely limited resources. The counsellors also found it difficult to deal with the stress of facing their clients' anger and frustration with the system, and felt helplessness amid the complexity of cases and the severity of the trauma.

Previous Literature on the Impact of Trauma Work

Therapeutic work with refugees and asylum seekers presents a set of unique social, cultural, political, and socioeconomic issues that mental health providers find difficult to manage. The Inter-Agency Standing Committee guidelines on mental health and psychosocial support in emergency settings (IASC, 2007) include integrating support systems; providing basic services and security; promoting community and family support;

focused, nonspecialised supports; and specialised services. These guidelines stated that the mental health and psychosocial problems of refugees and asylum seekers are highly correlated. Herman (2001) similarly suggested that recovery from traumatic experiences involves rebuilding stable and safe assumptions about the self and the world, which means that establishing safety is an integral step in recovering from trauma. In the case of Iraqi refugees in Jordan, they have not only escaped an environment in the grip of political violence, where they may have been subjected to attacks on themselves and their family, but also arrived in a country that has presented them with social stressors that make it difficult for them to start rebuilding their lives (WHO-AIMS, 2011). Thus, psychosocial counsellors working with this group could be affected by their clients’ complex presentations.

Several terms have emerged in the literature to describe the negative and positive influences on mental health providers of doing therapeutic work with individuals who have experienced trauma. Such terms used include *secondary traumatic stress* (Figley 1999), *vicarious trauma* (McCann & Pearlman, 1990), *posttraumatic growth* (Tedeschi & Calhoun, 1995) and *vicarious resilience* (Hernandez, Gangsei, & Engstrom, 2007).

Negative Aspects of Trauma Work

Figley (1999) defined secondary traumatic stress as “the natural, consequent behaviours and emotions resulting from knowledge about a traumatising event experienced by a significant other. It is the stress resulting from helping, or wanting to help, a traumatised or suffering person” (Figley, 1999, p.10). Figley (1999) related secondary traumatic stress to the definition of posttraumatic stress disorder (PTSD) provided in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 2000), in which Figley suggests that secondary traumatic stress is equivalent to

PTSD. Because refugees usually experience traumatic experiences before arriving in the host country, it is suggested that they may be struggling with posttraumatic stress symptoms and that the people helping them may experience similar symptoms. Although the notion of PTSD in the refugee population is disputed in the literature, this argument is beyond the scope of this paper (see Summerfield, 2001).

McCann and Pearlman (1990) coined the term vicarious trauma, which refers to the changes in individuals that can occur when they are repeatedly and indirectly exposed to traumatic material. Laidig, Brady, and Guy (1999) stated that it can result in changes to a therapist's cognitive schemas and belief systems, as well as negatively affecting the therapist's sense of identity, worldview, spirituality, levels of tolerance, and interpersonal relationships. In turn, this can disempower therapists, leading to absenteeism, poor work performance, and therapists prematurely leaving their jobs. Cunningham (1999) highlighted that when the trauma is inflicted by another human being, as is largely the case with refugees, it is much more devastating for therapists. Thus, due to the nature of their client stories, they may be subjected to vicarious trauma.

The previous literature predominantly focused on the negative impact of trauma work and largely employed quantitative methodologies. Thus, the focus on the negative impact has overshadowed the positive in the literature. Woodcock (1997) suggested that refugees embody emotional resiliency in the face of overwhelmingly adverse odds. The previous literature has shown that this resiliency has a positive impact on mental health providers.

Positive Aspects of Trauma Work

Originally, Tedeschi and Calhoun (1995) coined the term posttraumatic growth in reference to individuals who have experienced growth after a traumatic event. Therefore,

most of the research on this concept has focused on the client's growth. However, more recently, Arnold, Calhoun, Tedeschi, and Cann (2005) related posttraumatic growth to therapists' experience of working with trauma. They described posttraumatic growth as psychological growth that occurs in therapists after vicarious exposure to traumatic material.

Additionally, Hernandez et al. (2007) introduced the notion of vicarious resilience to illuminate the positive influence on therapists that occurs as a result of witnessing their client's resilience to adversity. Engstrom, Hernandez, and Gangsei (2008) explained that vicarious resilience influences mental health providers by reaffirming the value of therapy, regaining their hope, and making the professional and lay public aware of the impact and multiple dimensions of violence. These themes exemplify feelings of pride and privilege with regard to working with this particular client group and a high sense of achievement from seeing the progress that helping their clients results in.

Current research (Arnold et al., 2005; Linley & Joseph, 2006; Satkunanayagam, Tunariu, & Tribe, 2010) further suggested that working with people who have experienced trauma not only has a negative impact, but also a simultaneous positive impact; that is, mental health providers feel that they grow personally and professionally in spite of the negative impact of their work. Engstrom et al. (2008) argued that there are valuable reasons for developing and promoting the positive aspects of working in the traumatic stress field: in addition to self-care, which includes interpersonal support, professional development, and recreational activities (Harrison & Westwood, 2009), these positive aspects could be vital in combating the draining and fatiguing processes that therapists experience in this field.

Method

Because this study was one of the first studies to explore the experiences of

psychosocial counsellors in Jordan, a method that would allow an open and flexible exploration of such subjective experiences was utilised to overcome the limitation caused by predefined concepts set by instruments used to measure the impact of trauma work. Interpretative phenomenological analysis (IPA) is a method that sets out to explore individuals' personal experiences and how they make sense of their experiences in a specific context at a certain time. Therefore, the guiding principles of IPA (see Smith, Flowers, & Larkin, 2009) provided the course of data collection and analysis in this study.

Procedure

Following ethical approval from City University, a purposeful sampling procedure was used to recruit participants. The six psychosocial counsellors who volunteered to share their experiences were recruited by contacting organisations providing psychosocial counselling for Iraqi refugees. To ensure the participants had access to professional support, the inclusion criteria included the condition that they needed to be in supervision. As the field of mental health is small in Jordan, the study has not included the names of the organisations in order to maintain the anonymity of participants.

Participants

The four women and two men who volunteered to share their experiences had been working with Iraqi refugees from six months up to two years. Their ages ranged from mid-twenties to mid-forties. All the participants had received training on trauma treatment within the organisation they worked in and received weekly supervision. To ensure anonymity, pseudonyms were assigned in line with the participants' ethnicity.

Design

Semistructured interviews were utilised to collect data in this study because these allowed the participants to provide a full, rich account and permitted the researcher flexibility to explore interesting areas that emerged from the participants' accounts (Smith, 2003). The interview questions centred on the experiences of the psychosocial counsellors and were related to the findings of previous literature. The questions included what the participants' work meant for them, how the sociopolitical climate in Jordan and Iraq affected their work, the challenges and potential benefits they faced, and how they perceived they have changed because of their work.

Analytical Approach

In the IPA process, interview transcripts are analysed systematically. In this study each transcript was read separately and notes were made on the participants' descriptions. Shared meanings were then clustered to form themes rooted in the text. The results are presented in the form of quotes taken directly from the transcripts. This process acknowledges that the researcher interprets the text and recognises that direct access to the participants' subjective experience is not possible. An awareness and acknowledgement of researcher bias is integral and the method accepts that it cannot be completely eliminated. The analysis revealed three master themes from the transcripts: the effects of sociopolitical and socioeconomic factors on their roles, the enriching and motivating aspects of their roles, and coping with the distressing aspects of their roles.

Findings

The research findings describe three interconnected themes that emerged from the data. Each theme tries to capture the essence of what is being described, although similarities are found across them. The themes illustrate how working with this client group changed and influenced the counsellors in negative and positive ways in their personal and professional roles.

Master themes	Subthemes
Effects of sociopolitical and socioeconomic factors	"There's nothing you can do"
	"You feel like a little child"
	"Just picking up the pieces"
	Emotional burden
Enriching and motivating aspects of their roles	"Psychological value"
	Increased commitment
	"There's always a way back to life"
	"There's something special about the world"
Coping with the distressing aspects of their roles	Self-care
	"It's tough but it's worth it"

Table 1: Themes

Effects of the Sociopolitical and Socioeconomic Factors

The participants described the sociopolitical and socioeconomic challenges their clients experienced, such as basic needs not being met, lack of legal status, and ongoing violence in Iraq, which made the participants feel powerless, helpless and frustrated. The findings are presented in the following four subthemes: "There's nothing you can do", "You feel like a little child", "Just picking up the pieces", and emotional burden.

"There's nothing you can do". Sara described how her clients' unmet basic needs challenge her in providing therapy and make her feel as if she cannot help her clients.

> For more than one case, there is nothing that you can do, they tell you that they don't have enough to eat, or "I have no house, what can you do for me? You're going to talk to me? OK, but you cannot help me by talking to me. This isn't the time for talking, talking is a secondary need right now".

"You feel like a little child". Farah described feeling powerless in the face of UN resettlement decisions. She perceives herself as rebuilding her clients' lives and that what she has built up can be toppled over if the UN makes an unfavourable resettlement decision.

> You just get frustrated, because you would work with a client for three or four months and you cannot believe it when they finally manage to get on their feet and getting better, then suddenly it all gets torn down. You feel like a little child that was building then someone came and tore everything down.

"Just picking up the pieces". Lubna described how the ongoing violence in Iraq makes her question her role as a counsellor and reflect on what she needs to do to help her clients.

> When we work very hard and something happens in Iraq, for example an explosion in Iraq that kills the patient's brother, father or son etc. then it triggers a relapse in the progress we were making, and he goes through the post trauma syndrome again, the first time it happened I was speechless, at first I felt this incredible heavy feeling like I didn't know what to say, completely incapable of knowing what to do next, it still creeps up when I'm faced with a situation like that but I just put that feeling aside as best as I can and have to think we can still move forward, because if I just look at the client and say "I don't how you can get over this", because that's what I initially thought, then what good am I as a counsellor?

Emotional burden. All the participants described how the various stories that they heard from their clients affected them emotionally. Walid described how he experienced nightmares (a symptom of secondary traumatic stress) because of hearing his clients' traumatic stories.

> I hear a lot of horror stories from my clients, which you can consider as one of the difficulties or challenges we face at the job, as you know we are human after all, so sometimes hearing about the torture and the misery that they went through makes me, myself, have nightmares as well from all the stories we heard.

Farah described experiencing disruptions in her personal relationships, which is an aspect of vicarious trauma, due to the emotional burden of the stories that she hears from her clients.

> Now, whenever I listen to my friends' problems I cannot really sympathise with them because they seem so silly to me in comparison with what I hear in the job.

Enriching and Motivating Aspects of Their Roles

The participants expressed that they experienced positive aspects of working with this client group in spite of the difficulties. Four subthemes emerged from the interviews: "psychological value", increased commitment, "There's always a way back to life", and "There's something special about the world".

"Psychological value". Throughout the interviews, the research participants described how working with this client group enriched their lives in various ways. Hussam said:

> I have found myself and my role and I feel very satisfied doing it and dealing with the human element, I mean we are humans as well and I feel rewarded helping people from drowning… Nothing rewards you like knowing that you have achieved something, even if you have earned a 100 million, nothing rewards you like feeling like you've accomplished something.

Increased commitment. Through witnessing the issues the Iraqi community was facing in Jordan and by becoming more aware of the help they needed, the participants felt more committed to offering psychological services. Farah described how her work increased her commitment to therapy in Jordan and the Arab world. Furthermore, through learning about the Iraqi community's struggle, she started defending them in front of those who criticised them.

> Some say they deserve what happened to them, but after my work with them my beliefs changed. At first people would criticise them whenever I mentioned that I was going to be working with them, but after my work with the Iraqis, I started believing in their cause, defending them and fighting for them because they had no fault in what happened to them; they had nothing to do with what happened, they just woke up one day and saw that even neighbours had turned against each other, I believe that we have to stand with them and help them. They need our help. We can't wash our hands clean from their cause and call them liars, some people are really suffering and need our help. I can now see how important psychological work is in Jordan and in the Arab world.

"There's always a way back to life". The participants talked about how their self-concept had changed in their role as counsellors working with Iraqis. Ghada illustrated this by saying:

> I mean, you work with people on a very very deep level, in a way I haven't with other client groups and I guess this work makes me a better therapist because of the depth

> of the work. Nothing scares you any more, 'cause I've seen hell and have come back, so it teaches you that there's always a way back to life.

"There's something special about the world". The experience of becoming more aware and viewing the world from a different perspective emerged as a significant theme in different parts of the interviews. Sara emphasised this by saying:

> I realise there's something special about the world that I didn't notice before I was in this position; it changes you.

Coping with the Distressing Aspects of Their Roles

The participants described how self-care plays an important role for them, how it helps them, and how they try to maintain it. In the subtheme "it's tough but it's worth it", they spoke of how, despite the complexities and difficulties they face, the positive aspects of their work inspire them to continue working in this field.

Self-care. Walid described how using professional support when he experienced symptoms of secondary traumatic stress helped him overcome the experience and provided him with an understanding of the importance of gaining professional support.

> I talked to someone and discussed what happened, we started connecting the sessions that I had with the nightmares that I got. This helped me, because sometimes when you talk about things, it helps, and this is part of the self-care process, to share this with someone with experience and he can help you with his information and his expertise.

"It's tough but it's worth it". Sara described how the presence of positive and negative aspects of her role helps her to cope and makes her work manageable in spite of the difficulties she encounters.

> It's neither it's both, the difficulty in it as I mentioned earlier is the aspects neither I nor our clients can control, that's what makes it difficult, the helplessness, that's the difficult part. I wouldn't say it's easy but the support and the humanitarian part of it and the depth of it is what keeps me going so it makes it easier to keep going forward but no it's not easy, it's tough but it's worth it.

Discussion

The study found that the participants were affected in several ways by working within the sociopolitical and socioeconomic climates of Jordan and Iraq. They felt helpless when faced with clients' unmet basic needs, and powerless and frustrated by their clients' lack of legal status and the ongoing violence in Iraq. The difficulties in meeting basic needs and establishing safety within the Iraqis' sociopolitical and socioeconomic context appears to have hindered the participants' ability to provide therapeutic services. This made them reflect on their impact as counsellors and the benefit of therapy within that context. This is supported by Herman's (2001) three-stage model and the new IASC (2007) guidelines. It is also supported by Gilbert (2009), who found that counsellors working with Iraqis in an INGO in Jordan felt they needed to offer their clients *sympathetic listening* rather than therapy.

Jordan is a low- and middle-income country that has limited resources. The participants' accounts suggest that the implementation of the IASC guidelines to improve the

Iraqis' environment has been difficult. Although international funding had been provided, it might have been challenging to introduce a referral system to support the needs of Iraqis. This could be because implementing such a system is difficult within a country that does not have a previously established mental health system and could take some time to accomplish. Furthermore, due to the enthusiasm of donors to help Iraqis, many agencies entered the field with little capacity and attention paid to the needs of Iraqis (Horn & Strang, 2008).

The participants also described feeling emotionally burdened because of the stories that they heard from their clients. One participant voiced experiencing disruptions in her personal relationships in the form of feeling unsympathetic towards her friends' problems, which Laidig et al. (1999) suggested is an aspect of vicarious trauma. Another participant described experiencing nightmares because of the horrific stories his clients have told him, which Figley (1999) described as an aspect of secondary traumatic stress.

In addition to the negative impact, the participants voiced positive effects and positive change as a result of their work. The participants expressed an increased commitment to their work, which Engstrom et al. (2008) related to the concept of vicarious resilience. Moreover, the participants described experiencing other aspects of vicarious resilience, such as advocating through making the lay public aware of the impact of violence and reaffirming the value of therapy (Hernandez et al., 2007). The participants also expressed feeling that they had largely changed in a positive way, a notion supported by the concept of posttraumatic growth.

Similar to previous findings (Harrison & Westwood, 2009) the participants expressed that self-care is an integral part of mitigating the distressing effects of their work. The participants also described taking an active role in implementing self-care by actively seeking personal and professional support. Walid described how he used supervision to understand

the meaning of the nightmares he was experiencing, which stopped the occurrence of the nightmares. This finding is supported by McCann and Pearlman (1990), who argued that a therapist needs to engage in a process of integrating and transforming the traumatic experience in the same way that a client does during therapy.

In addition to self-care the participants also expressed that some aspects of their work make the difficulties worth it. That is, the positive aspects of their work, such as feelings of pride, recognition, and positive change in their self-concept and worldview, balance the negative aspects (Hernandez et al., 2007). Therefore, similar to the findings of Arnold et al. (2005) and Satkunanayagam et al. (2010), counsellors in this study suggested experiencing coinciding positive and negative effects.

Implications

As Jordan is now facing a major influx of Syrian refugees, war trauma is no longer a new notion being introduced into its communities. In fact, it is becoming embedded in its culture and an increasing number of service providers are encountering it daily. Therefore, to cope with the threat from its surrounding hostile environments, Jordan now more than ever needs empowered communities to remain stable if it is to continue to be the "safe haven" in the region.

The findings of this study suggest the following to help reduce the negative impact of working with refugees and asylum seekers:

1. Organisations providing psychosocial counselling need to continuously strengthen links with other organisations so they can refer clients to organisations that can fulfil their basic needs, either before or in conjunction with providing therapy.

2. Psychosocial counsellors need to have access to professional support to be able to transform their own traumatic reactions.
3. The nurturing facets of vicarious resilience at an individual and organisational level may prevent the distress caused by vicarious trauma. For example, to mitigate the powerlessness and helplessness therapists may feel, an organisation could provide outlets for their therapists to speak out against injustice and foster change in their communities.
4. Finally, linking therapists with policy-makers and beneficiaries may act as a barrier to vicarious trauma. Therapists usually gain a rich understanding of refugees' lives and the information they have about how unfulfilled basic needs, lack of legal status, and issues of resettlement effect clients, which usually disempowers clients and therapists, could help policy-makers and beneficiaries to improve services for survivors of political violence in Jordan.

Limitations and Future Directions

The first limitation of this study is that the sample was selected based on an inclusion criterion that the participants needed to be in supervision. This was to ensure that the participants had access to professional support. Therefore, counsellors working without attending supervision might have a different experience. The second limitation is that male participants might have not felt comfortable enough to be open with a female interviewer, as typically in the Middle East men do not express their emotions in front of women. As this study was qualitative in nature and only included participants who have access to professional support, it cannot be generalised. Therefore, further research needs to include

participants who do not have access to professional support to understand what challenges they might face.

Conclusion

The experience of working therapeutically with Iraqis in Jordan is multifaceted and complex. The themes that emerged in this study indicate that the psychosocial counsellors were negatively affected by the social and political stressors that their clients face. They also experienced a positive impact from the resiliency that their clients exemplify. The findings suggest that the negative impact of the work could be reduced by continuously striving to implement the IASC guidelines in Jordan and by cultivating an awareness of the positive impact.

REFERENCES

American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revised), Washington, DC: Author.

Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology*, *45*, 239–263.

Bader, F., Sinha, R., & Leigh, J. (2009). Psychosocial health in displaced Iraqi care-seekers in non-governmental organisation clinics in Amman, Jordan: An unmet need. *Prehospital and Disaster Medicine*, *24*(4), 312–320.

CDC – Mercy Corps (2007). *East Amman survey of Iraqis*. Amman: CDC & Mercy Corps.

Cunningham, M. (1999). The impact of sexual abuse treatment on the social work clinician. *Child and Adolescent Social Work Journal*, *16*(4), 277–290.

Duncan, J., Schiesher, D., & Khalil, A. (2007). *Iraqi asylum seekers in Jordan: A report of the ICMC-USCCB mission to assess the protection needs of Iraqi asylum seekers in Jordan*. Retrieved from http://www.aina.org/reports/iasij.pdf

Engstrom, D., Hernandez, P., & Ganagsei, D. (2008). Vicarious resilience: A qualitative investigation into its description. *Traumatology*, *14*(3), 13–21.

FAFO. (2007). *Iraqis in Jordan: Their number and characteristics*. Retrieved from http://www.dos.gov.jo/dos_home_a/main/Analasis_Reports/Iraqis%20in%20Jordan/Iraqis%20in%20Jordan.pdf

Figley, C. R. (1999). Compassion fatigue: Towards a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (2nd ed., pp. 3–28). Lutherville, MD: Sidran.

Gilbert, J. (2009). Power and ethics in psychosocial counselling: Reflections on the

experience of an international NGO providing services for Iraqi refugees in Jordan. *Intervention*, *7*, 50–60.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatisation of mental health therapists: Identifying protective practices. *Psychotherapy*, *46*(2), 203–219.

Herman, J. (2001). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror.* New York: Basic Books.

Hernandez, P., Gangsei, D., & Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process*, *46*(2), 229–241.

Horn, R., & Strang, A. (2008). A Jordanian case study: The implementation of the IASC guidelines on mental health and psychosocial support in emergency settings. *Intervention*, *6*, 291–293. Retrieved from http://sustainabledevelopment.un.org/content/documents/745habitat.pdf

Inter-Agency Standing Committee (IASC). (2007). *IASC guidelines on mental health and psychosocial support in emergency settings, Geneva: IASC.* Retrieved from http://www.humanitarianinfor.org/iasc/contents/products

IOM. (2008). *Assessment on psychosocial needs of Iraqis displaced in Jordan and Lebanon*. Retrieved from http://www.iom.int/jahia/webdav/shared/shared/mainsite/published_docs/brochures_and_info_sheets/report_psy_assessment.pdf

Laidig, J., Brady, J., & Guy, J. D. (1999). Vicarious traumatisation, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice*, *30*(4), 386–393.

Linley, P. A., & Joseph, S. (2006). Positive and negative aspects of disaster work. *Journal of Loss and Trauma*, *11*, 229–245.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatisation: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(2), 131–149.

Satkunanayagam, K., Tunariu, A., & Tribe, R. (2010). A qualitative exploration of mental health professionals' experience of working with survivors of trauma in Sri Lanka. *International Journal of Culture and Mental Health*, *3*(5), 43–51.

Smith, J. A. (Ed.). (2003). *Qualitative psychology: A practical research guide to research methods*. London: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretive phenomenological analysis: Theory, method, and research*. London: Sage.

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

Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering.* Thousand Oaks, CA: Sage.

WHO-AIMS. (2011). *WHO-AIMS report on mental health system in Jordan*. Retrieved from http://www.who.int/mental_health/evidence/mh_aims_report_jordan_jan_2011_en.pdf

Woodcock, J. (1997). Group work with refugees and asylum seekers. In T. Mistry & A. Brown (Eds.) *Race and group work* (pp. 254–277). London: Whiting and Birch.