Meeting Needs with Therapy: Refugee and Therapist Experiences of Psychodynamic Psychotherapy.

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Abstract

Current conflict across the world has led to unprecedented displacement of people. Research has captured the wide-ranging consequences of displacement on health and emotional wellbeing, identifying that refugees and asylum seekers require help and support in many areas of their lives. One of the resources available to them in the UK is psychodynamic psychotherapy. This study was the first of its kind to explore the experience of psychodynamic psychotherapy from the perspective of refugee and asylum seeker clients, and therapists working with those populations. Using a qualitative design, nine participants shared their experiences of psychodynamic psychotherapy in semi-structured interviews. The thematic analysis identified six themes to describe participants' experiences of psychodynamic psychotherapy within a distinct service context. The findings emphasise the unique experiences of clients and therapists, and the different starting points and needs that clients have at the beginning of therapy. Psychodynamic psychotherapy within the service under study is viewed positively by participants but also used flexibly. It is adapted through the modification of the therapeutic frame, joint working with other professionals and an active role in supporting needs including immigration and integration. Specific elements of the psychodynamic model that are helpful for refugees and asylum seekers are identified along with clinical and research recommendations.

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Introduction

This chapter provides a background to the issue of displacement and its position in the world. Moving from a global to a localised perspective, this chapter identifies and explores some of the experiences of displaced persons – refugees and asylum seekers –, the psychological impact of these experiences and the role of psychology and psychotherapy in attempting to support healing. A critique of Western psychological methods employed within cultural contexts and taking into account the characteristics of refugee populations raises questions about their relevance and suitability for refugees and asylum seekers, which this study aims to explore.

Setting the Scene: The 'Refugee Crisis'

The term 'refugee' is applied to displaced persons who have had to leave their home country due to war, persecution or natural disaster in order to seek refuge and safety elsewhere. The majority of displaced persons generally resettle in other parts of their home countries or countries surrounding them, but many travel long distances to seek asylum in countries further away from conflict (Burnett & Peel, 2001). Refugees are defined as a separate group from people displaced but do not cross an international border who are known as 'internally displaced persons' (Cherem, 2016) and are noted to have different experiences and rights such as no protection under international law (Lee, 1996).

In the United Kingdom (UK), refugee is a legal term applied to internationally displaced people who have sought asylum from the Government, meet the terms of asylum and had refugee status granted (Home Office, 2018). Before reaching refugee status, individuals may be 'asylum seekers' if they have applied for asylum and are going through

the asylum process or they may be 'failed asylum seekers' if their asylum application was not approved and they were not given refugee status. Outside of these strictly-defined legal terms in the UK, the term refugee is used more generally, as above, and will be used in this way to describe people during the displacement process, both before and after successful claims of asylum.

Over the last century, the world has witnessed consistent violent conflict causing fear and destruction. The impact of war is extensive; up to 90% of war victims are civilians caught up in violence due to where they live (Roberts, 2010). Those who escape war, trade fear-stricken experiences of home for dangerous journeys with indefinite endings, which is traumatic and costly (Weaver & Burns, 2001). In 2016, there were 67 million people of concern worldwide; 3.5 million in Europe (United Nations High Commissioner for Refugees, 2017).

Current Middle East conflict has required profound numbers of individuals and families to flee their homes and over one million people fled to Europe (Alisic & Letschert, 2016). This situation, labelled a 'refugee crisis' (Balsari, Abisaab, Hamill, & Leaning, 2015), is widely covered by the media and remains active in political discourse between European governments debating responsibility for receiving and supporting people seeking asylum and refuge.

The Experience and Impact of Displacement

Researchers exploring causes and consequences of forced migration have documented refugees' experiences pre-migration, and during migration and post-migration resettlement (Kirmayer et al., 2011). Experiences are diverse because though refugees have all been displaced, they come from many cultures and countries of origin. Refugees also exist in many

different contexts: travelling, living in temporary accommodation or circumstances, arriving in new countries or familiar countries, and re-settling into new areas on a longer-term basis. Pre-migration experiences can include persecution and incarceration (Yun, Mohamad, Kiss, Annamalai, & Zimmerman, 2016); witnessing and receiving violence in Eritrea and Sudan (Nakash et al., 2015); multiple displacements and separation from and loss of family members in Pakistan (Swaroop & DeLoach, 2015). Prevalence of traumatic experiences vary across the refugee population, but exposure to danger can significantly increase refugees' emotional distress (Rousseau & Drapeau, 2004) and depression (Montgomery, Jackson, & Kelvin, 2014) even after escaping from those circumstances.

During migration, refugees may reside in camps that can be highly stressful environments due to camp structures and safety concerns (Rasmussen & Annan, 2009) and systemic challenges such as complex relationships between staff and refugees (Papadopoulos, 2008). Although refugees have somewhere to stay, it appears that refugee camps can further perpetuate instability and the presence of danger during migration.

Arrival in new countries can also be a time characterised by uncertainty for refugees. Unaccompanied youths described arriving to safety from danger, living in limbo while decisions were made about status to remain, and striving to fit in and move forward (Thommessen, Corcoran, & Todd, 2015). Older adult refugees described better quality of life since resettling, but sorrow about not being able to visit others back home (Gautam, Mawn, & Beehler, 2017). Language impacted refugees' isolation and loneliness, and they could not worship in familiar ways, which affected cultural adaptation (Gautam et al., 2017). Obstacles to resettlement include finding employment, accessing education and maintaining culture alongside general disempowerment which restricted integration to the extent refugees wanted (Valtonen, 1998).

The UK Asylum Process. The UK offers asylum to people fleeing war and persecution as part of the 1951 Geneva Convention (Burnett & Peel, 2001). Seeking asylum in Britain can be lengthy and different outcomes can mark the end point: applications can be denied, potentially leaving seekers stateless and destitute without support; or seekers may be granted refugee status, indefinite leave to remain, humanitarian protection, discretionary leave to remain or leave outside the rules (British Red Cross, 2014). When people claim asylum in the UK, the Government meets asylum seekers' basic needs with accommodation, a small living allowance, and access to healthcare, until their claim is processed ("Asylum Support", 2016). However, the asylum process is highly stressful; claimants must attend a screening, an interview, evidence their identity and reasons for seeking asylum, which may have been impossible to retain on their journeys; claimants must not move accommodation, leave the country or work, or their claim will be invalidated ("Asylum Support", 2016).

If asylum is granted, transitioning from receiving asylum support to receiving 'mainstream' support such as access to employment and benefits is complicated and leaves many people with refugee status vulnerable and lost between the two systems (British Red Cross, 2014). Accessing health services can be difficult for refugee populations due to barriers such as language and communication difficulties (Morris, Popper, Rodwell, Brodine, & Brouwer, 2009). Further, the unique experiences of refugees can mean their health needs are not straightforwardly met through typical NHS health services.

Integration can be a complex process requiring negotiation between contexts and cultures, past and present, and place of origin and place of refuge (Bhatia & Ram, 2009). There is no consensus on the definition of integration; research on refugee integration explores various markers of integration, some considering it an individual process and others an interaction between refugees and host societies (Bakker, Cheung, & Phillimore, 2016). Refugees report diverse experiences of integration (Healey, 2014; Platts-Fowler & Robinson,

2015) and those in South Africa defined integration markers as access to adequate housing, education, healthcare services and job opportunities (Smit, 2015). Where a refugee settles impacts their integration (Platts-Fowler & Robinson, 2015): integration in the UK can be supported by settling in diverse neighbourhoods around city centres with acceptance of diversity and difference, which offer more shared activities and lasting interactions between their residents (Platts-Fowler & Robinson, 2015). Culturally-sensitive amenities and services also support integration whereas communities with only a limited recent history of accommodating diversity and difference appear to restrict integration (Platts-Fowler & Robinson, 2015).

Policy can impact refugee integration outcomes (Bakker et al., 2016), but is frequently overlooked. In Holland and the UK, current asylum and integration policy may contribute to exclusion of refugees rather than inclusion in terms of living in state-provided asylum housing and until recently being given vouchers for food and clothing instead of money (Bakker et al., 2016). UK councils painting asylum seekers' doors red in Middlesbrough (Bates, 2017) is a further, strikingly visual example of how refugees and asylum seekers are continually divided from their communities, old and new. However, services exist in the UK to support refugees with challenges relating to their asylum claims and integration. Services often offer information and advice about financial support and housing, training, and some offer psychological support and psychotherapy.

Impact on physical and mental health. Within health research, reliable and consistent associations have been found between forced migration and displacement, and many mental and physical health conditions. Pre-migration factors affecting adults refugees' mental health include education, economic and occupational status in their country of origin, disruption of social support, trauma and political involvement (Kirmayer et al., 2011). During

migration, its trajectory (route and duration), exposure to harsh living conditions like refugee camps, violence, further disruption of family and community networks and uncertainty about the outcome of migration also affect adults' mental health (Kirmayer et al., 2011). Post-migration factors include uncertainty about immigration status, unemployment, underemployment, loss of social status, loss of family and community social supports, concern about family members left behind and reunification, language learning difficulties, acculturation and adaptation (Kirmayer et al., 2011).

Research shows that how refugees are received by new countries can affect their emotional experiences and anxiety (Reijneveld, de Boer, Bean, & Korfker, 2005). This population is extremely powerless and vulnerable, living with fear of deportation and further displacement, which can exacerbate the effects of the distress they have already experienced (Ryan, Kelly, & Kelly, 2009). Indeed, negative public perception of individuals seeking asylum (Lynn & Lea, 2003) can mean that even when asylum seekers are able to meet some of their basic needs, establishing a sense of safety may be perpetually challenging.

Prevalence rates of refugees' psychiatric diagnoses can offer an indication of their psychological distress, though only for a proportion of those who access health services or become involved in research. A systematic review of approaching 7000 refugees identified 9% of adult refugees were diagnosed with post-traumatic stress disorder (PTSD) and 5% with major depression (Fazel, Wheeler, & Danesh, 2005). Similar proportions of depression are reported for adults in the general population, but the proportion of refugees experiencing PTSD is markedly higher (Alonso et al., 2004). These figures show that trauma is not inevitable for refugees. Mediating the relationship between refugee experiences and trauma responses may include protective contextual factors such as social support and religious beliefs (Johnson & Thompson, 2008) or whether someone is internally or internationally displaced (Porter & Haslam, 2005), or individual factors such as appraisal of their

experiences (Beck, 1979) or unconscious processes (Spermon, Darlington, & Gibney, 2010). Literature by Papadopoulos (2001) highlights the power of the 'refugee trauma' narrative, which appears to be contradicted by research on trauma prevalence rates and can blind people to other aspects of refugee personhood that may be more relevant to individuals, which should be held in mind by those working with or researching this population.

More recently, a study of Iraqi Yazidis displaced into Turkey identified 43% met diagnostic criteria for PTSD, 40% for major depression and 26% for both disorders (Tekin et al., 2016). Clearly, rates vary substantially between different studies in different areas, ranging from 8-37% for Iraqi refugees located in Western countries (Slewa-Younan, Guajardo, Heriseanu, & Hasan, 2015). It may be the case that combining data of different groups with different experiences and patterns of migration will obscure the needs of some. As such, the data on prevalence rates cannot be widely generalised. Anxiety is also commonly experienced by the refugee population, specifically Iraqi refugees in Jordan (Al-Smadi et al., 2017), but tends to receive less interest from researchers than trauma or PTSD (Fazel et al., 2005).

Diagnostic measures also vary between studies, affecting their quality. Some use structured clinical interviews based on standardised criteria of the Diagnostic Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013; Tekin et al., 2016), however, others use the Centre for Epidemiologic Studies Depression Scale (Takeda, 2000) which is considerably less thorough, based on North American population data and does not have equivalent validity cross-culturally (Lee et al., 2011). Diagnostic manuals – DSM and International Statistical Classification of Diseases (ICD) – are developed in Western cultures and may not be directly transferable to other cultures. Cultural concepts of distress remain highly relevant in Western healthcare and research (Kohrt et al., 2013), but appear subjugated at times by medical and psychiatric frameworks, which weaken the

quality, relevance and usefulness of cross-cultural research. To address this oversight, research should capture the words and stories of participants to ensure their cultural meanings are woven through the documents written about them, representing them in the media and academia.

Physical symptoms also cause difficulty for refugees, for example chronic pain is frequently reported by refugees from 21 different countries (Teodorescu et al., 2015) as well as tinnitus by Cambodian refugees (Hinton, Hinton, Loeum, Pich, & Pollack, 2008) following displacement, perhaps as a physical expression of psychological pain. Somatisation, presentation of psychological distress through bodily symptoms, is a more common way for refugees to present their distress in comparison to the general Western population (Rohlof, Knipscheer, & Kleber, 2014). Indeed, somatic symptoms are higher for refugees in comparison to others of the same culture, likely due to the prolonged stress endured and its long-term implications for health (Proroković, Cavka, & Cubela Adorić, 2005).

Taken together, refugee status can be characterised by escape from danger, instability, uncertainty, lack of secure statehood and living in stressful circumstances. Research shows that some refugees experience trauma and consequential emotional difficulties including PTSD, but these are not prevalent for all refugees.

Refugee Needs

Displacement leaves people physically and psychologically vulnerable and refugees may have different patterns of social care needs than non-refugees due to their experiences (McCrone et al., 2005). Despite their diversity, collective needs of refugees include language and information services (Feldman, 2006); accommodation; food; reading; writing (McCrone et al., 2005); and employment (Papadopoulos, Lees, Lay, & Gebrehiwot, 2004).

The health difficulties described earlier through epidemiological examples correspond to a range of health needs refugees have when settling in new countries; Wright et al. (2016) found 99% of refugees need healthcare and 43% need psychological services. Needs also include specialist mental health services and services for survivors of torture and organised violence (Feldman, 2006). Nonetheless, refugees' difficulties should be managed without pathologising normal human responses and with potential cultural differences in mind (Craig, Mac Jajua, & Warfa, 2009), although refugees may not necessarily be from a different cultural background.

Data describing how refugees access health services can indicate their acceptability: high proportions of Bosnian refugees in Chicago with symptoms of trauma do not seek mental health care (Weine et al., 2000) and in the UK, Somali refugees often do not seek treatment (McCrone et al., 2005). Barriers to accessing mental health care include negative understandings of psychiatry, not having enough information and fear of being stigmatised by communities (Bartolomei et al., 2016). Differences in cultural interpretations of mental health also contribute: research suggests that Somali refugee populations in London seek relief from distress through prayer rather than accessing services (McCrone et al., 2005) and Ethiopian refugees in the UK believe mental health difficulties have both supernatural and psychosocial causes, and are more familiar with using traditional remedies and informal health support from family through advice and care (Papadopoulos, Lees, Lay, & Gebrehiwot, 2004).

Indeed, although manualised psychological therapy is recommended in the UK as treatment for psychological distress resulting from trauma by the National Institute of Health and Care Excellence (NICE; 2018), the offer of such therapies to refugees should not be taken for granted as straightforward. Only a very small portion of the guidelines refer to refugee populations, but they do highlight that people with additional needs, such as those of refugees, may experience barriers to engagement and recommend that clinicians take these

into account (NICE, 2018). There are no references to treating refugees in NICE guidelines for depression (NICE, 2018a) or anxiety (NICE, 2011a).

These guidelines are informed by published empirical evidence, largely randomised controlled trials focused on symptom reduction, which constitutes only external indications of emotional distress and a fragment of the lived experience of refugees. The quantitative evidence on which NICE guidelines are based often omits the acceptability of treatments for patients and recorded experiences of receiving it. Service user experience research was not reviewed in the PTSD guidelines (NICE, 2018) nor service user experience of trauma-focused intervention in the service user experience in adult mental health guidelines (NICE, 2011), giving little indication of their experiences of the recommended interventions. This marks a significant limitation in the scope of the guidelines, rendering them patient-directed but not patient-centred based largely on the reports of clinicians and researchers, rather than patients and research participants.

Psychological Support

There is limited published research on effective psychological interventions for refugees, and that which has been published mostly focuses on individuals diagnosed with PTSD. It is indicated that cognitive behavioural therapy (CBT; Nicholl & Thompson, 2004; Palic & Elklit, 2010) and narrative exposure therapy (Slobodin & de Jong, 2015) can be effective for reducing PTSD symptoms. However, many studies lack convincing evidence and widespread conclusions cannot be made based on the diversity of the refugee population. Palic and Elklit (2010) highlight that refugees' traumatic reactions can be more complex than those defined by the PTSD diagnostic category, which mean traditional research methods using diagnostic criteria for participants may be poorly suited to studying effects of therapy with refugees.

While research on therapy outcomes and effectiveness is in short supply and may also have limited application, a small pocket of research has begun to explore the lived experience of refugees accessing therapy. Phenomenological research such as this can offer insight into psychotherapy from the perspective of those who have experienced or delivered it, offering rich detail and personal accounts that are overlooked in studies measuring effectiveness. Few studies have focused on exploring refugee experiences of receiving therapy, representing a substantial gap of refugee voices in the literature. Exploring clients' accounts of receiving therapy in research can offer information about its acceptability and usefulness. Though not generalisable, research of this kind is valuable because it supports the making of meaning regarding phenomena such as therapy effectiveness that may be otherwise undisputed.

Asylum seekers receiving trauma-focused CBT described feeling conflicted about whether or not to engage in therapy because it is difficult and therapists' advice to discuss their traumatic experiences conflicted with a desire to avoid talking about them (Vincent, Jenkins, Larkin, & Clohessy, 2013). Although participants in this study reported improvements in mood, self-worth and optimism, they also described perceiving the therapist or therapy as powerless and perceiving attending therapy as a sign of failure (Vincent et al., 2013), highlighting further reasons contributing to their conflict. These experiences of CBT, based on rich, reliable data analysed using detailed interpretative phenomenological analysis (IPA), suggest that it is not an intervention that feels comfortable from the outset, but can be helpful in relation to feeling better. However, the findings are limited to participants able to speak English at a full conversational level, likely restricting the range of clients sharing their experiences, thereby restricting the transferability of findings. Left unanswered is whether clients feel it was worth the difficult process and how they relate to the Western model of psychology.

Refugees experiences of un-specified psychotherapy were also mixed: positive experiences included "getting things off my chest" and symptom relief; and negative experiences included therapy being unhelpful, lack of therapist transparency, perceived micro-aggressions from therapists including insensitivity and disrespect regarding participants' cultural heritage (Al-Roubaiy, Owen-Pugh & Wheeler, 2017). These results suggest that the difference between themselves and therapists coloured many of the clients' negative experiences, but the process was also experienced as hard. The lack of specificity regarding therapy modality limits the transferability of Al-Roubaiy and colleagues' (2017) findings, despite their rigorous IPA analysis and appropriate methodology.

Taken together, the results of Vincent et al. (2013) and Al-Roubaiy et al. (2017) only begin to scratch the surface of refugee experiences of therapy. However, complementing them is the emerging literature on therapists' experiences of working with refugees, which can offer further insight into what therapy can offer refugees and the process of delivering it.

Research by Century, Leavey and Payne (2007) found that listening to the experiences and distress of refugees can be emotionally difficult for therapists, and that therapeutic practice is markedly different from working with other groups, particularly in relation to boundaries that felt 'threatened and sometimes lowered'. Therapists described their resources being limited in comparison to clients' levels of need and highlighted refugees' psychological and practical needs (Century et al., 2007). These results are strengthened by their appropriate methodology and transparent analysis, but as clinicians' therapeutic modalities were not described, their transferability is limited.

Therapists working in specialist agencies in Australia including organisations for resettlement and torture and trauma services described using integrative therapeutic approaches in order to meet refugee clients' unique needs (Schweitzer, Wyk, & Murray, 2015)). Participants highlighted their emphasis on supporting refugees to create meaning and

a sense of continuity, and the strong emotional responses they had to clients (Schweitzer et al., 2015). The evidence of this study was strengthened by a transparent and collaborative analysis, but dependability is limited by the general approach of therapists. To date, there is no empirical, published research exploring therapist experiences of delivering specific therapeutic interventions for refugees.

An overview of the literature of staff and refugee experiences of psychotherapeutic services including psychosocial and advocacy interventions by (Karageorge, Rhodes, Gray, & Papadopoulos, 2017) considered the experiences of both groups and identified four concepts relating to their experiences. The concepts were: mutual understanding, addressing complex needs, discussing trauma and cultural competence, and the authors highlighted how each of the concepts these could be enabled or disabled according to the work of each party (Karageorge et al., 2017). Combining the experiences of staff delivering psychotherapeutic services and refugees receiving them adds value to the research by considering their experiences in relation to each other and reflecting the relational nature of psychotherapeutic work.

Looking at the literature, qualitative research exploring refugee experiences of therapy is an under-researched field that needs to be studied in order to offer better understanding of what therapy is like for this population in relation to the range of needs that they have. Based on the depth that including therapist experiences added to an overview of the literature by Karageorge et al. (2017), it may be beneficial to include their perspectives in order to provide similar depth going forward.

Psychodynamic Psychotherapy

Psychodynamic psychotherapy is a therapeutic approach based on psychoanalytic theory, first developed by Freud in the late 19th century who introduced the concept of the unconscious that can shape conscious experience (Fine, 1990). Since its beginning, psychoanalytic theory has expanded and grown over the last century, developing into a theoretical approach influenced by many psychoanalysts including Carl Jung and Melanie Klein among others.

Psychodynamic psychotherapy aims to increase self-awareness and understand the influence of clients' pasts on their present behaviour (Lemma, 2003). Psychodynamic psychotherapy typically involves weekly sessions and can be briefer than traditional psychoanalysis (Shedler, 2012), however, it still exercises the psychoanalytic frame that creates the therapeutic environment for psychodynamic therapy to occur, for the unconscious to be explored, consisting of the physical setting and the therapist's internal setting (Lemma, 2003). Of primary importance is the relationship between client and therapist, which supports the expression of clients' unconscious material based on experiences of other people in their lives (Lemma, 2003).

Long-term psychodynamic psychotherapy has been found effective for many mental health conditions in Western populations including PTSD by reducing symptoms and increasing quality of life (Leichsenring & Klein, 2014; Leichsenring & Rabung, 2008) and depression (Fonagy et al., 2015). However, this field of research remains emerging and more research is needed to understand the outcomes and processes of psychodynamic therapy; it appears to be helpful for clients to relieve psychological distress, but we know little about why or how. There is limited consensus about the specific aims of psychodynamic psychotherapy sessions as it is a relatively unstructured approach (Westenberger-Breuer, 2007). However, the focus on affect and expression of emotion; exploration of avoidance of distressing thoughts and feelings; identification of recurring themes and patterns; past

experience; interpersonal relationships; and exploration of wishes and fantasies are distinctive to psychodynamic psychotherapy in comparison to other modalities (Blagys & Hilsenroth, 2000; Shedler, 2012).

Psychodynamic psychotherapy is a model of therapy available to refugees in the UK and suitable for working with their complex psychological difficulties. However, research considering the use of psychodynamic psychotherapy with refugee populations is scarce; Slobodin and de Jong's (2015) recent review of psychological interventions for refugees did not identify any studies investigating the efficacy of psychodynamic therapy. The aims of psychodynamic psychotherapy sessions with refugees are not predetermined and space can be offered to clients to explore their experiences of seeking asylum, becoming displaced and other trauma. It is unclear how psychodynamic psychotherapy may work in relation to the range of difficulties experiences by refugees including their instability, uncertainty and levels of practical needs such as needing accommodation and employment.

Psychodynamic psychotherapists have highlighted difficulties of working with refugees within a psychoanalytic frame, for example establishing a safe environment in the context of deportation threat and developing therapeutic relationships following extreme trauma at the hands of other humans (Ehrensaft, 2008). Further, working interracially can be complex; if race and difference are not discussed, clients can understand them as unimportant to the therapist and racial transference can be enacted, with white therapists being seen as highly competent in Western contexts and broaching racial issues seen as “taboo” (Qureshi, 2007). While this finding has very limited transferability, it is relevant to interracial psychotherapy in which clients have sought out psychodynamic psychotherapy. Case studies explore the process of psychodynamic psychotherapy with refugee clients from the perspective of the therapist (Boulanger, 2008; Katsounari, 2014), but voices of refugee clients are again absent from published literature. It is as yet unclear in the absence of good quality

literature how psychodynamic psychotherapy can attend to refugees' experiences of escape from danger, instability, uncertainty, statelessness and living in stressful circumstances.

In relation to working with Bosnian medical evacuees, Papadopoulos (1999) emphasised the importance of not pathologising survivors of violence's responses to the atrocities they experienced in order to not add to the subjection of abuse. Instead of imposing formal psychotherapy, which could have emulated the control that the evacuees had previously experienced in war, 'therapeutic witnessing' was offered, using active listening alongside a therapeutic relationship to witness individuals' testimonies, both spoken and unspoken (Papadopolous, 1999). Taking place within a widened therapeutic frame of regularity and boundaries, human contact and transference and countertransference informed the work, based on psychoanalytic theory but in an alternate form (Papadopoulos, 1999).

This apparent trend of researchers exploring experiences of therapy from the perspectives of therapists could be due to the complexities of working with refugees, recognising their vulnerability. However, considering the global imperative created by the aforementioned refugee crisis and the necessity this creates to support refugees experiencing distress, it is essential that research aims to understand the therapeutic experience of psychodynamic psychotherapy from the perspective of refugee clients and their therapists. This will enable the question of whether psychodynamic psychotherapy is appropriate, acceptable and useful for refugees to be addressed.

Research emphasises the uniqueness of subjective experiences of psychodynamic psychotherapy within the limited populations studied (Poulsen, Lunn, & Sandros, 2010; Werbart, Von Below, Brun, & Gunnarsdottir, 2015), which suggests that to understand psychodynamic psychotherapy, subjective experiences must be heard and interpreted so that the poignant therapeutic mechanisms might be identified. Indeed, knowledge of its usefulness, suitability and acceptability in the minds of clients might also support its

consideration in clinical guidelines, service planning and evaluation. In order to explore the literature on experiences of psychodynamic psychotherapy, a systematic literature review of client and therapist experiences will follow in the next chapter.

Rationale

Psychodynamic psychotherapy is currently offered for refugees and asylum seekers, but no research to date has explored how psychodynamic psychotherapy is experienced by clients and therapists and whether it is well-suited to working with these populations. How it is used by refugees and asylum seekers, given their experiences and circumstances is also an unexplored area.

As the first of its kind, this study aims to explore the experiences of refugees and asylum seekers who have experienced psychodynamic psychotherapy, and psychodynamic psychotherapists that work with these populations, in order to address the aforementioned gaps in the literature. It is hoped that this research will grow the very small body of literature on refugee experiences of therapy and also fill the gap of experiences of psychodynamic psychotherapy, specifically. The research question this project addressed is: how do refugee and asylum seeker clients and their therapists experience psychodynamic psychotherapy?

Systematic Review

Introduction and aims

As described in the introductory chapter to this thesis, there is no published literature exploring the experience of psychodynamic psychotherapy for refugees or psychodynamic psychotherapists working with refugees. This thesis aims to address that gap in the literature, but first, a systematic review of qualitative research studies exploring client and therapist experiences of psychodynamic psychotherapy was undertaken in order to explore and orientate to the literature on client and therapist experiences of psychodynamic psychotherapy. To date, no published reviews have focused on this topic and therefore it is not clear how much research has been published in relation this topic, which populations have been researched in relation to experiences of psychodynamic psychotherapy and what the findings are.

Client and therapist experiences related specifically to psychodynamic psychotherapy were chosen as the topic instead of a systematic review focused more broadly on refugee experiences of therapy and therapist experiences of working with refugees because although a review on that topic has also not been published, the inclusion of different therapy modalities within the same review was likely to dilute the emphasis on the therapeutic factors of different models. The findings of this alternative review would be valuable and offer insight into general therapeutic experiences of refugees and therapists working with refugees, the foundation it would offer the current thesis would be limited and likely mostly highlight the common factors of therapy (Hubble, Duncan, & Miller, 1999). By focusing on one therapeutic model, this review will consider the pertinent factors of client and therapist experiences of psychodynamic psychotherapy to provide a foundation for the current thesis and context with which the experiences of refugees and their therapists of the same model

can be considered alongside. This review also chose to focus on the experiences of both clients and therapists in order to add greater depth to the findings, taking into account the two key roles involved in psychotherapy.

The aim of this systematic review is to synthesise the literature and identifying common elements of experiences, and consider these in light of psychodynamic theory.

Method

Search strategy. Four electronic databases (MEDLINE, PsycInfo, PsycArticles and CINAHL) were searched for relevant studies unrestricted by date to consider the whole field of research. Search terms were informed by the search question 'what are client and therapist experiences of psychodynamic psychotherapy?'

Search terms were: (*therapy OR therapies OR counselling OR counseling OR psychoanalysis OR psychotherapy*) AND (*psychodynamic OR psychoanalytic*) AND (*qualitative* OR interview* OR phenomenol* OR narrative* OR "content analysis" OR "thematic analysis" OR "focus group" OR "focus groups" OR "discourse analysis"*) AND (*experience* OR perspective* OR perception* OR attitude**) AND *(therapist* OR psychotherapist* OR counsellor* OR psychologist* OR psychiatrist* OR client* OR patient* OR psychoanalyst* OR "service user")*.

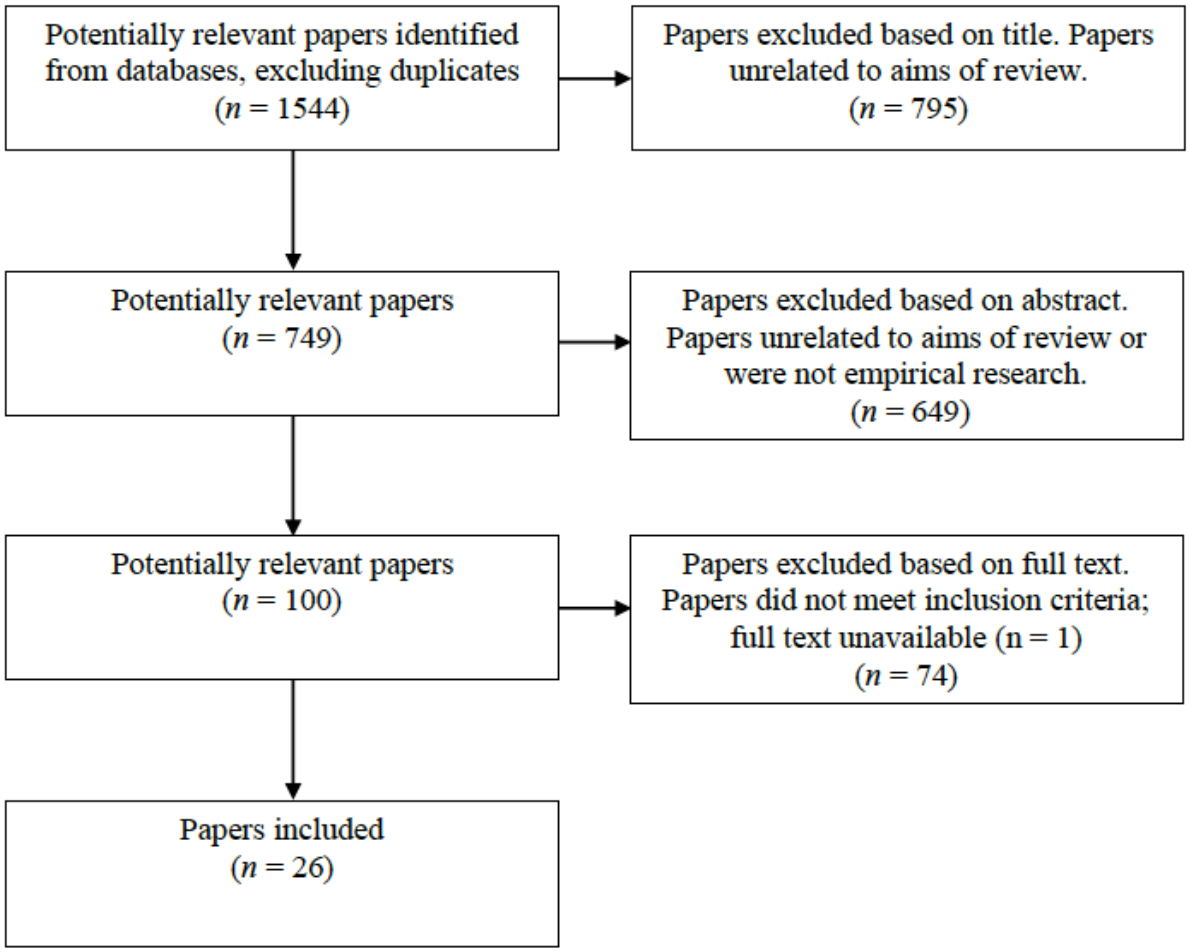
Inclusion criteria. This review included qualitative peer-reviewed empirical research studies in English, exploring the lived experience of individual psychodynamic psychotherapy for clients and therapists. Clients had to be a minimum of 17 years old so that the review remained relevant to the empirical research of the current thesis.

Quality assessment. The Critical Appraisal Skills Programme Qualitative Checklist (CASP; Critical Appraisal Skills Programme, 2014) was employed to evaluate the quality of identified studies. The checklist considers presence of a clear statement of aims; whether the

research design was appropriate to meet the aims; appropriateness of the recruitment strategy and data collection; relationship between researcher and participants; reflexivity; ethics and rigour of data analysis.

Selection of studies. Articles identified through the systematic search were first read by title to establish relevance to the search aim, then abstracts were read and if they still met the inclusion criteria then the full text was read in order to ascertain relevance to the review's aims. The CASP Qualitative Checklist was applied to evaluate the quality of studies. See Figure 1 for a flow diagram of study selection, based on recommendations by Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA; Moher, Liberati, Tetzlaff, Altman, & Prisma Group, 2009).

Figure 1. *PRISMA flow diagram of study selection process*



Analysis. Informed by Thomas & Harden's (2008) recommendations for the synthesis of qualitative research, a thematic synthesis was chosen as the method of analysis for its replicable process that enhances reliability. Results were divided into two groups in order to explore the experiences of therapists and clients separately, recognising that their distinctly different positions within therapy and different relationships to therapy may render similarly different accounts.

The stages of analysis were repeated separately for the two groups of studies beginning with open coding of all results. The studies that explored both client and therapist experiences clearly noted the source of the results data and therefore these could also be coded and divided between client and therapist experiences. Initial codes were synthesised

through grouping similar codes and identifying overarching themes that encompassed them. As the codes were explored in relation to each other, original text was also checked to ensure it corresponded to the content of higher-order codes and themes. Generating analytical themes (Thomas & Harden, 2008) was the final stage of analysis. Themes corresponding to the aims and research questions of the review were identified and extrapolated; the breadth of the realm of 'lived experience' meant all themes were relevant and therefore included.

Results

Search results. 26 published papers describing 26 separate studies met the inclusion criteria for this literature review and were of sufficient quality to include. 13 studies solely explored client experiences (Bury, Raval, & Lyon, 2007; Dulsster, Vanheule, Cauwe, Ingouf, & Truijens, 2018; Lilliengren & Werbart, 2005; Merriman & Beail, 2009; Poulsen et al., 2010; Qureshi, 2007; Shamai & Levin-Megged, 2006; Statham & Beail, 2018; Toto-Moriarty, 2013; Town, Lomax, Abbass, & Hardy, 2017; von Below & Werbart, 2012; Werbart & Levander, 2016; Werbart, Von Below, et al., 2015). Nine studies solely explored therapist experiences (Bowker & Richards, 2004; Fragkiadaki & Strauss, 2012; Gelman, 2004; Lilliengren & Werbart, 2010; Muston, 2017; Ryan, 2006; Symons & Wheeler, 2005; Werbart, Missios, Waldenström, & Lilliengren, 2017; Werbart, von Below, Engqvist, & Lind, 2018). Four studies explored both client and therapist experiences (Haskayne, Larkin, & Hirschfeld, 2014; Palmstierna & Werbart, 2013; Philips, 2008; Wilson & Sperlinger, 2004). See Table 1 for details of included studies.

Table 1. *Included studies*

Authors	Country	Subjects	Aims (research questions)	Data collection method	Analysis	Findings	Quality rating
Bowker & Richards (2004)	UK	10 therapists: 5 psychoanalytic psychotherapists, 4 psychodynamic counsellors, 1 therapist who practised as both psychotherapist and counsellor	To understand therapists' countertransference feelings or responses to clients who use English in therapy as a proficient second language; how therapists establish a good working alliance and conduct a successful therapy; monolingual therapists' techniques when working with bilingual clients.	Semi-structured interviews	Qualitative method based on McLeod principles of phenomenology and hermeneutics	Themes: 1. Separation and distance 2. Connection, an extra effort	Moderate (good description of analysis; no reference to ethical standards or procedure)
Bury, Raval & Lyon (2007)	UK	6 clients of psychodynamic psychotherapy	To understand clients' perspectives of their therapy; meanings given to experiences of initial referral and engagement with mental health	Semi-structured interviews	Interpretive Phenomenological Analysis (IPA)	Themes: 1. Seeking help and engagement 2. Beginning therapy 3. The therapeutic process 4. Endings	Good (clear analysis; reflexivity)

			services; factors perceived to be most and least useful in facilitating change; views of their therapist and the therapeutic relationship; how it affected their lives.				
Dulsster, Vanheule, Cauwe, Ingouf & Truijens (2018)	Holland	6 clients of Lacanian psychoanalytic therapy	Mapping and interpreting the factors that stand out as relevant to personal change in a naturalistic Lacanian psychoanalytic therapy from a first-person perspective.	Semi-structured interviews	Phenomenologically-inspired thematic analysis	Themes: 1. I experienced a surprising reframing 2. I met somebody who really listened to what I said 3. I learnt about myself by hearing my own speech 4. I see myself in a new light 5. I started to wondering what I really want.	Good (clear aims; appropriate methodology; discussed implications; avenues for future research)
Fragkiadaki & Strauss (2012)	UK	10 practitioners of psychoanalytic or	To gain a better understanding of the experience of termination of therapy, focusing on the	Semi-structured interviews	Constructivist grounded theory	Themes: 1. Therapist as a person 2. Therapist's awareness of termination	Good (ethical considerations; reflexivity;

		psychodynamic practice	experiences of psychoanalytic and psychodynamic therapists.			3. Development of the therapeutic relationship as it defines termination 4. Working through the termination 5. The aftermath	structured analysis)
Gelman (2004)	USA	15 Psychodynamically-orientated Latino clinicians working with Latino clients	To describe how a psychodynamic approach is being employed with Latinos.	Semi-structured interviews	Grounded theory	Categories: 1. An expanded psychodynamic approach 2. Modifications and elaborations of practice 3. Bridges to culture	Moderate (clear aims; appropriate methodology; limited consideration of ethical issues and reflexivity)
Haskayne, Larkin & Hirschfeld (2014)	UK	4 clients of psychodynamic therapy and their 4 psychodynamic therapists	To explore client and therapist experiences of therapeutic rupture and repair during long-term psychodynamic therapy.	Semi-structured interviews	IPA	Themes: 1. Negative emotions as dangerous 2. The therapeutic discovery 3. The struggle Positive connection	Good (clear aims; appropriate design; ethics and reflexivity discussed)

Lilliengren & Werbart (2005)	Sweden	22 young adult clients of psychoanalytic psychotherapy	To explore experience of curative and hindering aspects in psychoanalytic therapy.	Semi-structured interviews	Grounded theory	Categories: 1. Talking about oneself 2. Talking is difficult 3. Having a special place and a special kind of relationship 4. New relational experiences 5. Exploring together 6. Expanding self-awareness 7. Self-knowledge is not always enough 8. Something was missing 9. Experiencing mismatch	Good (clear statement of aims and research questions; ethics discussed; reflexivity)
Lilliengren & Werbart (2010)	Sweden	16 psychodynamic therapists	To explore experienced therapists' views of curative factors, hindering factors, and outcome in psychoanalytic therapy with young adults.	Semi-structured interviews	Grounded theory	Categories: 1. Developing a close, safe and trusting relationship 2. The patient making positive experiences outside the therapy setting 3. Challenging and developing the patient's thinking about the self 4. Becoming a subject 5. Increasing capacity to think	Good (clear aims; robust analysis; clear findings; clinical implications and areas for future research discussed)

						and process problems 6. The patient's fear about close relationships 7. Core problems remaining 8. The therapeutic process continues after termination	
Merriman & Beail (2009)	UK	6 clients with intellectual disabilities (ID)	To ascertain service users' views of their psychodynamic psychotherapy.	Semi-structured interview	IPA	Themes: 1. The referral process 2. Experience of psychodynamic psychotherapy 3. Positive and negative aspects of therapy 4. Outcome	Good (clear aims; robust methodology; clinical implications and areas for future research identified)
Muston (2017)	UK	12 psychodynamic therapists working with at least one client with multiple sclerosis (MS)	To consider therapists' reflections on the impact of MS on the internal worlds of clients with MS and the challenges MS presents and how these are worked with therapeutically.	Semi-structured interviews	Thematic analysis	Themes: 1. Reflections on the impact of MS on the internal world of clients with MS 2. Meanings attributed to MS 3. Therapists' work with clients with MS	Moderate (clear aims; appropriate design; reflexivity; limited discussion of ethics)

Palmstierna & Werbart (2013)	Sweden	11 clients of psychoanalytic psychotherapy and 9 psychoanalytic therapists	To explore patient and therapist experiences of therapeutic process and outcome in the most successful individual psychoanalytic psychotherapies with young adults.	Semi-structured interviews	Grounded theory	Categories 1. A growth-promoting and secure relationship 2. In-therapy factors 3. helpful factors in the patient's everyday life 4. Positive impacts and experienced changes	Good (clear aims; appropriate data collection; reflexivity and clinical implications discussed)
Philips (2008)	Sweden	3 clients of psychodynamic therapy who had grown up with mothers who had serious mental disorders; 3 psychodynamic therapists	To explore what characterises the psychotherapeutic process; whether specific problems arise in the therapeutic collaboration; what is helpful and hindering in therapy; which patterns of transference and counter-transference emerge.	Semi-structured interviews	Unspecified qualitative analysis	Themes: 1. Starting point 2. Therapeutic outcomes	Moderate (clear aims; well described, but unspecified analysis)

Poulsen & Lunn (2010)	Denmark	15 female clients with bulimia nervosa	To investigate the experience of individual psychodynamic psychotherapy by clients diagnosed with bulimia nervosa.	Semi-structured interviews	Grounded theory, phenomenological approach	Categories: 1. The Nondirective Approach 2. The Therapeutic Relationship 3. Duration of the Therapy 4. Outcome 5. Helpful and Hindering Factors	Moderate (clear analysis and procedure; clinical implications and areas for new research identified
Qureshi (2007)	Spain	1 client of psychodynamic psychotherapy	To understand how racial difference impacts the therapeutic relationship.	Semi-structured interview	Empirical phenomenology	Therapist components that contributed and detracted from the therapy process.	Moderate (limited value as only one subject)
Ryan (2006)	UK	13 psychoanalytic psychotherapists	To explore how class can enter the ongoing psychotherapy relationship.	Semi-structured interviews	Grounded theory	1. Working-class and lower-middle-class therapists with middle-class patients 2. Middle-Class therapists with working class patients	Moderate (appropriate design; limited discussion of ethical issues; reflexivity)

Shamai & Levin-Megged (2006)		11 clients who were Holocaust survivors	To explore how Holocaust survivors experienced psychodynamic therapy and how their traumatic experiences affected the therapeutic process.	Semi-structured interviews	Phenomenological method	Themes: 1. Knowing and not knowing the story of the trauma 2. Therapy as a reproduction of the trauma and its aftermath 3. The fight to keep the therapist as a split object 4. The perception of therapy as interminable 3. Creating alternative narratives to the traumatic narrative	Moderate (Limited reflexivity)
Statham & Beail (2018)	UK	10 clients with ID	To find out how individuals with ID experience psychodynamic psychotherapy.	Semi structured interview	Thematic analysis	Themes: 1. Accessibility 2. Acceptability 3. Effectiveness	Good (clear aims; robust analysis; clinical implications discussed)
Symons & Wheeler (2005)	UK	10 psychodynamic counsellors	To explore the experiences of other therapists, with the intention of providing information that may help counsellors to	Semi-structured interviews	Grounded theory	Categories of dilemmas: 1. Prior to making a decision 2. After making a decision 3. As a result of the outcome of their actions	Moderate (clear aims; appropriate study design to address aims; ethics

			manage the frame appropriately and therapeutically.				considered; no reflexive statement)
Toto-Moriarty (2013)	USA	14 clients recovered from bulimia	To understand the therapeutic factors in psychodynamic psychotherapy for bulimia.	Semi-structured interviews	Grounded theory	Themes: 1. Engagement and building the therapeutic alliance 2. Decoding the adaptive meaning of the symptom 3. The therapy relationship 4. Signs of progress as the therapy work deepened 5. Adjunctive treatments within psychodynamic work	Moderate (Limited reflexivity)
Town, Lomax, Abbass & Hardy (2017)	Canada	7 clients presenting with medically unexplained symptoms (MUS)	To examine patients' subjective experience of engaging and participating in an intensive short-term dynamic psychotherapy to explore assumptions about the role of emotion in MUS.	Semi-structured interviews	IPA	Themes: 1. Barriers to examining emotion processes 2. Therapeutic process leading to change 3. Psychological change and improved wellbeing	Good (clear aim and procedures; ethics considered; reflexivity; areas for future research identified)

Von Below & Werbart (2012)	Sweden	7 clients dissatisfied with psychoanalytic psychotherapy	To explore dissatisfied patients' subjective view of their psychotherapies and what contributed to their dissatisfaction.	Semi-structured interviews	Grounded theory	Categories: 1. Categories of dissatisfaction 2. Experienced outcome 3. Positive aspects of psychotherapy	Good (clear aims; appropriate methodology; limited reflexivity)
Werbart & Levander (2016)	Sweden	14 clients of psychoanalytic psychotherapy with anaclitic or introjective personalities	To explore changes in underlying dynamic structures patients' subjective view of changes during and after psychoanalysis.	Semi-structured interviews	Inductive thematic analysis	Themes: 1. Patients' view of changes 2. Patients' view of the analyst 3. Patients' view of the analytic method	Good (clear aims; ethics considered; rigorous analysis; clear findings)
Werbart, Missios, Wadenstrom & Lilliengren (2017)	Sweden	14 psychodynamic therapists	To explore how therapists experience, make sense of and reflect on their own clinical work in successful cases of psychoanalytic psychotherapy.	Semi-structured interviews	Inductive thematic analysis	Core categories: 1. Being particularly motivated to be this patient's therapist 2. Maintaining a safe and attentive therapeutic position 3. Assiduous work every session 4. Having confidence in the patient's capability to direct the life after therapy	Good (clear statement of aims; appropriate methodology; clinical implications and areas for further

							research identified)
Werbart, von Below, Brun & Gunnersdottir (2015)	Sweden	20 clients of psychoanalytic psychotherapy who showed reliable deterioration or no reliable change at termination	To explore psychotherapy experiences among non-improved young adults who lack symptom reduction after psychoanalytic psychotherapy.	Semi-structured interviews	Grounded theory	Themes: 1. Spinning One's Wheels 2. Experiences of the Therapy and the Therapist 3. Outcomes of Therapy 4. Impacts of Life Circumstances	Good (clear aims; appropriate methodology; systematic analysis; new areas for research identified)
Werbart, von Below, Engqvist & Lind (2018)	Sweden	7 psychodynamic therapists	To explore therapists' experiences of therapeutic process in psychoanalytic psychotherapy with non-improved young adults.	Semi-structured interviews	Grounded theory	Core categories: 1. Experiences of the therapeutic process 2. Experiences of therapy outcomes	Good (clear aim; appropriate methodology; ethical considerations discussed and clinical implications included)

Wilson & Sperlinger (2004)	UK	6 clients who dropped out of psychodynamic therapy; 6 psychodynamic therapists	To examine the experience of drop-out from the perspective of both patient and therapist.	Semi-structured interview	IPA	Client themes: 1. Approach/avoidance of painful feelings 2. Conflicting wishes for functional help vs intensive psychotherapy 3. Detachment vs involvement with the therapist 4. Therapy as a threat and a loss of control 5. Fears of dependence, loss and abandonment Therapist themes: 1. Emotional impact of being 'left' by a patient 2. Using theory to manage feelings 3. Using feelings to inform theory 4. Developmental issues for the therapists	Good (reflexivity; standardised analysis; clear aim and consideration of ethical issues)

Client experiences. Six themes relating to the experiences of clients receiving psychodynamic psychotherapy were identified. The themes were:

1. The Process
    - 1.1. Expectations
    - 1.2. Addressing problems
    - 1.3. Being challenged
    - 1.4. Talking
    - 1.5. Changeability
    - 1.6. Internalising the process
2. Emotional Experience
3. Impact
    - 3.1. Difference in how I am
    - 3.2. Gaining new perspectives
    - 3.3. Limited impact
4. The Space
    - 4.1. Safe space
    - 4.2. Strange space
5. Therapeutic Relationship
    - 5.1. Proximity
    - 5.2. Changing over time
    - 5.3. A special kind of relationship
    - 5.4. Continuity
    - 5.5. Therapist's role
6. Ending

1. 'The Process'. This theme captured clients' experiences of the psychodynamic approach and process. Subthemes 'expectations', 'addressing problems', 'being challenged', 'talking' 'changeability' and 'internalising the process' will be discussed in turn.

1.1. Subtheme 'expectations' highlighted that many clients entered psychodynamic psychotherapy with ideas about how it would be. Some were not sure what to expect (Bury et al., 2007); others understood that therapy was a space to talk about problems (Merriman & Beail, 2009). Clients expected answers (Bury et al., 2007), strategies for managing bulimic symptoms (Poulsen et al., 2010), therapy to be as depicted in the media (Bury et al., 2007) and change at the end (Bury et al., 2007). For example, one client fantasised that they would become "great and fantastic" (Werbart & Levander, 2016). Therapy could be different to expectations (Statham & Beail, 2018; Town et al., 2017; von Below & Werbart, 2012), which some clients experienced as disappointing (Werbart, Von Below, et al., 2015). Clients described entering therapy with a specific reason (Dulsster et al., 2018; Qureshi, 2007).

1.2. Subtheme 'addressing problems' captured clients' experiences of attending to difficulties (Dulsster et al., 2018; Haskayne et al., 2014; Statham & Beail, 2018), which could align with their goals for therapy (Lilliengren & Werbart, 2005; Town et al., 2017). Clients described increasing their awareness of problems (Bury et al., 2007; Dulsster et al., 2018) and addressing problems through defining them, which offered structure, made them easier to manage (Lilliengren & Werbart, 2005), and helped clients take a step back from their difficulties (Bury et al., 2007; Dulsster et al., 2018). Increased awareness was not always experienced positively; it could lead to feeling sadness and emptiness (von Below & Werbart, 2012). Making sense of problems and working through them was helped by addressing the problem each session (Lilliengren & Werbart, 2005). Clients could become more active in

managing obstacles after "realising eventually that the therapist did not have the answers" (Palmstierna & Werbart, 2013).

1.3. 'Being challenged' was a subtheme that included clients' descriptions of valuing therapists challenging and confronting them (Toto-Moriarty, 2013; Town et al., 2017; Werbart, Von Below, et al., 2015; Wilson & Sperlinger, 2004), for example on deflection (Toto-Moriarty, 2013) and avoidance (Poulsen et al., 2010; Town et al., 2017). Clients believed being challenged helped them go deeper into issues and not "skirt around" things (Town et al., 2017), develop new adaptive behaviours (Town et al., 2017) and "stay accountable and committed to recovery" (Toto-Moriarty, 2013). Therapists were experienced positively as persistent (Poulsen et al., 2010; Toto-Moriarty, 2013; Town et al., 2017; Wilson & Sperlinger, 2004), pushing clients to open painful issues (Shamai & Levin-Megged, 2006). They described therapists challenging in a safe and respectful way that didn't cross boundaries (Toto-Moriarty, 2013).

Many clients wanted more challenge (Palmstierna & Werbart, 2013; Shamai & Levin-Megged, 2006; Werbart & Levander, 2016; Werbart, Von Below, et al., 2015), however, others experienced challenge as painful, describing therapy as "emotionally demanding" (Haskayne et al., 2014). Some reported being pushed "too hard" (Merriman & Beail, 2009), not liking what their therapist said (Statham & Beail, 2018) and wondering whether another therapist would help them bring things up differently (Shamai & Levin-Megged, 2006).

1.4. 'Talking' referred to the range of experiences clients had in relation to speaking in therapy, which could feel good (Lilliengren & Werbart, 2005; Merriman & Beail, 2009; Palmstierna & Werbart, 2013; Philips, 2008; Qureshi, 2007; von Below & Werbart, 2012) and was generally a positive, helpful experience (Lilliengren & Werbart, 2005; Merriman & Beail, 2009; Philips, 2008; Shamai & Levin-Megged, 2006; Toto-Moriarty, 2013). "Getting the hang of talking" (Bury et al., 2007) involved initial difficulties (Bury et al., 2007;

Lilliengren & Werbart, 2005; Philips, 2008): clients did not know what to say (Bury et al., 2007; Merriman & Beail, 2009; Werbart, Von Below, et al., 2015) and felt ashamed (Philips, 2008). Opening up about themselves was hard (Bury et al., 2007; Palmstierna & Werbart, 2013; Shamai & Levin-Megged, 2006) and could evoke anxiety (Bury et al., 2007; Lilliengren & Werbart, 2005; Werbart, Von Below, et al., 2015). However, clients described learning to talk and express themselves better (Dulsster et al., 2018; Lilliengren & Werbart, 2005; Toto-Moriarty, 2013; Werbart, Von Below, et al., 2015).

Clients learned about themselves through hearing themselves talk and realising what was inside (Dulsster et al., 2018; Lilliengren & Werbart, 2005; Palmstierna & Werbart, 2013; von Below & Werbart, 2012), but some did not feel able to talk about everything in therapy, for example race (Qureshi, 2007), sexual issues (Wilson & Sperlinger, 2004) and emotions (Town et al., 2017; von Below & Werbart, 2012).

1.5. 'Changeability' was a subtheme capturing the fluidity of clients' feelings about therapy and how therapy changed over time. Clients described changes during the process as a "rollercoaster of different stages" beginning with scratching the surface (Bury et al., 2007), also saying that it could be "ok for a few weeks" then "a few weeks of it being annoying" (Haskayne et al., 2014). The changeability of sessions was echoed in clients' changeable feelings about therapy, which could involve feeling reluctant whilst simultaneously looking forward to sessions (Wilson & Sperlinger, 2004), not liking to come but liking the therapist (Shamai & Levin-Megged, 2006), critical but seeing positives (Poulsen et al., 2010). Clients were positive about the therapeutic approach (Philips, 2008; Poulsen et al., 2010), describing it as "a method for thinking and functioning better" (Werbart & Levander, 2016) and appreciating its focus (Town et al., 2017; Werbart & Levander, 2016) and attention to underlying trauma (Town et al., 2017). Many clients experienced benefitting from their therapy (Bury et al., 2007; Lilliengren & Werbart, 2005; Qureshi, 2007; Shamai & Levin-

Megged, 2006; Statham & Beail, 2018; Town et al., 2017; Werbart, Von Below, et al., 2015), but others also reported resisting it, despite knowing they needed it (Shamai & Levin-Megged, 2006), not seeing the point but seeing benefits (Town et al., 2017) and scepticism (Palmstierna & Werbart, 2013).

1.6. 'Internalising the process' was a subtheme that captured clients' experiences of adopting aspects of therapy: learning from and taking on the unstructured approach (Poulsen et al., 2010), strengthening patience (von Below & Werbart, 2012), surrendering high standards (Werbart & Levander, 2016; Werbart, Von Below, et al., 2015) and reflecting between sessions (Haskayne et al., 2014).

2. 'Emotions'. This second theme captured clients' experiences of working with their emotions throughout therapy. Clients described previously not feeling emotions (Haskayne et al., 2014; Shamai & Levin-Megged, 2006; Toto-Moriarty, 2013; Town et al., 2017), which could be due to growing up in families that didn't welcome feelings (Toto-Moriarty, 2013; Town et al., 2017) or anxiety about how they would be perceived by others (Town et al., 2017). Some clients described not knowing where their feelings came from (Shamai & Levin-Megged, 2006; Town et al., 2017) or difficulty identify them (Town et al., 2017).

Clients described therapists inviting emotions into sessions (Poulsen et al., 2010; Toto-Moriarty, 2013; Town et al., 2017; Werbart & Levander, 2016), but also feeling conflicted and fearful about experiencing painful feelings (Haskayne et al., 2014; Town et al., 2017; Wilson & Sperlinger, 2004). They described distancing themselves from emotions in sessions for "self-preservation" (Haskayne et al., 2014) by intellectualising anger (Town et al., 2017), telling stories through others (Shamai & Levin-Megged, 2006), creating new stories excluding loss (Shamai & Levin-Megged, 2006), thinking about other things (Lilliengren & Werbart, 2005) and forgetting (Shamai & Levin-Megged, 2006). Many clients had had difficult experiences or traumas (Shamai & Levin-Megged, 2006; Toto-Moriarty,

2013; Town et al., 2017), but some described not enjoying opening up (Bury et al., 2007) and disliking therapists introducing painful topics (Statham & Beail, 2018).

Expressing emotion was a part of clients' psychodynamic psychotherapy (Lilliengren & Werbart, 2005; Philips, 2008; Statham & Beail, 2018; Town et al., 2017), which could be helpful (Haskayne et al., 2014), allow previously inaccessible material to emerge and support understanding of the mind-body connection (Town et al., 2017). One client highlighted what they learned from their painful emotions in therapy: "there's a period where you're feeling really awful which is kind of when you've hit the spot of whatever it was that's causing it" (Bury et al., 2007). Clients described having "sorted out" their unclear feelings (Lilliengren & Werbart, 2005) and talking them through (Toto-Moriarty, 2013), highlighting that not feeling genuine emotions could hinder therapy (Town et al., 2017; von Below & Werbart, 2012).

Increased emotional awareness was reported by clients, including their depth (Town et al., 2017). Clients reported recognising their emotions (Poulsen et al., 2010), deciphering which was which (Town et al., 2017), looking at their cause (Town et al., 2017) and how they managed them (Poulsen et al., 2010; Toto-Moriarty, 2013). With increased awareness, clients experienced changing their responses to emotions (Poulsen et al., 2010; Toto-Moriarty, 2013; Town et al., 2017). Clients described more acceptance of their emotions (Town et al., 2017; Werbart & Levander, 2016), referring to them as "the inevitable product of life experiences" (Town et al., 2017), learning that they had a right to express their emotions (Lilliengren & Werbart, 2005; Toto-Moriarty, 2013; Werbart & Levander, 2016) and needed to express emotions (Lilliengren & Werbart, 2005; Town et al., 2017; Wilson & Sperlinger, 2004).

3. 'Impact'. was a theme regarding the changes that clients experienced in relation to their psychotherapy. This theme was comprised of three subthemes, 'difference in how I am', 'gaining new perspectives' and 'limited impact'.

3.1. 'Difference in how I am' (Statham & Beail, 2018) captured the changes clients reported, of which many related to the difficulties they had had prior to starting therapy (Bury et al., 2007; Dulsster et al., 2018; Lilliengren & Werbart, 2005; Merriman & Beail, 2009; Philips, 2008; Qureshi, 2007; Shamai & Levin-Megged, 2006; Toto-Moriarty, 2013; Town et al., 2017). Differences were reported in behaviour (Merriman & Beail, 2009; Palmstierna & Werbart, 2013; Statham & Beail, 2018; Toto-Moriarty, 2013; Town et al., 2017), including a reduction of behaviours relating to eating disorders (Poulsen et al., 2010; Toto-Moriarty, 2013) and uptake of new, positive behaviours (Shamai & Levin-Megged, 2006; Town et al., 2017). This may have been supported by new understandings of behaviour (Dulsster et al., 2018; Poulsen et al., 2010; Town et al., 2017).

In positive terms, clients described better self-awareness (Bury et al., 2007; Lilliengren & Werbart, 2005; Palmstierna & Werbart, 2013; Poulsen et al., 2010; Qureshi, 2007; Toto-Moriarty, 2013; Werbart & Levander, 2016), self-acceptance (Poulsen et al., 2010; Toto-Moriarty, 2013; Town et al., 2017; Werbart & Levander, 2016) and wanting a better life for themselves (Dulsster et al., 2018; Palmstierna & Werbart, 2013; Werbart & Levander, 2016). Clients also described improvement in their emotional experience (Shamai & Levin-Megged, 2006; Statham & Beail, 2018; Toto-Moriarty, 2013; Werbart & Levander, 2016; Werbart, Von Below, et al., 2015): less anxiety and hopelessness (Werbart & Levander, 2016) and more calmness and happiness (Werbart, Von Below, et al., 2015). Clients' bodily symptoms improved (Shamai & Levin-Megged, 2006; Town et al., 2017), as did relationships with others (Palmstierna & Werbart, 2013; Poulsen et al., 2010; Shamai & Levin-Megged, 2006; Toto-Moriarty, 2013; Town et al., 2017; Werbart & Levander, 2016; Werbart, Von Below, et al., 2015), supported by compassion and forgiveness towards others (Toto-Moriarty, 2013), openness about feelings with others (Town et al., 2017) and tolerance of conflicts (Werbart & Levander, 2016).

Negative impact was also reported by clients: decreased emotional wellbeing (von Below & Werbart, 2012; Werbart, von Below, Brun, & Gunnarsdottir, 2015; Wilson & Sperlinger, 2004) and becoming less expressive (von Below & Werbart, 2012; Werbart & Levander, 2016). One client described feeling a loss of their "former excitation and strong emotional reactions" (Werbart & Levander, 2016), which could have been felt as a loss of themselves.

3.2. 'Gaining new perspectives' was the second subtheme illustrating the impact of psychodynamic psychotherapy, described by many clients (Lilliengren & Werbart, 2005; Werbart & Levander, 2016). New perspectives applied to clients' crises and problems (Dulsster et al., 2018), trauma (Shamai & Levin-Megged, 2006), themselves (Dulsster et al., 2018; Town et al., 2017; Werbart & Levander, 2016) and approaches to help-seeking (Shamai & Levin-Megged, 2006). New perspectives included symbolic meaning of symptoms (Toto-Moriarty, 2013) and detection of repetitive patterns in their lives (Werbart, von Below, et al., 2015). New perspectives gave cause to behaving differently, such as finding a new job (Dulsster et al., 2018) and realising the importance of attending to their own perspectives rather than others' (Lilliengren & Werbart, 2005; Town et al., 2017).

3.3. The final subtheme was 'limited impact', highlighting how clients did not always experience cure or absolute improvement. Clients described changeable improvement (Poulsen et al., 2010; Statham & Beail, 2018) and problems could remain at termination (Lilliengren & Werbart, 2005; Philips, 2008; Werbart, von Below, et al., 2015): some did not think their eating disorder was in the past (Poulsen et al., 2010) and others described feeling the same (Merriman & Beail, 2009; Shamai & Levin-Megged, 2006; Statham & Beail, 2018). However, clients highlighted that some progress was made, despite the limits of impact (Werbart, Von Below, et al., 2015). Others did not believe that their problems could be

changed and thus were not surprised by them remaining at the end of therapy (Shamai & Levin-Megged, 2006).

Limited impact was attributed to the therapy and therapist (Lilliengren & Werbart, 2005; Shamai & Levin-Megged, 2006), including therapy being too short (Poulsen et al., 2010), only working individually (Qureshi, 2007) and receiving little help to change problems in practice (Bury et al., 2007; Lilliengren & Werbart, 2005; Shamai & Levin-Megged, 2006; von Below & Werbart, 2012). They described wanting something extra such as journaling (Lilliengren & Werbart, 2005; Philips, 2008; Toto-Moriarty, 2013; Werbart & Levander, 2016). Clients noted positive influence from factors outside therapy such as starting activities (Palmstierna & Werbart, 2013; Werbart, Von Below, et al., 2015) and talking with others (Philips, 2008), and negative influence of stressful life events and accommodation issues (Werbart, Von Below, et al., 2015).

Some clients stopped therapy due to lack of progress (Wilson & Sperlinger, 2004); others described seeking further treatment (Shamai & Levin-Megged, 2006; von Below & Werbart, 2012; Werbart & Levander, 2016), different types of therapy (Lilliengren & Werbart, 2005; Philips, 2008; von Below & Werbart, 2012; Werbart, Von Below, et al., 2015) or alternative treatments such as medication (Bury et al., 2007; Philips, 2008; Toto-Moriarty, 2013; Werbart, Von Below, et al., 2015).

4. 'The Space'. This fourth theme reflected client experiences of the therapeutic setting. Two subthemes were 'safe space' and 'strange space'.

4.1. 'Safe space' captured clients' positive experiences of feeling safe in the therapeutic space (Palmstierna & Werbart, 2013; Shamai & Levin-Megged, 2006; Toto-Moriarty, 2013; Werbart, von Below, et al., 2015). This was supported by being able to speak freely without fear of consequences (Dulsster et al., 2018; Lilliengren & Werbart, 2005; Poulsen et al., 2010; Toto-Moriarty, 2013), feeling comfortable (Bury et al., 2007; Poulsen et

al., 2010; Statham & Beail, 2018), confidentiality (Toto-Moriarty, 2013) and space to talk and reflect (Dulsster et al., 2018; Lilliengren & Werbart, 2005; Werbart, Von Below, et al., 2015). The atmosphere of therapy was described as therapeutic (Toto-Moriarty, 2013), permissive, respectful and accepting (Lilliengren & Werbart, 2010).

4.2. 'Strange space' was the antithesis of the safe space described by clients, capturing their experiences of discomfort (Wilson & Sperlinger, 2004), which could be due to the silence (Bury et al., 2007; Poulsen et al., 2010), therapy feeling demanding (Bury et al., 2007; Werbart & Levander, 2016) and the setting feeling "unnatural" (Bury et al., 2007) due to the formal boundaries (Bury et al., 2007; Poulsen et al., 2010; Werbart & Levander, 2016). Clients described many anxieties relating to their therapy ranging from where they were physically going (Statham & Beail, 2018) and worrying about what would happen (Merriman & Beail, 2009; Philips, 2008), to uncertainty about how therapy might help (Bury et al., 2007; Philips, 2008; Werbart, Von Below, et al., 2015; Wilson & Sperlinger, 2004). Many worried about what the therapist thought of them (Bury et al., 2007; Qureshi, 2007; Statham & Beail, 2018; von Below & Werbart, 2012; Werbart & Levander, 2016) and wanted to be liked (Bury et al., 2007; Qureshi, 2007). Clients described wondering about their fit with their therapist (Wilson & Sperlinger, 2004) and worrying about hurting them or their relationship (Shamai & Levin-Megged, 2006; Statham & Beail, 2018). Others described anxiety about developing dependency on therapy (Wilson & Sperlinger, 2004) or people finding out that they attend sessions (Bury et al., 2007).

Clients described initially not understanding the method (Bury et al., 2007; Haskayne et al., 2014; Werbart, Von Below, et al., 2015) and appreciating explanations (Bury et al., 2007; Statham & Beail, 2018). They had to "learn the ropes" (Bury et al., 2007) and it took time to get used to therapy (Bury et al., 2007; Lilliengren & Werbart, 2005), which improved their experience of the space (Bury et al., 2007; Poulsen et al., 2010). Many clients described

struggling with lack of structure (Poulsen et al., 2010; von Below & Werbart, 2012; Werbart, Von Below, et al., 2015; Wilson & Sperlinger, 2004) and some highlighted how the therapy space could stir up memories of past trauma (Shamai & Levin-Megged, 2006; Wilson & Sperlinger, 2004), contributing to its strangeness through a paradox of being safe, yet threatening (Shamai & Levin-Megged, 2006).

5. 'Therapeutic relationship'. This broad theme captured clients' experiences of their relationships with their therapists. Five subthemes are described: 'Proximity', 'relationship changed over time', 'a special kind of relationship', 'continuity' and 'the therapist role'.

5.1. 'Proximity' was a subtheme capturing clients' experiences of closeness and distance in the therapeutic relationship. Clients described positive relationships (Merriman & Beail, 2009; Palmstierna & Werbart, 2013) characterised by feeling comfortable and close to their therapist (Bury et al., 2007; Shamai & Levin-Megged, 2006; Toto-Moriarty, 2013; Werbart & Levander, 2016) that helped them to bear the pain of therapy and continue attending (Haskayne et al., 2014; Shamai & Levin-Megged, 2006; Town et al., 2017; Werbart, Von Below, et al., 2015). Supporting closeness was positive perceptions of the therapist as emotionally sensitive (Haskayne et al., 2014), professional (Bury et al., 2007; Werbart & Levander, 2016; Werbart, Von Below, et al., 2015), caring (Haskayne et al., 2014; Palmstierna & Werbart, 2013; Poulsen et al., 2010; Qureshi, 2007; Shamai & Levin-Megged, 2006; Statham & Beail, 2018; Toto-Moriarty, 2013), understanding (Palmstierna & Werbart, 2013; Qureshi, 2007; Toto-Moriarty, 2013; Werbart & Levander, 2016; Wilson & Sperlinger, 2004) and non-judgemental (Palmstierna & Werbart, 2013; Poulsen et al., 2010; Qureshi, 2007). Clients also experienced therapists positively as a coach or guide (Town et al., 2017), believing them wise (Haskayne et al., 2014; Lilliengren & Werbart, 2005; Shamai & Levin-Megged, 2006; Werbart, von Below, et al., 2015), valuing what they said and their insight (Dulsster et al., 2018; Lilliengren & Werbart, 2005; Qureshi, 2007; Town et al., 2017;

Werbart, von Below, et al., 2015), and appreciating their questions (Bury et al., 2007; Poulsen et al., 2010; Shamai & Levin-Megged, 2006; Toto-Moriarty, 2013).

Closeness was further supported by a positive sense of the therapist's humanity (Poulsen et al., 2010; Qureshi, 2007; Toto-Moriarty, 2013; Werbart & Levander, 2016; Werbart, Von Below, et al., 2015), feeling listened to and the therapist remembering what they had said (Bury et al., 2007; Dulsster et al., 2018; Lilliengren & Werbart, 2005; Poulsen et al., 2010; Shamai & Levin-Megged, 2006; Statham & Beail, 2018; Toto-Moriarty, 2013; Werbart, von Below, et al., 2015; Wilson & Sperlinger, 2004). Clients described feeling contained and drew connections between the therapist and good parents (Shamai & Levin-Megged, 2006; Town et al., 2017; Wilson & Sperlinger, 2004).

Distance in the relationship was also described (von Below & Werbart, 2012; Werbart, Von Below, et al., 2015), including feeling lonely (Werbart & Levander, 2016) and perceiving the therapist as impersonal (Poulsen et al., 2010; von Below & Werbart, 2012; Werbart, von Below, et al., 2015). Distance could be affected by lack of "confidence, closeness or trust" (von Below & Werbart, 2012) and clients doubting therapists' interest in them (Poulsen et al., 2010; Werbart & Levander, 2016). Clients also described keeping a distance (Wilson & Sperlinger, 2004) through concealing parts of themselves (Bury et al., 2007; Philips, 2008; Qureshi, 2007), maintaining self-reliance (Shamai & Levin-Megged, 2006) or enacting past relationships with figures who were not helpful (Philips, 2008; Qureshi, 2007). Some clients also appreciated the therapist maintaining a distance as it helped them to talk (Wilson & Sperlinger, 2004).

Feeling misunderstood could perpetuate clients' experiences of distance in the therapeutic relationship (Bury et al., 2007; Poulsen et al., 2010; Qureshi, 2007; von Below & Werbart, 2012; Werbart & Levander, 2016; Wilson & Sperlinger, 2004), as could a sense of powerlessness (Bury et al., 2007; Haskayne et al., 2014; Merriman & Beail, 2009; Qureshi,

2007). Clients also described feelings of hostility and envy towards the therapist (Poulsen et al., 2010), perceptions of therapists as uncaring (Poulsen et al., 2010), irritated (Bury et al., 2007; von Below & Werbart, 2012), passive (Lilliengren & Werbart, 2005; Poulsen et al., 2010; Werbart, Von Below, et al., 2015) and patronising (Haskayne et al., 2014).

5.2. Subtheme 'changing over time' captured clients' experiences of the therapeutic relationship developing and changing (Bury et al., 2007; Poulsen et al., 2010), for example realising the therapist's sympathy (Poulsen et al., 2010), realising the therapist was "genuinely invested in helping" (Toto-Moriarty, 2013) and seeing more of the therapist (Qureshi, 2007). Many clients described trust taking time to develop (Haskayne et al., 2014; Lilliengren & Werbart, 2005; Philips, 2008; Toto-Moriarty, 2013) and highlighted its importance (Toto-Moriarty, 2013; von Below & Werbart, 2012). One study reported that dependent relationships could develop (Merriman & Beail, 2009).

5.3. 'A special kind of relationship' reflected clients' experiences of the therapeutic relationship being different to other relationships (Lilliengren & Werbart, 2005; Statham & Beail, 2018; Werbart, von Below, et al., 2015; Wilson & Sperlinger, 2004) and talking differently to their therapist than with others (Lilliengren & Werbart, 2005; Qureshi, 2007; Statham & Beail, 2018). A key difference was how the relationship could be used to effect change through addressing and working through issues that arose (Palmstierna & Werbart, 2013; Toto-Moriarty, 2013; Wilson & Sperlinger, 2004) and noticing unhelpful patterns (Philips, 2008; Shamai & Levin-Megged, 2006; Werbart & Levander, 2016). Clients described internalising the therapist by remembering what they have said (Toto-Moriarty, 2013; Town et al., 2017), thinking things through as they did with their therapist (Lilliengren & Werbart, 2005; Toto-Moriarty, 2013), taking on their "laissez faire" attitude (Poulsen et al., 2010) and using the relationship as a model (Toto-Moriarty, 2013).

The emphasis put on therapists' self-disclosure by clients also highlighted the 'special' nature of the therapeutic relationship. Some clients described their therapist as "mysterious" and not talking about themselves (Philips, 2008); others wanted to know about their therapist's personal life (Poulsen et al., 2010). Therapists' self-disclosure was viewed positively, making the therapist appear more relatable (Toto-Moriarty, 2013), and increasing clients' willingness to open up themselves (Qureshi, 2007).

5.4. 'Continuity' captured the importance of consistency and stability for clients (Toto-Moriarty, 2013; Werbart & Levander, 2016). Unplanned breaks in therapy could be straightforwardly accepted (Merriman & Beail, 2009) or stressful (Philips, 2008) and disruptive (Palmstierna & Werbart, 2013). Clients described unplanned breaks evoking anger (Wilson & Sperlinger, 2004) and blaming themselves, inferring that they were "troublesome" (Philips, 2008) and heightening clients' awareness of risk of losing their therapist, disrupting trust (Philips, 2008; von Below & Werbart, 2012).

5.5. 'Therapist's role' was the final subtheme under the theme 'therapeutic relationship', which captured clients' perspectives on how therapists worked within the therapeutic relationship. Therapists were described as "the pivot of everything" (Bury et al., 2007), highlighting their importance. Clients valued therapists' "outside" position (Lilliengren & Werbart, 2005) and objectivity (Wilson & Sperlinger, 2004), which offered perspective. They described support from therapists in thinking, for example challenging self-defeating thoughts (Lilliengren & Werbart, 2005; Werbart, Von Below, et al., 2015), thinking in different ways (Palmstierna & Werbart, 2013) and for themselves (Lilliengren & Werbart, 2005; Poulsen et al., 2010; Werbart & Levander, 2016). Clients described therapists encouraging self-reflection (Lilliengren & Werbart, 2005) and facilitating exploration of feelings and experiences (Lilliengren & Werbart, 2005; Toto-Moriarty, 2013).

Clients also described wanting therapists to be more active (Palmstierna & Werbart, 2013): to give advice (Lilliengren & Werbart, 2005; Palmstierna & Werbart, 2013; Philips, 2008; Poulsen et al., 2010; von Below & Werbart, 2012; Werbart, Von Below, et al., 2015; Wilson & Sperlinger, 2004), lead their talking (Bury et al., 2007; Lilliengren & Werbart, 2005; von Below & Werbart, 2012; Werbart, von Below, et al., 2015) and summarise (Philips, 2008; Poulsen et al., 2010). Clients wanted physical contact (Poulsen et al., 2010; Shamai & Levin-Megged, 2006; Werbart & Levander, 2016; Wilson & Sperlinger, 2004) and wondered how therapy would be with another therapist (Lilliengren & Werbart, 2005; Qureshi, 2007; Shamai & Levin-Megged, 2006; Town et al., 2017; Wilson & Sperlinger, 2004).

6. 'Endings'. The final theme reflected clients' experiences of therapy termination being an important time that "evoked a range of emotions" (Bury et al., 2007). Clients described not wanting to end therapy (Shamai & Levin-Megged, 2006; Statham & Beail, 2018; Werbart & Levander, 2016) and feeling anxiety (Bury et al., 2007; Merriman & Beail, 2009); some proposed follow up sessions to ease the ending (Poulsen et al., 2010). Many said ending was a difficult experience (Bury et al., 2007; Merriman & Beail, 2009; Poulsen et al., 2010; Statham & Beail, 2018; von Below & Werbart, 2012) due to the loss of relationship (Bury et al., 2007) or believing that the process was unfinished (Poulsen et al., 2010). Others reflected on the ending feeling abrupt (Poulsen et al., 2010; von Below & Werbart, 2012) suggesting they did not feel ready for it.

Conversely, one client described ending therapy due to "feeling good" (Shamai & Levin-Megged, 2006) and others described continuing to apply their new skills and experiences from therapy after the ending (Palmstierna & Werbart, 2013; Philips, 2008).

Therapist experiences. Six themes relating to the experiences of therapists working psychodynamically with clients were identified. These were:

1. Hard work every session
2. The Relationship
    2.1. Centrality of relationship
    2.2. Balancing closeness and distance
    2.3. Relationship as intervention
    2.4. Feelings about clients
3. Challenges
4. Endings
    4.1. Meeting as two people
    4.2. Relationship and ending as inseparable
    4.3. The right time
5. The therapeutic frame
    5.1. Threats to frame
    5.2. Maintaining the frame
    5.3. Modifying the frame
6. Therapy did some good

1. 'Hard work every session'. This theme captured therapists' descriptions of the importance of working hard, being persistent, confronting and challenging clients (Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013; Werbart et al., 2017, 2018). Therapists experienced their work as requiring courage to not avoid difficult topics (Werbart et al., 2017) and be honest and confronting (Philips, 2008). They described shining a light on

clients' unconscious interactions (Haskayne et al., 2014), challenging patients' thinking (Lilliengren & Werbart, 2010) and working actively towards joint goals (Palmstierna & Werbart, 2013). Some reflected on how they should have challenged clients more (Lilliengren & Werbart, 2010) and how they challenged themselves (Ryan, 2006).

Therapists reported offering containment (Muston, 2017; Philips, 2008); containing despair by sitting with "the terribleness" (Muston, 2017) and offering explanations and meaning (Lilliengren & Werbart, 2010). Interventions included making interpretations (Lilliengren & Werbart, 2010; Philips, 2008; Ryan, 2006; Wilson & Sperlinger, 2004). Tolerating uncertainty was also described by therapists in reference to the unknown in clients' lives (Muston, 2017; Werbart et al., 2017; Wilson & Sperlinger, 2004) and also their own uncertainty within therapy sessions (Bowker & Richards, 2004; Fragkiadaki & Strauss, 2012; Muston, 2017), for example whether clients could understand interpretations and use them (Bowker & Richards, 2004).

Another element of therapists' hard work was recognising clients' defences (Muston, 2017; Werbart et al., 2017; Wilson & Sperlinger, 2004), for example bilingual clients using second languages to distance themselves from emotional experiences (Bowker & Richards, 2004; Gelman, 2004). Indeed, many therapists reported sensitivity to clients' use of language (Bowker & Richards, 2004; Werbart et al., 2018), such as changing from formal to informal language (Gelman, 2004). Therapists paid attention to clients' accents (Bowker & Richards, 2004; Ryan, 2006) and felt anxiety about bilingual clients struggling through an "extra layer" of language to reach them (Bowker & Richards, 2004). Therapists overcame this anxiety by checking clients' understanding and "making extra effort to listen carefully to a bilingual client's meaning at all levels" (Bowker & Richards, 2004). Non-verbal and unconscious communication took on special importance with clients working in their second language (Bowker & Richards, 2004). Therapists reported using their speech in their work with clients,

for example softening their voice to speak to the child part of the client (Haskayne et al., 2014) and switching between languages to help clients regulate emotion (Gelman, 2004).

Generally, therapists experienced optimism about the therapy process (Gelman, 2004; Werbart et al., 2018); one described a "never ever give up attitude" (Werbart et al., 2017), exemplifying the theme of 'hard work every session'.

2. 'The Relationship'. This theme captured therapists' experiences of therapeutic relationships with clients, which were considered "odd" because both parties knew from the beginning that it would end (Fragkiadaki & Strauss, 2012).

2.1. 'Centrality of relationship' was a subtheme that reflected how therapists believed their relationship with clients was a central part of therapy or the "core curative factor" (Gelman, 2004; Lilliengren & Werbart, 2010).

2.2. 'Balancing closeness and distance' was a subtheme capturing therapists' descriptions of navigating the space between themselves and clients. Supporting closeness, therapists described bringing themselves as individuals to the therapeutic relationship along with their experiences (Fragkiadaki & Strauss, 2012; Werbart et al., 2017), feeling equipped to understand clients thanks to an understanding of themselves (Gelman, 2004; Ryan, 2006). Therapists widely felt connection to clients (Fragkiadaki & Strauss, 2012; Gelman, 2004; Lilliengren & Werbart, 2010; Werbart et al., 2017), supported by genuine interest (Lilliengren & Werbart, 2010), learning about them (Gelman, 2004) and demonstrating emotional sensitivity (Haskayne et al., 2014). Many therapists shared positive perceptions of clients (Lilliengren & Werbart, 2010; Werbart et al., 2017, 2018) and admired their bravery for attending therapy (Palmstierna & Werbart, 2013; Philips, 2008). Underpinning closeness was trust, which therapists described as essential (Lilliengren & Werbart, 2010; Philips, 2008; Werbart et al., 2017).

Therapists were also sensitive to distance in the relationship (Fragkiadaki & Strauss, 2012; Lilliengren & Werbart, 2010; Werbart et al., 2017, 2018). They described clients regulating distance through cancelling or not attending sessions (Lilliengren & Werbart, 2010; Philips, 2008; Werbart et al., 2018), not bringing parts of themselves to therapy (Lilliengren & Werbart, 2010; Werbart et al., 2018), and in one case attempting to do their own therapy (Haskayne et al., 2014). Therapists understood distance in relation to clients' previous relationships (Lilliengren & Werbart, 2010; Philips, 2008; Ryan, 2006) and perceptions of the therapist (Palmstierna & Werbart, 2013; Werbart et al., 2018).

2.3. 'Relationship as intervention' referred to how the therapeutic relationship could support change for clients. Therapists positioned themselves as a new person for new relational experiences (Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013; Philips, 2008; Werbart et al., 2017), hoping to model reliable figures (Palmstierna & Werbart, 2013; Werbart et al., 2017) and ways for dealing with emotion (Werbart et al., 2017). Therapists also used the therapeutic relationship to "challenge the patient's way of being" through exploring difficulties in the relationship (Lilliegren & Werbart, 2010; Werbart et al., 2017) and the emotions the relationship evoked for clients (Haskayne et al., 2014).

2.4. 'Feelings about clients' constituted a subtheme. These were described by therapists and understood as countertransference. Countertransference feelings were considered unconscious communications from clients (Muston, 2017) relating to early experiences (Bowker & Richards, 2004) and unexpressed emotions (Haskayne et al., 2014; Muston, 2017; Philips, 2008; Ryan, 2006; Wilson & Sperlinger, 2004). Positive countertransference feelings included compassion, interest and wanting to help (Werbart et al., 2017, 2018). Negative transference feelings included envy (Bowker & Richards, 2004; Ryan, 2006), guilt about privilege (Ryan, 2006), helplessness (Lilliengren & Werbart, 2010; Muston, 2017), anger (Palmstierna & Werbart, 2013; Ryan, 2006; Wilson & Sperlinger,

2004), disgust (Wilson & Sperlinger, 2004) and inadequacy (Bowker & Richards, 2004; Fragkiadaki & Strauss, 2012; Haskayne et al., 2014; Ryan, 2006).

Therapists considered it key to not act out their countertransference (Philips, 2008; Ryan, 2006; Werbart et al., 2017), which was supported by reflecting on their experiences (Werbart et al., 2017) and using personal therapy and supervision (Muston, 2017; Philips, 2008; Ryan, 2006; Wilson & Sperlinger, 2004). Through their feelings about clients, therapists described learning about themselves (Fragkiadaki & Strauss, 2012; Ryan, 2006; Werbart et al., 2017; Wilson & Sperlinger, 2004).

3. 'Challenges'. This theme captured the difficulties that therapists described experiencing in their psychodynamic work with clients. They reported a "sense of untouchable areas" in relation to what could be explored in therapy (Haskayne et al., 2014; Lilliengren & Werbart, 2010; Muston, 2017; Philips, 2008; Ryan, 2006; Werbart et al., 2018) and being unable to help clients articulate things that they couldn't (Ryan, 2006). Another challenge was feeling unsure of what was happening in the therapy, which could generate anxiety (Muston, 2017; Ryan, 2006; Symons & Wheeler, 2005; Werbart et al., 2018). The potential for enactments was a challenge for therapists (Fragkiadaki & Strauss, 2012; Muston, 2017; Philips, 2008; Wilson & Sperlinger, 2004) and therapists described resistances in clients as similarly challenging (Philips, 2008; Werbart et al., 2017).

4. 'Endings'. This theme captured therapists' strong awareness of therapy termination, which was primarily described by Fragkiadaki and Strauss (2012). Subthemes 'meeting as two people', 'relationship and ending as inseparable', 'the right time' and 'therapy process is never truly finished' are described in turn.

4.1. Subtheme 'meeting as two people' reflected how therapists described bringing themselves as individuals to endings and the emotional impact (Fragkiadaki & Strauss,

2012), which they coped with by talking to colleagues (Fragkiadaki & Strauss, 2012) and thinking theoretically (Wilson & Sperlinger, 2004).

4.2. 'Relationship and ending as inseparable' highlighted therapists' experiences of endings reflecting the therapeutic relationship and good endings being about both parties (Fragkiadaki & Strauss, 2012). Unsettled relationships were associated with erratic endings and "proper" endings associated with relationships with intense involvement (Fragkiadaki & Strauss, 2012).

4.3. 'The right time' for endings was highlighted by therapists who exercised caution to not "enter into a process that should have required continuing a few more years" (Lilliengren & Werbart, 2010), but described clients sometimes terminating therapy too hastily and in an unresolved manner (Fragkiadaki & Strauss, 2012; Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013). Therapists described practicing ethically around endings by not prolonging therapy unnecessarily (Werbart et al., 2017) and suggesting that patients should instigate the ending to have control over it (Fragkiadaki & Strauss, 2012). Some believed that some clients needed longer therapy but also recognised that it might not be the right time for the client (Lilliengren & Werbart, 2010; Werbart et al., 2018).

4.4. 'Therapy process is never truly finished' captured therapists' perspectives that the end of therapy sessions did not mean the end of the journey for clients who continued the work independently (Fragkiadaki & Strauss, 2012; Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013; Werbart et al., 2017). They also described continuing to feel connection with clients following termination of therapy (Fragkiadaki & Strauss, 2012).

5. 'The therapeutic frame'. This theme captured therapists' experiences of establishing and working with the boundaries of the psychodynamic model. Subthemes were: 'threats to frame', 'maintaining the frame' and 'modifying the frame'.

5.1. 'Threats to frame' included therapists' experiences of the therapeutic frame they held in therapy being challenged by clients, which could evoke emotional conflict for therapists (Symons & Wheeler, 2005). Understanding threats symbolically and culturally helped to reduce conflict (Gelman, 2004; Symons & Wheeler, 2005), as did familiarity with particular pressures (Symons & Wheeler, 2005).

Therapists described tension between "reality factors" and maintaining the frame and analytic stance (Ryan, 2006). Some saw reality as a legitimate part of therapy (Gelman, 2004); others described practicalities having a negative influence on therapy (Lilliengren & Werbart, 2010; Muston, 2017; Ryan, 2006). Therapists reflected on the symbolic meaning of practical issues that threatened the frame to diffuse the tension between reality and the frame (Gelman, 2004).

5.2. 'Maintaining the frame' captured therapists' experiences of holding boundaries, which involved "setting limits with regard to timeframes, the aim of the contact" (Philips, 2008) and not disclosing things about themselves (Bowker & Richards, 2004). Therapists stressed the importance of regularity and continuity (Lilliengren & Werbart, 2010; Muston, 2017; Werbart et al., 2017) and one therapist highlighted how holding the frame could lead to significant moments in therapy (Symons & Wheeler, 2005).

5.3. 'Modifying the frame' captured therapists' experiences of working flexibly and creatively with clients – described as expanding the frame and psychodynamic approach (Gelman, 2004). Therapists described modifying their work based on the needs of individuals (Gelman, 2004; Lilliengren & Werbart, 2010; Symons & Wheeler, 2005; Werbart et al., 2017) to support clients' sense safety (Palmstierna & Werbart, 2013; Symons & Wheeler, 2005) and enhance cultural sensitivity (Gelman, 2004). Therapists reflected that changes to the therapeutic frame impacted clients' experience of therapy (Lilliengren & Werbart, 2010;

Symons & Wheeler, 2005) and asserted the importance of reflecting on why they made changes to the frame (Gelman, 2004; Symons & Wheeler, 2005).

6. 'Therapy did some good'. This theme captured therapists' experiences of seeing change in clients (Werbart et al., 2018) and core issues continuing (Lilliengren & Werbart, 2010; Werbart et al., 2018). Therapists described progress and improvement stemming from clients improving their awareness of problems (Lilliengren & Werbart, 2010; Muston, 2017; Ryan, 2006) and sharing a thinking process with therapists, which helped clients reflect on their difficulties independently (Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013) and take on challenges (Werbart et al., 2017).

Therapists also described improvement in clients' views of themselves (Lilliengren & Werbart, 2010; Muston, 2017; Werbart et al., 2017), insight (Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013; Werbart et al., 2017), confidence (Palmstierna & Werbart, 2013; Werbart et al., 2017), relationships (Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013) emotional understanding (Haskayne et al., 2014; Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013) and emotional expression (Muston, 2017; Philips, 2008).

Discussion

This review sought to identify the breadth of qualitative literature exploring experiences of clients and therapists engaged in psychodynamic psychotherapy. Results for clients and therapists were analysed separately in order to explore their different positions within therapy, but this discussion will consider themes in relation to each other.

Overall, the data across included studies provides rich, subjective insight into the lived experience of psychodynamic psychotherapy across the UK, Holland, Sweden, Denmark, Spain, Canada and the USA. Included studies used appropriate samples, collected

data appropriately and each used well-described qualitative methods of analysis, enhancing their rigour. These factors mean that the results of this review are transferable to other clinical settings in which psychodynamic psychotherapy is delivered.

Turning to the themes, key to both client and therapist experiences of psychodynamic psychotherapy was the therapeutic relationship. As a fundamental part of psychodynamic psychotherapy (Saketopoulou, 1999), it is unsurprising that the therapeutic relationship was highly regarded and that its depth and intricacies were described by clients and therapists. Both clients and therapists spoke about the closeness and distance that could be experienced, highlighting their shared sensitivity to their proximity to each other. Their parallel comments about how the relationship could be used as a source for learning and trying out new ways of relating also suggests that the therapeutic relationship can be an effective aspect of psychodynamic psychotherapy. This process translates to psychodynamic theory of realising unconscious models of relationships through re-enacting them in the therapeutic relationship and re-evaluating them (Lemma, 2003).

The special aspect of the relationship as described by clients aligns with its centrality described by therapists, offering insight into how it might be different to relationships with others due to support from therapists to prioritise and use it. Populations of clients with eating disorders (Poulsen et al., 2010; Toto-Moriarty, 2013), "mentally disturbed parents" (Philips, 2008), learning disabilities (Merriman & Beail, 2009; Statham & Beail, 2018), medically unexplained symptoms (Town et al., 2017) and experiences of the Holocaust (Shamai & Levin-Megged, 2006) were included in this review and all were from Western countries. There was a lack of attention in the included studies to any cultural difference between clients and therapists, so it is unclear how this may relate to their experiences. It may be that shared culture between clients and therapists helps to support the alignment found in relation to the therapeutic relationship; further research may shed more light on this. Indeed, a wider range

of client populations would also shed more light on the experiences of psychodynamic psychotherapy for different groups and explore which factors may be shared or differ.

The results also highlight how the ending of therapy is a key time for both clients and therapists, each describing its significance and how the work continues beyond termination. Therapists spoke about endings in more detail, highlighting how considered they were in order to encourage their therapeutic value, in line with psychodynamic theory about endings (Klein, 1950). However, the results highlight the difficulty in this endeavour in the context of strong feelings of loss described by both parties. Only one study (Fragkiadaki & Strauss, 2012) focused in depth on this part of psychodynamic psychotherapy and only from the perspective of therapists. Therefore, given the pertinence of endings for both parties, it may be beneficial for future research to explore this in order to explore the processes at work in more detail.

The nature of therapy was spoken about by clients and therapists, each speaking in similar terms, yet emphasising different elements. The 'hard work every session' described by therapists was echoed in clients' descriptions of the therapist role and aspects of 'the process' in terms of being challenged and addressing problems. Under 'impact', clients' descriptions of 'gaining new perspectives' and making changes may be supported by the work of therapists to offer interpretations, key to helping clients develop conscious awareness of themselves (Kris, 1956). Together, these results highlight that therapists' active work is recognised by clients, however some subtleties were not mentioned by clients, such as therapists' attention to communication and containment (Bion, 1967), though this may have contributed to clients' sense of feeling understood as described within the closeness of the relationship and the safeness of the space, respectively. As psychodynamic psychotherapy is an unstructured approach, it is significant that there was alignment between the experiences of therapists and different groups of clients. This suggests that the principles that underpin

psychodynamic psychotherapy are active and present for both parties in their experiences of the nature of psychodynamic psychotherapy.

Clients and therapists both spoke of the impact of therapy, highlighting how clients could benefit and also its limits. There was a shared perspective that psychodynamic psychotherapy could improve clients' awareness and management of problems, their emotional understanding and expression, insight and sense of themselves. The alignment in these results is positive, suggesting that the positive impact can be clear to both parties involved. Clients and therapists also highlighted that core problems could remain, which appeared to be accepted by therapists, but challenged by clients who had high expectations for therapy and described wanting more active support. It is clear how a dynamic of clients wanting practical help and therapists focusing solely on psychic factors could be present in therapy and represent a 'threat' of reality that therapists described. The limits of psychodynamic psychotherapy appear to be recognised by both clients and therapists, but can be an area of different perspectives.

Clients' descriptions of the therapeutic space were reflected in therapists' descriptions regarding the therapeutic frame, a key concept from psychoanalytic theory hinged on holding boundaries around the therapy in order to create a new space for a new relationship (Szecsödy, 1997). Modifying the frame by working flexibly and being responsive to clients' needs corresponded with the development of the 'safe space' in the eyes of both clients and therapists. Interestingly, therapists' descriptions of maintaining the frame through not disclosing information about themselves and setting limits appears to correlate with clients' descriptions of the space seeming 'strange' and anxiety-provoking. The psychoanalytic setting is designed to be a space for clients' repressed emotions surface (Lemma, 2003), so it may be that clients' experiences of feeling anxiety were attributed to the therapy setting, as that space supported the expression of their emotion. However, although clients found many

aspects of the therapy difficult and felt anxiety and other emotions in relation to it, it had the potential to be a helpful therapeutic experience if those emotions could be explored. The fact that many of the clients were drawn from populations dissatisfied with therapy or that showed no improvement suggests that the anxiety they felt may have only been consciously attached to their direct therapy experience rather than explored to identify the nature of unconscious processes at work.

Therapists spoke of the importance of continuity in the maintaining frame, which was echoed by clients who also emphasised the difficulties arising when the continuity was disrupted; taken together the results offer greater insight into the difficulties associated with disrupted continuity or unplanned breaks. This suggests that not all elements of the frame were directly experienced negatively, but that when the frame is modified, as recognised by therapists, it can impact clients.

Clients' description of therapy being a 'strange space' and highlighting their challenges also corresponds with the challenges reported by therapists. Uncertainty and anxiety were present for both parties, highlighting how psychodynamic psychotherapy may be hard to grasp at various stages. Further, the challenge for therapists of not being able to explore some areas of clients' lives corresponded with the distance that clients sometimes described wanting and also the conflict they felt in relation to experiencing painful emotions. These results put words to a potentially unspoken process that occurs in psychodynamic psychotherapy between clients and therapists that therapists described struggling with and not understanding because it could not be addressed in sessions. This process may be further exacerbated by clients' sense of not being able to speak about issues such as race and sexual issues, as recorded under subtheme 'talking'. It may be beneficial for future research to consider the unspoken elements of therapy in more detail to shed further light on this process from the perspective of participants rather than theory.

Taken together, the results are broad and there is overlap with the common factors associated with psychotherapy (Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003), however, it is in the detail that we see the unique factors of psychodynamic psychotherapy that were pertinent to clients' experiences and were believed to play a role in change and improvement. These included the use of the therapeutic relationship to identify and re-evaluate unconscious models of relating and the therapeutic frame.

Limitations and directions for further research. The area of research exploring client and therapist experiences of psychodynamic psychotherapy is emerging and it is encouraging to see the range of populations studied. Given the emphasis of psychodynamic psychotherapy on unconscious processes, the focus in research on the conscious experience of participants can appear removed from the content of therapy. Indeed, descriptions of the quality of the therapeutic encounter and the richness of transference and countertransference experiences offers a flavour of the unconscious activity that may have accompanied participants' conscious experience, but the quality of the analysis is limited by the richness of data, which may lose richness due to the restriction to conscious material. However, in order to use the voice of clients, this is a necessary restriction that is nonetheless valuable and essential to exploring therapy experiences.

The focus of this systematic review was wide, looking at client and therapist experiences generally; therefore, the results are varied and captured at a surface, descriptive level, limiting the depth of exploration. However, this offers a good quality overview of the literature. This review was also restricted to English-language publications, perhaps overlooking key research in other languages and cultures. Future literature reviews in this field should explore as wide a range of voices and languages as possible. It is a strength that all the included studies were published, peer-reviewed and quality assessed, enhancing the rigour of available evidence.

This review identifies avenues for future research that may further inform clinicians, clients and service providers about experiences of psychodynamic psychotherapy including the significant aspects such as the therapeutic relationship, the ending and the therapeutic frame. It would be valuable to explore how these aspects affect other populations with different needs, for example those characterising the refugee population. This thesis will address one avenue by specifically exploring experiences of psychodynamic psychotherapy for refugees and asylum seekers and therapists, which is a population that has not previously been researched in this context.

Methodology

This chapter describes the rationale for the research methodology chosen for this study, the theoretical background, participant recruitment, data collection and analysis.

Ontology and Epistemology

In the process of planning research studies, questions regarding the nature of the existence of phenomena and how it can be understood or thought about must be considered prior to developing methods to capture data relating to the phenomena. These questions and identification of ontological and epistemological positions help to ensure that the methods chosen are appropriate to address and meet the research aims.

Ontology, the question of the nature of reality and what can be known about, is a question that has been considered by many philosophers. Ontology can be considered on a continuum between the positions of realism, belief in an objective social reality that exists outside of people's awareness of it, and relativism, belief in reality and the nature of existence as individual, multiform and not objectively discoverable (Grix, 2010). Ontological positions within research must be thought about in order to consider the research's position to the phenomena under study; whether reality is real or relative will implicate whether it can be explained or described (Grix, 2010).

Closely related to ontology is epistemology, the the branch of philosophy concerned with theorising knowledge: what can be known and the nature of the relationship between knower and what can be known. There is an close connection between ontology and epistemology because the position taken in relation to what reality is will determine what can be known about that position on reality. As with ontology, epistemology can be thought about on a corresponding continuum between the positions of positivism, which proposes that

reality can be discovered and explained through scientific methods of measurement and quantification of phenomena that establishes a single externally determined law (E. Miller, 1999), and constructivism, which proposes that knowledge about the nature of existence and the world is constructed or created by individuals based on their experiences of and interactions with the world (Gray, 2013). Indeed, social constructionism aligns closely with constructivism, but proposes that knowledge about the nature of reality is less based on individual perspectives stemming from individual experiences, but that it is constructed through social processes and rooted in language (Gergen, 1985).

Both ontology and epistemology feed in to the selection of methodology appropriate to researching in the context of chosen positions, which will be discussed in turn within this chapter.

Critical Realism

This research adopts position of critical realism, a meta-theory that sits in the middle of the positions of realism and relativism, and positivism and constructivism (Grix, 2010). Critical realism originated in the work of Roy Bhaskar (2013) and emerged in the development of post-positivist thought. Bhaskar (2013) identified an "epistemic" fallacy in realism, highlighting how what was considered to exist was reduced to what could be known about. Critical realism draws on components of both realism and relativism, and positivism and constructionism to deliver a comprehensive philosophical theory of ontology and epistemology (Brown, Fleetwood, & Roberts, 2002).

Critical realism emphasises that ontology and epistemology are different and proposes that a real, objective reality exists, but that what happens in reality is not the same as what can be observed (Danermark, Ekstrom, & Jakobsen, 2005). Critical realism proposes three

distinct ontological domains: the empirical, actual and real; the empirical is what can be observed, the actual is what happens and the real produces the actual events that happen (Danermark et al., 2005). As such, according to critical realism, reality is not transparent, but deep, and though there is an objective reality, the empirical domain is unable to observe it completely and objectively (Danermark et al., 2005).

Further, though observations of the empirical domain can offer theory about the events of reality, critical realism suggests that they should not be taken as completely explanatory due to the depth of reality. Knowledge about the world can be shown to be false based on new evidence and new theories, equally as fallible as the previous theories due to the depth of the unobservable, can be developed (Danermark et al., 2005). In the pursuit of knowledge, reality should not just be considered at the level that is observable, but the mechanisms that may impact on the empirical domain should also be identified and understood.

In critical realism, the gap between theory and reality is considered an 'ontological gap' between what we experience and understand, what actually happens and the extent of phenomena which produce reality (Danermark et al., 2005). In short, unobservable phenomena influence observable phenomena and therefore it is only possible to understand the social world when unobservable events are considered in addition to the observable (Bhaskar, 2013).

Bhaskar (2013) proposes that researchers produce knowledge that is a social product, recognising how research is undertaken in context that will impact on findings and how interpretation is necessary in order to understand the observable. In social science, this is understood as a double hermeneutic, which highlights the layers of interpretation of phenomena applied by those experiencing and those researching it (Danermark et al., 2005). Critical realism acknowledges how knowledge of reality can be socially constructed, but

differs from social constructionism through its belief about reality being more than a social construction (Bygstad & Munkvold, 2011). Though critical realism recognises an objective reality, it also recognises how knowledge can be altered by the language with which it is expressed and exists within different contexts and structures that constitute the depths of reality (Danermark et al., 2005).

The epistemological position of critical realism closely relates to contextualism, an epistemological position that proposes that knowledge is situation-dependent and limited to the context in which the data was collected and analysed (Madill, Jordan, & Shirley, 2000). The basic assumptions of contextualism are that human acts are a part of a continuously changing reality and are primarily intentional (Jaeger & Rosnow, 1988). The contextualist perspective also highlights the role of the researcher in interpreting data and how their specific context will affect how data is considered and understood (Madill et al., 2000). Contextualism aligns closely to the critical realist ontological perspective, proposing real events of reality, albeit continuously changing and affected by context, both seen and unseen (Jaeger & Rosnow, 1988).

Justification of the use of Critical Realism and Contextualism

This study aimed to capture individuals' experiences of the phenomena of psychodynamic psychotherapy; exploring subjective experiences in the context of theory about the nature of psychic reality that can be observed and experienced by another person (psychotherapists). It is recognised that the phenomena of psychotherapy does not correspond with a specific ontology (Salvatore, 2011) and research has highlighted the subjectivity of experiences of psychotherapy (Elliot & Williams, 2003; Watson & Rennie, 1994) including the different experiences of therapists and clients of shared sessions (Llewelyn, 1988). Though

psychotherapy is based on communication, potentially aligning it with a social constructionist epistemological position, psychodynamic psychotherapy does not solely rely on language but also unconscious emotional communication that is interpreted in line with psychodynamic theory, which provides an objective explanation for the emotional life of individuals. Therefore, this research takes both of these positions into account by recognising the explanatory theoretical framework that psychodynamic psychotherapy uses and the value of exploring the subjective experience of psychotherapy in order to extend current knowledge and consider some of the unseen structures in the context of psychodynamic psychotherapy offered to refugees.

Critical realism accepts the use of theory as a starting point for empirical research, which can be used to help build a new and more accurate explanation of reality (Fletcher, 2017). In the case of this study, it builds on psychodynamic theory and will consider its use with a population whom until now have not been the subject of research regarding experiences of psychodynamic psychotherapy. Critical realism is appropriate to capture the nuances of individual experience within a framework of existing theory and identify the unobservable mechanisms that underpin it for refugees and psychodynamic psychotherapists that work with refugees.

Critical realism recognises the role of interpretation of phenomena through both participants and researchers applying meaning, which is a factor associated with research exploring the lived experiences of others. In addition, the emphasis on knowledge being impacted by the context of the data collection and analysis also makes it appropriate for qualitative research that takes place in a single service, recognising how any knowledge derived from the data would be specific to that context and the unobservable structures surrounding it.

Methodology: A Qualitative Approach

This study uses a qualitative methodology, stemming from its ontological and epistemological positions. At its centre is the voice of participants describing their experiences of psychodynamic psychotherapy delivered in one service from the positions of clients and psychotherapists. As outlined in the introduction to this thesis and systematic review, the literature on experiences of psychodynamic psychotherapy is devoid of the voices of refugee populations and those working with refugees in this context. Therefore, a qualitative approach is appropriate to address the identified gap in the literature and offer an understanding of how psychodynamic psychotherapy is experienced and understood by refugees receiving it and psychotherapists delivering it to refugees.

Method: Contextual thematic analysis

Thematic analysis is described as method of qualitative analysis for systematically identifying, organising and offering insight into patterns of meaning in data (Braun & Clarke, 2012). It is an accessible and flexible method that allows for analysis to identify what is common to the way a particular topic is spoken about and make sense of commonalities (Braun & Clarke, 2012). The process of thematic analysis is governed by guidelines for standardisation to allow for the method to be applied to data in a deliberate and rigorous way that is theoretically and methodologically thorough (Braun & Clarke, 2006).

The flexibility in thematic analysis comes from the opportunity to apply it in contexts of different ontological and epistemological positions. It is also a method that can be applied inductively, allowing an analysis to be approached from the bottom-up and driven by the data itself, or deductively using a top-down approach that is shaped by concepts or ideas that the researcher brings to the data (Braun & Clarke, 2012). The literature highlights the

impossibility of conducting a purely inductive thematic analysis due to the role of the researcher analysing the data through their own understanding (Braun & Clarke, 2012). However, due to this study's emphasis on the experiences of participants, the thematic analysis will orientate towards an inductive approach. An inductive approach, not being directly driven by theory, also fits with the approach of critical realism that holds existing theory in mind loosely and with a view of its fallibility and incompleteness.

The thematic analysis used in this study is considered a contextual thematic analysis, highlighting how it will look for commonality in participants' accounts of their experiences within one specific context, corresponding with the epistemological positions of critical realism and contextualism that highlight how knowledge is context-specific.

Setting

This research was conducted within one service that offers psychosocial support to refugees and asylum seekers based in the UK. The service is provided and managed by a third sector organisation and primarily provides caseworkers to support and advise refugees and asylum seekers in relation to practical issues such as immigration and accommodation. Refugees and asylum seekers are able to approach the organisation and refer themselves for support; they are allocated a specific caseworker to work with during their time of accessing support. The range of time that the service can be accessed is not defined by the service, but depends on the needs of refugees and asylum seekers.

Within the wider service, there is also a psychodynamic psychotherapy service that is available to any refugee or asylum seeker accessing the wider service and is delivered by qualified honorary psychodynamic psychotherapists. To access psychodynamic psychotherapy, caseworkers can refer potential clients to the psychotherapy service following

an initial conversation about whether they would like to access psychotherapy. Potential clients are assessed by one of the psychodynamic psychotherapists and if they agree to work together, clients are offered a minimum of six psychotherapy sessions. Alongside their psychotherapy, clients are still able to access support from their caseworker and there can be regular dialogue between the caseworker and psychotherapist to discuss any practical issues that may arise and interfere with clients' therapy, but not the content of sessions.

The service being researched in the current study is not the only service in which psychodynamic psychotherapy is offered to refugees and asylum seekers, but the model of the service differs from other services that are available by way of the complementary role of caseworkers. Refugees and asylum seekers are able to access psychodynamic psychotherapy and other models of psychotherapy including art therapy and CBT from other services in the UK; however, this is often the sole service offered by those services. The combination of psychodynamic psychotherapy offered alongside casework means that the service offers a unique context for clients.

Design

This study employed a cross-sectional, qualitative research design based on the contextual thematic analysis method. Semi-structured interviews were used to gather rich data from participants in order to hear their experiences of psychodynamic psychotherapy within the context of one service. Semi-structured interviews were chosen to enable the researcher to guide participants to areas of specific interest to the researcher whilst allowing space for the researcher to be led by participants to important aspects of their experience and areas that could not be pre-conceived due to the subjectivity of human experiences and the depth of reality.

The focus of this study on one service and exploring clients' experiences of it characterises a service evaluation design; this is different to research which typically will seek to produce generalisable knowledge (Twycross & Shorten, 2014). However, having outlined the distinctive setting of this research and recognising the contextualist epistemological position of knowledge existing in relation to its context, it is valuable to explore the phenomenon of psychodynamic psychotherapy for and with refugees and asylum seekers in this context. In addition, the aim of this study is to explore clients' experiences beyond satisfaction with the service and taking into account therapists' experiences of delivering psychodynamic psychotherapy with this group of clients extends the remit of the study away from a solely evaluative design.

Being based in one setting will limit the generalisability and transferability of the findings of this study because though they will offer insight and knowledge into the use of psychodynamic psychotherapy with refugees and asylum seekers, which is also provided elsewhere for these populations, how the therapy is experienced is likely to be impacted by the context of the wider service, for example the support of caseworkers with practical issues and needs. Therefore, although the model of psychodynamic psychotherapy is provided for refugees elsewhere, the findings of this study may not be directly transferable to those other services due to the unique context. However, the findings will offer knowledge about the use of psychodynamic psychotherapy with the refugee population in relation to this unique service from the positions of critical realism and contextualism.

Participants

Participants were recruited from two populations: clients that had received psychodynamic psychotherapy and psychotherapists that delivered psychodynamic psychotherapy in the same

service. All participants were recruited using purposive sampling in order to reach the necessary groups and maximise opportunities to explore a wide range of data.

The inclusion criteria for each participant group differed. However, for all groups, participants could be males or females, of any age, ethnicity or cultural background, and speaking any language – there was no stipulation to speak English as interpreters were used as necessary.

Clients had to be refugees or asylum seekers who had accessed psychodynamic psychotherapy through the service under study for any length of time. They may have accessed therapy with or without an interpreter. In order to remain open to exploring a wide range of experiences of psychotherapy, this study did not stipulate how many sessions clients had to have undertaken or that they must have 'completed' therapy. Ideally, clients would have attended at least two therapy sessions, however, recognising that this population of clients is difficult to recruit to research, the minimum number of sessions required for inclusion was one. This allowed for a brief experience of therapy and openness to experiences of clients deciding not to pursue therapy after a brief experience.

Therapists had to be involved in delivering psychodynamic psychotherapy in the service under study. Three therapists worked for the service at the time of recruitment, hence, every therapist was approached to participate.

Sample size. It is noted that there are no rules regarding sample sizes in qualitative research (Patton, 2002), but selecting a sample size can be complicated (Vasileiou, Barnett, Thorpe, & Young, 2018). Based on the research design, the number of potential participants was limited and therefore the researcher planned to interview as many participants as possible; to allow for a detailed analysis, the minimum sample size was six clients and three therapists. All of the service's psychodynamic psychotherapists were interviewed and all available clients from the service were interviewed.

Clients and psychodynamic therapists from other psychodynamic psychotherapy services for refugees and asylum seekers were not sampled due to the specific context of the service under study, which was likely to influence participants' experiences of therapy.

Measures

All participants were interviewed individually using a semi-structured interview developed specifically for this study, which was the only material used for data collection. As the study progressed, questions were reflected on and revised as data was collected and participants shared their experiences. This ensured that the interview was accurately shaped to capture participant experiences.

Client interviews primarily aimed to explore experiences of the psychodynamic therapy they received and how therapy related to their needs. Client participants were asked to reflect on what was going on in their lives at the time of beginning therapy; how it was helpful or unhelpful; how they experienced their therapist; and whether anything in their lives or circumstances changed as a result of therapy.

Therapist experiences of working with refugee and asylum seeking clients were also explored to develop a more inclusive understanding of clients' therapy (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Therapist participants were asked about how they came to be involved with the service; their experiences of working with refugees and asylum seekers; what brings clients to therapy and how they use it; the usefulness of psychodynamic therapy for this client group; and thoughts on continuing to work with this client group in the future. See appendix F for all initial interview questions.

Procedure

Recruitment. Recruitment of client participants was aided by the service's therapists who identified approximately 30 clients who had accessed the psychodynamic psychotherapy through the service. This list was not made available to the researcher, but service caseworkers played a vital role in making initial contact with potential client participants, which was either made over the telephone or in person. Caseworkers offered information about the study to potential participants that was shared in person using a printed information sheet (appendix B), translated as necessary, or over the telephone using the key points of the study (appendix E). Potential participants were invited to contact the researcher or consent verbally to being contacted about the study by the researcher. Traditional methods of contacting potential participants using posted letters were less relevant for this client group who were unlikely to have consistent or secure addresses, or the means to contact others by telephone if they wished to take part. Due to the circumstances of potential client participants, it was not always possible for caseworkers to make contact with them. In other cases, for example if caseworkers were aware of a change in the client's circumstances that had considerably increased their vulnerability, they considered the client not suitable for participation and did not make contact.

Contact was made on the phone between the the principal investigator and potential client participants, using telephone interpreters as necessary, to discuss the study and address questions. If clients wished to participate then a date and time to conduct the interview was arranged. Initial meetings to discuss the study were also offered to potential participants if they wished to ask discuss the study in person.

Therapists were approached to participate in the study on an individual basis. Information sheets were shared with therapists and they were invited to contact the researcher if they were interested in participating.

Interviews. Participants who expressed interest in participating were invited to attend an individual interview. Participants were offered an interpreter for their interview and they wanted one, it was arranged prior to the interview. Interpreters were chosen sensitively and participants were asked if they had any requirements, such as a preference of gender. Regional dialects were also taken into account.

Interviews lasted approximately 60 minutes and began with a conversation about the study in order for participants to give informed consent. Informed consent was recorded using a written form (see appendix C), also translated as necessary. Audio recording of interviews and consent for recording was discussed prior to commencing any recording. When participants declined to be recorded, detailed field notes including verbatim quotes were taken instead, consistent with constructivist grounded theory.

Interviews were semi-structured, directed and shaped by the researcher but used open ended questions to allow for in-depth exploration of participants' experiences, true to the constructivist grounded theory approach. As is typical in qualitative research, initial interview questions were initially developed for this study that corresponded with its aims, but were revised as interviews developed and new areas for exploration are identified by participants. Clients were compensated for their time with £10.00 at the end of the interview.

Analysis

All recordings and field notes were transcribed by the researcher. Each interview was analysed by thematic analysis (Braun & Clarke, 2006) as data collection progressed, allowing new codes to emerge throughout the process.

The first phase of the thematic analysis was familiarisation with the data, involving transcribing the data, listening to it whilst reading the transcription and reading through

transcriptions. This allowed the researcher to listen to the words of participants, consider the tone of language and the emotional flavour of interviews. Initial ideas were noted for each interview.

The second phase of thematic analysis involved generating initial codes (Braun & Clarke, 2006). Data from interviews was combed through systematically, from start to finish, to highlight its content and allow all its ideas to emerge. Initial codes stuck closely to the data to maintain an inductive process. See appendix G for example of initial coding.

The third phase of thematic analysis involved searching for themes through arranging and grouping initial codes into potential themes. In this phase the researcher began considering the relationships between codes, between themes and between subthemes (Braun & Clarke, 2006).

Reviewing themes is the fourth phase of thematic analysis, which involved checking and ensuring that all potential themes accurately reflect initial codes and that the content of initial codes is accurately captured in potential themes. Reviewing themes also involves checking that potential themes reflected the entire data set (Braun & Clarke, 2006). At the end of this phase, the researcher had a sense of what the different themes were, how they fitted together and the overall story they told in relation to the data (Braun & Clarke, 2006). To enhance rigour and maintain accountability to the method of the study, the themes were reviewed and discussed in research supervision with the internal supervisor.

The fifth phase of thematic analysis was defining and naming the themes based on their content, highlighting what was of interest in the story of each theme (Braun & Clarke, 2006). By the end of this phase, the researcher was able to define the theme and describe the scope and content through the use and naming of subthemes in addition to the naming the overarching themes. See appendix H for example of a named theme and corresponding initial codes.

The sixth phase of the thematic analysis was writing up the themes and telling the story of the data to produce the report (Braun & Clarke, 2006). Writing up this study involved balancing the experiences of clients and therapists in order to tell their joint story of psychodynamic psychotherapy in the current service. Quotes from the interviews were used to illustrate the story and bring the themes to life so that readers could see the way participants described their experiences.

Self-reflexivity

As this study is based on a contextualist epistemology, it is recognised that the author's context and experiences play a part in it. For this reason, reflexivity in qualitative research is essential to ensure transparency and improve robustness (Engward & Davis, 2015)

I am positioned in this study as a clinical psychologist in training undertaking research as a requirement of my qualification. Through my training I have learned about psychodynamic theory and practice alongside other models, and I use it in therapeutic work with clients. Alongside my training, I have also been a client of psychodynamic psychotherapy, which helped me understand and process emotions brought up by my course, clinical work, research and personal life. Personally, I have found psychodynamic psychotherapy valuable.

I have no personal experience of being an asylum seeker or refugee; in contrast, I am a White British female who lives in relative privilege and safety. However, I identify politically as socialist and believe strongly in supporting others. I am aware that people who are refugees or asylum seekers are repeatedly marginalised and one of my motivations within this research was to elevate their voices.

My interest in research related to refugees and asylum seekers and psychotherapy was

born of a combination of my experiences. As a therapist, I believe in the benefits of psychotherapy and I began this research process hopeful that it is also helpful for refugees and asylum seekers.

Ethical considerations

Cross-cultural research is recognised as being susceptible to extensive and complex ethical issues. This study was approved by the University of Essex's research ethics committee (appendix A).

Power imbalance between researcher and participants. The power differential between researchers and participants is recognised as a key issue in cross-cultural research (Marshall & Batten, 2004). Participants in this study were potentially vulnerable to coercion into participation due to difficulties understanding their position as potential participants or choice about participating. To counter this and support informed consent, participants were given as much information about the study as possible, which made clear their rights to choose to participate and withdraw without giving a reason. The study was discussed with potential participants and they were encouraged to ask questions. The details of consent forms were also discussed with participants as well as their choice about being audio recorded. That two participants declined to be recorded suggests that participants understood their rights.

The information sheet and consent form were translated as necessary so that prior to participation, participants fully understood the nature of the study, what was expected of them and their rights. All participants were offered the use of an interpreter during informal discussions of the study and during interviews so that they understood as well as possible the nature of the study and their role in it.

The researcher also aimed to cultivate a collaborative stance with participants, promoting participants as experts to allow them to speak freely and decide for themselves what they wanted to share. The message that neither participation nor non-participation in the study would affect participants' relationships with the service was reinforced with participants from all initial conversations regarding the study.

Potential for interviews to cause distress. Interviews were designed to be as minimally intrusive and distressing as possible for all participants. For therapist participants, the interview focused primarily on the experience of clients and the nature of their work with clients, which was unlikely to be distressing. However, though the focus of interviews with client participants was also the nature of therapy and not the content, it was anticipated that there was potential for their interviews to unintentionally increase distress levels. As the factors associated with clients attending therapy, such as becoming displaced or experiencing traumas, were distressing, distress may have been evoked through reflecting on their therapy or raising their traumatic experiences in relation to their therapy experiences. Hence, client participants' distressing experiences were not directly asked about, but the study held in mind the potential for distress.

This study also sought to ensure that the interview did not feel overly formal or demanding as clients' experiences of interviews as part of the asylum seeking process may have been stressful. Every effort was made to ensure participants felt comfortable and safe during their interview; relevant caseworkers were informed of clients' participation in the study and any distress that arose during their interview. If participants became distressed, they received compassionate responses and conversation moved to more neutral subjects to allow some emotional space. Participants were offered to take a break or discontinue the interview if they wished. Participants were also given information about other sources of

support that could help in the time following their interview, which included a follow up therapy session with their previous therapist.

Data storage. As interviews were audio recorded, the secure storage of data was considered an ethical issue in this research study. All audio recordings were stored securely in electronic format on the password-protected University of Essex server. File names did not contain participant-identifiable data as participants were allocated a number and no identifiable details of interpreters used were recorded. Audio recordings were transcribed by the researcher into electronic documents containing no participant-identifiable information; files contained participant numbers as means of distinction and were stored on the password-protected University of Essex server. In order for participants to be able to withdraw their data up until the thesis was submitted, a document that translated participant initials to participant numbers was compiled by the principal investigator and also stored securely in a password-protected document on the University of Essex server.

Dissemination

The results of this study will be disseminated through all invested organisations. The final thesis will be revised and prepared for publication following the author's completion of the Doctorate in Clinical Psychology course. Publication will be sought from the Journal of Refugee Studies or an alternative publisher in a relevant journal.

Results

This chapter will present the findings of the current study. First, demographic information about the participants will be outlined, then the themes generated from the data. Finally, a thematic map is presented.

Participant Information

Nine participants took part in this study in total. Six of these were clients: five females and one male. In terms of immigration status, five clients identified as asylum seekers and one identified as a refugee. Clients' countries of origin included Albania, India, Pakistan, Sri Lanka, Zimbabwe and the Democratic Republic of the Congo.

Three therapists participated in this study, two females and one male, all of whom were qualified psychodynamic psychotherapists. Due to the very small size of the population sampled, demographic information is restricted to maintain anonymity and confidentiality. All therapists had been working in their current role for at least one year. See table 2 for the order of interviews.

Table 2. *Order of Interviews*

Interview Order	Pseudonym	Role	Interpreter use	Length of therapy
1	Valerie	Therapist	No interpreter	-
2	Ashley	Therapist	No interpreter	-
3	Jude	Therapist	No interpreter	-
4	Victoria	Client	No interpreter	6 weeks
5	Esther	Client	Interpreter	2 months
6	Roshan	Client	Interpreter	6 weeks
7	Fathima	Client	Interpreter	15 months
8	Lina	Client	Interpreter	12 months
9	Sara	Client	No interpreter	6 months

Detailed Findings

Six themes were developed through the analysis. Each theme and related subthemes will be discussed and explored in turn. Table 3 outlines the themes and subthemes.

Table 3. *Themes and subthemes*

Themes	**Subthemes**
Breaking Isolation	Alone and isolated
	Making a connection
	Talking and sharing
	The relationship
Different Starting Points	Different backgrounds and cultures
	Role of early life
	Range of needs
External and Internal Security	No stable home – no inner home
	Supporting immigration and integration
	Safe space
	Trust
Psychological Impact	Emotional impact
	Better understanding of myself
One Step on a Path	Therapy can provide a stepping stone
	Needing more than one type of intervention
	Ending
	Limitations
Help	What helped
	Flexibility
	Joint working

Breaking Isolation was a process that happened during psychodynamic psychotherapy, which was described by both clients and therapists. Subthemes will be explained below to tell the story of this theme.

Alone and isolated was a subtheme reflecting an experience that all clients spoke about experiencing prior to beginning therapy, which included having no-one to talk to:

> *"I didn't have no-one, you know, to speak about my everyday things"* (Client Lina)

Here, Lina clearly defines her loneliness caused by not having someone to talk to. Other clients described:

> *"I didn't have anyone because of course I had my relatives here but they have isolated me because of this case. Some of them are big peoples so they said 'oh, we don't want our surname to be dragged on this mud – we don't want all this'. So they don't even want to, with what happened between me and my brother – they have isolated themselves from me."* (Client Victoria)

> *"So... I mean I wasn't very, going out or had any contact with friends, I mean I just... I pushed a lot of people away from my life because of my situation and because whatever I used to feel like."* (Client Sara)

These clients, Victoria and Sara, explain how they became isolated through family rejection and pushing people away, hinting at the multitude of ways people can find themselves alone.

Clients' isolation was recognised by one therapist:

> *"Many clients are all alone. They have a roof over their head but they are alone."* (Therapist Jude)

This therapist recognises the difficult circumstances of clients and highlights being alone as an unmet need that surpasses the practicalities of accommodation. Therapist Ashley reflected on clients being isolated due to difficulties trusting other people and therapist Valerie offered an interpretation of clients' isolation as having a protective purpose:

> *"They find it very important to preserve and protect themselves by remaining isolated."* (Therapist Valerie)

These excerpts illustrate the isolation that clients experienced and therapists' reflections on the origins and reasons for clients' isolation, the impact of these on relationships and how they may maintain isolation.

Making a connection was a subtheme relating to clients developing relationships first with therapists and then with others, demonstrating a positive effect of the therapeutic relationship. Interaction with others was something that clients described wanting:

> *"Someone just to hear me, that's what I wanted."* (Client Victoria)

Clients also shared that building the therapeutic relationship in therapy took time and in the early stages of therapy, the effect of the new relationship meant that they shared facts rather than their feelings:

> *"It was very slowly because the first time you don't know the person."* (Client Lina)

> *"In starting initial sessions I was just telling my story like 'this happened, that happened', I wasn't much sharing my feelings or my worries."* (Client Sara)

However, clients' sense of the therapeutic space changed as their therapeutic relationships grew, for example client Lina described feeling *"much better"* once her relationship with her therapist had developed. Another client explained that after a few sessions, she started to share how she felt:

> *"Once I started to feel comfortable, I started to share more."* (Client Sara)

With sharing more also came a sense of feeling understood:

> *"She really understood me and she really helped me."* (Client Victoria)

> *"As I kept coming, I also understood that yes my therapist is listening to me and I started to know that yes she is understanding me."* (Client Sara)

Making connections extended to building relationships outside the therapy room. One client, described *"gathering with others"* as an additional connection to the one she made in therapy and a way of managing stress:

> *"So I reduced my stress so now I'll just be thinking about something which is good and go out if I... the stress comes and I go out and chat with others. Yeah, we've got umm... they're here the corner down there, there's a hall there for like local people, people to talk."* (Client Victoria)

Therapists recognised that clients wanted someone to listen to their distress and to share their stories with, as illustrated by the following excerpts:

> *"I always feel that it's an utter privilege that somebody will come and tell their story. And they want to tell it and want to let me share it with them."* (Therapist Valerie)

> *"One of the main roles of working here I think and working therapeutically is bearing witness. Some, not all, want to tell you about what they've been through."* (Therapist Ashley)

Ashley's experience of working with clients telling their stories highlights that clients feel different ways about sharing their experiences. This was also reflected in this research study as some clients declined to take part. Ashley highlights the sensitivity with which therapists respond and the importance they place on bearing witness to clients' experiences. Therapists also shared that building the therapeutic relationship in therapy took time:

> *"What comes first, always comes first, is building an alliance, and that can take a long time."* (Therapist Jude)

Therapists described finding social networks for isolated clients and working on re-establishing relationships:

> *"Some people, it could be about re-establishing relationships because when you're traumatised, the very thing that gets damaged are relationships – people withdraw."* (Therapist Ashley)

> *"We will often work together with the caseworker in writing letters to solicitors, to the Home Office, supporting accommodation, thinking about if a*

> *client is very isolated, where else they can be a part of another support network."* (Therapist Valerie)

This subtheme highlights a small difference in the perspectives of therapists and clients on establishing relationships beyond therapy. Clients' emphasis on the connection with their therapist suggests that they may prioritise their therapeutic connection, despite therapists also promoting ways of extending their opportunities to make connections. However, clients' relationships outside therapy were not specifically asked about, which may be why they were not mentioned by more clients.

Talking and sharing was a subtheme comprising clients' descriptions of speaking to therapists openly about everyday life, problems, burdens and their children:

> *"I didn't hide anything from them because I know that if I didn't tell them the facts, how would they help me?"* (Client Fathima)

> *"[Therapist name] is very nice and my interpreter is very good, so with sharing your heart feels better and you're light – you feel lighter."* (Client Fathima)

Client Fathima's rationale prioritises speaking openly in order to receive as much help as possible; she also described feel lighter as a result. Other clients also recognised that they needed to share openly to receive help and the impact of that sharing:

> *"I shared all my problems with her and it was difficult, but I realise that in this country I am in a condition where I have to share all these things with somebody who can help me."* (Client Roshan)

> *"I had multiple problems, I was thinking about my family and about my children. When I went to see [therapist name], I talked and I felt much better. The talking it was like evacuating."* (Client Esther)

Clients described talking about their past, which some valued, but others found painful and difficult, hinting at the challenging experiences of refugees and asylum seekers. Clients described the experience of being asked about family and relationships:

> *"When she asked me personal questions about my family – it didn't go well. It makes me feel bad somehow. It hurts me because I'm not with my family – I can't see them and they can't be with me."* (Client Esther)

> *"I mean it's never been easy to tell my life stories, my experiences, whatever happened in childhood or with my relationship in my marriage."* (Client Sara)

Similarly, client Lina wanted to avoid talking about her past with her family because they have been separated:

> *"No actually because I wanted to avoid speaking about my past and it wasn't easy to speak about your family who you haven't seen for a while."* (Client Lina)

Here, Lina highlights how her current separation from her family made it difficult to talk about them and her past. Factors specific to refugees and asylum seekers, for example their escape from danger and experiences of loss may make talking particularly hard for this population of clients. It may also be the case that clients' current circumstances and isolation made talking hard, adding an additional layer to the process of breaking isolation.

Using an interpreter was also briefly mentioned by two clients who spoke positively about how their interpreter helped to convey what they wanted to say:

> *"There was another interpreter who was a man, who was able to covey everything that I said to the lady who gave me counselling. That man was also wonderful; he's a great man."* (Client Roshan)

> *Researcher: "Were there ever any misunderstandings?"*
> *Participant: "No it never happened because the interpreter that comes is very nice and we understand each other."* (Client Fathima)

Both of these clients' descriptions extend beyond the interpreters' role of translation and comment on their personal attributes, that they are "wonderful" and "nice". It is important to note the power of interpreters within therapeutic encounters and how powerless clients may feel if they are faced with a language barrier. These comments may reflect this power imbalance and place the interpreters in an idealised position, which may in turn support clients' trust of the interpreters. Additionally, interpreters' roles likely expand beyond translation and provide a further supportive role in breaking isolation by providing an additional, potentially therapeutic, relationship for clients. It may be the combination of these roles that contribute to clients' positive experiences of interpreters.

From the perspective of therapists, one reflected on how contact between client and therapist could also be made in the absence of language, by clients' physical presentation:

> *"There was one man that I saw who had a terrible stutter and he turned up in the session wearing plastic bags under his socks, pyjamas under his trousers and then his outer clothing on him and a big thick coat and a carrier bag that was full of pills and his medical card and cream and a toothbrush and that*

> *was it. I asked him why he was wearing these clothes because he showed me and I wondered with him why did he have pyjamas and it's because he doesn't know, he said he didn't know, where he was going to be at the end of each day so he kept his pyjamas on and the plastic bags were for warmth. But also the medicine in his bag, sorry pain killers, he had a bag full of pain killers plus a medical card. How he was able to make contact with me was by showing me how damaged he was because it was my interpretation that this was something that showed me how damaged he was internally, how much pain he was in. Both, physically and psychically, psychologically. So, you know, sometimes that is as much as the contact could be, which is saying "look, I'm suffering here", but that's still an acknowledgement of something."* (Therapist Ashley)

Here, Ashley describes seeing the presentation of a client and understanding that as a communication of emotional damage and pain. Ashley's interpretation of the client's behaviour and words about the purpose of their clothes, and hypothesis about the emotional pain he may be experiencing but be unable to articulate, offers more communication between the two of them. Ashley highlights how therapists acknowledge clients' suffering across mediums, which suggests that talking explicitly about pain is just one way for clients to overcome isolation. Talking to a therapist who can interpret and recognise clients' emotional worlds may support the overcoming of isolation in an additional way, especially for clients unable to share their pain using language. Ashley goes on to speak about the importance of this "*emotional contact*" that adds depth to talking and sharing, highlighting how therapists listen for the emotional meaning in clients' speech.

In all, this subtheme highlights that talking contributes to breaking clients' isolation and it was both beneficial and difficult. Barriers to talking were recognised by both parties, but were perceived to be overcome in different ways. Interpretation appears to have aided communication both through language interpretation, mentioned only by clients, and

psychodynamic interpretation, described only by therapists, suggesting this was not an explicit process for clients. Language interpretation contributed to breaking language barriers and facilitating talking and sharing for clients, but this may not have been mentioned by therapists because of their reliance on other means of communication. This reliance on different means of communication highlights a discrepancy in client and therapist experiences and it is unclear whether this is recognised by participants.

The relationship is the final subtheme of theme 'Breaking Isolation', comprising the experiences of the therapeutic relationship between client and therapist described by participants. Positive experiences for clients including feeling cared for, secure, comfortable:

> *"I was feeling secure with her. The only person that I trust was her. And you can't say with other people that you don't know everything about your life, so she was the only person."* (Client Lina)

> *"[Therapist name] was someone who gives advice and cares about my life – that made a massive difference to me."* (Client Esther)

> *"You know there are some people who when they are counselling you, you know the way they speak, you feel like maybe this person is my blood – blood sister or blood brother. You just feel it, the way she was speaking to me, you know she is just... kind."* (Client Victoria)

Here, client Victoria describes feeling a special bond with their therapist that felt akin to a family bond. Similarly, other clients described feeling able to speak freely and in a way that they weren't able to with others:

> *"Yeah the things which I did not tell the counsellor in [name of town], I explained to them to [therapist name], but she did not.... she was just... she was willing, she wanted to hear everything what happened to me and help me from there."* (Client Victoria)

> *"I was opening everything to her and she was the only one"* (Client Lina).

Generally, therapists were widely described by clients as a good people, suggesting that they had positive experiences of them:

> *"The person who gave me counselling, I unfortunately forgot her name, but she was a very nice person."* (Client Roshan)

> *"She is a nice person and she is very good – she's a nice person in terms of counselling she is a nice person."* (Client Victoria)

> *"She supported me and the support made things easier."* (Client Esther)

One client also described a positive experience of feeling understood, but shared that she initially worried about her therapist:

> *"So I was getting that sense that whatever I'm saying actually... because before I had this fear that this thing – what if she's not understanding me and what is she misjudge me or, did not get what I'm trying to say, what I'm really feeling inside? So I was bit nervous about that."* (Client Sara)

This excerpt illustrates how clients can have a range of feelings about therapists. Introducing a new dimension to the therapeutic relationship, client Fathima hinted at the power imbalance

that can be present in therapeutic relationships through therapists making the decisions about sessions:

> *"I come whenever they call me I come and attend it."* (Client Fathima)

However, imbalance was not described by the majority of clients. Their descriptions of therapists are wholly positive which may be an indication of very good experiences, but may also be an illustration of the power imbalance between clients and therapists.

From the perspective of therapists, Valerie described remaining mindful of some clients potentially developing dependent relationships with them:

> *"Some of them develop a dependent relationship with you and that can be challenging as I think I said earlier that then you have to start talking about an ending."* (Therapist Valerie)

Indeed, she also expressed concern about clients' having overly positive perceptions of therapists:

> *"A lot of them are scared to be completely truthful. Everything can be quite idolised, which, yeah can be important but I think it's important that clients are able to communicate things they're not happy with."* (Therapist Valerie)

These excerpts highlight the potential bias of clients being overly positive about their experiences to therapists. However, therapists described how some clients are unable to engage in a therapeutic relationship:

> *"Some are not ready to enter an alliance, but we make it clear that they can always come back."* (Therapist Jude)

> *"So they may come for one session and then find it too difficult to sit and be with you, for whatever reason and will not return."* (Therapist Ashley)

These excerpts vocalise the experience of clients who have not taken part in this study – highlighting that the relationship between client and therapist can be too difficult for some because they may not be ready or it may be too hard. Therapist Jude also recognises that this may change over time and explains that they can try again.

To summarise this theme of breaking isolation, therapist Jude spoke of therapy breaking a pattern for clients of being forgotten:

> *"They're kept in mind and not forgotten."* (Therapist Jude)

In this subtheme, clients' descriptions echoed therapists' beliefs that therapy can give clients an experience of someone who is supportive of them. Clients and therapists both express caution regarding the therapeutic relationship and clients were generally more wholly positive about their experience whereas therapists were more reserved and consistently thoughtful about the potential for difficulties arising. All client participants had engaged in therapy and thus none described not being able to build a therapeutic relationship with their therapist.

Taken together, these subthemes highlight how refugees and asylum seekers can be a lonely population, but that therapy can provide a supportive relationship that can support clients to break out of isolation, though it is difficult. Clients and therapists both recognised barriers to breaking isolation but described different methods of overcoming these. Both also

highlighted how the therapeutic relationship can be imbalanced, with clients having less authority than therapists.

Different starting points was a theme speaking to the unique circumstances and experiences of each client accessing therapy. As noted by therapist Jude, *"they all have different starting points"*. Each subtheme in this theme will be explored in more detail:

Different backgrounds and cultures was a subtheme capturing the diverse range of countries of origins, religious beliefs and cultures that participants described. Therapists described:

> *"I mean people are referred to us from all over the world obviously."* (Therapist Valerie)

> *"There's a lot diversity in the people we see."* (Therapist Ashley)

Another therapist commented on the impact of different cultures on therapy:

> *"Well, depression is a word that we use a lot here, but there is no word for it in some languages. I have been in sessions where the interpreter has to find a way to interpret the word depression."* (Therapist Jude)

> *"You also have to have an awareness of colonial history and how people might relate to that. Different religious beliefs also play a part."* (Therapist Jude)

This excerpt hints at the discrepancies that could enter therapy through difference between clients and therapists and how Jude addresses them through awareness, interpretation, and

patience as parties try to overcome differences. Understandably, clients did not reference their diversity, but this may hint at limited contact with each other in the wider service and not having awareness of the context of the service nor feeling part of a collective group.

Role of early life was a subtheme described by all therapists reflecting on the emotional impact of difficult early life experiences for clients:

> *"With this man, he had been, I think he had lived with his aunt and in another country as well in Africa, so I got a sense there was something quite broken in his early childhood which meant that the trauma he went through in terms of leaving his country of origin, or secondary country of origin, meant that he was more fragmented and more damaged than some of the other people that we see."* (Therapist Ashley)

This is an example of how clients' experiences are held in mind and used during psychotherapy with refugees and asylum seekers to understand the emotional state of clients at the time they access therapy, having become displaced. This relationship was further illustrated using attachment theory (Bowlby, 1969):

> *"The stronger and more intact you are internally, and you've got good resource, you've got good attachments, good family connections when you're growing up, you can respond to things differently."* (Therapist Ashley)

> *Researcher: "So if they had slightly better experiences when younger, you might be perceived as less threatening?"*
> *Participant: "Yeah, yeah."* (Therapist Valerie)

These excerpts highlight how clients can be positively influenced by their early life experiences as well as negatively, offering protective or risk factors to developing emotional

difficulties as a result of their experiences and may impact who enters therapy as a result. Therapist Ashley described getting "*a hint*" of clients' internal worlds and their early experiences, but therapist Jude also explained that many clients cannot remember their early lives, which may limit how much therapists can use these understandings of clients:

> *"We can get a clue from their early lives, but many can't access that, they forget. I'm seeing one chap, he's pretty ill, can't remember appointments, let alone his early life."* (Therapist Jude)

The impact of clients' early lives also influenced the amount of emotional contact that therapists could make, which may affect the degree to which clients engage in therapy:

> *"Depending on how supported they are, and depending on how good their support systems are and their attachments in early life, you can at times make emotional contact with individuals who can think about what it means to have lost what they've lost."* (Therapist Ashley)

Therapists' emphasis on clients' early lives highlights a difference in perspective to clients who did not talk about their early lives. This may reflect the difficulties talking about their pasts as described under subtheme 'talking and sharing' or a discrepancy between therapist and client conceptualisations of their difficulties. It may also be the case that due to the adverse experiences of this population, their early experiences are overtaken by their later difficulties or traumas, or the current uncertainty and instability of their lives that may take priority.

Range of needs referred to the wealth of emotional, physical and social needs that clients present with when accessing therapy. Therapists described assessing clients' needs in assessment sessions and bearing them in mind throughout therapy:

> *"We try on assessment to think about what does an individual client actually need or what can they benefit from or what can they make use of, which actually is something very challenging to know after one assessment."* (Therapist Valerie)

Need for practical support was very prevalent for clients and therapists drew a distinction between the practical and emotional needs for clients. Therapist Valerie explained that clients are in need of homes and food, which made her question how therapy could help:

> *"You know a lot of them have no home, no food, do they really want to come and talk about feelings?"* (Therapist Valerie)

There is a sense of hopelessness in this excerpt, hinting at the emotional impact on therapists of working with this client group, which may be due to the distinction drawn between practical and emotional needs that highlight the boundaries of the work of a therapist, restricted to emotions in the context of widespread need.

The different needs of different immigration statuses were also highlighted by therapists:

> *"There's a sense of difference between difficulties that an asylum seeker might come with and the difficulties a refugee will come with."* (Therapist Valerie)

> *"I think another way of looking at it is thinking whether they are refugees or asylum seekers as well... because if they're refugees, they're more likely to be settled so they're more likely, if they're granted full refugee status, they're, in terms of their housing, would be far more settled because they've been given*

> *housing through the local authority as opposed to the home office and they'll been given financial assistance as well. And they'll probably be allowed to work as well. Whereas if they're asylum seekers then... and depending what country they're from, and some of them have been here for years on end, they're in a more precarious position."* (Therapist Ashley)

This distinction made by Valerie and Ashley may provide a means of anticipating clients' levels of needs in assessments.

Clients reflected on their positions at the start of therapy:

> *"My case was going on at one side and I recently came out of my relationship with my ex-husband, my divorce was also going through... Mentally, emotionally I was so disturbed."* (Client Sara)

> *"Before doing therapy, I always felt bad, I wanted to hurt myself and I can't think straight."* (Client Esther)

> *"I could have even killed myself because it was really hurting me, what happened in my life, you know."* (Client Victoria)

> *"Actually, when I came here for the first time for the counselling, I was so deeply upset mentally."* (Client Roshan)

These excerpts illustrate the difficult experiences ensuing for clients Sara, Esther and Victoria before accessing therapy and the emotional impact they had. Other clients described being emotionally overwhelmed by the impact of losing their countries, families, refugee claims and having been tortured and abused. Client Esther described needing help with Home Office appeals, which was her *"biggest problem"*. Needing solicitors and financial support was

identified by clients alongside social needs for clients having difficulties in their relationships with family members and others.

Taken together, the theme 'Different Starting Points' captures the individuality of clients. Though therapists appear to see clients in line with psychodynamic theory that emphasises individuals' early experiences, which clients did not mention, they also emphasise the different needs of clients that are highlighted by clients themselves.

External and Internal Security was the third theme identified during the analysis.

No stable home and therefore no inner home was a subtheme that drew inspiration from a description by therapist Jude about clients' circumstances. The effects of living situations on psychological wellbeing were also explained by therapist Ashley:

> *"The majority of the people we see are... concerned about where they're living... and that also has an influence on their psychological state of mind because if you're settled, you're going to go home this evening back to a settled and safe space."* (Therapist Ashley)

This excerpt highlights how living stability can allow psychological stability, but also hints at the inverse – that unstable living environments can cause unstable states of mind, which would amplify the emotional effects of clients' traumatic experiences.

Therapist Ashley also described their sense of the hostility clients experience in the UK that also contributes to unstable living conditions:

> *"Dealing with a country that doesn't want you is the reality for some and especially if you look at the news... So you're dealing with the reality of people who also know they're not wanted here; and some people want to go home, they don't want to be here, but they can't."* (Therapist Ashley)

This excerpt highlights how societal and political factors can contribute to instability beyond clients' immediate living environments. Feeling unwanted and subjection to prejudice likely add to clients' sense of insecurity and may affect how much they can engage with psychotherapy and process emotions in the context of physical insecurity.

A client described their experience of a difficult living situation and its connection with their mental health:

> *"One day, I wasn't home and I received a letter from the Home Office. It was confidential letter and she opened it; she read it and she threw it in the bin. I found out, then I was very upset. Then I came here and spoke to them, then she wrote to the Home Office and told them that this is the problem, that it should be sorted out. Because of that letter, I went into depression. It was a confidential information and it leaked. If I had not checked the bin, I probably would have never found out about that Home Office letter."* (Client Fathima)

Further, another client explained that it was difficult to talk about her feelings when she needed help with a letter to the Home Office:

> *Researcher: "What is it like when you went to therapy and were encouraged to talk about your feelings when you had a big problem and needed more practical help like writing letters to the Home Office?"*
> *Participant: "It's really difficult. I can't sleep, I am constantly thinking about the same problem and it keeps me awake. I have no solicitor here and the Home Office are asking for more evidence. The Home Office won't help me unless I give them evidence but I haven't got a solicitor. I don't have a solicitor and I spoke to my caseworker and they told me to speak to my solicitor."* (Client Esther)

This again refers back to the conflicts of practical and emotional needs discussed in subtheme 'range of needs'.

There is alignment between client and therapist perspectives on the impact of their external world on their internal world, though clients do not describe the impact of societal discrimination. Therapists' consideration of clients' internal worlds echoes psychodynamic theory; the attention to the internal world against the unstable and unsafe external worlds of refugees and asylum seekers is an interesting contrast with which to consider the relationship between internal and external worlds.

Supporting immigration and integration was a subtheme that captured the efforts of therapists to support the development of security for clients. Clients described appreciating having letters written to the Home Office to support their asylum claims and other interventions:

> *"She has helped me a lot. She wrote to Home Office about my mental health; she helped me a lot with my accommodation."* (Client Fathima)

> *"They made a report with the counselling that they had with me about what conditions I had undergone and why I have come here and what is my condition now, what is my mental status now. All that are, if not mental status, what, how I feel depressed and all those things, they wrote a report and it was sent to my solicitor. This was a good help."* (Client Roshan)

Support with accommodation and liaising with immigration authorities appears to be highly valued by clients.

Psychotherapy was a new experience for many clients, which meant that integration was necessary. Clients described feeling unsure about therapy:

> *"Therapy back home in the Congo is very different and so when coming here, I didn't have a clear idea."* (Client Esther)

> *"I used to feel, think that I had a lot of questions in my mind like 'what will happen', 'how they will go', 'what questions they will be asking me' and 'what I have to do' basically. I had no idea really – I wasn't sure."* (Client Sara)

Therapists described supporting integration into psychotherapy, which involved introducing themselves in ways to dispel negative perceptions and offering explanations:

> *"We don't want to be seen as the person that forces them but we want to be seen as the person that shows some care and hope in their lives."* (Therapist Valerie)

> *"Psychotherapy itself has a culture – it's western as well. Clients will often have no idea what therapy is and will come and ask 'what do I get out of it?' They have to understand what the therapist is about."* (Therapist Jude)

Here, therapist Valerie illustrates how she wants to support clients to have a positive experience of their therapist, perhaps seeing it as an opportunity for clients who have not had previous experience of therapy. Indeed, therapist Jude highlights the questions clients initially bring to therapy and the importance of clients understanding the therapist. However, answering clients' concerns and supporting integration to therapy was not a straightforward process:

> *"It's not easy to understand what therapy is – it's a process they have to go through."* (Therapist Jude)

This suggests that the early stages of therapy, especially for clients for whom therapy is a new experience, may be particularly challenging as they become accustomed to the process. Though therapy can provide security, which may come during and after integration into the culture of psychotherapy, initially it may feel very unsafe for clients. Ultimately, however, therapists described bearing this in mind and doing what they could to encourage choice:

> *"Yeah I think there's a lot of sometimes struggle in engaging the client to arrive at a first session. It's how much, and how, we contact them to enable that because we don't want to be seen as the person that's forcing them to come."* (Therapist Valerie)

One therapist also described a positive reaction to a client's integration in their local community:

> *"She was able to make use of the therapy service to start to mourn the loss of, you know, her country and her children. Also, to start to make new links with her country here, so she had very... she led this women's group in her local church and it was amazing."* (Therapist Ashley)

Across this subtheme, there was alignment between client and therapist perspectives in relation to supporting immigration and integration. However, this is a significant adaption of psychodynamic psychotherapy which typically only focuses on clients' psychic experiences. The excerpts of participants highlight the inescapable difficulties present for refugees and asylum seekers in terms of immigration and isolation that may make it difficult to engage in psychodynamic psychotherapy. It is clear that these are considered by therapists but the rationale behind the adaptations is not entirely clear. It is significant that many clients

did not understand therapy, highlighting an additional potential barrier for clients to engaging in psychodynamic psychotherapy, but it is positive that therapist worked on socialising them to the model.

Safe space was a subtheme that captured how therapy provided external security and psychological security. A client described wanting a private place:

> *"I didn't want to actually to expose everything about myself to everyone. I just wanted that place that was available for me."* (Client Lina)

Therapists were unanimous in their beliefs that a safe space in therapy was vital, had the power to be reparative and supported trust:

> *"A sense of safety is crucial."* (Therapist Jude)

> *"Therapy is about a safe space... and it's about people being able to feel able to bring whatever it is that's going on in their minds that they can't talk to other people about and they're not going to be judged but we're going to explore it together. So, the sessions, and that's why we also try to have, well we do, we have the same room, we have the same time, and it's on the same day. And that again provides the stability, and that's again a very psychoanalytic concept of containment."* (Therapist Ashley)

> *"So yeah, it's not at the least but it's a safe space that can be incredibly reparative."* (Therapist Valerie)

The disparity between how many clients and therapists spoke about the importance and benefits of a safe space suggests that this may be a higher priority for therapists than clients, or may be more conscious for therapists. Given that most client participants were asylum

seekers and their wider life is still not characterised by safety and stability, the safety of the therapy space may not have been enough to generate a general sense of safety that clients were conscious of. Without wider safety, the safe space described by therapists may not be experienced as reparative for clients as hoped. Alternatively, the safe space may be overshadowed by the other elements of therapy that are deemed important and meaningful to clients, such as the therapeutic relationship described earlier.

Trust captured how therapy provided for clients a sense of internal security. Clients described how much they had wanted to trust:

> *Researcher: "And was there anything... you said you helped that therapy would help to reduce some of the stress."*
> *Participant: "Yes, because it was someone that I trusted and I was able, actually, to say lots about myself."* (Client Lina)

> *Researcher: "What was most important to you?"*
> *Participant: "About sessions?"*
> *Researcher: "Yeah"*
> *Participant: "I think trust and... to be able to trust someone and I mean for me it was just... one thing I realised that it's ok to say out things and not keep it to yourself."* (Client Sara)

Sara illustrates how important it was for her to trust her therapist and how that supported her to say things she wouldn't ordinarily share. Though she later explained that trusting is still hard, therapy was nonetheless a positive experience for her in terms of offering an opportunity to build trust.

> *"In starting... initial sessions I was just telling my story like 'this happened, that happened'; I wasn't much sharing my feelings or my worries. I was just*

> *going 'ok, this happened into my life, that happened, this this', but I wasn't really sharing what I was feeling and what fears or, you know... it only started to happen after taking a couple of sessions and then you know, once I started to feel comfortable then I started a bit open up and yes I started to share my feelings about, like, I cannot trust anyone."* (Client Sara)

Therapists also recognised how important trust was for clients and also how it was an important benchmark of progress. Reflecting the process articulated by client Sara, therapist Jude explains how gauging trust can help him reflect on the progress a client is making in sessions:

> *"There are signs that it is going somewhere: if the patient shares something that they've never shared before, that shows it's a safe space, confidential."* (Therapist Jude)

These excerpts highlight how trust can be difficult for clients at first, but over time can become easier and indicate progress. Therapist Jude's description suggests that as a therapist they are in tune with this process, which may help to provide internal feelings of security for clients.

There are similarities between the perspectives of clients and therapists on trust, which suggest that is it similarly valued and prioritised.

Psychological Impact was the fourth theme identified during the analysis. The subthemes comprising this theme will be discussed in turn.

Emotional impact described the effect therapy had on clients' and therapists' emotions. Clients described positive changes to their feelings: relief, confidence, openness, relaxation:

> *"But once I started to come here again and again, and started to talk to her, I felt more a bit relaxed. It was like some burden but now it... all that burden was just coming off."* (Client Sara)

> *"I got the confidence that if I had to say something to someone, if I would be telling about myself... I guess I would not be really worried that, should I say this, should I keep quiet about it."* (Client Sara)

> *"It's really... even now it troubles me but when I just think about what [therapist name] told me, it reliefs me."* (Client Victoria)

> *"I'm still having all those depressive memories and other things, but yet, comparatively, compared to what I was before this counselling, I am feeling a little better."* (Client Roshan)

Interestingly, clients also described how therapists influenced their emotions within sessions:

> *"Without upsetting my mind, she gave me counselling. It was a real real help."* (Client Roshan)

> *"Sometimes even I cried."* (Client Roshan)

> *"Actually when she was seeing that I was getting a little bit nervous about, when I speaking about my past, she will stop and change the subject so make me calm down."* (Client Lina)

These excerpts describe some of the feelings that arose within therapy sessions for clients. Client Roshan's account hints at a potential anxiety for clients before starting therapy – that

they may become more upset or emotionally distressed as a result of speaking about their difficulties. Not having his mind upset appears to be viewed positively by Roshan, which may have been possible through his therapist offering containment for his emotions so that they were not too overwhelming for him. However, describing himself crying does suggest that client Roshan did feel sadness during sessions.

Meanwhile, client Lina's account describes her anxiety that arose at challenging times in therapy and the therapist moving away from or avoiding difficult subjects to help reduce that. This approach may have been employed to lower the amount of distress that arose for Lina in sessions; however, her description of feeling "*a little bit nervous*" suggests that the therapist may be avoiding these feelings by changing the subject. This experience was valued by client Lina, but it is not clear how this contributed to her progress. Lina noticing how she felt while she spoke about difficult experiences demonstrates emotional awareness, which may have been a psychological impact of therapy.

In contrast to clients' experiences, the emotions brought up for therapists were very different: therapist Jude described their work as "*exhausting, draining, emotionally shredding*". Other therapists described:

> *"Part of the work is about bearing witness to that and I think having to sit with it is incredibly difficult at times."* (Therapist Ashley)

> *"I have been left shaken by patients when they tell me about their experiences and life stories."* (Therapist Jude)

Sitting with clients' stories was described as "*difficult*" and "*very challenging*" by other therapists. The importance of tuning into emotional responses and using them to

understand and support clients, using the psychodynamic concept of countertransference, was highlighted:

> *"Even if, inside if you're thinking 'this is so awful', you sit with it and that process allows them to come back. So it's really important to be yourself quite internally strong and robust to a certain extent so that they can come back. And sometimes there will be times when they don't turn up and you're relieved because it is distressing."* (Therapist Ashley)

Here, the necessity of challenging emotions is described by therapist Ashley and it is likely that high emotions will inevitably be present while working therapeutically with clients who have experienced multiple traumas.

The clear distinction between the emotions described by clients and therapists may be due to the process of therapy as described by Ashley above: clients process their experiences and reduce their emotional distress, while therapists bear witness to clients' stories which will cause them distress. These findings may also reflect the feelings that participants feel most comfortable discussing, or may reflect the roles within therapy that they ascribe to themselves – the helper and the helped.

Taken together, the changes are in line with the hopes that therapists described having for clients and suggest that therapy has been helpful emotionally. However, the emotional impact of psychodynamic psychotherapy is clearly different between clients and therapists. The dialectic emotions highlight the role of the therapist as a container (Bion, 1967), helping to relieve clients' painful feelings by taking them in, understanding them and offering them back to clients in a way that they are palatable. This could support the feelings of comfort in clients but also leave therapists with residue of difficult and challenging emotions due to the potential extremity of clients' experiences.

Better understanding of myself was the second subtheme of the theme Psychological Impact. Clients described learning things about themselves, including that they needed someone to talk to and gaining new awareness of their needs:

> *"I started to feel that yes something was missing actually I needed someone to speak to because if during that time, if I had no-one, I am sure I would be just... keeping things on my own and just getting more worried about it."* (Client Sara)

> *Researcher: "Has your view of what you need changed since having therapy?"*
> *Participant: "Yes"*
> *Researcher: "In what way, can I ask?"*
> *Participant: "Because I start to be more open as a person. Before I actually didn't want to speak to no-one, it was very difficult for me. I was crying so very often and from a normal person I was switching to sad person. So that helped me to change in those certain ways."*
> *Researcher: "So did you learn to talk... to be more open with how you were feeling?"*
> *Participant: "Yes"* (Client Lina)

This realisation for Sara is likely a psychological benefit from therapy as it offers insight into how speaking to others may help her in the future.

Similarly, therapists spoke about how therapy can help clients:

> *"It can restore them, help develop sense of being themselves, security within."* (Therapist Jude)

Therapist Ashley described clients acknowledging loss, reflecting clients having new understandings of their experiences:

> *"She was able to make use of the psychotherapy sessions in terms of acknowledging what loss she'd been through and that was about leaving her country of origin and also the loss of her, I think she had one or two children."* (Therapist Ashley)

These excerpts demonstrate alignment in client and therapist perspectives on gaining new understanding through psychodynamic psychotherapy, which is consistent with the psychodynamic concept of making the unconscious conscious and gaining new insight into oneself.

One Step on a Path was a theme about the journey that participants placed therapy on.

Therapy can provide a stepping stone was a subtheme comprising participants' references to where therapy could lead. Clients spoke about referral on to new services:

> *"[Therapist name] knew that there was a certain session; she postponed it a little bit more and then she referred me to GP to continue more session. I'm waiting as well for another foundation – [other charity] that support people in the same condition as I am. And I am in waiting list for them to offer some therapy."* (Client Lina)

> *"They chose another place for me where I can get counselling. The thoughtfulness is very important."* (Client Roshan)

These excerpts place clients' psychodynamic psychotherapy in a context of other services offering specialist therapeutic support for refugees and asylum seekers.

Client Esther described having built a relationship with another organisation that could support her with other needs including "*a place to sleep*". This highlights the requirement for a range of services to support clients' needs and how psychodynamic psychotherapy is not designed to meet the practical needs of asylum seekers and refugees. Within the current service, clients have caseworkers to help connect them with services to meet their practical needs, which may allow clients to engage in psychodynamic psychotherapy differently because some needs can be met outside therapy. However, these needs are very present for clients because they live in uncertain circumstances and therefore an element of considering practical needs and services to support them may always enter the therapy space.

Therapists also described their focus on onward referrals from the service:

> *"Hopefully it's a stepping stone to go on and access more therapy other types of talking therapies."* (Therapist Valerie)

> *"So you're dealing with that and she's been referred to a specialist rape clinic, counselling service as well, so it's... I did that just this morning so I was quite pleased, I was like 'yes – got her referred somewhere'."* (Therapist Ashley)

> *"Essentially, the work I've been doing with her and with a few other men and women is referring them to mental health services because some of them as well, some do have access to GPs and primary health care but some don't."* (Therapist Ashley)

Here, therapist Ashley explains that finding specialist support is a priority and therapist Valerie hopes that clients will go on to access further types of talking therapy recognises the potential support of a range of therapeutic approaches. Hoping that clients will begin a process that can be built upon was described:

> *"I hope they have a good experience of their therapist and can take them with them when they finish. It can be a new experience, a good experience to build on."* (Therapist Jude)

> *"They can begin to process, make sense of things themselves, and use that outside of sessions"* (Therapist Jude)

These excerpts show how clients might use different resources at different times, each building on the last. Therapist Jude mentions what he hopes clients will take away with them from therapy to support the next steps on their paths. They each described working with other organisations to promote their working relationships and some of the challenges:

> *"The challenge is referring them on and accessing organisations that don't have long waiting lists and aren't saying to you they've closed their waiting list or they can't see them for a very long time."* (Therapist Valerie)

> *"I have a young boy that's very suicidal and I've tried to refer a couple of times to primary psychiatric services and they've picked him up and have given him an assessment and then said that they can't continue seeing him until his asylum case is resolved, he's going to, of course he's still going to have these difficulties which doesn't make sense at all so it's back to us."* (Therapist Valerie)

> *"It's a challenge about whether we should be seeing them in this setting or whether they should be referred to a more psychiatric setting, and then how we can help them access that."* (Therapist Valerie)

Therapist Valerie highlights how clients' presentations, asylum status and other organisations' waiting lists can all be obstacles to referring clients to new organisations. Though this is clearly a priority for therapists, it appears to be a complicated process that requires overcoming obstacles. The fact that it is not raised by clients suggests this may not be a part of therapy that is openly discussed or shared; it is unclear why this is or whether this is picked up consciously or unconsciously by clients. Referrals to further sources of therapeutic support can be a commonplace part of therapy, especially for clients with complex emotional experiences, however, in this context it may speak to the limitations of the current service and how long-term support may not always be available to offer.

Needing more than one type of intervention was a subtheme reflecting the range of support clients recognised they needed. Clients spoke positively of the benefits they received from other activities such as language classes and attending university – reflecting on the benefits of combining activities:

> *"I was going there every Monday again, but that time I wasn't going to school I was just sitting at here at home. So I was going there every Monday, but it wasn't helping me to be honest."* (Client Victoria)

> *"She said if you're free then you can get admission in ESOL classes in the college and it will improve on your English. I did take up admission in the college and they told me about different community centres that go there, do yoga, do knitting classes. Then lots of other activities so that my mind would be busy."* (Client Fathima)

Therapists described finding additional support for clients beyond therapy:

> *"Those who need more support, we try to find them something else. It may not be therapy, but the support may be therapeutic. Something where they can engage, maybe make friends, share their story, be grounded and feel connected."* (Therapist Jude)

> *"It might be referring them to ESOL English classes, art classes, massage classes because massage is very good for trauma as well where so much trauma gets lodged in the body."* (Therapist Ashley)

Recognising the therapeutic potential of a wide range of activities is a community-minded intervention that deviates from an individual therapy model. The active referral by therapists also represents an adaptation to the psychodynamic model, which may be necessary due to the refugee context of needing support with integration in the UK through learning English or continuing education, alongside needing emotional support. Therapist Ashley's description offers an illustration of how working flexibly may support a client beyond the therapy room; it also could contribute to increasing a client's sense of community and integration.

Ending was also a subtheme that consolidated many participants' statements. Clients described struggling with the ending, feeling stressed, worried, and that it felt abrupt:

> *"She helped me a lot actually and when, in the end of our session and she said 'that's it, it's finished', I was so worried – what I'm gonna do, where I'm gonna go."* (Client Lina)

> *"Yes I was very much worried. I told her and she told me... I was worried that if I needed to speak to someone, if something comes up in the future then what will happen, who will I turn to and who will I speak to."* (Client Sara)

These excerpts illustrate the emotional impact that ending therapy has for clients and the questions it brings up specifically for clients Lina and Sara. Clients' anxieties also relate to the anxieties of therapists about clients developing fostering dependency under subtheme 'good relationship'. One client described how their ending was eased by planning another session in the future:

> *"I was worried about it so she told me that we can have a review session again after one month or two month – whenever if I feel like it, then we can see what happens."* (Client Sara)

A therapist also described the ending being a difficult time:

> *"And then there's the dilemma of how long do you continue to work with them, and then what do you do, how do you manage an ending, and probably the ending of seeing a patient is the most challenging. And often I will, along with supervision, decide that I might want to see someone for a bit longer or it's time to refer on... To feel you've made that right decision is difficult. And I'm always very aware that I don't want to – a lot of these people come because of an enormous amount of loss they've experienced and they bring their trauma in terms of attachments and separation, and then I don't want to feel like I'm re-traumatising them by developing an attachment and then saying sorry you can't be seen anymore."* (Therapist Valerie)

Here, therapist Valerie appears to be experiencing a dilemma relating to the uncertainty about ending at the right time for the client. She recognises that the ending of therapy will have an impact on clients and employs supervision to help her think about her options. However, she also reflects on the positive impact of the ending:

> *"I suppose seeing the ending not as something that's terrible and very rejecting but that they can take away something good with them inside, a good experience, a good object, a good relationship that then they can go and use."* (Therapist Valerie)

The focus on endings aligns with psychodynamic theory. As highlighted by therapist Valerie, it may be particularly unclear with refugee and asylum seeker clients when the 'right' time for ending is; their emotional wellbeing may not appear entirely improved due to their difficult circumstances, the instability of their lives and level of practical needs. The alignment in perspectives between clients and therapists regarding endings suggests this is a time in therapy that is given due consideration and is an opportunity to discuss the emotions surrounding the end of therapy.

Limitations is the subtheme that captured the limits of therapy described by participants. Clients described therapy having helped them, but only to an extent:

> Researcher: *"Ok, I wondered, so you said you hoped to feel less stressed at the beginning, did she help you to reach that?"*
> Participant: *"Yes, she did. Of course not 100%, but yes she did help me a lot."* (Client Lina)

> *"I can't say that I'm completely fine or I'm completely out of the depression and difficult situation, I'm still having all those depressive memories and other things, but yet, comparatively, compared to what I was before this counselling, I am feeling a little better."* (Client Roshan)

Other clients described having not learned about themselves and experiencing the positive effects of therapy as being short lived:

> *"Have you learned anything about yourself in that time? No, not about myself."* (Client Fathima)

> *"Actually, as I said again, it's not a complete coming out of the situation, still I am having sleepless nights, but the thing is, when I come to the counselling, I feel a little better and comforted and that will remain for one or two or three days, but afterwards, again, I go to the same situation, particularly sleepless nights."* (Client Roshan)

Therapists also recognised the limits of therapies and spoke about struggling with matching what they could hope for with the realities of therapy. Some described not expecting too much change of clients:

> *"I don't think we can expect... it's about matching what we can hope for to the reality of what we can do, and that's obviously a constant challenge. And again that varies enormously."* (Therapist Valerie)

> *"So the shifts are sometimes small, but that's enough as well, and one has to be realistic about really how much you do here, but it's a very powerful process as well, I think."* (Therapist Ashley)

Here, therapist Ashley illustrates the balance to be struck between being realistic about the amount of change to expect from clients, whilst maintaining hope and giving credence to the therapeutic model she has trained in. Working with refugees and asylum seekers for potentially short periods of time may not offer ample opportunity for therapists to see the extent of impact they may otherwise hope for, so making a conscious effort to observe small

changes may be a strategy to maintain faith in the potential impact of psychotherapy with this client group.

Therapists also reflected on a minority of clients that they believed could not manage psychotherapy:

> *"Those individuals who have had so much violence projected into them, lodged into them, that they're just very angry. And that's very difficult because they don't have the mind for psychotherapy to be able to sit and think about their losses and what their current difficulties mean and what does it mean to live in the UK as well. So there are a sort of category of people who can't manage it, and they also tend to not come back as well. So they may come for one session and then find it too difficult to sit and be with you, for whatever reason and will not return."* (Therapist Ashley)

> *"Some people can't engage psychotherapeutically, or some people can engage up to a different level. And some people feel very persecuted and don't understand what that might be."* (Therapist Valerie)

Indeed, other clients may suddenly improve in their presentation and therefore no longer believe therapy is necessary:

> *"A man I have seen and who found therapy shaming, humiliating, they can take a flight into health"* (Therapist Jude)

These excerpts illustrate how therapy can evoke strong emotions in clients that make it difficult for them to engage in the process. The voices of clients who declined to pursue therapy are also absent from this study so it is not possible to hear their experiences in

comparison; alternative therapeutic interventions may feel less persecuting for this group of clients.

The findings of this theme highlight the importance of identifying a range of sources of support for clients and not solely relying on psychotherapy. There are similarities between client and therapist perspectives, except for therapists describing the difficulties of onward referrals. The voices of therapists included the stories of clients who they saw but could not engage in therapy; these clients did not appear to participate in this study and therefore there is a discrepancy between client and therapist voices in this domain. It is unsurprising that psychodynamic psychotherapy is limited in the context of working with refugees and asylum seekers due to the 'range of needs' they have; proportionately it may have less impact than with other populations with other experiences. It is possible that the limitations identified may make psychodynamic psychotherapy appear to be too limited for working with refugees and asylum seekers, but the identification of beneficial impact in the context of limitations alongside 'psychological impact' described earlier should also be held in mind.

Help is the theme that captured participants' perspectives on how the process of therapy helped clients.

What helped is the subtheme capturing clients' descriptions of the elements of therapy they perceived as beneficial:

> *"The counselling itself was a great help."* (Client Roshan)

> *'The [service] really helped me because the way she counselled me it was really, it really helped me from deep of my heart. It really helped me."* (Client Victoria)

Victoria speaks here about her positive experience of therapy, expressing the depth of its help. Clients also frequently said that nothing was unhelpful, which may suggest their experiences were slightly idealised or that being critical of their therapy is very difficult for them. This may relate back to the power imbalance in the therapeutic relationship hinted at by a client under the theme 'Breaking Isolation'.

Valued parts of working with their therapist were described by clients. Advice was highly appreciated by many clients:

> *"Umm, it was meaningful because even myself personally, I just thought 'ok, now yes she gave me this advice of just think about the good things and move on with your life – read books, read news, read, go and gather with others'."* (Client Victoria)

> *"Yes, I did get a lot of help from this. They gave me lots of advice – do this, do that and you will feel better and this will be better for you. So yes."* (Client Fathima)

Other valued practices included encouragement to think positively:

> *"And afterwards, she was asking not only this, in your life you would have had some happy moment, tell about that. And that also she was hearing. And by balancing these two things, she shifted me from these troublesome thoughts to the happy moments in life. She advised me to think about that also. So, from this category I went into that category."* (Client Roshan)

This excerpt highlights how meaningful it was for client Roshan to talk about the happy moments of his life, which may have been difficult to remember in difficult circumstances. Focusing on the emotional impact of "troublesome thoughts" is a similar practice to that of

cognitive therapy. Related to this was client Victoria's description of her therapist acknowledging her past trauma but also the life she still had in the present. Both these elements of therapy that were meaningful for clients involved a re-focusing of clients' minds and a use of perspective.

Examples of people in similar circumstances who have moved on was described as helpful by one client:

> *"Whatever is happening in your life, one day it will just cross... and she said also, we were on the same path even, some of my relatives they were on the same path and they moved on with their life. Now they have great lives is what she said."* (Client Victoria)

As was support with "keeping busy", which worked as a distraction against negative thoughts for a client, which relates to principles of behavioural therapy:

> *"Whatever thoughts come in to my mind, I tell them and then they tell me 'no, this is how you should think and join an activity, join... keep yourself busy with an activity. When your mind is busy, you won't get any negative thoughts'."* (Client Fathima)

Helpful ways of working were also described from the perspective of therapists. Therapists explained the importance of bearing witness to and sitting with clients' emotional pain. Therapists described:

> *"I think one of the main roles of working here I think and working therapeutically is bearing witness. And some, not all, want to tell you about what they've been through. And when they first come into the country they have to tell their story to, you know, lawyers or the Home Office, but to tell*

> *your story about your psychological damage is a far more different and difficult process as well and acknowledging what you've lost. And so part of the work is about bearing witness to that and I think having to sit with it is incredibly difficult at times."* (Therapist Ashley)

> *"I have to take them where they are and respond to that."* (Therapist Jude)

These excerpts highlight the position of 'being with' that is taken up by the therapists. Therapist Jude's reflection is also person-centred, allowing clients' experiences to be at the centre of this psychodynamic psychotherapy. Therapists also described it being sometimes difficult to make emotional contact with clients, which may be due to limited emotions being brought to sessions by clients. This connects to the time participants described it taking to develop therapeutic relationships, which may be difficult in short-term work. Primarily, therapist Ashley spoke about the containment that therapy offered for clients, which they noted is different to what other professionals that clients have contact with can offer:

> *"Containment is huge in this area, but psychotherapeutically that's a very important concept to provide that stability for people, especially who have very chaotic lives. So psychodynamically, for example, on the flip side of that, the clients can come here and see their caseworkers but they may be seen in different rooms, on different days, see volunteers or their caseworkers, so there's lots of different people they see. Whereas here, and this is a really important part of the service, we provide containment, based on psychological principles of containment. So they get, the more safer they feel, the more that can be explored and projected."* (Therapist Ashley)

Here, containment is presented as a vehicle for promoting feelings of safety for clients that support psychological work to ensue. Ashley sets it apart from clients' contact with other professionals, framed as a component of psychodynamic psychotherapy.

Therapists also spoke about the importance and helpfulness of their training keeping them and clients feeling contained:

> *Researcher: "Is not breaking boundaries one of the main ways you stick to the psychodynamic stance?"*
> *Participant: "Keeping boundaries and not always doing things – it is easy to get sucked into being the helper. Sitting with pain is what I do, and seeing what comes of that. I also have my ethical stance and our training keeps us on track."* (Therapist Jude)

> *"You have to always try and stay within that, your own training, which is also a container as well."* (Therapist Ashley)

Here, Ashley reflected on how their training kept them as a therapist feeling contained, whilst containing clients' emotions. This suggests that the therapists' training offers a foundation, roots, from which to work and to offer a safe space for both parties involved in therapy. Therapists also described their training as helping them to maintain an ethical stance and boundaries – encouraging reflection and understanding of why sometimes boundaries shift or are crossed. Therapists spoke about maintaining a position of being with rather than doing for and their belief about this being a healing position of consistency:

> *"I have to be flexible without losing my stance, by not breaking the boundaries. Consistency through the same room, same time, same therapist, making them aware of breaks, these are designed to help an ordinary client as well as a traumatised client. This helps them to trust, be settled. It's like if you*

> *re-potted a plant again and again, would the plant thrive in its new pot? The client needs to put down roots in the sessions."* (Therapist Jude)

> *"You can be compassionate, but not to the extent of doing things that you shouldn't be – the patient needs to rebuild their life themselves."* (Therapist Jude)

Finally, therapist Jude described using interpretations in their work with clients, similarly to as therapist Ashley described in subtheme 'talking and sharing', which they reflected that some clients can make use of:

> *"One session she wanted to talk about her headaches – I suggested that her body was speaking what her mind can't."* (Therapist Jude)

Interpretations can offer hypotheses about clients' emotional worlds. In this case, therapist Jude interprets the client's physical pain as an expression of psychological pain, which may have supported the client to understand how they were feeling.

Reviewing client and therapist accounts of what they believe is helpful in therapy, there are clear differences between them. Clients valued interventions that changed their perspective on negative thoughts, supported behavioural change and offered advice. These are more concrete and perhaps more easily noticeable for clients. Therapists' focus on being person centred, bearing witness, offering containment and interpretations are elements of therapy that may be subtle, but align with psychodynamic theory and clearly underlie their work but in a way that is perhaps not obvious to clients.

Flexibility was the penultimate subtheme, capturing therapists' descriptions of how flexibility and creativity within therapy was necessary when working with refugees and asylum seekers:

> *"At first the need to be flexible I found quite anxiety provoking because I think we're very keen as individuals to stick to the known and this is how I was taught, this is how I need to practice and therefore that makes me a good therapist. But I really enjoy the flexibility now and the freedom of that. I feel very empowered by the fact that I, and I can only say that in retrospect, that I try something and ok, it might not have worked, but then I can try it in a different way and that way worked."* (Therapist Valerie)

> *"I think as a therapist you have to be creative."* (Therapist Ashley)

Therapist Valerie describes how flexibility at first caused her anxiety but now feels more comfortable. The excerpt suggests that flexibility is inconsistent with her training and is therefore an example of how she has had to adapt her practice with refugees and asylum seekers. A distinction between psychotherapy in other settings and the current one was also made:

> *"So I think we always hold that in mind as we're working with them, which is very different kind of therapy again, from what we we'd be normally doing."* (Therapist Valerie)

Valerie explained that in order to be flexible as a psychotherapist, she held her psychotherapy model, but softened the therapeutic frame to allow flexibility in:

> *"The longer I've been here the more I've realised that although I'm trained as a psychotherapist, it's more about using that as a thinking behind the practice."* (Therapist Valerie)

Having sessions less frequently than weekly is an example of how the psychodynamic frame can be softened.

Clients explained how they valued being able to see their therapists as less frequent intervals, which meant less frequent travelling for those coming from a long distance, and how being contacted by phone and email was also a positive experience that offered relief:

> *"Umm... you know what, I felt yes it was not good but at the other hand, again, because she was emailing me anyway to see how I'm doing; she was emailing so from there I was getting a relief anyway."* (Client Victoria)

> *"Yes. So when it was every week, I didn't have a lot to talk because only every week, but when it was every two weeks, I had quite a lot to speak and discuss with her."* (Client Lina)

The flexibility described by participants represents alteration to the psychodynamic frame and an adaptation of psychodynamic psychotherapy. It may be that factors important within the refugee context such as very limited financial resources that restrict how many sessions can be attended, instability in terms of accommodation or the complexity of clients' emotional experiences impact the adaptation of the model. It may also be the case that because therapists are working alongside caseworkers to support clients, they may emulate the range of communication methods offered by the wider service and adopt the flexibility offered by caseworkers who do not hold a psychodynamic frame. This could offer clients consistency in terms of what to expect from the service as a whole.

Joint working was the final subtheme describing the importance of therapists working together with caseworkers in order to help clients. Joint working between therapists and caseworkers was valued highly by clients:

> *Participant: "As much as she could do, actually she did a lot. She tried to help me with the immigration, trying to speak to my caseworker about other things, yes she did."* (Client Lina)

> *"Then my therapists and my caseworker, they both wrote to Home Office and enquiry was done. I'm still in sharing but it's a different place. But that... the stressful position that I was in, I've come out of that. So yes, they did help me."* (Client Fathima)

It was also valued by therapists:

> *"Some are living in hostels, some are homeless, so there's a very chaotic nature to the sessions as well. So part of it is listening and then trying to speak to the caseworker about the difficulty with home so that one of the things I have worked out is that once their home life is settled to a point, then you can make some progress to a limited extent in the sessions."* (Therapist Ashley)

> *"I've spoken with her caseworker so the caseworker does, sort of, the more active work in terms of trying to maybe deal with the complaints procedure or trying to deal with the agency that's responsible for the accommodation."* (Therapist Ashley)

> *"We will often work together with the caseworker in writing letters to solicitors, to the home office, supporting accommodation."* (Therapist Valerie)

These excerpts illustrate the nature of joint work being often focused on issues such as immigration and housing. A therapist described the balance and boundaries between the roles of themselves and caseworkers:

> *"I suppose really we really need to be aware as therapists of us getting too involved in the more practical aspects because that can be our defence against the anxiety of working with the raw feelings. It's very easy for a client to evoke us into getting busy for them rather than staying with the unbearable feelings that they're not able to communicate. So we have to think about are we acting into something unhealthy, this isn't our role, or how useful – I suppose, is this useful or is this going to be counterproductive to what we're doing. Also I suppose there's also the fine line between staying as a therapist and crossing over what the caseworker's responsibility is, yet trying to help them at the same time. So I think the more contact we can have with the caseworker the more communicative we can be with the caseworker, the better."* (Therapist Valerie)

Here, therapist Valerie outlines how increased contact with the caseworker also supporting a client helps her to maintain her role as therapist. In an earlier subtheme clients' 'range of needs' were identified, and for Valerie it may be reassuring that she does not have to ignore some of the needs that are outside the remit of psychodynamic psychotherapy by involving a caseworker for additional input. In this sense and with this support and alliance, therapists can work flexibly both within and outside therapy sessions in service to clients.

Joint working represents a further adaptation to the psychodynamic model; similarly to therapists working flexibility, it modifies the psychodynamic frame and shifts boundaries. Given the unique service model of this service, this adaptation is context-specific due to the role of caseworkers working alongside psychodynamic psychotherapists.

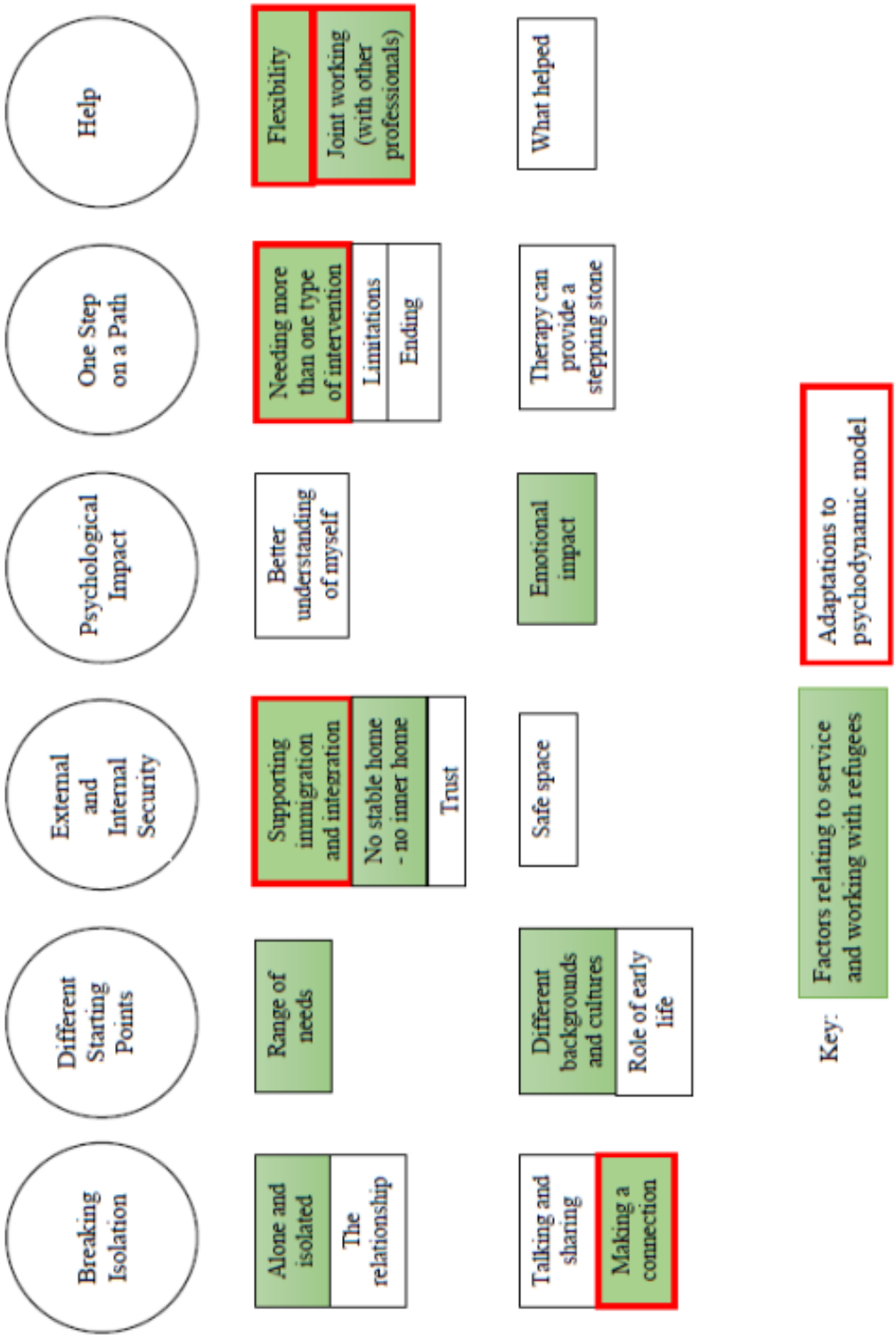
This theme outlined the inputs believed to help clients in therapy. Though there was difference in clients' and therapists' perspectives of what was helpful and contributed to improvement, there was consensus that flexibility and working together were both helpful.

These both reflect adaptations to the psychodynamic model, which may be necessary when working with refugees and asylum seekers due to their context.

Thematic Map

Using the six themes identified during the analysis, a thematic map was constructed to provide a visual representation of the findings. Figure 2 depicts how psychodynamic psychotherapy is experienced by clients and therapists based on their accounts. Clients' experiences are strengthened by the similarly unique experiences of therapists' that give depth and understanding to the processes of psychodynamic psychotherapy for and with this client group.

Figure 2. *Visual Representation of the findings*



Across the themes that capture how clients and therapists spoke about similar areas of psychodynamic psychotherapy, their perspectives were characterised by similarities and differences. These are elements that are likely to be present within therapeutic encounters and consideration of them together provides an opportunity to highlight areas of divergence. In the thematic map, subthemes are categorised by whether they feature similarities or differences between clients and therapists, and the details of which will be described below. Subthemes including factors important to the refugee context and working in a refugee service are also highlighted in the map, represented by green boxes. Subthemes highlighting the psychodynamic approach, specifically how it is adapted, are represented by red boxes. The details of these are also described in more detail below.

Within the theme 'Breaking Isolation', participants' perspectives of clients being 'alone and isolated' were similar in this subtheme that relates to the refugee context of clients. There was also alignment on the importance of the therapeutic relationship in subtheme 'the relationship'. There were differing perspectives between clients and therapists in subtheme 'making a connection': clients focused on connecting to their therapist and while therapists also described connecting to clients, they extended their thoughts to connecting clients to other external groups. This suggests that therapists hold in mind clients' context and respond by adapting the psychodynamic model. Identifying social networks may be a necessity for working with refugees influenced by how wider services support them, leading to a more pragmatic response to clients' isolation by therapists.

In relation to the 'talking and sharing' described by both parties, there was also difference between perspectives on overcoming barriers to talking. Clients described language interpretation, which relates to their context; and therapists described interpreting clients' unconscious communication in line with psychodynamic psychotherapy. Different

methods of interpretation may have different emotional implications: the interpretation of unconscious communication appears to add a layer of emotional understanding and contact for therapists, whereas language interpretation may not offer the same depth of emotional understanding for clients.

Within theme 'Different starting points', clients and therapists both recognised the 'range of needs' clients present with, which is a factor of the refugee context. However, difference lay in therapists describing clients' 'different backgrounds and cultures', which connects to working in a refugee service and their position of seeing many clients. Therapists described the 'role of early life' contributing to clients' starting points for therapy, which was not mentioned by clients but reflects psychodynamic psychotherapy. The impact of different perspectives is unclear, but could potentially conflict.

Within theme 'External and Internal Security', participants were aligned in their perspectives on the connection between clients' external and internal worlds, captured under subtheme 'no stable home – no inner home', which is associated with clients' circumstances of instability and isolation. Participants also perceived the importance of 'trust' similarly. There was alignment between client and therapist perspectives on 'supporting immigration and integration', which is again specific to clients' refugee context. This practical support is a significant adaption of psychodynamic psychotherapy, likely influenced by the service context and the practical support that refugees require with immigration.

In terms of participants' references to therapy as a 'safe space', this was highlighted principally by therapists. It is possible that accessing therapy within a service context that is chiefly associated with clients' immigration status may diminish clients' sense of the service being a safe space; however, this was not described.

Within theme 'Psychological Impact' participants were aligned in their perspectives in subtheme 'better understanding of myself'. However, there was clear difference in the

emotional impact of therapy for clients and therapists: clients described feeling better and therapists described painful feelings in relation to clients. Therapists highlight that their responses relate to the circumstances of refugees, specifically the emotional pain attached to their experiences that is present in the transference and felt by therapists, which is specific to psychodynamic psychotherapy.

Within theme 'One Step on a Path', there was similar recognition by both clients and therapists that 'therapy can provide a stepping stone' to receiving other sources of help. However, difference lay in how therapists highlighted the difficulties included in onward referrals. Similar perspectives were expressed by participants on clients' 'needing more than one type of intervention' such as language classes and education, which reflects their refugee context, the range of needs and practical support they can require. However, the referral of clients to additional services by therapists is an adaptation to the psychodynamic model, used to actively respond to the context of clients and the needs they present with. This is similar to the role that clients' caseworkers may undertake, but it is unclear whether this is an expectation in the wider service.

Participants were aligned in their perspectives of 'ending' being poignant in psychodynamic psychotherapy. Further, they were aligned on the 'limitations' of therapy, suggesting that both clients and therapists were realistic about what they could hope to achieve.

Within theme 'Help', there were clear differences in perspectives in the subtheme 'what helped': clients valued concrete interventions that they could see impacting them and therapists viewed elements specific to the psychodynamic model as helpful. Therapists appear connected to their model, but clients do not share the same psychodynamic perspective. These differences have the potential to conflict if clients want active intervention and change whereas therapists focus on clients having an experience of being understood.

Clients and therapists were both aligned in their recognition of the helpfulness of 'joint working' and 'flexibility', however, these both represent adaptations to psychodynamic psychotherapy. Many factors of the refugee context such as limited resources to pay for travel to sessions and uncertainty around immigration status influence the need to work flexibly and jointly with caseworkers. Joint working is associated with the context of the therapy service – there are caseworkers available to support clients with practical issues, which means there is more scope for therapists to be involved in that process. However, despite one therapist reporting that joint working helped them to maintain boundaries, the act of working flexibly and jointly with caseworkers to influence clients' external worlds is nonetheless an adaptation to psychodynamic psychotherapy that appears to be a response to clients' refugee circumstances.

Taken together, factors relating to clients' being refugees are sometimes responded to by therapists adapting psychodynamic psychotherapy. These adaptations often reflect the wider service context that the therapists work within, reflecting its focus on practical support. Adaptations to the psychodynamic model were generally viewed as helpful by both clients and therapists. In contrast, differences in perspective were predominantly present in relation to therapists' work specific to psychodynamic psychotherapy.

Chapter summary

This chapter described six themes reflecting the experiences of psychodynamic psychotherapy for clients and therapists within the service under study. Experiences of clients and therapists were sometimes similar, but also differed; adaptations to the psychodynamic model were also described. These will be considered in more detail within the discussion chapter alongside existing literature and theory.

Discussion

This final chapter will consider the findings of this study in light of previous research and existing theory. The aim of this study was to explore experiences of psychodynamic psychotherapy for refugees and asylum seekers, and therapists working with these populations. The findings shed light on the processes at work during psychodynamic psychotherapy for refugees and asylum seekers, based on the accounts of clients and therapists.

Summary of findings

This study asked how refugee and asylum seeker clients, and therapists working with these populations experience psychodynamic psychotherapy in the context of a specific service that offers a range of support to refugees and asylum seekers. In answer to this research question, participants' data was organised into six themes that identified commonalities in the data in line with thematic analysis. The experiences of clients and therapists were both consistent and inconsistent, which is outlined in the thematic map in the results chapter. The findings highlighted that clients begin therapy at different starting points, which therapists were more aware of than clients, and that psychodynamic psychotherapy with refugees and asylum seekers does not lead to a fixed end point, but recognition of therapy being one step on a path and the importance of clients' next steps in finding further support.

Within psychodynamic psychotherapy, clients can break out of isolation and experience positive change in their sense of external and internal security; external security was predominantly highlighted by therapists, suggesting that it is harder to achieve for clients perhaps due to their wider social context and insecurity. Therapists' efforts to support clients' immigration and integration also constituted an adaptation to the model of psychodynamic

psychotherapy. Psychodynamic psychotherapy had a psychological impact through clients' and therapists' emotional experiences and clients' understanding of themselves. In addition, help was experienced in different forms and there were different perspectives on what was helpful between clients and therapists. Working flexibly and working jointly with caseworkers to offer a wider range of support were valued by both parties, but reflect adaptations to the psychodynamic model.

Taken together, the findings emphasise the unique experiences of clients and therapists. They highlight that psychodynamic psychotherapy is adapted when working with refugees and asylum seekers in this context, which it is experienced positively and is viewed as helpful by both clients and therapists. Finally, it can support the meeting of a range of needs that clients present with, each specific to their circumstances and experiences.

Key findings in relation to existing literature

At first, the themes identified in the results of this study appear wide-ranging and not directly related to psychodynamic theory. However, among the subthemes lies information about how psychodynamic theory is used within psychodynamic psychotherapy with refugees and asylum seekers. The findings will also be considered in relation to literature on general experiences of psychodynamic psychotherapy and refugee and asylum seekers' general experiences of therapy.

Therapists described bearing witness which is consistent with the theoretical framework of psychodynamic psychotherapy – especially with survivors of trauma (Boulanger, 2008). Bearing witness is a psychoanalytic term referring to therapists validating and offering testimony to clients' experiences of being wounded by reality, paying close attention to dissociation or other defence mechanisms that may perpetuate trauma

unconsciously (Boulanger, 2008). It relates to the 'therapeutic witnessing' used by Papadopoulos (1999) in psychodynamically-informed work with Bosnian medical evacuees. Papadopolous (1999) highlighted the importance of respecting the complex realities of those evacuees and accepting their experiences without pathologising them, which relates closely to the descriptions by therapists in this study who emphasised bearing witness to clients, and accepting and responding to clients where they are.

Bearing witness was not described in existing literature exploring therapists' experiences of working psychodynamically with other populations, not including refugees. This suggests that bearing witness is an element of psychodynamic psychotherapy that has a specific and important role in the work of psychodynamic therapists working with refugees and asylum seekers, perhaps relating to the characteristics of this population, the experiences they have had and their complex emotional responses.

Therapists' adoption of a position of 'being with' clients' emotions and experiences is key to psychodynamic psychotherapy and particularly dynamic supportive therapy (Misch, 2000). 'Being with' reflects the psychoanalytic stance (Lemma, 2003). This finding is also new and not reflected in qualitative literature exploring the use of psychodynamic psychotherapy with non-refugee populations, or literature on therapists working with refugees, suggesting that it is especially relevant to the use of the psychodynamic model with refugees and asylum seekers.

Containment for clients was also described by therapists, consistent with psychodynamic theory (Bion, 1962) and existing literature of therapists working psychodynamically with clients from other populations (Muston, 2017; Philips, 2008). The reference of therapists to their training being a container for themselves was a new finding that is not echoed in existing literature. This may reflect a greater need for containment for therapists that work psychodynamically with refugees and asylum seekers than

psychodynamic therapists working with other populations. Existing literature notes how the 'refugee trauma' narrative can impact those working with refugees, blinding therapists to other issues and oversimplifying complex presentations (Papadopoulos, 2001). Using this systemic perspective to consider the findings relating to therapists' need for containment, it highlights the potential for trauma narratives to affect therapists in addition to the immediate therapeutic work. This perhaps represents an additional layer to psychodynamic psychotherapy that may not be as present for other populations. Therapists finding containment in their training suggests that returning to psychodynamic theory can help them feel secure in their work.

Clients did not directly describe containment, but referred to a sense of internal security that was supported by trust, which reflects containment. Trust has been highlighted in existing literature as of particular importance to refugees and asylum seekers in CBT (Vincent et al., 2013) and was recognised by therapists in this study. It appears that containment is a common element of psychodynamic psychotherapy with many populations including refugees and asylum seekers. Trust is also a common human element of therapy that applies to all types of psychotherapy (Wampold, 2012).

The descriptions of countertransference by therapists in the current study align with psychodynamic theory, which recognises the feelings evoked in therapists by clients as unconscious communication (Lemma, 2003). The emphasis by therapists on the emotional impact of clients, including the experience of challenging emotions, is also captured in literature exploring psychodynamic therapists' experiences of working with other populations (Bowker & Richards, 2004; Fragkiadaki & Strauss, 2012; Haskayne, Larkin, & Hirschfeld, 2014; Lilliengren & Werbart, 2010; Muston, 2017; Palmstierna & Werbart, 2013; Ryan, 2006; Wilson & Sperlinger, 2004). This suggests that countertransference is a pertinent aspect of psychodynamic psychotherapy for therapists working with both refugee and non-

refugee populations and that the presence of challenging emotions is not only linked to the experiences of refugees. However, the extremity of the emotions described by therapists working with refugees in the current study does appear to be a new finding that is qualitatively different to the descriptions of therapists working with non-refugees. This corresponds to the descriptions of therapists working therapeutically with refugees and asylum seekers using unspecified models (Apostolidou, 2016; Century et al., 2007), which suggests that it may not just be present when the feelings evoked by clients are conceptualised psychodynamically as countertransference.

Therapists described using interpretations of clients' behaviour and unconscious communication. This is a classic psychodynamic technique that emphasises the depth of behaviour and emotional experience, and contributes to the awareness of unconscious experience (Bibring, 1954). This finding echoed the experiences of psychodynamic therapists working with other populations (Lilliengren & Werbart, 2010; Philips, 2008; Ryan, 2006; Wilson & Sperlinger, 2004) and was not found in research exploring therapists' experiences of working with refugees generally. Thus, making interpretations is a key element of psychodynamic psychotherapy working with refugee and non-refugee populations that appears to be specific to the model. It may be the case that psychodynamic interpretations are useful for working with refugees and asylum seekers because they offer an additional, psychoanalytic language in the face of language differences between therapists and clients. By maintaining their psychodynamic stance, therapists remained aware of clients' early life experiences and attachment experiences (Bowlby, 1969) to understand how clients may relate to therapy, representing another way that psychodynamic theory is used with this population.

However, as mentioned in the subtheme 'talking and sharing', it is not clear how interpretations are used by clients as they were not explicitly described. The psychodynamic interpretations offered by therapists may have contributed to clients' better understanding of

themselves. Increased self-awareness is consistent with the experiences of clients accessing psychodynamic psychotherapy from other, non-refugee populations (Bury et al., 2007; Lilliengren & Werbart, 2005; Palmstierna & Werbart, 2013; Poulsen et al., 2010; Qureshi, 2007; Toto-Moriarty, 2013; Werbart & Levander, 2016). This was not echoed in any existing published research exploring general therapy experiences of refugees and asylum seekers, which suggests that this may also be specific to psychodynamic psychotherapy as a result of the emphasis on interpretation of unconscious material.

Explaining their way of working psychodynamically with refugees and asylum seekers, the therapists in this study described holding their psychodynamic stance, but softening the frame. The psychodynamic frame traditionally holds boundaries, for example around the consistency of session times, days and location (Bridges, 1999). This finding highlights how the psychodynamic model is adapted in psychotherapy with refugees and asylum seekers. Therapists described softening their boundaries under 'flexibility', which suggests that therapists use psychodynamic techniques within psychodynamic psychotherapy but change the boundaries from that of traditional psychodynamic psychotherapy.

In relation to existing literature, this finding is not entirely new. When working with other populations, therapists also describe modifying the frame within psychodynamic psychotherapy and for a number of reasons (Gelman, 2004; Lilliengren & Werbart, 2010; Palmstierna & Werbart, 2013; Symons & Wheeler, 2005; Werbart et al., 2017). Psychodynamic therapists working with other populations describe reflecting on why the frame is adapted and this being an essential part of psychodynamic work (Gelman, 2004; Symons & Wheeler, 2005). The rationale for flexibility was not articulated by the therapists in this study, but it may be a method of empowering clients or overcoming obstacles to attending therapy on a weekly basis. Doing this also provides greater flexibility and responsiveness to clients' presentations and current experiences. The benefits this gave

clients were articulated by the clients themselves, helping to enrich the therapists' descriptions. The anxiety described by a therapist about developing flexibility in the psychodynamic approach was similar to that described in existing literature (Symons & Wheeler, 2005), suggesting that modifying the psychodynamic frame is rarely an easy or straightforward process.

Adopting an untraditional style of psychodynamic psychotherapy may be a way of psychodynamic psychotherapists supporting themselves in very challenging work with refugees and asylum seekers. This was not a reason described in existing literature, but the extent of refugees' and asylum seekers' presentations and needs likely make working with this population, particularly difficult in a traditional psychodynamic model. Therapists described the distress and trauma in the transference and it may be that by adopting a more supportive therapeutic style by 'softening the frame', the therapists are able to meet clients' needs in different ways, while simultaneously protecting and looking after themselves.

All the theoretical constructs, associated with psychodynamic theory, were described by therapists in this study. This is unsurprising as it reflects the different positions of clients and therapists within therapy, one of whom is equipped with theoretical understanding and training. It is also reflected in the findings of the systematic review described earlier in this thesis in which clients did not refer to psychodynamic theory in their accounts. The lack of descriptions from clients in this study reflecting psychodynamic theory does not mean that psychodynamic techniques were not valued by them. The findings suggest that they have been described in different ways; for example, it is through 'talking and sharing', which clients valued, that bearing witness is possible and the importance of a 'safe space', as described by participants, maps onto containment.

The discrepancy between client and therapist emphasis on psychodynamic psychotherapy creating a safe space is interesting and may relate to the instability and

uncertainty that characterises the refugee population. It is noted that the literature on client and therapist experiences of psychodynamic psychotherapy in a range of populations that did not include refugees, as reviewed in the systematic review chapter of this thesis, does not directly echo the discrepancy found in the findings of this thesis. Remarkably, it echoes the findings in reverse: the importance of a safe space in psychodynamic psychotherapy is emphasised by clients, but not by therapists. This finding may be specific to refugees and asylum seekers accessing psychodynamic psychotherapy because as the findings describe, therapists are acutely aware of the unstable and unsafe external world of refugee and asylum seeker clients and therefore hope and try to create safety within therapy. However, due to their unsafe external worlds, the safeness of the therapy space is unlikely to be enough to neutralise the threat present in clients' lives and generate a conscious sense of safety. This differs from the contexts of other populations of clients accessing psychodynamic psychotherapy.

The importance of a safe space in therapy was not referred to in research exploring refugees' and asylum seekers' general experiences of therapy (Al-Roubaiy et al., 2017; Vincent et al., 2013) or therapist experiences of working with refugees (Century et al., 2007; Schweitzer et al., 2015), which suggests that the creation of a safe space is specific to psychodynamic psychotherapy, both with clients who are refugees and from other populations. This corresponds with the emphasis on the therapeutic frame, which is designed to create a safe space within psychodynamic psychotherapy through the use of boundaries around the therapeutic space. It is interesting that alongside alterations to the psychodynamic frame through flexibility and joint working with caseworkers, the safe space is emphasised by therapists in the current study and not clients. The psychodynamic frame is theoretically designed to create a safe space for clients to express themselves and therefore due to the alterations, therapists may have to consider the safety of the therapeutic encounter for clients

in a way that is separate from the way it is considered in psychodynamic theory. It may be the case that clients in the current study do not widely describe psychodynamic psychotherapy as a safe space, unlike non-refugee clients of psychodynamic psychotherapy, because of the alterations to the therapeutic frame, which appear to be less extensive and more considered in descriptions in existing research by therapists working psychodynamically with other, non-refugee populations (Symons & Wheeler, 2005).

The relationship between clients' internal and external worlds is described in the findings, for example how a sense of safety can be reflected in one can be reflected in the other and the competing external and internal pressures of practical and emotional needs present in clients' lives. This relates to the Jungian concept of an Umwelt described by Papadopoulos (2011). The interplay of the individual factors of psychodynamic psychotherapy, reflecting the internal world, and the refugee context, the external world, are of particular significance given the "harshly defining" external worlds of refugees and the limits of psychodynamic approaches through their focus on the internal world (Papadopoulos, 2011). The meaning ascribed during the translation of external experiences to internal experiences, and then individuals' subsequent construction of their Umwelt has the potential to create cycles of reinforcement (Papadopoulos, 2011). Therefore, the external reality of therapists' sensitivity to the need for safety for clients and accommodating needs by adapting the psychodynamic practice is likely to hold unconscious meaning for clients and it is unclear what they are or how this may perpetuate clients' difficulties. It is consciously experienced by clients as positive, but the unconscious consequences of this practice are unclear.

Both clients and therapists described the importance of the therapeutic relationship, which is emphasised in psychodynamic theory and considered the foundation for any psychodynamic work (Lemma, 2003). The role of the therapeutic relationship is also widely emphasised by clients of psychodynamic psychotherapy from other populations and

psychodynamic therapists working with other populations, as described in the systematic review. However, this is also the case for refugees who undergo CBT (Vincent et al., 2013) and therapists of unspecified therapeutic modalities working with refugees (Century et al., 2007; Schweitzer et al., 2015), which means that this finding is not exclusive to psychodynamic psychotherapy.

The emphasis on endings by both clients and therapists highlights a further psychodynamic factor within the psychotherapy described by the clients and therapists in this study, specifically the consideration of endings as a loss of an attachment relationship that may re-traumatise clients. This aligns with previous research exploring therapists' experiences of psychodynamic psychotherapy with other populations (Fragkiadaki & Strauss, 2012) and other clients of psychodynamic psychotherapy emphasising the difficulty of ending (Bury et al., 2007; Merriman & Beail, 2009; Poulsen et al., 2010; Shamai & Levin-Megged, 2006; Statham & Beail, 2018; von Below & Werbart, 2012; Werbart & Levander, 2016). Therapy ending, particularly the sadness of ending, was also emphasised by research exploring asylum seekers' experiences of CBT (Vincent et al., 2013), but not by therapists working therapeutically with refugees (Century et al., 2007; Schweitzer et al., 2015). Clearly, endings are not unique to psychodynamic psychotherapy: all therapies end at some point, however, the way that endings are thought about within psychodynamic psychotherapy, for example the consideration of the relationship between the therapeutic relationship and the ending (Fragkiadaki & Strauss, 2012), separates them from endings in other therapeutic modalities and this can be seen in the fact that they are considered by psychodynamic psychotherapists working with refugees, but not in other research exploring therapist experiences of working with refugees.

The helpful parts of therapy described by clients (valuing healing stories of others, flexibility and advice in terms of managing difficult feelings) do not appear to reflect

psychodynamic theory as they describe shifting boundaries. They are not echoed in existing literature on the experiences of non-refugees accessing psychodynamic psychotherapy, but they are consistent with existing literature relating to refugees' general experiences of therapy (Gilkinson, 2010; Marusiak, 2013; Stuart, 2009) which suggests that they are not experiences unique to psychodynamic psychotherapy and perhaps relate to the clients' context as refugees: having less hope and more practical needs. Clients' descriptions of talking openly and freely relates more closely to the psychodynamic concept of free association (Lemma, 2003). Clients' valuing talking is also present in both the existing literature on client experiences of psychodynamic psychotherapy (Lilliengren & Werbart, 2005; Merriman & Beail, 2009; Palmstierna & Werbart, 2013; Philips, 2008; Qureshi, 2007; von Below & Werbart, 2012) and refugees' general experiences of therapy (Al-Roubaiy et al., 2017). New findings included clients' appreciation of thinking positively and remembering good memories as well as difficult memories. These ideas are related to the principles of cognitive therapy (Beck, 1979) and thus it is surprising in the context of exploring experiences of psychodynamic psychotherapy and that they are new given that previous research has explored experiences of CBT with asylum seekers (Vincent et al., 2013).

All descriptions about how the psychodynamic model is used with refugees and asylum seekers are new findings, not previously reported in existing literature because research of this kind has not been done before. There is some overlap with existing research exploring client and therapist experiences of psychodynamic psychotherapy, refugee and asylum seekers' general experiences of therapy, and therapist experiences of working with refugees. These overlaps highlight the commonalities of experience across these different contexts and hint at how the findings relate to psychodynamic theory and factors associated with being a refugee or asylum seeker. The findings also emphasise how psychodynamic psychotherapy is experienced by refugees, asylum seekers and therapists differently to other

models of therapy and in the context under study, and identify factors that are unique to the use of psychodynamic psychotherapy with the refugee population.

The psychodynamic concept of bearing witness (Gautier & Scalmati, 2010) is specifically pertinent to working psychodynamically with refugees and asylum seekers. Indeed, the extent of adaptations to the psychodynamic frame described in this study also appears to be specific to working with refugees and asylum seekers. The presence of caseworkers in the current service is a factor that allows the adaptation to happen, but the flexibility is an element of the findings that may be more transferable to other settings as it is less reliant on the context of the current service. The adaptations to the psychodynamic frame that usually help to create a sense of safety for clients may implicate the safety achievable within psychodynamic psychotherapy for refugees and asylum seekers, though this may be also implicated by the unstable context endured by clients.

The commonalities between the current findings and existing literature on refugees' general experiences of therapy reflect therapeutic factors that are valued but not specific to psychodynamic psychotherapy. The therapeutic relationship, incorporating trust and talking about difficult material, is consistent with the common factors model, which proposes that the outcome of therapy can be attributed to and shaped by client contribution, the therapeutic relationship and therapist characteristics (Drisko, 2013). The model highlights the lack of significant difference in therapy outcomes across different models of therapy (Luborsky et al., 2002) and raises the question of whether unique therapeutic techniques are as influential and important as considered in the associated theories. Indeed, data from meta-analyses suggests that the adherence to the process of specific interventions is also unrelated to outcome (Truijens, Zühlke-van Hulzen, & Vanheule, 2018), leading to conclusions that the unique ingredients of different models of intervention do not make a difference to outcome (Wampold, 2015) and that manualised therapy is not superior to non-manualised therapy

(Truijens et al., 2018). However, there is a lack of empirical research to support claims that common factors are enough to produce change for clients and there is not enough research focused on the process of psychotherapy to help understand how unique factors contribute (Mulder, Murray, & Rucklidge, 2017). Common factors reflect broad elements of therapy and it is argued that they are necessary for unique factors to exist (Mulder et al., 2017).

This study's focus on experiences rather than therapy outcome offers an opportunity to consider the depth of therapeutic factors and the debate around common and unique factors differently. These findings offer qualitative support to existing research on the importance of common factors and highlight their role in providing a foundation for psychodynamic psychotherapy with refugees and asylum seekers. Common factors are emphasised most by clients in this study, which is understandable given that they reflect the human elements of therapy and are not complicated or overly theoretical. However, to solely attribute the findings to the common factors would overlook how they map uniquely onto psychodynamic psychotherapy with refugees and asylum seekers and are emphasised due to the meaning they hold and the context in which they are experienced. The therapeutic relationship appears to have a particular significance for refugees who are isolated, which is especially pertinent to these clients' contexts.

The findings also highlight the importance of factors unique to the psychodynamic modality, including bearing witness, which holds unique significance with refugees and asylum seekers due to the nature of their experiences that are present, consciously and unconsciously, in therapy, and interpretation, which can facilitate clients' insight into themselves. Therapists also highlight the importance of the context around the therapy and needing containment for themselves when working with clients' conscious and unconscious distress. These factors reflecting psychodynamic theory are necessary for therapists to do their work.

Psychodynamic psychotherapy is a relational psychotherapy, which can explain why there is such a considerable overlap between these findings and common factors of therapy. To reduce these findings to common versus unique factors overlooks the intricacies of how the therapeutic relationship is used within psychodynamic psychotherapy with refugees and asylum seekers. These findings go beyond outcome and consider the unobservable meaning of valued common and unique factors. The common factors model is supported by data reflecting a positivist epistemology, inferring that the effectiveness of therapies can be measured through observable outcomes relevant to specific issues. As outlined in the methodology of this thesis, this study takes the position of exploring the unobservable elements of psychotherapy relating to the depth of reality, therefore although the findings highlight the importance of common factors in the context of psychodynamic psychotherapy with refugees and asylum seekers, they also emphasise the unique meaning that they hold, which considers them beyond relating to outcome.

Evaluation

Critical analysis of qualitative research involves detailed review of how the study was undertaken (Ryan, Coughlan, & Cronin, 2007), which allows for greater understanding of the context in which findings emerged and identification of weaknesses to be overcome in future research, among other things. There is no consensus about the standards to judge qualitative research (Rolfe, 2006), but criteria for the evaluation of qualitative research have been devised by Charmaz (2014) and include evaluating credibility; originality; resonance; and usefulness.

Credibility concerns whether this study has achieved "intimate familiarity" with the phenomena explored, the quality of the data, use of comparisons across data, logical links between the data, analysis and argument (Charmaz, 2014). This study has achieved

familiarity with refugee, asylum seeker and therapist experiences of psychodynamic psychotherapy, however the extent of intimacy was limited by the amount of data available for analysis. Recruitment of refugees to health research is difficult (Gabriel, Kaczorowski, & Berry, 2017), which was also the case in this study. Although a range of clients were interviewed of different genders, countries of origin and asylum status, the small number that consented to participate in this study limited the number of experiences that could be explored. Indeed, the voices of clients who had decided not to pursue psychodynamic psychotherapy were absent in this study. It was positive that clients who had pursued psychodynamic psychotherapy had had at least six sessions of psychodynamic psychotherapy, however no clients who had decided not to pursue psychodynamic psychotherapy expressed an interest in participating in the study, which restricted the variety of experiences explored. Further, the small sample from a single service limited the amount of data collected and experiences explored. This limits the generalisability of findings. However, the findings of this study are presented in the context of a small sample and it is still beneficial to hear the voices and experiences of individuals who are often omitted from research.

Credibility is high in the analysis of this study. Following the procedure for thematic analysis allowed for a systematic and standardised analysis, strengthening the credibility of the findings. Comparisons were made between data and themes to ensure that disparities between accounts as well as consensus were addressed, and assumptions and biases were explored through the use of a reflective diary throughout the research process. Comparing all these sources were an ongoing process throughout the analysis, providing a sense of perspective and grounding in the data. The themes constructed during the analysis cover the breadth of participants' data and were discussed during research supervision to establish their reflections of the data and explore the subthemes they captured. Themes and subthemes all

have their credibility evidenced with verbatim quotes from participants. Credibility was also enhanced by the regular input from the study's supervisors with whom the data, analysis, findings and interpretation of findings were discussed in detail.

Originality is the second criterion with which to evaluate qualitative research. Originality considers the new insight offered by themes, the theoretical significance of the study, and how it challenges, increases or refines existing theory and practice (Charmaz, 2014). As outlined in the introductory chapter, this study is the first of its kind. This chapter has outlined how the findings corroborate those found in existing research exploring client and therapist experiences of psychodynamic therapy, and refugee, asylum seeker and therapist experiences of therapy in general. This has identified some of the common factors that support psychotherapy with refugees and asylum seekers regardless of model and the pertinence of specific psychodynamic factors. The findings of this study provide new insight into how psychodynamic theory is used within psychotherapy with refugees and asylum seekers and how it is experienced.

Thus, to conclude the evaluation of the originality of this study, the findings provide new insight into how psychodynamic psychotherapy applies to refugees and asylum seekers, and how it is experienced in different terms such as the impact on their emotions and understanding of themselves.

Resonance is the penultimate criterion to consider in evaluating qualitative research. Charmaz's (2014) questions include whether themes reflect the "fullness of the studied experience", whether fluid meanings are revealed, and whether the findings make sense to participants or similar others and offers deeper insight into their experience.

The initial research questions were broad, which allowed for a broad range of data to be collected. Despite this, the themes constructed from the data were able to encompass the range of participants' descriptions of their experiences. Within the findings, the dialectics

within subthemes, for example clients wanting to talk but also wanting not to talk under 'talking and sharing' were described in order to paint the full picture of the data and honour the experiences of different participants. These practices increase the resonance of this study, as did having therapist participants check the findings to confirm that it is accurate to their experience. Indeed, one of this study's supervisors was a clinician qualified in psychodynamic psychotherapy with extensive knowledge and experience of working with refugees and asylum seekers, who could also comment on the resonance.

It is important that the meaning ascribed to experiences is understood accurately by researchers and therefore meaning was clarified during interviews with participants. In this study four clients required interpreters; though this overcame language differences between the researcher and participants and allowed participants to share their experiences, it was also felt to limit the connection made between researcher and participant as interpreters did not always convey the emotions expressed by participants through their speech. All clients requiring interpreters were experienced in using them through their therapy and so it was felt that they were able to express their experiences, but clarifying questions were also frequently used in order to relay back the researcher's understanding of both the content of participants' speech but also the emotions participants felt in their stories and in the interviews themselves.

Though interpreters were asked to translate participants' words exactly as they were said, the issue was raised by interpreters of needing to make sense of what participants shared when direct translations were not possible. Unfortunately, due to the different languages of participants, different interpreters were required for each interview when an interpreter was required, which likely added an additional layer of meaning making to the interviews (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005) . Resonance will be fully evaluated through the dissemination of this study to the service, participants who have requested it and other invested parties.

Usefulness is the final criterion recommended to evaluate qualitative research. This study's usefulness was supported by keeping the words in subthemes and themes as close to those of participants as possible, in order that the analysis could be transparent and understood by readers, including participants themselves.

This study has identified areas for future research to examine. Indeed, the new findings relating to the identified further support needed by clients accessing psychodynamic psychotherapy and how psychodynamic theory is used by therapists working with refugees and asylum seekers sheds light on this under-explored area of research both with the populations used in this study but also other populations.

This study's usefulness can also be evaluated in terms of how it contributes to knowledge. It emphasises the depth of individuals' experiences of psychodynamic psychotherapy, reinforcing the choice of critical realism, and contributes the voices of refugees and asylum seekers to the body of knowledge constructed about their experience in the academic world. What have been identified are the importance of common and unique factors within psychodynamic psychotherapy for refugees and asylum seekers, which should provide insight for psychotherapists into refugee and asylum seekers' experiences of therapy, and offer information for other refugees or asylum seekers who may be considering taking up therapy. This study sheds light on the acceptability of psychodynamic psychotherapy for clients, the experience of therapists and their need for support and containment while working with refugees and asylum seekers. It also identified the range of needs psychodynamic psychotherapy can help to meet and the necessity for therapists to work alongside other members of staff such as caseworkers who can provide practical support to clients through joint working.

Reflections on the research process

On the whole, I have found this research project thoroughly interesting and been excited about its aims and values. I have been pleased to work with refugees and asylum seekers and explore psychodynamic psychotherapy in more detail as these are both areas of special interest to me as a clinician. However, at other times I have felt hopeless, concerned and oppressive, which has been difficult. I now see how these feelings mirror those shared by participants and I think I previously underestimated the complexities of working with highly traumatised individuals both as a therapist and a researcher.

I found it more difficult than I expected to separate being a therapist and a researcher, the two parts of my role as a trainee clinical psychologist. Being a researcher in this study has involved talking with participants about painful experiences, which is something that often happens in the therapeutic work I undertake. Talking about these experiences in one-off interviews was a new experience for me and clients frequently spoke about both difficult past experiences and difficult present experiences. I noticed myself in earlier interviews with clients avoiding asking for more detail about difficult experiences for concerns that clients would become distressed while they are already in difficult, uncertain circumstances. At times, especially when a client became angry during an interview, I have worried that clients did not understand the nature of participation and that I tricked them into being part of it, which has caused me anxiety and discomfort. The emotionally demanding nature of my course and events in my personal life also made it difficult to probe and fully be with the emotions of participants. I feel regret for these limitations, but I believe I did the best that I could in my circumstances and have reflected on the process.

I have used personal psychodynamic psychotherapy as a resource for managing and exploring these feelings, thinking about the relationships that clients may have had with other people in authority and my countertransference. I was also reminded by my research

supervisor that I had put in place ethical standards that I was adhering to, which supported clients' informed consent. With these in mind, my trust in participants slowly increased and I noticed that my experience of trusting during this research mirrored one described to me. This supported me to remain curious about participants' experience, to respect that their emotions could be part of the process of exploration and recognise that participants could choose what to talk to me about.

During the analysis phase of the research, I sometimes felt overwhelmed by the wealth of data, but really valued using the procedure of constructivist grounded theory. My awareness of my feelings enabled me to be alert to the danger of condensing data into focused codes too broad and categories too vague. On reflection, I think my anxiety about keeping the voices of participants alive in the analysis also motivated me to manage this.

As I now approach the end of this project, I feel proud of what I have created and know that I have done my best in the circumstances I have been in. I believe the pain of the process has been worth it to document the lived experiences of therapists and clients in what has been found in this study to be valuable work.

Reflections on the findings

Having completed the analysis and write up of this study, I was pleased to find that clients have had positive experiences of psychodynamic psychotherapy. As outlined earlier, this was also a hope I had for the study and initially I saw the data in a more positive, less balanced way; I also felt anxiety about how the limitations identified would be received by the service. It was through supervision from my field supervisor that I was supported to see the richness of dialectics and the importance of limitations. I also became aware of my desire for 'permission' to be critical about a service that I felt had much more authority than I.

I can see a connection between my experience of interviewing clients for this study and therapists' experiences of working therapeutically with them, which makes me feel empathy, relief, and respect for their commitment to the work. I hope the findings of this study give testament to the experiences of all the participants interviewed.

Clinical implications and recommendations

The findings of this study illustrate how psychodynamic psychotherapy can help refugees and asylum seekers accessing individual psychotherapy, based on the lived experiences of clients and therapists. The untraditional style of psychodynamic psychotherapy described by participants has been found to be an acceptable, helpful intervention for refugees and asylum seekers that can help clients break out of isolation, reduce their distress and increase their understanding of themselves. The extended role of psychodynamic psychotherapists in meeting practical as well as emotional needs can be recognised, along with the importance of working jointly with other professionals that can support issues such as immigration and liaising with authorities on behalf of clients, providing holistic support. This may affect the the safety of the therapeutic space that is possible to achieve when boundaries are shifted.

Though the nature of how psychodynamic psychotherapy is used when working with refugees and asylum seekers is outlined by therapists, the healing effects of offering a safe space, support with integration, and a supportive, therapeutic relationship should not be overlooked. Services working with refugees and asylum seekers should consider how they offer consistency and support a sense of physical safety for clients. Within the therapeutic relationship developed between clients and therapists, psychodynamic psychotherapists should remain conscious of power imbalances. Given refugees' and asylum seekers' past and

present relationships with authority figures and power, a relationship with this dynamic could be potentially detrimental to psychotherapy.

The findings also highlight how the techniques and interventions used by psychodynamic psychotherapists can be experienced differently by therapists and clients; clients tended to notice the impact on their feelings. In terms of evaluating the impact of psychodynamic psychotherapy, either formally through service evaluation or informally during the process of therapy, it may be useful to use an emphasis on clients' emotions and the small changes experienced by clients, which should be emphasised.

The techniques that clients described specifically supported them should be held in mind by psychodynamic psychotherapists and other therapists. Though some of these appear to be contrary to traditional psychodynamic psychotherapy, psychodynamic psychotherapists working with refugees and asylum seekers should feel supported by these findings to work flexibly and creatively with their therapeutic frame, as this approach was valued by both clients and therapists. Psychotherapists should use their clinical judgement to assess when and why this is appropriate, necessary and in clients' best interests, reflecting on how and why boundaries change, and the most helpful flexing of boundaries.

The findings of this study reinforce the individual circumstances of refugees and asylum seekers at the outset of therapy, based on their unique and wide ranging experiences. The role of clients' cultures and other differences such as religious beliefs should not be overlooked as they contribute to clients' different starting points. In clinical practice, psychotherapists should maintain openness during the assessment of refugees and asylum seekers and bear in mind that sharing all of their experiences may not feel safe for clients, as trusting others can be difficult in the first instance. Assessment of this client group could take place over a number of sessions in order to build rapport during the assessment process.

Clinical implications also refer to the recommendation of trauma focused therapy for refugees (NICE, 2018b). This study's findings do not dispute the relevance of trauma for refugees and asylum seekers, but also demonstrate that help can take many forms. Indeed, refugees and asylum seekers struggle with many different unmet needs before starting therapy and therefore using a trauma focused approach, for example trauma-focused CBT (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005) or EMDR (Shapiro & Solomon, 1995), to address predominantly psychological needs may be inappropriate until other needs have been met, either through therapy or other means. This study has highlighted how immigration status can also affect clients' starting points for therapy and therefore it may not be appropriate that clinical guidelines exist for the refugee population but not the asylum seeker population. Clinical guidelines should be developed for both populations.

Finally, this study identified that additional support is needed after psychodynamic psychotherapy, and often alongside it. Clients and therapists in this study described the importance of working on immigration issues and other organisations and systems, which steps into systemic and political frames. This is outside the therapy room and, inherently, moves away from traditional psychodynamic psychotherapy. However, this work may fall into the realm of working flexibly, especially if it is supported by other professionals such as caseworkers, which appears to help therapists maintain some therapeutic boundaries. Refugee and asylum seeker clients may benefit from psychodynamic psychotherapists not taking a purely individual approach to therapeutic work and organisations working with refugees should also not work in isolation. Communication and links between these organisations should help support the identification of the correct, specialist support that refugees and asylum seekers need. Working at a systemic level and working collaboratively with other services to support these populations has the potential to be powerful in terms of promoting

change both for the individuals and from a political level. It may also help counter the feelings of helplessness that therapists described.

Research implications and recommendations

This study can be part of a bigger, developing body of work exploring refugee and asylum seeker experiences of psychodynamic psychotherapy and wider experiences of psychodynamic psychotherapy.

In order to understand the context and narratives within the refugee population in more detail, future research exploring the factors that are important about the refugee experience, from the perspectives of refugees, would be helpful. It is hoped that this would support understanding of the psychological needs of this population and offer an opportunity to create an alternative, personally-derived narrative that may differ from the 'refugee trauma' narrative (Papadopoulos, 2001).

It is difficult to know how much of the findings of this study are attributable to psychodynamic practice, both because this study was limited to one service and because of the alterations to psychodynamic psychotherapy applied. Future research should explore refugee and asylum seeker experiences of psychodynamic psychotherapy in and across different services. This would shed light on which findings may be exclusive to the context of this study and the different styles adopted by psychodynamic psychotherapists working with refugees and asylum seekers. It would be beneficial to explore what is significant to the refugee experience, what is model specific and what relates to common factors and general support in order to understand the roles of common and unique factors in more depth. Including the experiences of therapists in future studies would also similarly add depth and context to the data of clients.

Indeed, more research is needed to explore client experiences of psychodynamic psychotherapy with clients from a range of populations with differing levels of unmet needs, backgrounds and displacement experiences, in order to explore the processes at work for clients. This would help to identify processes specific to refugees and asylum seekers in relation to psychodynamic psychotherapy and how factors such as the therapeutic relationship are considered in those other contexts.

Research with populations of psychodynamic psychotherapy clients with similarly high unmet needs such as homeless people may also shed light on the key factors that make this therapeutic approach more or less successful with clients who commonly have high levels of unmet needs. Work of this kind would help to grow the body of literature promoting the voices of refugees and asylum seekers alongside other vulnerable and marginalised populations who have experienced psychodynamic psychotherapy. It would also serve to further highlight these populations' internal and emotional experiences, which are often overlooked because they are assumed to be struggling with meeting practical needs.

Future research can also explore in more detail some elements of the findings of this study. This could include exploring the impact of power in the therapeutic relationship with refugees and asylum seekers, and experiences of interpretation within this therapeutic modality. Though research has been carried out with refugees and asylum seekers involved in therapy generally, the therapeutic modalities under exploration should be described in future research in order to understand the usefulness and acceptability of defined therapeutic approaches. This would particularly be in service to refugees and asylum seekers who may want to make informed decisions about the type of therapy they undertake.

Conclusions

The findings of this study suggest that there is a place for psychodynamic psychotherapy for refugees and asylum seekers requiring emotional support. However, the model of psychodynamic psychotherapy appears to differ from traditional psychodynamic psychotherapy, taking a supportive stance with more flexible boundaries. This model of psychodynamic psychotherapy can help to meet a range of needs for clients, but the unconscious consequences of adaptations to the model are unclear. Given the degree of clients' unmet needs, it appears that psychodynamic psychotherapy is best offered alongside other supports in order to make it more holistic.

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Appendices

Appendix A – Ethical Approval

14 February 2017

MISS A. HAYES

[redacted]

Dear Annabel,

Re: Ethical Approval Application (Ref 16053)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative on behalf of the Faculty Ethics Committee.

Yours sincerely,

Lisa McKee
Ethics Administrator
School of Health and Human Sciences

cc. Research Governance and Planning Manager, REO
Supervisor

Application for Ethical Approval of Research Involving Human Participants

This application form must be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research must not commence until written approval has been received (from departmental Director of Research/Ethics Officer, Faculty Ethics Sub-Committee (ESC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project. Ethical approval cannot be granted retrospectively and failure to obtain ethical approval prior to data collection will mean that these data cannot be used.

Applications must be made on this form, and submitted electronically, to your departmental Director of Research/Ethics Officer. A signed copy of the form should also be submitted.

Applications will be assessed by the Director of Research/Ethics Officer in the first instance, and may then passed to the ESC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc.) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Title of project:
   Client and therapist experiences of psychodynamic psychotherapy with the [redacted] refugee therapy service.

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
   Do you object to the title of your project being published? Yes ☐ / No ☒

3. This Project is: ☐ Staff Research Project ☒ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Annabel Hayes	School of Health and Human Sciences
Dr Sarah Davidson	[redacted]
Dr Frances Blumenfeld	School of Health and Human Sciences

5. **Proposed start date:** ~~01/11/2016~~ 10/02/17

6. **Probable duration:** 24 months

7. Will this project be externally funded? Yes ☐ / No ☒
   If Yes,

8. What is the source of the funding?
   n/a

9. If external approval for this research has been given, then only this cover sheet needs to be submitted

External ethics approval obtained (attach evidence of approval) Yes ☐/ Nc ☒

Declaration of Principal Investigator:
The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): .....

Name(s) in block capitals: ANNABEL HAYES

Date: 06/02/2017

Supervisor's recommendation (Student Projects only):
I have read and approved the quality of both the research proposal and this application.

Supervisor's signature: .....

Outcome:
The departmental Director of Research (DoR) / Ethics Officer (EO) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR / EO considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the ESC ☑
This application is referred to the ESC because it does not fall under Annex B ☐
This application is referred to the ESC because it requires independent scrutiny ☐

Signature(s): .....

Name(s) in block capitals: WAYNE WILSON

Department: SHS

Date: 8/2/17

The application has been approved by the ESC ☐
The application has not been approved by the ESC ☐
The application is referred to the University Ethics Committee ☒

Signature(s): .....

Appendix B – Participant Information Sheet

[redacted] [redacted]

Participant Information Sheet

Study title
Client and therapist experiences of psychodynamic psychotherapy with the [redacted] refugee therapy service.

My name is Annabel Hayes and I am a trainee clinical psychologist from the University of Essex. You are invited to take part in a research study that relates to the [redacted] refugee therapy service. The purpose of this study is to explore how clients have experienced therapy, seeking to understand their experience and how it relates to their other needs.

Before you decide whether you could like to participate, you need to understand why the research is being done and what participating involves. Please take time to read the following information and ask questions if anything you read is not clear or you would like more information. This research has been approved by the University of Essex.

Why have you been invited?
You have been invited to be part of this research study because you have participated in the therapy service as a client or therapist and have first-hand experience of the therapy service.

Do I have to participate?
You do not have to participate; it is up to you to decide whether you would like to. The information below will describe the study, including what is involved for participants. You can take this information sheet away with you and take time to think about whether you would like to participate, and if you decided that you would, I will then ask you to sign a consent form to show that you agree to take part. You are allowed to withdraw at any time, you do not have to give a reason. If you decide to not take part or withdraw, this will not affect your relationship with the [redacted]

What is involved?
If you choose to participate in this research study, you will be invited to come and talk about your experience of the therapy service. This conversation will last approximately 1 hour and take place at the [redacted]

We only need to meet one time and you have a choice about whether our conversation is audio recorded. Any recordings of our conversation will not contain any personal information about you, except what you share. The recording will be kept securely and only listened to by

the interviewer and her two research supervisors. The audio recording will be destroyed at the end of the study.

What are the possible disadvantages of taking part?

This research study does not intend to disadvantage you, but it will require approximately 1 hour of your time. If you are a client, there is a chance that talking about your experience of therapy may be difficult for you. If you are still receiving support from the [redacted] further support can be made available from your caseworker and we can direct you to additional sources of support that we hope can help.

What are the possible benefits of taking part?

We cannot promise that the study will help you but the information that you provide can help develop [redacted] therapy services and other therapy services available to refugees and asylum seekers. For your time and any expenses of attending your interview, you will be reimbursed £10 at the end.

What will happen to the results of the research?

The results of this research will be the thesis element to my doctorate in clinical psychology. Following completion, the results will be shared with the [redacted] but this will contain no information that identifies you personally. Publication in a journal will also be sought.

If you would like more information or to participate in this research study, please contact me or fill out a contact form and I will contact you.

Name: Annabel Hayes
Telephone number: [redacted]
Email address: [redacted]

If you would like me to contact you, please tear off this section and give the information to your caseworker, one of the therapists, or the reception. I will contact you as soon as I can.

Name: .....

Telephone number: .....

Email address: .....

Please contact me about participating in your research study.

Appendix C – Participant Consent Form

[redacted] [redacted]

Research Participation Consent Form

Title of study: Client and therapist experiences of psychodynamic psychotherapy with the [redacted] refugee therapy service.

Principal investigator: [redacted]
Institute:
Supervisors:

	Please initial
• I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
• I understand that my participation is voluntary, that I am free to withdraw at any time without giving any reason, and that withdrawal will not affect my right to access any [redacted] services.	☐
• I understand that my caseworker may be informed of my participation in this study so that they can support me if necessary.	☐
• I understand that the information held and maintained by the University of Essex will be stored securely and may be listened to by the principal investigator and her two research supervisors.	☐
• I understand that the findings of this study may be published anonymously.	☐
• I agree to take part in the above study.	☐

Participant name (capitals): .....

Participant signature: .....

Date: .....

Researcher name: .....

Researcher signature: .....

Date: .....

Has this form been translated? **YES** **NO** Translator's name .....

Appendix D – Participant Resource Sheet

Participant resource sheet

Thank you for taking part in this research study. We understand that talking about your experiences may have been difficult or emotional. It is important that you take care of yourself if you experience any emotional reactions following your interview today.

Talking about our experiences can affect everyone in different ways, so please make use of the resources listed below if you feel like you need extra support.

For emotional support:

- Talk to a friend or family member who you feel comfortable sharing with, or ask them to sit with you for support
- An additional therapy session can be made available from the Tavistock therapists, if you think it would help you
- Speak to your GP, if you have one, who may also know of other sources of support
- For people registered with a GP in Islington, the Accept Consortium can offer counselling and other forms of therapy. Telephone: 020 7263 6947 http://www.accept-consortium.org.uk/
- For people registered with a GP in Islington, Hackney and Haringey, the Refugee Therapy Centre offers individual or group support. Telephone: 07828 047 099 https://www.refugeetherapy.org.uk/
- Counselling, help and advice is available from Freedom from Torture for people who have experienced torture. Telephone: 020 7697 7777 https://www.freedomfromtorture.org/about_us/london_centre
- The Refugee Council offers therapeutic support: https://www.refugeecouncil.org.uk/what_we_do/therapeutic_casework

If you would like support with other things:

- Speak to your [redacted]aseworker
- The Refugee Council also offer help and advice: https://www.refugeecouncil.org.uk/how_can_we_help_you/i_am_a_refugee_looking_for_advice

Appendix E – Information Sheet for Caseworkers

Information sheet for caseworkers

This information sheet has been compiled to help you to discuss the [redacted] research project with potential participants. I hope that as a team you will be able to contact each of the clients identified by the therapists to invite them to participate in the study. If you have any questions or anything is unclear, please feel free to email me at [redacted]. Thank you for being a part of the project.

These are the general messages to convey:

- I would like to invite you to be a part a research project that the [redacted] is running.
- The purpose of the project is to explore what people think of the [redacted] therapy service.
- You have been invited to be part of this study because you have had first-hand experience of therapy from the therapy service.
- If you would like to participate in this study, you will be asked to come and talk to a researcher about your experience of the therapy service.
- Your experience is unlike anyone else's and what you have to share is really valuable.
- She will ask you some questions about what it was like to come and talk to your therapist.
- You won't have to talk about what you talked about with your therapist, but about how you found meeting with them and what impact it had on you.
- You won't have to talk about anything that you don't want to talk about.
- This conversation will last up to 1 hour and take place at the [redacted] Centre in Angel.
- You do not have to participate; it is up to you to decide whether you would like to.
- If you do decide to participate, you will be reimbursed £10 at the end of the interview for your time and any expenses of attending.
- We hope that the results of the study will help improve the therapy service for other people.
- If you would like to ask some questions or talk about participating, you can contact the researcher [redacted] by telephone on [redacted]. Or you can email her at [redacted].
- If you would like the researcher to contact you instead, you can consent to her contacting you by telephone or email. Please could we confirm your telephone number and email address if you would like her to contact you.

Appendix F – Initial interview questions

For clients:

1. How long have you been coming to the [redacted] and what first brought you to the organisation?
2. Tell me about what it was like to be offered therapy
    - Was therapy a new experience for you?
    - What, if anything, did you know about psychodynamic therapy?
3. What contributed to your decision to seek out and/or accept therapy?
4. What was going on in your life then?
    - What did you believe was missing from your life?
    - What ways did you have of looking after yourself?
5. Tell me what it was like to receive therapy?
    - What did you find most meaningful?
    - Why was it meaningful?
    - *What was most important to you?*
    - *What was helpful?*
    - *What was unhelpful?*
6. What has changed for you since you have had therapy?
    - Has your view of what you need changed since therapy?
7. How did you experience your therapist?
    - *What was it like to build your relationship?*
8. After having had these experiences, what advice would you give to someone who is considering taking up therapy?
9. So you have any suggestions for us, regarding the research or the therapy?
10. Is there anything else you think I should know to understand your experience?
11. Is there anything you would like to ask me?

For therapists:

1. How long have you been coming to the [redacted] and what first brought you to the organisation?
2. Tell me what it is like to work therapeutically with clients in this service.
3. What are the challenges of working with refugees and asylum seekers?
4. What are the opportunities of working with refugees and asylum seekers?
5. What is your perception of where clients are at in their lives at the beginning of their therapy?
    - What was your perception of what you needed?
6. What reflections do you have on the usefulness of psychodynamic therapy for refugees and asylum seekers?
7. Tell me about any experiences of clients being unable to engage in therapy.
8. Tell me about your thoughts about continuing work with this client group in the future.
9. Do you have any suggestions for us, regarding the research?
10. Is there anything else you think I should know to understand your experience?
11. Is there anything you would like to ask me?

<u>Examples of probing questions to be used for clarification and further detail:</u>

- What did you mean when you said....?
- Can you tell me more about....?
- Can you give me an example of...?
- Why...?

Appendix G – Example of Initial Coding

This example was taken from client Victoria's interview.

Researcher (R): So to start with, can I ask you how long you've been coming to [service name] and what first brought you to the organisation?

Participant (P): Umm, I think I came in 2016? 2016 that was around, say, February time. I might be mistaken but I cannot remember the month which I came in 2016. I was struggling to get some money to go to Liverpool so I went online and I read, it was saying, they help with money like bus fare to go to Liverpool because I wanted to submit my fresh claim there in Liverpool. It was far away so I could not manage the bus fare because it was almost £40-something with the train. So I went there to [service name] and I explained to them the situation, how it is, so they said 'we can give you £46' I think. It was 46 or something like that and then when I was there they asked me certain questions, so I had to explain to them how I came here from Zimbabwe. And how my experience til now, honest I'm living here and why I came here from Zimbabwe. I explained to them. So they said they can be helping me every three months and they suggested that I, the situation, the way it was by that time, they suggested, 'oh you can see a therapist; we have a therapist here; you can see a counsellor'. So they advised me to see a counsellor, of which I had a counsellor in [town name]. So something happened there in [town name].. My relative there was threatening me so I had to move out from [town name] so I came here and started to see [therapist name].

Comment [AH1]: Came to service in 2016

Comment [AH2]: Reading online about help with money for bus fares

Comment [AH3]: Needing money to go to Liverpool and submit asylum claim

Comment [AH4]: Explaining situation and given money

Comment [AH5]: Explaining how I came to UK from Zimbabwe

Comment [AH6]: Saying they would help every three months

Comment [AH7]: Advised me to see counsellor

Comment [AH9]: Moved and came here for therapy

R: Yeah

P: She was my therapist, my counsellor. I think that was for six week's sessions; if I'm not mistaken that was six weeks sessions.

Comment [AH10]: Therapy for six weeks

R: Ok

P: Yeah that's what happened.

R: Right. So you'd had some counselling in – sorry where did you say it was before?

P: It was in [town name]. Yeah I had a counsellor there in [town name] so almost one year and a half from 2015 to last year, 2016 around March. Yeah.

Comment [AH11]: Previous therapy

R: Ok... So the [service name] therapy was your second experience of therapy was it?

P: Yeah my second experience, yes.

Comment [AH12]: Second experience of therapy

R: What was it like when you offered therapy from [service name]?

P: Ummm, I really liked it because the trauma which I went through... even now I still need a counsellor although I'm on the waiting list so... I really wanted counselling with [therapist name]. What was it, [therapist name]?

Comment [AH13]: Liked being offered therapy

Comment [AH14]: Still needing a counsellor after therapy has ended

R: [Therapist name]

P: [Therapist name], yes. But the problem now is I've started school. She wanted me there on Mondays, those are the days that I attend my university.

Comment [AH15]: Therapy and school clashing

R: Ok

P: So when they offered me counselling sessions, I, you know the experiences that I went through, you know, some of the things that we just disappear. You know, like stress. The way she runs the counselling service was really good. I liked it. It was, even my life changed the way she was counselling me. Some of the things changed like she advised me to change my number because there were things that were happening with my relatives. She said change your number and certain things you going, mix up with others, go and socialise with others, it's what I'm doing right now ya.

Comment [AH16]: Stress disappeared

Comment [AH17]: Liking way she runs counselling service

Comment [AH18]: Life changing

Comment [AH19]: Advising me to change number

Comment [AH20]: Advising me to socialise

Comment [AH21]: Doing as advised

R: Ok.. So the short amount of work was still quite helpful for you?

P: Yeah it was really helpful. To be honest it was really helpful, though I wanted her to carry on with me, but she could not do that anyway but it was really helpful. But she, she said 'since here it's far away, you are living there in [town name], there are some counselling services that are nearer which we can advise your GP'. So she advised my GP to refer me somewhere else, which that's what happened.

Comment [AH22]: Therapy was helpful

Comment [AH23]: Wanting to carry on

Comment [AH24]: Advising GP

Comment [AH25]: Therapist found service nearer client's home

R: Ok. Thank you for that. Um, so I know that therapy wasn't a new experience for you.

P: Yeah, it wasn't new. I had another one in [town name].

R: And what did you know about psychodynamic therapy?

P: Umm, say that?

R: Psychodynamic therapy... so there are different types of therapy or counselling that you can be offered. Was the type ever described to you before you came?

P: No.

Comment [AH26]: Not knowing type of therapy

R: Was it just called counselling?

P: Yes, yes, yes.

R: Ok. Did you have any ideas about what it would be like before you started at [service name]? Maybe based on your other experiences?

P: Yeah, I had an idea. Because she asked me 'why are you here?' So, no, at first what she said was she rang me, she said you know what, I am going to be your counsellor. So [service name] they said you needed counselling services so you can come. And I went there, I think it was a Wednesday, so she said 'what is it?' and I explained everything to her and she said 'oh we can meet up the other week'. So I knew what it was going to be, my counselling yeah.

Comment [AH28]: Asking me 'what is it'

Comment [AH29]: Explaining everything to her

Appendix H – Example of Theme

Theme	Initial codes	Quotes
Trust	Finding someone I trusted	"It was someone that I trusted and I was able, actually, to say lots about myself."
	Being able to trust someone was most important	"I think trust and... to be able to trust someone and I mean for me it was just... one thing I realised that it's ok to say out things and not keep it to yourself."
	Good experience of trusting therapist	Researcher (R): "Ok... but you had this good experience of trusting your therapist." Participant (P): "Yes."
	I never thought I would be trusting her	"Yeah I never thought I would be trusting her in terms of my... I mean it's never been easy to tell my life stories, my experiences, whatever happened in childhood or with my relationship in my marriage."
	Once I started to trust, telling her became easier	"So... and to talk about all of these, it's been very hard. But yeah once I started to

	trust, and started to feel more comfortable, then I felt that yes things become more easier in terms of telling her."
The only person I trust was her	"I was feeling secure with her. The only person that I trust was her. And you can't say with other people that you don't know everything about your life, so she was the only person."
I had lost trust and used to think I should never say whatever I feel	"And that is the thing I really learned because I was living in that belief that... and because I lost the trust as well, so I used to think that I should never say whatever I feel, whatever had happened in my life to anyone so.... This is what I learned actually."
Not difficult to trust therapist	R: "Yeah I think trust is very important in therapy... was it difficult at first to trust her?" P: "No."
Shared that I cannot trust anyone	"I started a bit open up and yes I started to share my feelings about, like, I cannot

	trust anyone."
Trust is still very hard for me	"I know I still I would not be able to trust completely to anyone, still I know it's really really hard for me."
I still have problems like trusting issues	"A few things I'm still, I have some problems like I have trusting issues so much. That thing, I don't know how I will overcome with it, but I don't know let's see."
Trust is very important for clients	R: "I get the impression that trust is very very important for this group." P: "Yeah, yeah definitely"
Beginning of work is about developing trust	"I think a lot of the work at the beginning in the initial sessions is about developing a sense that they can trust us."
Clients have had their trust abused	"Trust obviously, so many people have experienced such an abuse of trust"
She trusts me and doesn't want to see anyone else	"And also, she trusts me, she tells me, she comes in every week and tells me 'I trust you' and doesn't want to see anyone else."

The process is working is clients share something that they haven't shared with anyone else	"It says something about the process if they share something that they haven't shared with anybody else."
Therapists showing that they are different	"I'm always aware that we are, perhaps, the same as the home office, the same as the solicitor, and they've come to defend themselves. I try and work a lot on showing them that obviously that isn't so."