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The American University in Cairo

School of Humanities and Social Sciences

**Lay Counselors Experiences with Counseling their Peers; the Impact of Being a Lay
Counselor and Providing Therapy to Traumatized Sudanese Refugees in Cairo**

A Thesis Submitted to

Department of Sociology, Anthropology, Psychology and Egyptology

in partial fulfillment of the requirements for

the degree of Master of Arts in Community Psychology

by Baher Ibrahim

September 2015

TABLE OF CONTENTS

Abstract	4
Introduction	5
Sudanese Refugees in Egypt	5
Mental Health Problems of Refugees	9
PTSD in Refugees	11
Cultural validity of PTSD	12
Treatment of PTSD in Refugees	13
Narrative Exposure Therapy for PTSD in Refugees	16
Lay Counseling: Definition and Uses	19
Effect of lay counseling on the counselors	22
Methodology	25
Participants	25
Procedures	27
Data Collection	27
Data Analysis	30
Results	32
Discussion	53
Conclusion	66
Limitations	67

References	69
Appendix A (English and Arabic informed consent forms).....	76
Appendix B (Interview questions in English and Arabic).....	80
Appendix C (Thematic Analysis 6 step guide)	81
Appendix D (Checklist of criteria for good thematic analysis).....	82
Appendix E (Guidelines for publication of qualitative research).....	83
Appendix F (Example of full interview transcript)	84

Abstract

This research is a qualitative study into how lay counselors are affected by their training in and practice of a community-based lay counseling intervention. A group of refugees from a Sudanese refugee community in Cairo, Egypt were trained in Narrative Exposure Therapy and subsequently provided it to members of their community suffering from post-traumatic stress disorder (PTSD). Narrative exposure therapy (NET) is a short-term psychotherapy based on the principles of cognitive behavioral therapy (CBT), exposure therapy and testimony psychotherapy. NET has been shown to be effective in relieving symptoms of PTSD in refugees. After completing the training and completing NET with one client, semi-structured interviews with the trained lay counselors were conducted to discover the impact of the training and provision of therapy to their peers on them.

Background literature suggests that serving as a lay counselors may have one of two effects; the lay counselors may become psychologically empowered from the experience of helping their peers (Alexander, Mollink & Seabl, 2010), or they may suffer from the effects of secondary stress syndrome as a result of exposure to the traumatic memories of their peers (Peltzer, Matseke & Louw, 2014; Shah, Garland & Katz, 2007). Thematic analysis of interviews conducted with the lay counselors revealed that the experience of training and providing therapy was a largely positive one from which they emerged psychologically empowered and motivated. In addition, several other themes were identified. These include the suffering of Sudanese refugees, a strong sense of community, resilience and coping strategies and logistic challenges and cultural barriers to providing therapy in the community. Implications for future research as well as future community based lay counseling mental health interventions in the Sudanese refugee community in Cairo are discussed.

Lay Counselors Experiences with Counseling their Peers; the Impact of Being a Lay Counselor and Providing Therapy to Traumatized Sudanese Refugees in Cairo

As far back as 1959 (Albee, 1959) a report on human resources in mental health demonstrated that not only was the number of mental health professionals at that time insufficient to treat all those in need, but also that it would always be insufficient. This is no less true for Egypt, where there are 1.44 psychiatrists and 0.11 psychologists per 100,000 (WHO, 2006). While mental health services are scarce in Egypt, there is a strong need for them in the Sudanese refugee community that is not being adequately met (Meffert & Marmar, 2009).

Sudanese Refugees in Egypt

Though a comprehensive overview of the Sudanese refugee situation in Egypt is outside the scope of this proposal, an introduction to the situation and context of this marginalized group is necessary to provide a background to the conflict and how they came to reside in Egypt. The 1951 Convention relating to the Status of Refugees defines a refugee as someone who

owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 1951).

In Egypt, designation of refugee status is the responsibility of the UNHCR office in Cairo. This process has been fraught with difficulties and disappointments, as many Sudanese living in Cairo have failed to attain official refugee status from the UNHCR, and are thus forced to reside illegally in the country. The number Sudanese refugees in Egypt by the end of 2014 reached 20,000 (UNHCR, 2014), in addition to a further 14,000 asylum seekers (an asylum seeker is one who has fled his or her country of origin and applied for refugee status but is still

awaiting a decision from the host government). It is possible that the actual number is much higher than this. One estimate puts it in the hundreds of thousands (Interview with Harrell-Bond, B., African and Middle East Refugee Assistance, 2006, cited in Meffert et al., 2010). Before the influx of refugees from Syria as a result of the ongoing armed conflict that started there in March 2011, Sudanese constituted the largest proportion (73%) of refugees in Egypt under the protection of the UNHCR (2004). At the end of 2014, however, the number of Syrian refugees in Egypt had risen to 150,000 (UNHCR, 2014).

Sudanese refugees are the product of the longest running civil war in Africa. The war between North and South Sudan claimed over two million lives and displaced millions more (Coker, 2004). In very general terms, the civil war was waged between the governing Arabic speaking, Muslim North and the indigenous language speaking African South whose religious makeup is divided mainly between Christianity and traditional African religions. It ended with the peace agreement of 2005, followed by the 2011 referendum that saw the birth of South Sudan as an independent country. This sweeping generalization is not meant to deny the nuances of the conflict or the diversity of the Sudanese people, but is made merely for the purpose of clarification for those unfamiliar with the conflict. The South Sudanese are themselves a very diverse group composed of several tribes and ethnicities. Because of the marginalization of Sudanese refugees in Egyptian society, Sudanese have become neighbors with tribes and ethnicities that they may have never had contact with in their own country. These divisions along ethnic and tribal lines have at times become highly politicized and problematic, leading to conflict not only in Sudan but also in exile, such as conflicts between Nuer and Dinka South Sudanese in Cairo in 1991, as a consequence of members of one faction committing atrocities against the other back home. This subsequently led to the dissolution of the South Sudanese

student organization in Cairo in 1992 and the establishment of several ethnically based associations that mobilized members along tribal and ethnic lines (Moro, 2004).

The lives of Sudanese refugees in Cairo are plagued with difficulties. Although Egypt is signatory to the 1951 convention, its adoption of several reservations to the convention means that refugees have limited rights in Egypt. For example, refugees in Egypt cannot obtain employment without a work permit, which is similar to any other foreign worker in the country. This is impossible for those who have been denied official refugee status and are residing illegally in the country. Refugees also do not have the right to citizenship. Children born to illegal residents can neither approach their embassy for citizenship nor obtain Egyptian citizenship. Full integration of Sudanese refugees into the host community is effectively impossible, creating a marginalized community in a sprawling urban metropolis of millions (Grabska, 2006).

It is not only illegal status that contributes to marginalization of Sudanese refugees in Cairo. Many have borne the brunt of xenophobic and racist attitudes from Egyptian society itself. Most respondents in Grabska's study (2006) complained of maltreatment at the hands of employers, racial abuse in public spaces and exploitation by landlords and shop owners. This was especially pronounced among the darker skinned African refugees from the South. However, those from the North did not fare much better. Even though Islam is the dominant religion in Egypt, Arab Muslim refugees from North Sudan have also complained of racism.

In addition to racism and discrimination, lack of jobs in the formal sector forces many Sudanese in Cairo into low-skilled jobs on the black market, such as cleaners, construction workers and street vendors (Grabska, 2006). A lack of secure legal status and minimal access to

legal recourse means that they are subject to exploitation by employers, with long working hours, poor conditions and low wages.

The Egyptian government is notorious for its mistreatment of Sudanese refugees. One of the worst examples was the violent and deadly dispersal of a protest camp of Sudanese refugees in front of the UNHCR office in Cairo in December 2005 (American University in Cairo Forced Migration and Refugee Studies Program, 2006). The UNHCR had suspended refugee status determination in response to the 2005 peace agreement in Sudan, on the grounds that refugees could now safely return to their country. This angered many refugees who had hope for resettlement in a third country with better conditions. Refugees and asylum seekers camped in front of the UNHCR headquarters in Cairo for three months to protest this decision (Meffert et al., 2010).

With the difficulties of living in Egypt, the best refugees can hope for is resettlement to a first world country such as the United States, Canada or Australia. Egypt is viewed as a temporary stage in which one seeks asylum in the hope of being resettled to a third country. However, their hopes are usually shattered as their stay in Egypt becomes prolonged, with no end in sight. Aspirations for a better life are suspended indefinitely (Mahmoud, 2011).

On top of discrimination, xenophobia and difficult living conditions, refugees experience profound psychological change and identity conflict as a result of their situation. Mahmoud (2011) describes the crisis of identity experienced by Sudanese refugees due to the internalization of multiple “ambiguous, ambivalent and conflicting identities”. These identities are the result of conflicts back home as well as the difficult circumstances of being a refugee in Egypt. A person from the South can be a South Sudanese in the context of the conflict with the North, a member of a particular tribe or ethnicity in a South of diverse ethnicities, or simply a

“Sudanese” facing discrimination from the Egyptian government along with his fellows from the North. This is compounded by the concept of “refugeehood”, which comes to define a person and becomes a master status above and beyond all other identities (Marlowe, 2009). Marlowe explains that the master status of “refugee” eventually becomes institutionalized to define the identity and experience of the refugee. Furthermore, the disproportionate focus of the media on the extraordinary events of poverty, violence and conflict has come to define the public’s understanding of refugee life and draws attention away from the less sensational, everyday problems refugees experience after relocation. In addition, the media reinforces this narrative, “with overtones of racial profiling and sensationalism”. Although overt racism and discrimination are easy to recognize, there is often another type of racial profiling that is much harder to discern; the well-intentioned but misguided attempts to help. While well-meaning, viewing refugees through the lens of extraordinary events of conflict and destitution serves to reinforce a discourse of victimization and helplessness. This identity confusion is one of the most common stressors of forced migration (Stein, 1986).

Mental Health Problems of Refugees

Due to the pre-migration and post-migration stressors refugees and asylum seekers face, they are at risk for a number of mental health disorders. By definition, they are a vulnerable group fleeing their countries of origin for fear of their safety and well-being. This is compounded by the disillusionment and disappointment that develop when new problems inevitably arise in the country of resettlement (Craig, Jajua & Warfa, 2009). A range of negative psychological effects can result from refugee experiences, such as grief, anxiety, depression, feelings of helplessness, somatization, anger, shame and survivor guilt (Victorian Foundation for Survivors of Torture, 1998). In addition to their material losses, immense existential losses can be

experienced, such as loss of identity, homeland, culture, hope and trust. These losses are compounded by extreme isolation and humiliation (Burnett & Thompson, 2005).

Refugee populations have shown increased rates of post-traumatic stress disorder (PTSD), depression, generalized anxiety disorder, panic disorder, substance abuse and self-harm relative to rates in the general host population (Bhugra, 2004). Craig, Jajua and Warfa (2009) estimate the incidence of PTSD to be ten times more likely in refugees than in age matched native populations. Refugees are in fact one of the largest groups at risk for PTSD (Nickerson, Bryant, Silove & Steel, 2011).

Sudanese refugees are no exception. Tempany's (2009) review of the literature found that most quantitative studies reported high rates of psychopathology, especially PTSD and depression, in Sudanese refugees. Meffert and Marmar (2009) conducted a mental health needs assessment among refugees in Cairo from the Darfur region in western Sudan. They found symptoms of moderate to severe emotional distress, depression, trauma, interpersonal conflict, domestic violence and community conflict. In addition, they found the refugee mental health care system in Cairo to have a piecemeal structure with many gaps in the outpatient services, due to having developed in an ad hoc manner from the contributions of multiple NGOs dedicated to the care of refugees.

There is a caveat, however, which has implications for treatment. Qualitative studies found that although many refugees reported symptoms of traumatic stress, their functioning was not necessarily impacted as a consequence. In fact, many reported that they were more concerned with current stressors such as family troubles rather than past trauma. It is possible that Sudanese refugees have positive coping mechanisms that help them to cope with stress and thus preserve their functioning despite symptoms of traumatic stress. Indeed, a qualitative study with Sudanese

refugees in Australia (Khawaja, White, Schweitzer & Greenslade, 2008) found that despite traumatic experiences in the pre-migration and transit phase as well as difficulties in resettlement in the post-migration phase, they had numerous coping strategies across all mechanisms. Such strategies included religious belief and cognitive strategies such as reframing the situation and focusing on future aspirations. The current research identified coping mechanisms among the lay counselors consistent with the literature.

It is important to be acquainted with coping mechanisms and the cultural context of the particular population one is working with. Otherwise, there is the risk of well-intentioned professionals unknowingly working against established and effective coping strategies that are used in a particular cultural context (Jeppson & Hearn, 2005). In addition, cultural competence is very important, because there is very little literature on appropriate interventions for Sudanese refugees (Tempany, 2009). It is not clear which, if any, standard western-developed treatments for PTSD will be beneficial for this very different population.

PTSD in Refugees

Post-traumatic stress disorder is defined by the fifth edition of the Diagnostic and Statistical Manual (American Psychiatric Association, 2013) as a “trauma or stress-related disorder” occurring in response to exposure to a traumatic event. The traumatic event must meet certain criteria; either direct exposure, witnessing in person, indirect exposure by learning that a friend or family member was exposed to trauma, or repeated or extreme indirect exposure to details of traumatic events that happen in the course of professional work. It does not include indirect exposure via media. To establish a diagnosis of PTSD, symptoms from four clusters must be present. The first cluster is persistent re-experiencing of the event, for example in the form of nightmares, recurrent and intrusive memories or flashbacks. The second cluster is

avoidance symptoms, where one exerts persistent effort to avoid distressing trauma related stimuli. The third symptom cluster is negative cognitions and mood, such as persistent negative emotions related to the trauma and negative, distorted beliefs about oneself and the world. The final symptom cluster is altered arousal or reactivity, such as irritable and aggressive behavior, self-destructive behavior, exaggerated startle response and sleep disturbances. Meeting one criterion from each of the first two clusters, and two criteria from each of the third and fourth clusters qualifies for a diagnosis for PTSD.

Cultural validity of PTSD

In reviews of treatments of PTSD in refugees, the issue of cultural sensitivity is a very frequent concern. This is not only because of the issues inherent in applying a western-developed treatment to a non-western population, but also because the very notion of PTSD as a universal diagnosis applicable to all people is challenged. Summerfield (1999) argues that “for the vast majority of survivors posttraumatic stress is a pseudocondition, a reframing of the understandable suffering of war as a technical problem to which short-term technical solutions like counseling are applicable”. He laments what he describes as “a globalization of Western cultural trends towards the medicalization of distress and the rise of psychological therapies”. Kienzler (2008) describes two polar positions in this debate. One argues that PTSD is a universal and cross-cultural valid response to trauma that can be cured by clinical and psychosocial measures, while the other argues that PTSD is a culturally constructed diagnosis that makes sense only within the particular cultural and moral framework of the West.

Since the study population of this research was composed of Sudanese refugees and not a western population, it can be argued that PTSD may not be a culturally relevant diagnosis to the current study. However, previous research on Sudanese refugees in particular has found that

there are indeed high rates of PTSD and other psychopathology. While the narratives of suffering may be different from those in western populations and can only be understood within their specific cultural context, this does not negate the very real distress refugees can suffer as a result of their experience.

Treatment of PTSD in Refugees.

Although much research has been conducted in industrialized countries on effective treatment of PTSD in civilian populations exposed to traumatic events such as accidents or sexual violence, very little is known about effective treatment of PTSD in civilians affected by war (Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004). In a study comparing war-related traumatic events in soldiers to those of civilian life, Prescott (2012) found that soldiers who suffered PTSD as a consequence of war-related events were less likely to report re-experiencing symptoms and feelings of fear and helplessness. In addition, it was found that suicidal ideation was less likely to be reported in war-related PTSD than in civilian trauma. Prescott suggests that “war-related events as compared to similar civilian events occur in contexts that may buffer some of the consequences of trauma”. Research on PTSD treatment in refugees lags behind that for other traumatized populations (Nickerson, Bryant, Silove & Steel, 2011). The nature of stressful events that refugees are exposed to during war, in addition to the stressful conditions they continue to live in even after fleeing their country of origin, has implications for any psychotherapeutic treatment for PTSD in this population. Furthermore, most well-established treatment protocols for PTSD, such as CBT and exposure therapy; require a safe and reassuring environment which may be hard to ensure in a refugee setting (Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004).

Nickerson, Bryant, Silove and Steel (2011) broadly divided treatment protocols for PTSD in refugees into two categories; trauma focused therapy and multimodal interventions. Trauma focused therapy, such as CBT, testimony psychotherapy and NET, focuses mainly on the trauma experienced by the refugee. Trauma focused approaches are grounded in a cognitive behavioral framework and emphasize two processes; correction of cognitive and memory distortions and extinction learning. Since fear conditioning is implicated as the main etiological factor in the pathogenesis of PTSD by pairing extreme fear at the time of occurrence of the traumatic event with other stimuli reminiscent of the trauma (Rauch, Shin & Phelps, 2006), successful resolution of PTSD happens when the refugee recounts and re-experiences the trauma until he or she becomes desensitized to it, and the trauma no longer arouses feelings of fear. Through this process of extinction learning, the refugee learns that cues that were initially conditioned with the traumatic event no longer result in aversion and avoidance, thereby reducing anxiety (Milad et al., 2006). In addition, trauma focused approaches alleviate PTSD symptoms through overcoming avoidance behavior, procession of traumatic memories and altering maladaptive appraisals of risks.

Multimodal interventions arise from the premise that a sole focus on trauma is insufficient to address the complex needs of refugees, and so take a more multidisciplinary approach. They involve a variety of services such as general assistance with resettlement in addition to direct psychotherapeutic approaches. The multimodal approach has dominated refugee mental health care in recent decades (Nickerson, Bryant, Silove & Steel, 2011). Proponents of multimodal interventions argue that in addition to being insufficient to address the varied and complex needs of refugees, approaches that focus solely on trauma may do more

harm than good by allowing them to relive traumatic events at a time of heightened stress, thus causing adverse emotional reactions.

Nickerson, Bryant, Silove and Steel's (2011) systematic review found that despite the need for better controlled studies, trauma-focused therapy shows promise in alleviating PTSD in refugees, while the current practices of multimodal interventions in refugees are lacking in empirical support. More evaluation of the additive effects of elements currently included in multimodal interventions is needed.

It is one of the trauma-focused therapies, Narrative Exposure Therapy (NET), that was utilized in this study. NET allows patients to re-experience the trauma by narrating their whole experience in their own words without focusing on the single most traumatic experience, in the process allowing them to reconstruct a new, meaningful narrative of their experience that fits into their life story (Schauer, Neuner & Elbert, 2011).

Palic and Elklit (2011) conducted a systematic review of prospective treatment outcomes studies on psychosocial treatment of PTSD in refugees. Reviewed treatments included musical therapy, standard cognitive behavioral therapy (CBT), group CBT, exposure therapy, multidisciplinary treatment consisting of supportive social intervention in addition to psychiatric treatment and psychotherapy, psychodynamic therapy, psychosocial group interventions, trauma focused psychotherapy, testimony psychotherapy and narrative exposure therapy (NET). Large effect sizes were found in CBT studies, and they concluded that CBT was largely suitable for treatment of core PTSD symptoms. They also found that NET's efficacy for treatment of PTSD in refugees was well established. Possible reasons for this efficacy include that NET was designed specifically as a short term therapy that can be delivered in a limited resource setting such as refugee camps, in addition to being designed to be easily learned by laypersons without

extensive training. Thus, it may be an ideal therapy for refugees living in resource-limited conditions. In addition, because many cultures value the oral tradition of storytelling, it is possible that a therapy based on the creation of a narrative is likely to be adaptable to and seen as acceptable by many cultures (Hijazi, 2012). Another possible reason for the effectiveness of NET is that in NET the individual is able to construct a coherent narrative out of traumatic and stressful memories while having someone at their side. The therapist is witness to the individual's trauma and suffering. Because the written narrative is given to the individual at the end of therapy, it may be useful as a testimony to injustices suffered, helping restore a sense of dignity and humanity (Schauer, Neuner & Elbert, 2011).

Another review by Nicholl and Thompson (2004), while lamenting the dearth of research and methodological limitations, also found promise in culturally sensitive adaptations of CBT. Palic and Elkit's (2011) review found similar promise in culturally sensitive CBT. For example, the use of CBT in Southeast Asians, while managing cultural sensitivity through the use of Buddhist metaphors and mindfulness was effective in reducing symptoms of PTSD, anxiety and depression.

Narrative Exposure Therapy for PTSD in Refugees

Narrative exposure therapy was developed by Neuner, Schauer, Elbert and Roth (2002) to be a short-term psychotherapy based on CBT exposure techniques and testimony psychotherapy. In exposure therapy, the patient identifies the single most traumatic event and relives it in full detail with all its associated emotions until habituation of the emotional response is achieved. Testimony psychotherapy is a method that was developed by Lira and Weinstein, but published under the pseudonyms Cienfuegos and Monelli (1983), to treat survivors of the repressive Pinochet regime in Chile. Rather than focus on one event as in exposure therapy, in testimony

therapy the patient narrates their entire life from the moment of their birth until the present, while giving a detailed report of the traumatic events they have experienced.

Narrative exposure therapy involves an integration of the principles of exposure and testimony therapy. Similar to exposure therapy, NET confronts the patient with traumatic memories and all their associated emotions, with the eventual aim of habituation of the emotional responses to traumatic memories. However, NET has an added mechanism, which is to correct the distortion of memories of traumatic events. Distortion of memories of traumatic events makes narratives fragmented and contributes to persistence of PTSD symptoms (Ehlers & Clark, 2000). NET reconstructs the memories of traumatic events and weaves a consistent and meaningful narrative that is eventually integrated into the individual's life story.

NET is highly suitable for refugee populations. It is a short-term psychotherapy, which makes it favorable for refugee populations given the large numbers of people requiring treatment and the dearth of trained mental health professionals. In addition, it relies on the oral tradition of storytelling, which is a common element across cultures (Neuner, Schauer, Klaschik, Karunakara & Elbert, 2004). Thus, it seems to have cross-cultural competence and applicability.

Several trials to date have documented the efficacy of NET in refugee populations. A study by Neuner, Schauer, Klaschik, Karunakara and Elbert (2004) compared NET to supportive counseling and psycho-education for treatment of PTSD in a refugee settlement in Uganda. One year after treatment, only 29% of those who received NET still fulfilled the criteria for PTSD. On the other hand, 79% and 80% of those who received supportive counseling and psycho-education respectively still fulfilled the diagnostic criteria for PTSD. The fact that this study took place in a refugee settlement in Africa rather than a safe setting in an industrialized country

shows that NET holds promise as an effective short-term therapy for refugees who still live in stressful conditions despite fleeing their country of origin.

Coker (2004) described the experiences of suffering that Southern Sudanese refugees recounted at a UNHCR-sponsored health clinic in Cairo. She notes that because of the unique nature of their experiences, they have “no ready-made cultural ‘script’ for their experiences”. Therefore, they “must remake their stories as they go, telling of illnesses and social breakdowns for which ordinary metaphors are profoundly unsuited”. Though her study was not on NET, it is precisely this “story” or “script” that NET attempts to remake.

Another study by Neuner et al. (2008) trained lay counselors from a refugee settlement in Uganda in NET. These lay counselors then provided NET to a group of refugees from their community suffering from PTSD. The outcomes were compared to refugees who received trauma counseling or no treatment. NET had fewer dropouts than trauma counseling (4% compared to 21%), and at follow-up, 70% of NET and 65% of trauma counseling recipients no longer met the criteria for PTSD, as opposed to only 37% of the no treatment group.

Neurobiological research on NET as a psychotherapy for refugees with PTSD has shown promise. A randomized controlled treatment trial (Adenauer et al., 2011) assigned 34 refugees with PTSD to either NET or a waitlist and measured neuromagnetic oscillatory brain activity resulting from exposure to aversive and neutral pictures. In addition to reduction of PTSD and depressive symptoms in the NET group and their persistence in the waitlist controls, the NET group showed increased brain activity in the parietal and occipital lobes in response to threatening pictures. This suggests that NET increased cortical top-down processing of aversive stimuli, and that this greater allocation of attention to potential threats may allow a person to re-evaluate the danger of a situation more accurately, thus reducing PTSD symptoms.

A review by Palic and Elklit (2011) of prospective treatment outcomes studies of PTSD in adult refugees found that NET was one of two treatments that had the best documentation of effects in the reviewed literature (the other was culturally sensitive CBT for Southeast Asians). Therefore, based on the literature, it appears that NET is a promising form of therapy for the study population of Sudanese refugees living in Cairo and suffering from PTSD.

One limitation of trauma focused approaches such as NET (Miller & Rasmussen, 2010) is that they are insufficient to address the needs of war affected and traumatized civilians such as refugees. Refugees face a multitude of ongoing psychosocial stressors such as poor economic conditions and lack of employment. Therefore, material needs may take precedence over psychological needs for them. This was indeed the case for some PTSD affected refugees receiving NET in this study.

Lay Counseling: Definition and Uses

As there will never be enough trained mental health professionals to provide therapy to all those in need, and those that are present are usually not accessible to disadvantaged communities, the concept of lay therapy, whereby help is provided to those in need by non-specialists, becomes an attractive alternative. It is precisely for this reason that lay counselors have been widely used in varied settings such as community mental health centers and schools (Danish & Brock, 1974).

Although the term “lay counseling” seems self-explanatory by virtue of its contrast with “specialist” counseling, there is no consensus on an exact definition. Some authors consider the complete lack of training as the defining factor of a lay counselor. For example, Seaberg (1979) defines lay counseling as

the interaction between two or more individuals where at least one individual, *without training for the role and without organizational auspices*, attempts to help the other(s), predominantly *through verbal means of an intuitive or unspecified origin*, to understand, to cope with, or to modify problems of psychosocial functioning where the counselor is not a party to the problem [italics added]. (p. 511)

According to this definition, any sort of training will tamper with the “lay” in “lay counselor”. Indeed, Seaberg (1979) contends that “any prescription for tampering with this naturally occurring process through training is premature. Obviously, once trained, lay counselors are no longer lay counselors”. Such a definition strictly excludes the study population of this study, since the refugees from the community, despite being laypersons, were indeed trained by specialists to provide a specific type of psychotherapy, NET. Using such a definition of lay counseling restricts it to more informal interactions such as those that occur between family members and friends on a daily basis where one offers help in resolving the other’s problem and therefore it is not Seaberg’s definition of lay counselors that was used in this study.

Rather, lay counselors in this study are conceptualized in the same way as in Neuner et al.’s (2008) study, where they used what they called “trained lay counselors” in a randomized trial of NET. These are laypeople who have no prior training in mental health services, but are trained to provide a particular service to meet a need in the community.

Trained lay counselors have been used for a variety of interventions across the globe. Seaberg (1979), despite the differences in definition, considers non-professional providers of help to be the “basis of prevention in mental health”. They have been used to provide counseling to sufferers of HIV in South Africa (Peltzer, Matseke & Louw, 2014), to refugees suffering from

PTSD in an African refugee settlement in Uganda (Neuner et al., 2008) and to survivors of the 2004 southeast Asia tsunami in India (Gauthamadas, 2007).

Neuner et al. (2008) conducted a randomized controlled trial among a group of Rwandan and Somalian refugees suffering from PTSD in an African refugee settlement. Community members with no prior experience in mental health services were trained in short-term narrative exposure therapy. These newly trained lay counselors then provided NET to a randomly chosen subgroup of the traumatized refugees. The study showed that provision of short-term therapy by lay counselors with only limited training was indeed helpful in treating war-related PTSD in a refugee camp. This finding suggests that lay counseling has the potential to not only provide relief to the millions of refugees and displaced people around the world, but also that it is effective in a setting that is less than ideal, such as a refugee settlement. It shows that despite ongoing problems that refugees suffer from after their displacement, short-term therapy delivered by lay counselors can be effective. However, Neuner et al.'s (2008) study did not look at the effect of the provision of therapy on the lay counselors themselves.

Gauthamadas (2007) investigated a large scale intervention implemented by the Academy for Disaster Management, Education and Training (ADEPT) in an area of India severely affected by the 2004 tsunami. The intervention relied mainly on trained lay community counselors. It involved recruitment and training of community members such as survivors, grassroots level leaders and people who were already active in the relief effort such as disaster response workers and youth leaders. Evaluation of the effort showed that the trained lay counselors delivered higher quality assistance compared to the untrained relief workers. In addition, the study also looked at the effect of the training on the trainees themselves. Several positive benefits were revealed such as a better ability to reach out to the community than in the past, acquisition of

basic counseling skills such as active listening and use of reflective silence and the ability to train co-workers in similar psychosocial interventions. This last benefit is crucial if such community interventions are to be sustainable. It is hoped that the initial trainees will retain the knowledge and skills they received during training and then train a further cohort of community members, spreading the benefit. In this particular study, trainees retained the knowledge they had learned at 16 months follow-up, which offers hope for similar interventions elsewhere. Following the success of this intervention, ADEPT published a manual for community counselors on psychosocial interventions in disasters (Gauthamadas, 2005). To replicate the benefits produced, the Indian department of education distributed guidelines on community psychosocial intervention in schools which followed the guidelines of ADEPT's manual.

Effect of lay counseling on the counselors

While many studies have focused on the effectiveness of interventions involving lay counselors, few have looked at the effect of these interventions upon the counselors themselves. What do they experience? Do they feel more capable, like the participants in Gauthamadas's study (2007) or are they overwhelmed by the trauma and experiences of others. In short, *what happens to them?*

As already mentioned, there have been successful cases where the training and provision of counseling left a positive impact on the trainees. The trainees in Gauthamadas's study (2007) felt confident that they could translate learning into practice and underwent an "internal transformation" by taking part in "reconstructive activities" with the survivors. Although they found that working with grieving survivors of the tsunami was stressful, they were able to cope with this stress by holding meetings with the other community counselors to vent their feelings, share their experiences and support each other. Another study of a community intervention

utilizing lay counselors in South Africa (Alexander, Mollink & Seabl, 2010) also showed a positive impact. Female counselors providing support to women victims of violence from an impoverished community in South Africa emerged from the intervention empowered psychologically. Semi-structured interviews showed that they showed empowerment in intrapersonal, interpersonal and behavioral components of psychological empowerment.

This notion of improvement through helping others was first identified by Riessman (1965). Riessman referred to this as the “helper therapy principle” and observed that “while it may be uncertain that people *receiving* help are always benefited, it seems more likely that the people *giving* help are profiting from their role” (p. 27). The “helper therapy principle” has stood the test of time, with much more recent studies documenting its role in empowering lay counselors. An exploratory study of community health workers (Roman, Lindsay, Moore & Shoemaker, 1999) recruited from a population of low-income mothers sought to examine the effect of the helper role on these women. They were recruited to function as community health workers (CHWs) to provide social support to at-risk pregnant women. Findings revealed that the majority of women experienced positive impact such as “positive feelings about self”, “sense of belonging”, “greater self-esteem” and feeling “energized by helping others”.

There is, however, another side to the story. Just as it is possible for community lay counselors to experience the positive benefits of helping, it is also possible to experience a host of negative outcomes. Some studies have revealed that it is possible for lay counselors to experience symptoms very similar to PTSD, known as secondary traumatic stress, by listening to the traumatic experiences of victims. Secondary traumatic stress is a syndrome of symptoms almost identical to those of PTSD, including symptoms of intrusion, avoidance and arousal; and is sometimes referred to as “compassion fatigue” (Figley, 1995). These symptoms follow as a

result of a caring relationship between two people, one of whom has been subjected to a traumatic experience and another who vicariously experiences the trauma (Figley & Kleber, 1995).

A study of HIV lay counselors in South Africa (Peltzer, Matseke & Louw, 2014) identified several negative effects on the counselors. Half of the counselors were potentially secondary traumatic stress cases. Seeing and testing more HIV cases was associated with greater secondary stress. Likelihood of secondary stress was greater if the counselor himself/herself was HIV positive. Such findings have implications for this study, in which the Sudanese community members who were recruited to provide NET to their peers in the refugee community, while not suffering from PTSD, were themselves refugees nonetheless.

Another study (Shah, Garland & Katz, 2007) was conducted with humanitarian aid workers in India. Humanitarian aid workers are, like lay counselors, not trained in mental health treatment, although they are often in a position where they must provide psychological support. They are, as the authors of the study describe them, an informal system of “barefoot counselors”. For this reason, they are very similar to the lay counselors that were recruited in this study. This study revealed that all the humanitarian aid workers in the sample reported secondary traumatic stress as a consequence of their work. Furthermore, 8% met criteria for PTSD. Despite this, they are “the only source of counseling by default” (Shah, Garland & Katz, 2007) for some communities. Therefore, it is imperative that more research examine how lay counselors are affected by their work and how they can be shielded against the negative effects of secondary stress while maximizing helper benefits.

Not even trained clinicians are immune to the effects of secondary stress. Pulido (2007) found “intense and unprecedented” secondary traumatic stress symptoms in mental health

clinicians who were treating clients for issues related to the September 11th, 2001 terrorist attacks on the World Trade Center in New York City. This constituted an “indirect” exposure to terrorism that left high levels of secondary stress as long as 30 months after the attacks.

It is therefore evident from the literature that the training of community members to provide lay counseling services can affect them in one of two ways. It can either empower them and increase their resources of self-esteem and self-confidence; or it can cause them to vicariously experience the trauma of their clients and become more stressed. The aim of this research was to examine how members of a community of Sudanese refugees in Cairo would be affected by the experience of serving as lay counselors to other Sudanese refugees who are suffering from PTSD.

Methodology

Participants

This research was part of a larger study conducted by Dr. Kate Ellis, Assistant Professor in the psychology department at the American University in Cairo. The larger study aimed to test the effectiveness of training Sudanese refugees to deliver NET amongst those suffering with PTSD in their community in Cairo. The primary outcomes examined were the effectiveness of the delivery of NET by lay counselors and the ability to maintain model fidelity whilst training lay counselors with the assistance of an interpreter. The current study explored specifically how the lay counselors were affected by the process of training and provision of therapy.

Because of the difficulties in reaching a vulnerable and marginalized community, such as refugees who have suffered racism and discrimination at the hands of the host society, such populations are not always easily accessible. Even if accessible, it is not always easy to enlist the cooperation of marginalized populations. The community of Sudanese refugees in Cairo is an

example of such a population. Entry into such communities often involves approaching community leaders and a lot of community politics are at work..

For this intervention, a particular community center in a community of Sudanese refugees was visited over several months to assess the need for NET and interest in receiving training. Those interested then volunteered and the chairman of the community center helped arrange meetings to discuss issues such as time commitment and ability to read and write in Arabic. It was through this process of referral that potential lay counselors were recruited for training in NET. While there were other community centers for refugees in the area, this one was chosen because of its ability to reach out and connect to the greatest number of people in the community; and this particular community was chosen because of the lack of psychosocial support services in the area.

Once potential lay counselors were identified, they were assessed by interviews for certain qualities important in providing therapy, such as listening skills, ability to provide unconditional positive regard, and empathy. Those who possessed these qualities, and did not suffer from PTSD, were chosen to be trained in NET. Ten community members were selected to receive training in NET. Of these, seven continued to provide NET to assigned clients who suffered from PTSD. Ultimately, four of the seven trained lay counselors who completed the training and worked with clients could be accessed to participate in this study. Three of these were men and one was a woman. Three were teachers and one worked as a housekeeper. Two of them were Christian and two Muslim. One spoke only Arabic, two could speak English better than Arabic and one was fluent in both. Their standing in the community ranged from one who had been present in Egypt since 1999 and those who had only recently arrived to Egypt. At the

time of interviewing, each lay counselor had completed the NET protocol with at least one client.

The potential clients were identified in the same way, by referral from the community center. The referrals were assessed for PTSD and those who met the criteria of the DSM-5 (American Psychiatric Association, 2013) were offered therapy.

Procedures

The community members selected to receive training in NET were trained by a clinical psychologist from the American University in Cairo. Due to language barriers, training was provided through an interpreter who speaks Sudanese Arabic and English, who was also a Sudanese refugee with experience in providing translation in psychosocial services for refugees in Cairo. Although there were concerns about material being lost in translation, previous studies (Lambert & Alhassoon, 2015) showed that the use of interpreters in refugee populations suffering from PTSD and depression did not impact treatment outcomes.

The training was completed over a period of four weeks. After training was completed, each lay counselor was assigned one client suffering PTSD to provide the treatment to. These clients were randomly assigned to either NET or, a waiting list which also functioned as a control group. After the therapy was delivered, the controls were provided NET as well. Supervision was provided to the lay counselors during the therapy by the clinical psychologist and throughout the duration of the project.

Data Collection

After the lay counselors provided NET to their clients, semi-structured interviews were conducted with them to collect qualitative data on their experience of being trained and providing therapy to others. Written informed consent was obtained from the lay counselors prior

to conduction of the interviews, which were audio recorded with a portable recording device (see Appendix A for the English and Arabic consent forms). Since some lay counselors spoke one language better than the other, they were asked if they wanted to conduct the interview in English or Arabic. Two interviews were conducted in Arabic, one in English, and one was started in Arabic but changed to English halfway through at the participant's request. The rationale behind collecting qualitative data was to explore all possible feelings, thoughts, emotions and reactions that they experienced during the entire process, as well as any personal transformations or changes they underwent as lay counselors. Qualitative data is the ideal method to obtain such rich data and provide an in depth picture, which cannot be obtained with a checklist, rating scale or questionnaire. Interviews were used to allow the lay counselors to speak with more freedom than they could with other qualitative methodologies, such as focus groups.

In addition, using this method is in line with previous research. This same method was used in a similar study (Alexander, Mollink & Seabl, 2010), where female lay counselors were interviewed and qualitative data collected to determine if the process of counseling left the women empowered. Open ended questions and qualitative data have also been used to collect data from HIV lay counselors in investigations of secondary traumatic stress (Peltzer, Matseke & Louw, 2014).

Eight open ended questions (below) were asked to obtain the data (for the list of questions in Arabic, see Appendix B).

- 1) Can you please describe your experience while you were receiving training?
- 2) Can you please describe your experience while you were providing therapy?
- 3) How did the training you received enhance your knowledge and skills?

- 4) What do you feel you did well as a counselor?
- 5) How do you feel that you have been affected by the experience of being a counselor?
- 6) In your opinion, what makes an effective therapist?
- 7) How effective do you think you were as a counselor?
- 8) What difficulties did you encounter while providing therapy?

The list of questions was developed by adaptation of the list of questions used in Mollink's (2009) qualitative study to assess empowerment of female lay counselors, as well as consultation with Dr. Ellis and members of the community center. The questions were designed to explore several issues, such as the subjective experience of the lay counselors of being trained in NET and providing it to their clients and their feelings, thoughts and emotions while counseling their clients.

Most importantly, the questions sought to explore how the lay counselors felt the process of being a counselor had affected or changed them. The two main possibilities alluded to earlier were that they would either become empowered and more confident, or that they would experience their clients' trauma vicariously and become stressed. However, there were other possibilities such as an inadequacy of the training was not adequate to help their peers or lack of fidelity to the training if they felt that it was not helpful. Another possibility was that they would see no value in sitting in a room and talking about bad memories. Finally, there was the added concern that training and supervision through an interpreter would make it more difficult to learn. Although the list of questions was influenced by the findings of previous research, they were designed to be open-ended and interviews were semi-structured rather than structured. Leeway was given to the interviewed lay counselors to express themselves and talk about issues

other than those in the question list. In this way, an inductive approach was utilized that allowed the themes to be driven by and identified based on the data.

English interviews were transcribed verbatim and Arabic interviews were translated to English and transcribed. Access to the recordings was restricted to the principal investigator and the thesis advisor.

Provisions were made to refer interviewees for immediate therapy if they disclosed that they had become distressed during the interview or during provision of therapy to their clients, though ultimately this did not happen.

Data Analysis

Thematic analysis was conducted to identify the main themes that emerged from the interviews. Thematic analysis is “a method for identifying, analyzing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail” (Braun & Clarke, 2006). In thematic analysis, the researcher analyzes the transcripts of the interview (or focus group) and identifies groups of quotes that point to a similar idea or pattern. Each set of such quotes is grouped together, and the overarching theme of each set is identified. This process is repeated until all themes have been identified. It starts with a thorough reading and familiarization with the data, while taking note of items of potential interest. The dataset is coded, and themes are identified from the codes. The themes are then reviewed, and a map or chart of themes and sub-themes is produced. Finally, the final themes are defined and named. To improve reliability, this process is usually done by more than one researcher independently, and then inter-rater reliability is assessed.

Thematic analysis was carried out using the six-step method employed by Braun & Clarke (2006). (see Appendix C for the full 6 step guide to thematic analysis). This started with

getting very familiar with the interview data and transcribing the interviews. This was followed by generation of preliminary codes. When coding, any data extract that was generated by one question but was relevant to a different question was included in both or moved to the most suitable theme/code. The author rated each extract of data and coded it. The extracts were checked independently by the project supervisor to ensure reliability. After code generation, themes were searched for and identified, following by a review of these themes. After review, the themes were named and a report of the results produced.

The report of the results was written following the publishability guidelines of Elliott, Fisher and Rennie (1999). These include guidelines specific to the publication of qualitative research; such as coherence, being grounded in examples and resonance with readers. In addition, they include guidelines that apply to both quantitative and qualitative research; such as appropriate methods, respect for participants, clarity of presentation and contribution to knowledge (see Appendix E for the full list). Furthermore, Braun and Clarke's (2006) 15-point checklist of criteria for thematic analysis was also followed. This aim of these criteria is to ensure that certain standards have been adhered to during the analysis, starting from the transcription through the coding and analysis and the production of the final written report (see Appendix D for the full list).

Thematic analysis offers several advantages (Braun & Clarke, 2006) such as flexibility, ease of communication of results to the general public and useful summarization of key features of data. However, there are added advantages to thematic analysis that apply specifically to this research. It is a useful method of analysis in community based research, as it gives the participants a voice in a way not possible with codebooks that are used with checklists and

surveys. Most importantly, it allows unanticipated and unexpected findings to emerge, which was essential in this study as it was not known how the lay counselors would respond.

Results

Thematic analysis identified eight recurring themes throughout the responses to the interview questions: training benefits, suffering of Sudanese refugees, empowerment, sense of community, sustainability, resilience and coping strategies, qualities of an effective therapist and challenges. The results are presented by interview question and displayed to show the themes, codes and an example extract from each code. The extracts are to provide a glimpse of the discussion. For an example of a full transcript, see Appendix F. As themes recurred frequently in response to each question, they are discussed once rather than being repeated under each question.

Themes identified

Eight themes were identified in the analysis of responses to the interview questions. These themes recurred throughout the responses to all questions.

Training benefits

The structure of the training course was applauded as systematic, well-structured and moving at a reasonable pace. Foremost among the training benefits was a learning experience from which the counselors emerged with greater knowledge about mental health. They learned more about mental health, mental illness and their determinants. They also learned to be effective Narrative Exposure Therapists. Furthermore, there was the personal benefit of learning to manage stress and difficult emotions and increase psychological mindedness in preparation for providing therapy to others. As one participant succinctly put it, “it [the training] treated me before I could treat someone”.

Suffering of Sudanese refugees

Another salient theme, recurring throughout the analyses of most of the questions, was the suffering of Sudanese refugees as a result of both past pre-migration stressors and ongoing stressors in Egypt. Lay counselors spoke of traumatic experiences of war, personal loss and displacement back home. These problems were compounded by new stressors in Egypt, such as the lack of adequate support agencies or networks for refugees, particularly lack of help from the UNHCR. In addition, they spoke of racism at the hands of the local population, poor living conditions and a lack of employment. The role of post-migration stressors in ongoing psychological distress was acknowledged. As one participant put it “We Sudanese, we came to Egypt, but the commissioner’s office [UNHCR] does not help...on the contrary, there is someone who came with some mental problems, they increase here”.

Empowerment

Empowerment was also a prominent theme. The training and experience of providing therapy increased counselors’ capacity to provide needed help in their community as well as train others in NET as they had been trained. One participant described a sense of personal achievement and pride at having attended the NET training and received a certificate. Lay counselors spoke of their motivation to become better therapists, their desire to help as many people suffering from trauma as they could and their confidence in their abilities as therapists. One lay counselor said “the course gave me positive motivation. It gave me very positive motivation to help people in need”. Another said “I definitely believe that I will just continue helping people who are having trauma issues”.

Sense of community

Also apparent from the counselors' responses was a strong sense of community that bound the Sudanese refugee community of Cairo together. They spoke of the importance of helping the community with their newly gained knowledge and skills and the implausibility of *not* helping people. One participant said "we have started to try to help the community now – after the training. I cannot – after I have gained this information – keep it to myself. It is very important to try to deliver what you know to help others".

All counselors spoke of their suffering as refugees in collective rather than individual terms; the suffering being a process that afflicts the whole community. The sense of community was also manifest in the solidarity between members of this marginalized group. Relationships between therapists and their clients often transcended the traditional therapist-client relationship. It was common for therapists to visit their clients at home either because of concerns about confidentiality at the crowded community center or just to visit a client who was physically sick. One counselor spoke of how one could not enter a neighbor's home empty handed; "like if I want to go to their home and I know that they have a problem, I cannot just go like that, like I can buy some juice or anything to take to them... Because I know they have problems, they are sick".

Sustainability

Sustainability of the community-based lay counseling intervention was also a theme. The lay counselors spoke of the importance of disseminating their newfound knowledge in the community and referred to how they were now training peers in the community in the same skills that they were trained in. One participant described how each therapist started with "one client" and how he hoped that the intervention would continue in this manner once their clients

completed their therapy sessions. Another described his vision for a wider reach for this intervention; “it starts with me, then the family, then the community”.

Challenges

Challenges to providing therapy and how they were managed constituted a significant portion of therapists’ experiences. Challenges encompassed general logistic challenges as well as challenges specific to the community. Logistics were a problem for all four therapists. The community center where the therapy sessions took place was noisy, crowded and uncomfortable. Interruptions were frequent and some clients were concerned about confidentiality. Because of the limited space, it was common for sessions to be cut short so that the room could be used for another purpose. However, there were several efforts to overcome these challenges. When there was a concern about confidentiality for one female client, the male therapist agreed to her request that he visit her at home where she would be more comfortable. Although it was culturally inappropriate for a man to visit a woman who was living alone, this was successfully negotiated by having one of the female therapists accompany him during the visit. Problems of noise, time and crowdedness were managed by therapists by modifying an already difficult daily schedule. One therapist would wake up two hours earlier than usual to be able to finish work early and arrive at the community center before it got crowded. Despite the considerable effort involved, a strong sense of community and feeling of duty toward those in need meant that they were happy to do it. One lay counselor said “the work is a bit tiring. But in a way I am doing this because someone needs it... I put in more effort, I leave home early to get to work early and be able to leave work early, so I can come meet the client”.

Lay counselors also spoke of the emotionally draining nature of providing therapy. All therapists described how they experienced difficult emotions as a result of their clients’ painful

narratives. While three of them were able to manage these emotions, the fourth broke down and cried with her client, though as the therapy progressed she reported that her client's mental status improved. One lay counselor spoke of the disappointment he felt when he was unable to engage his first client in therapy despite considerable effort. This client dropped out prematurely. The exhausting nature of providing therapy was acknowledged by a lay counselor who emphasized that it was necessary for a therapist to have a laid back and relaxing job so that he would be in a good psychological state when meeting the client. His own job as a housekeeper in a place two hours away from his home did not fulfill these characteristics.

Other problems included a perceived lack of importance of psychological needs in the face of pressing material needs. This was in fact why one client dropped out prematurely, as he had misunderstood the purpose of the therapy and was expecting financial assistance. This client was also suspicious of possible ulterior motives of the therapy and demanded that none of his data be used for any purpose. This is not surprising in a marginalized community that has become accustomed to racism, humiliation and much disappointment at the hands of the host community.

Challenges to providing therapy specific to the community involved cultural barriers such as the aforementioned case when a female client asked a male lay counselor to visit her at home.. Although he did not face any problems, he expressed his initial uneasiness at having a female client and visiting her at home. Although these cultural barriers did not present a problem, he would have preferred that a female therapist attend to his client due to the sensitive nature of her narrative.

Gender emerged as a salient subtheme in this context. Three of the four lay counselors mentioned that one had to be sensitive if therapist and client were not of the same gender. One

lay counselor, a young woman, when asked about her opinion of the attributes of an effective therapist, mentioned the fact that she was a woman first and foremost and how she had to clearly introduce herself and her qualifications in order to be taken seriously; “like, I’m a lady, right? If I want to try to counsel a man...first of all introduce yourself to know you, whom you are, ok?”

The male counselor who visited a female client at home explained how this request had made him feel uncomfortable. He said “I wished there was a public place instead like this [the community center]. It would have been better”. He expressed concern about the impression the community would have if seen alone with a woman; “And sometimes, you know, our people – when they see a man and woman alone...Of course I do not know their impression or what they will say, but they do have an idea that we are doing work here. But I still don’t know about the community. The community is not very educated, so one should take these things into account”. However, these cultural barriers were successfully negotiated. He visited the client at home in the company of one of the female therapists so as not to be seen entering her home alone. He described how having a female client talk about rape and sexual violence “was hard for me at the beginning”. For example, He recalled a question she asked him that he had difficulty responding to; after narrating her experience of sexual violence and rape while in detention, “how are you a man and able to control yourself and listen to all these things?” Eventually, though, he was able to “build trust with the client” and achieve a positive outcome.

A third lay counselor, when talking about the attributes of a successful therapist, mentioned reputation and honest first and foremost, giving an example of how a dishonest male therapist would behave in the context of a therapeutic relationship with a female client. “If it is not good, and you are not honest, because talking to people, you may talk to females sometimes, and if you are not honest, you will turn the story upside down... Sometimes it’s very hard having

male and female”. This did not constitute an impediment to a successful therapeutic relationship, however, for it ultimately comes down to “your personality, whom you are”.

Resilience and coping strategies

Despite significant adversity, therapists displayed several coping mechanisms in both their experience as therapists and their everyday lives. Chief among these was a culture of acceptance; that problems and challenges are an everyday fact of everyone’s life and that to live one must accept these challenges and deal with them. There was also a willingness and ability to overcome several logistic challenges related to time and place by modifying an already difficult daily routine; rather than dropping out prematurely. In addition to overcoming logistic challenges, there was also a willingness and ability to also overcome cultural barriers that may have impeded therapy, such as when a female client asked a male therapist to visit her at home because of concerns about privacy at the community center. There was also a sense of optimism despite adversity and difficult living conditions. A focus on future aspirations and ambitions rather than past trauma was common to all interviewed lay counselors. One said”Tomorrow is definitely sunny and tomorrow is definitely good. There are good things in the world and the future no matter how many bad things we’ve been through. Tomorrow can be better”.

Qualities of effective therapist

Rather than being a theme that emerged in all responses, this theme was specific to the response to a question about what the lay counselors thought were qualities of an effective therapist. They described a wide range of skills and qualities required for therapists in general and Narrative Exposure Therapists in particular. These included active listening, attentiveness, giving the client room to speak, exercising a non-judgmental attitude, empathy, a non-directive approach, punctuality and maintaining confidentiality.

Table 1: Thematic analysis of question one (Can you please describe your experience while you were receiving training?)

Theme	Code	Extract
-Benefits of training -Empowerment -Sustainability	-Training was beneficial -Personal sense of achievement -Training of trainers -Learning experience	<i>Interviewee 1: Yeah, they have problems and that's why the knowledge that we get, and we have given certificates, right? So I'm so much pleased for the certificate that we have given. That's why we are now starting now teaching people. We are now training people. The knowledge that we get from the doctor, that's what we are studying now, training people now about it. Yeah, yeah now we understand a lot of things actually.</i>
-Suffering of Sudanese refugees	-War, loss -Psychological problems	<i>Interviewee 2: There are a lot of people who are suffering....especially the Sudanese, who spent a long time in war. I mean, most Sudanese have mental problems. You see friends at work, they all have problems. Like, there was one person who lost all his family in the war...lost his children, lost his mother, lost his father</i>
-Suffering of	-Psychological	<i>Interviewee 2: We Sudanese, we came to Egypt, but</i>

Sudanese refugees	<p>problems</p> <p>-Trauma of life in Egypt</p> <p>-Lack of support from UNHCR</p>	<p><i>the commissioner's office [UNHCR] does not help...on the contrary, there is someone who came with some mental problems, they increase here.</i></p>
<p>-Benefits of training</p> <p>-Sense of community</p>	<p>-Improved self-care</p> <p>-Collective suffering</p>	<p>Interviewee 4: <i>It [the training] helped my personality – it helped me to avoid stressful things that can affect me personally or affect the family... Most importantly, I personally benefited. I am part of the suffering that exists and went through the same stressful situations.</i></p>
<p>-Sense of community</p> <p>-Sustainability</p>	<p>-Helping the community</p> <p>-Dissemination of knowledge</p>	<p>Interviewee 4: <i>it starts with me, then the family, then the community. As for the community, we have started to try to help the community now – after the training. I cannot – after I have gained this information – keep it to myself. It is very important to try to deliver what you know to help others</i></p>
-Benefits of training	-Improved knowledge about	<p>Interviewee 4: <i>I believe that this illness is a very difficult one, more difficult than something that a</i></p>

	mental illness	<i>doctor can see. Sometimes, it is very hard to discover it...But there are some symptoms...that one can discern... ..The illness has grades too. There are cases that are worse, and others that are relatively better</i>
-Sustainability	-Sustainability	Interviewee 4: <i>Every one of us started with one client, and through this there will certainly be sustainability</i>

Table 2: Thematic analysis of question two (Can you please describe your experience while providing therapy?)

Theme	Code	Extract
-Challenges -Suffering of Sudanese refugees	-Difficult emotions	Interviewee 1: <i>For the first time when I meet her. When she was crying, I also cried. Why? Because she was in very troubled conditions. Yeah, because – she tells me her husband died in 2000</i>
-Challenges	-Primacy of material over psychological needs -Suspicion about	Interviewee 2: <i>I have seen 2 clients. The first client is the one I told you about earlier...On the 2nd session, he got upset at me and said he did not want to continue.</i> Baher: <i>Why didn't he want to?</i> Interviewee 2: <i>He actually wanted material help...So</i>

	actual purpose of therapy -Client dropout	<i>his understanding was that maybe somebody would give him money, maybe somebody would help him materially. When he realized that this was not the case, he withdrew and told us not to tell anyone what he had said [in the sessions]</i>
-Challenges -Resilience and coping strategies -Sense of community -Suffering of Sudanese refugees	-Struggles of daily life in Cairo -Helping the community -Acceptance -Attempt to overcome challenges	Interviewee 2: <i>...it [providing therapy] needs someone who has time and whose job is laid back. Now I work as a [housekeeper] ...the work is a bit tiring. But in a way I am doing this [counseling] because someone needs it...I put in more effort, I leave home early to get to work early and be able to leave work early, so I can come meet the client...These are challenges for the person...This is normal, everyone faces challenges in life. If you want to deliver information to someone, you must face challenges. We must be able to overcome these challenges.</i>

Table 3: Thematic analysis of question three (How did the training you received enhance your knowledge and skills?)

Theme	Code	Extract
-Training benefits	-Improved knowledge about	Interviewee 1: <i>...sometimes you can find somebody who has mental problems, not sick actually but the</i>

	<p>mental illness</p> <p>-Social support</p>	<p><i>mental problems come from what – from when you are thinking too much, or when you have a lot of problems...I will just try to advise... I will just try to be near, to be near to him or her...so that she cannot think too much.</i></p>
-Training benefits	<p>-Attentiveness & listening skills (therapist skills)</p> <p>-Adherence to the therapeutic process</p>	<p>Interviewee 2: <i>Definitely. It gave me a lot of information. It taught me how to listen to a client and stop writing to listen to the client. After the client narrates the whole problem, I can go back and make records. I memorize and pay attention and keep things in my memory.</i></p>
-Training benefits	<p>-Nonjudgmental attitude</p> <p>-Non-directive approach (therapist skills)</p>	<p>Interviewee 2: <i>Because sometimes, if a person does not take a course and the client is talking, you might blame him and say “No, it should be like this. It should be like this”. In the course I learned that I should let the client say everything.</i></p>
-Training benefits -Challenges	<p>-Managing difficult emotions</p> <p>-Difficult</p>	<p>Interviewee 2: <i>Even if there are difficult things, I don't do that [cry]. Even if it gets to the extent of crying, like if someone is crying...I can't cry with him, even if it is very hard. I control myself so I can</i></p>

	emotions	<i>help....They taught us how to control, how to do “control self” [said these words in English] in situations where you might hear difficult things.</i>
-Empowerment -Training benefits	-Learning experience -Motivation -Greater capabilities	Interviewee 3... <i>I became capable. Not like at the start. In the beginning I had no background about anything...It gave me motivation to be more capable, to be able to listen to another person a lot.</i>
-Empowerment	-Greater ambition	Interviewee 3: <i>You find that you have new ambitions</i>
-Benefits of training	-Training was necessary to become an effective therapist	Baher: <i>OK. So, without the training, would you have been able to provide the therapy?</i> Interviewee: <i>No, no, no of course I couldn't. I would even make mistakes...How would I know? It's very difficult.</i>
-Training benefits	-Improved knowledge about mental illness and NET's mechanism	Interviewee 4: <i>The secret is a person who suffers from this and remembers the dates and remembers the past will, with repetition, sometimes be able to make himself forget these things, these concerns.</i>

Table 4: Thematic analysis of question four (What do you feel you did well as a counselor?)

Theme	Code	Extract
-Training benefits	-Making client feel at ease	<i>Interviewee 1: Then, when I introduce myself, I just tell them that just feel free, don't fear anything...just try to tell me everything.</i>
-Sustainability	-Training of trainers	<i>Interviewee 1: Yeah, because the knowledge that, when the doctor was teaching us she told us that the same thing that I'm going to teach you is the same thing that you're going to share your patients.</i>
-Sense of community -Challenges	-Noise at the center -Efforts to overcome challenges -Giving clients material support	<i>Interviewee 1: Yeah, and then, I used to go to their home because sometimes here there was a lot of noise. I offer myself to go to their home. Yeah, sometimes like, like if I want to go to their home and I know that they have a problem, I cannot just go like that, like I can buy some juice or anything to take to them... Because I know they have problems, they are sick...</i>
-Sense of community	-Conflict resolution skills	<i>Interviewee 1: Like, for example if you fight, if you caught people just on the way fighting or quarreling, you will not just go and leave them like that, no... You must try and advise them</i>
-Empowerment	-Motivation	<i>Baher: OK, what else do you think you performed well</i>

	-Self-improvement	<p><i>in?</i></p> <p>Interviewee 1: <i>I worked hard on everything and I will try to do more than this, so this can help my skills and also help a person in need.</i></p>
-Challenges	-Efforts to engage client -Client dropout	<p>Baher: <i>What else did you do well?</i></p> <p>Interviewee 2: <i>I also did well...with the first client whom I met and could not continue with, I used to go bring him from his home. I would come here [the center] and not find him, and he does not have a telephone, I go and look for him inside and outside the center...I wanted to continue with him with the same effort. I wanted to bring him every time until we could finish the five sessions, but I was not lucky enough.</i></p>
-Resilience and coping strategies	-Focus on future aspirations	<p>Interviewee 4: <i>And then I always encourage her to focus...Yeah. On the future, the main things, she must focus in the things that may help her through trouble. Not focusing in the past.</i></p>
-Sense of community	-Importance of serving the community	<p>Interviewee 4: <i>She just start new life...instead of trying to be somebody who is unique and who is not important to the community</i></p>
-Sense of community	-Helping the community	<p>Interviewee 4: <i>I'm definitely believe that I will, as, as long as I, I will just continue helping people who are</i></p>

-Empowerment	-Self-improvement	<i>having trauma issues. I will definitely, uuh so far, I am just a learner...I don't see myself that...I know everything</i>
-Sustainability		

Table 5: Thematic analysis of question five (How do you feel that you have been affected by the experience of being a counselor?)

Theme	Code	Extract
-Empowerment	-Managing difficult emotions -Motivation -Greater capabilities	<i>Interviewee 1: The course gave me 100% motivation. I used, one used to be afraid of certain things that happen, but I found motivation in the course, to be able to control yourself, so you can be able to help a sick person in front of you who has had a psychic trauma</i>
-Suffering of Sudanese refugees -Challenges	-Trauma of living in Sudan -Managing difficult emotions	<i>Interviewee 3: ...she [his client] had gotten very agitated and nervous and stood up [when describing her traumatic experience of rape], and I felt affected inside but of course I could not cry or say something...Because if I'd said or done something she might have said "You are all men! [implying that all men are bad and similar]"</i>

-Suffering of Sudanese refugees	-Collective suffering	<i>Baher: When you are on your own...for example at work or anywhere else, did the experiences she told you about affect you in any way?</i>
-Sense of community	-Trauma of life in Sudan	<i>Interviewee 3: No, no. Well, it would not affect me like that. I consider this-we originally came from a very problematic region... We came from the Nuba Mountains; we hear these things a lot. I mean, that's why I told you were are never far from these events</i>
-Resilience and coping strategies	-Habituation, desensitization	
-Training benefits	-Improved self-care	<i>Interviewee 3: It [the course] treated me before I could treat someone</i>
-Training benefits	-Managing difficult emotions	<i>Baher: ... let's assume that you had gone to talk to this woman without taking the course and listened to these stories</i> <i>Interviewee 3: No, no, no. I'm telling you, it might make me commit crimes! I might cause problems. It would be difficult...I wouldn't be able to wait [for her to finish]. I would tell her "enough". I might cry with her and instead of treating her everything would go wrong</i>
	-Commitment to volunteering	<i>Interviewee 4: ...and yeah, I know it's just volunteer job...other people sometimes, they don't accept to</i>

-Sense of community	-Helper therapy principle	<i>work as volunteers...And um, maybe that's the point and to me, doesn't mean that I am losing anything because I am helping</i>
	-Helper therapy principle	Interviewee 4: <i>I feel that by helping people I am already...gaining. And yeah and also this is another experience to me.</i>
	-Helper therapy principle	Interviewee 4: <i>Because helping others, giving advice to other people, that is success. That is not a failure</i>

Table 6: Thematic analysis of question six (In your opinion, what makes an effective therapist?)

Theme	Code	Extract
-Qualities of effective therapist	-Honesty	Interviewee 1: <i>to be successful...first of all to be honest, ok?</i>
-Qualities of effective therapist	-Proper introduction	Interviewee 1: <i>Like for example, I'm a counselor, if I, if I want to advise somebody, ok? Like, I'm a lady, right? If I want to try to counsel a man, ok? First of all you must introduce yourself... First of all</i>
-Challenges	-Cultural barriers	<i>introduce yourself to know you, whom you are, ok?</i>
-Qualities of effective therapist	-Professional appearance	Interviewee 2: <i>... and number two his appearance [clothes]. You have to dress well. Because...the client can come and be dressed poorly. If he comes</i>

	-Setting an example for the client	<i>and sees that you also are poorly dressed, this can give a negative impression. The therapist should be well dressed in clothes that suit him...This can even help the client's mental state. He will see that you are well dressed, while he is not well dressed. He may change his mind and decide to dress better, he may take a shower.</i>
-Qualities of effective therapist -Challenges	-Having a sound psychological state -Pre-existing stresses in therapist's life	Interviewee 2: <i>He must be in a high "form", not be exhausted, not upset by anything. You have to be complete so you can give all information to the patient...I mean you must not be upset from anyone...If you are upset from someone, and then meet someone else and they talk to you, they can make you more upset- you understand?</i>
-Qualities of effective therapist	-Responsibility -Importance of acceptance by the community	Interviewee 4: <i>First of all, he has to be a responsible person. Second, he has to be accepted by the community.</i>

Table 7: Thematic analysis of question seven (How effective do you think you were as a therapist?)

Theme	Code	Extract
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<p>-Training benefits</p> <p>-Resilience and coping strategies</p>	<p>-Confidence</p> <p>-Training was necessary to become an effective therapist</p>	<p>Baher: ...we talked about the things that make a counselor good...Do you think you have these things? Like, do you think you were able to be an effective counselor?</p> <p>Interviewee 1: Yes... Yeah, me I have that all things into myself, I have it</p>
<p>-Training benefits</p> <p>-Resilience and coping strategies</p>	<p>-Optimism</p> <p>-Focus on future aspirations</p>	<p>Interviewee 2: There was a client I met who had suffered a trauma; I was able to show her that there is life and there is a good future, a sunny future, today is not like tomorrow. Yesterday is not like today. Today is different because if you go through hard things today, tomorrow you are prepared.</p>
<p>-Empowerment</p> <p>-Training benefits</p>	<p>-Self-improvement</p> <p>-Ambition</p> <p>-Training was necessary to become an effective therapist</p>	<p>Baher: OK, what do you think went wrong with the remaining 35% [of your performance]? Like, when you meet your next client, what will you do to raise that 65%?</p> <p>Interviewee 3: With my first client, there was some fear [on the therapist's part] at the beginning and I innovated as I went along. With the next client I'll be more capable...I didn't know what to do [with the first client], but after I started I found myself progressing smoothly. But next time there won't be</p>

		<i>any fear</i>
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Table 8: Thematic analysis of question eight (What difficulties did you encounter while providing therapy?)

Theme	Code	Extract
-Suffering of Sudanese refugees -Challenges	-Lack of adequate medical care for Sudanese refugees -Primacy of material needs over psychological -Difficult questions from the client	<i>Interviewee 1: she was...asking me a question, like for example this training, if, if she needs help, do the doctor can help her or not...Like if she needs help, if you tell doctor to assist like if she has money... To give her for going to hospital...and I tell her that I don't know but I try just to confirm from the doctor</i>
-Challenges -Training benefits	-Managing difficult emotions	<i>Interviewee 1:...it used to be hard because they, once they are narrating themselves they used to cry and they don't feel good</i>

<p>-Challenges</p> <p>-Sense of community</p>	<p>-Commitment to providing therapy despite difficult daily life</p>	<p><i>Interviewee 2...well it needs time, to be able to deal with and manage the client, it needs you to be prepared. When you are coming from your work which is a bit tiring, and then the counseling session itself is long, one hour and twenty minutes, or 90 minutes. So it needs someone who has a bit of a laid back job.</i></p>
<p>-Training benefits</p> <p>-Greater mental health literacy</p>	<p>-Importance of sound psychological health</p> <p>-Attentiveness (therapist skills)</p>	<p><i>Interviewee 2: Because when you come to sit with the client, you need to be in a good psychological state, so that you can help in every way...Because the counseling session requires that you ask about everything, everything.</i></p>
<p>-Resilience and coping strategies</p>	<p>-Acceptance</p>	<p><i>Interviewee 2: This is normal, everyone faces challenges in life. If you want to deliver information to someone, you must face challenges. We must be able to overcome these challenges. I tried to...prepare myself [for the counseling].</i></p>

Discussion

This research project sought to discover the impact of providing therapy (in this case Narrative Exposure Therapy) to Sudanese refugees in Cairo who have been exposed to trauma,

on the trained lay counselors who are themselves from the Sudanese refugee community in Cairo. Thematic analysis of the interview transcripts provided a detailed and nuanced picture of the effect of being Narrative Exposure Therapists on the lay counselors.

Overall experience of the training

Experiences of all four lay counselors during both the training and the therapy were overwhelmingly positive. All expressed their gratitude at having been given the opportunity to undergo the training. Although not all the counselors spoke English, the use of an interpreter to deliver the lectures does not seem to have negatively impacted the learning and training experience, in line with previous research. Lambert and Alhassoon (2015) conducted a meta-analysis of randomized trials comparing trauma focused therapies to controls in refugee populations suffering from PTSD and depression. They found that the use of an interpreter did not have a significant impact on treatment outcomes. There may even have been some benefit to using an interpreter; one participant even expressed satisfaction at the chance to improve his English skills by listening to the English lectures and observing the interpreter simultaneously translate it to Arabic.

Improved psychological health after the training

The four counselors interviewed unanimously attested to the benefit of the training course, which extended beyond simply equipping them to provide therapy. On a personal level, it provided skills in stress management and contributed to improved psychological health of the counselors. One lay counselor described how the lifeline exercise in the practical component “was really good. It led us to improve...mentally” She further went on to applaud the training as “good because you can express everything that’s affecting you”. The training offered the lay

counselors a valuable cathartic opportunity to express themselves and have their own narratives listened to before they could go on to offer therapy to their peers.

Greater mental health literacy

The personal benefit of the training course extended beyond an improved psychological health of the counselors. On the theoretical level, there was an increase in knowledge about the symptoms, signs and effects of mental illness. One participant mentioned that before the training, he did not know “that cases like this [mental illness] existed”, but was later “surprised that there are many cases like this, especially in the community I live in”. The “cases” counselors described, though not using psychiatric terminology, encompassed a range of conditions such as depression, stress and psychosis. For example, one participant described a (presumably depressed) client who was “not a loving person” and was always “gloomy” and “alone”, withdrawn from society. Another participant talked about people she had seen (though not clients) that were “mad” and would be seen “laughing alone” and “talking alone” or “running naked”, presumably a case of psychosis. Another common condition described was the state of distress clients experienced that resulted from a constant focus on past traumatic experiences. One participant described such individuals as unable to function because “the mind is far”, with the aim of therapy being to “settle back the mind”.

Counselors also mentioned an increased appreciation of the importance of psychological health and recognized the emotionally draining nature of being a therapist. For example, one therapist described how it was imperative that one’s mind should be as free as possible of troubling thoughts to be able to listen to and absorb the client’s narrative. “If you are upset from someone, and then meet someone else and they talk to you, they can make you more upset- you understand?” He explained that it was necessary to be “devoid of any upsetting feelings. Your

psyche should be open, to say good things, to find a solution for the person in front of you”.

Another participant described how she cried when her client cried as she relayed her narrative of war and loss. Those who did not cry also admitted to feeling affected by the narratives of trauma they heard, but were more adept at managing these emotions.

There was also an improved understanding of how psychological therapy operates. One participant explained that the therapy worked when “he [the client] cries, he gets rid of these accumulated things that were the cause of his pain...this is also one of the things I learned in the practical training”.

Vicarious trauma

Besides an improvement in psychological health and mental health literacy, the training appears to have improved therapists’ capability to manage difficult emotions that arose while listening to their clients’ narratives.

For example, one lay counselor explained how the course “taught us...that one must take control of his nerves, no matter how hard the words or the trauma of the client are. They taught us how to control, how to do ‘control self’ in situations where you might hear difficult things”. The ability to manage stressful emotions arising from vicarious trauma is one essential for a Narrative Exposure Therapist as the therapy is premised on allowing the client to narrate their whole life experience, including traumatic memories. The training seems to have adequately prepared the lay therapists to manage these emotions.

Previous research with lay counselors has shown mixed results regarding the potential for emotional fatigue and secondary stress that result from vicariously experiencing the client’s trauma. Alexander, Mollink and Seabl (2010) found that lay counselors became psychologically empowered from the experience of helping their peers. Other studies found that counselors

suffered the effects of secondary stress as a result of exposure to the traumatic memories of their peers (Peltzer, Matseke & Louw, 2014; Shah, Garland & Katz, 2007). In this study, however, lay counselors largely showed resilience in the face of trauma. One participant described how he and his community had already “reached a point of saturation” from the frequency and commonality of the traumatic experiences they had been subject to, so that “when you hear these experiences a lot...you will not get really affected...it won’t really affect you because they were present before and you hear them a lot...you have Darfur, you have inside Khartoum...so it won’t really affect you”.

There was, however, one incident when a lay counselor was affected emotionally to the point of crying upon hearing the client’s narrative. However, this did not seriously affect the therapist, nor did it preclude improvement of the client’s psychological state as the sessions progressed. The participant described how her client cried as she described her plight in both Sudan and Egypt. Hearing her client’s narrative made her feel “pain that also make me to cry with her”. However, this is better interpreted as an expression of empathy rather than secondary stress or emotional fatigue, as the participant did not report any lingering negative effects on her as a result of providing therapy. As with the other counselors, she reported a positive experience for herself as a therapist. She also reported that although her client cried as she narrated her life history during the first session, during subsequent sessions her mood was improved and she did not cry again.

Acquisition of new skills

All the lay counselors described how the training successfully equipped them with the basic skills and behaviors which are a core component of NET training (Schauer, Neuner & Elbert, 2011). These included active listening, unconditional positive regard, empathic

understanding and the ability to manage difficult emotions. For example, one participant illustrated how it would have been impossible to listen to his client's traumatic experience of rape and torture without the training, saying how without being equipped by the training, listening to his client "might make me commit crimes! I might cause problems [though he did not mention to whom]...it would be difficult because I would be unable to listen to her". He explained how, without the course "I wouldn't be able to wait [for the client to finish]. I would tell her 'enough'. I might cry with her and instead of treating her everything would go wrong". The training therefore seems to have effectively equipped the lay therapists with one of the most important skills required of a therapist providing NET; active listening. This is particularly salient in NET as the ethos of NET is to allow the client to reflect on their whole life and construct a coherent narrative, in the process making meaning out of past unprocessed traumatic experiences by viewing them in the context of the client's ongoing life (Schauer, Neuner & Elbert, 2011). Therefore, the training seems to have satisfied its primary aim of producing trainees who possess and can apply the basic skills needed of a Narrative Exposure therapist.

Sense of community

Thematic analysis of the interview transcripts revealed a strong sense of community irrespective of the training and therapy. One participant, speaking of his desire to help the community after benefiting from the training, said "it [the benefit] starts with me, then the family, then the community. As for the community, we have started to try to help the community now – after the training. I cannot – after I have gained this information – keep it to myself. It is very important to try to deliver what you know to help others". Although the experience of training and therapy is not responsible for the creation of this already existing sense of

community, it is reasonable to assume that it helped to cement and increase it by successfully channeling counselors' desire to help their community.

Prior experiences in Sudan as well as Egypt served as a nodal point around which narratives of community were created. The same participant described how he was "part of the suffering that exists and went through the same stressful situations. I had problems too". Another participant described how he was not emotionally stressed by clients' narratives of traumatic experiences "because I was with the people who came from the war, I saw some of these experiences myself. There were things I experienced myself. There were other things that I did not experience myself, but others did". Mentions of war and the problems in Sudan were often described in the context of problems "we" are suffering from. "We came from a war; there are a lot of big challenges for anybody", said one participant. "You know, people are fighting in Sudan, we have no peace", said another.

The sense of community identified offers hope for the implementation of future similar interventions using NET for two reasons. First, a strong sense of community suggests the willingness of community members to offer help and support to those in need. Furthermore, because shared experiences of adversity, trauma and refugeehood served as a nodal point around which narratives of community were created, a therapy such as NET in which these common experiences are recounted to construct a meaningful narrative may hold greater appeal for both Sudanese refugee lay counselors and clients. The weaving of a narrative as a collaborative effort between a client and a lay counselor who has had similar experiences may itself serve to further contribute to development of a sense of community.

Client outcomes

All felt that they had done an effective job as therapists and were confident in their abilities. All described positive outcomes with their clients. One participant described a client who “got much better”. He described with pride how, despite her trauma, he “was able to show her that there is life and there is a good future”. Another participant described how he helped one of his clients who was “not loving...not happy...not smiling” by helping her “make some little transformation in her life instead of her focus on the past and just smother herself”. Another participant described how his client, upon getting better “came here [the community center where therapy took place] and thanked all the people, including the doctor. I heard good things [about my performance]”. This client even expressed a desire to continue the therapy beyond the planned six sessions.

Empowerment

In the study by Alexander, Mollink and Seabl (2010), lay counselors emerged from the experience psychologically empowered on the intrapersonal, interactional and behavioral levels. In this study, lay counselors appeared to emerge empowered at the intrapersonal and interactional levels, though there was no discernible change on the behavioral level.

Although no scale was used to measure empowerment in this study, lay counselors described how they emerged from the experience of training and providing therapy empowered on a number of levels. On the intrapersonal level, the training left them psychologically empowered by giving them the opportunity to narrate their own experiences and improve their own psychological state as they underwent training in NET. One participant described how he went from having “no background about anything” to achieving the “motivation to be more capable” after attending the training. Another said he “learned how to help anyone who has a problem, who faces a problem”. In addition, the positive outcomes with their clients further

contributed to a sense of self-efficacy, confidence in the ability to help more people and a strong motivation to help more people. All asserted that they had done an effective job as therapists and wanted to achieve sustainability of the therapeutic services they were providing in the community. One participant said “Every one of us started with one client, and through this there will certainly be sustainability” while another said “we have started to help a lot of people. We’ve helped maybe more than four people. And we were able to help. If there is time maybe we can help a lot of people”.

Psychological empowerment at an interactional level was apparent as well. The skills learned in the training generalized to other areas of the counselors’ lives besides providing therapy. For example, one participant mentioned her improved ability at conflict resolution, problem solving and management of difficult emotions.

There did not seem to be a sense of psychological empowerment at the behavioral level. Apart from new coping skills that allowed the trained lay counselors to more effectively manage their emotions and interactions with others, there was no apparent change in behavior. For example, none reported an increased ability to assert themselves in the face of racism or discrimination.

Although beneficial, it is important not to overstate the positive effects that such empowerment may have on the lives of the lay counselors. Despite greater feelings of self-efficacy, self-confidence and general usefulness to the community, it is unclear and unlikely that these benefits will dramatically alter the reality of xenophobia and discrimination that the lay counselors live in. However, they may assist in better coping skills to deal with everyday problems.

Challenges

While the experiences of all counselors were generally positive, some challenges did emerge. The majority of these challenges were unrelated to the therapeutic process and involved logistics such as the setting where the sessions were held. Since the sessions were held at a small community center that hosted many other activities and people, counselors complained about the level of noise, the lack of privacy and the limited availability of space which meant that the therapy sessions were sometimes cut short.

Even with the door closed, privacy was a concern and counselors complained of people intruding without prior warning. One client asked for her therapist to visit her at home because she did not feel comfortable describing her experiences of rape and sexual violence at the community center. The noise level at the community center was quite high at times, particularly when children were present, which also contributed to making the setting uncomfortable. The limited availability of space meant that sometimes the full ninety minutes of the session could not be held because the room would be needed for other activities. One participant said he managed this by trying to arrive as early as possible; "I put in more effort, I leave home early to get to work early and be able to leave work early, so I can come meet the client".

Based on this, it is recommended that future mental health interventions in the Sudanese refugee community, whether utilizing NET or other modalities, have a designated venue for the conduction of therapy sessions that addresses concerns of comfort and confidentiality. Although this is a standard requirement for conduction of therapy sessions anywhere, it takes on greater importance in a close-knit, marginalized community such as this one.

Other challenges involved cultural factors that needed to be taken into consideration.

Other difficulties arose as a result of misunderstandings about the purpose of the therapy, the possible benefits that could be accrued or the belief that the British clinical psychologist who

trained and supervised the therapists could help with matters such as processing asylum requests with the United Nations High Commissioner on Refugees (UNHCR) or bringing family members from Sudan. One of the therapists suffered a disappointment when his first client dropped out of the therapy after realizing that there would be no monetary help and demanded that no records about him be kept. The Sudanese refugee community has a significant need for more mental health services. A mental health needs assessment in 2009 (Meffert & Marmar) among refugees in Cairo from the Darfur region of Sudan found symptoms of moderate to severe emotional distress, depression, trauma, interpersonal and community conflict and domestic violence. This need is compounded by the fact that the refugee mental health system in Cairo has a piecemeal structure with many gaps in its services. Despite this, for many refugees material needs take precedence over psychological ones. This is in line with Miller and Rasmussen's observation (2010) that one limitation of the trauma-focused approach, such as NET, is that it insufficiently addresses the needs of civilians who have borne the brunt of war, such as refugees. Refugees face a number of psychosocial stressors, some of which are unrelated to past traumatic events, such as poor living conditions. Considering the subjection of Sudanese refugees in Cairo to racism, discrimination and xenophobia from the local population, their illegal status and lack of recourse to the law, in addition to lack of well-paying jobs and exploitation by landlords and employers (Grabska, 2006), it is not surprising that material needs would take precedence over psychological needs for some members of this population.

Another challenge arose with one of the lay counselors when he was asked some questions which were not expected and which he could not answer. For example, he was asked about the possibility of the therapy continuing for longer beyond the planned six sessions or where the client could seek help if she felt she needed it again. He did not have a response ready

and had to improvise. He laments “the doctor [who trained us] should have told us about it before, so that I do not get surprised and do something wrong”.

However, both issues were discussed comprehensively during the training. Out of the therapists interviewed, only one seems to have had this issue. This raises concerns about how some training concepts may have been lost in translation for some of the counselors.

Suffering of Sudanese refugees and coping mechanisms

A central theme throughout all interviews, in both the clients’ narratives and therapists’ experiences, was the multitude of traumatic experiences and mundane everyday concerns that contributed to the suffering of Sudanese refugees. These included experiences of war, loss of family members through death or separation, illegal detention, physical torture, sexual violence and rape. The traumatic experiences of war formed such a central part of clients’ narratives that one participant, himself having been through similar experiences, said “I discovered many things about people who are coming from a war”. He recounted the experience of one of his clients who was physically tortured; “they broke her right hand to get information...She was innocent of everything”. Other examples of torture included “nails can be pulled off...hands can be broken”.

Sudanese refugees carry the memory of these traumatic experiences to Egypt with them, but once away from the horrors of war, other problems arise. A common complaint was a lack of support agencies, particularly lack of support from the UNHCR, which was consistent with previous findings (Meffert et al., 2010). “It [the UNHCR] does not help, uh, on the contrary, there is someone who came with some mental problems, they increase here. He came from Sudan with a problem, when he went to apply [to the UNHCR] so they could solve his problem, the problem got bigger”. He went on to lament “One sometimes says “I wish I had stayed in

Sudan, it would have been better”. When we approach someone with a problem to solve it, it becomes bigger. This is the problem of most Sudanese”.

In addition to a lack of support agencies for refugees, racism from the local population was a common source of stress, in line with Grabska’s (2006) findings. One participant described how Egyptian boys driving *tuktuks* would drive around a Sudanese person in circles and harass them. In fact, her client’s arm was broken in this manner after the harassment caused her to fall to the ground where she was left crying until a group of Sudanese men happened to pass by and help her. Another common stressor was a lack of well paying, decent jobs which forced many into low-skilled jobs with poor working conditions, also consistent with Grabska’s (2006) findings. One of the counselors spoke of his exhausting job as a housekeeper, while another (currently a teacher) relayed her very brief experience as a domestic worker in an Egyptian home. It lasted a few days during which she was derided and ridiculed by her Egyptian employer for her inability to work and clean everything “one by one”. It ended abruptly by the participant packing her things and leaving.

Despite these numerous stressors, a number of coping mechanisms emerged in the thematic analysis. Similar to the findings of Khawaja, White, Schweitzer and Greenslade (2008), several adaptive coping mechanisms were identified. Central among these was a focus on future aspirations rather than past trauma. One participant described how he focused on “tomorrow” and encouraged his client to do the same;

Another common coping strategy was acceptance; “I am part of the suffering that exists and went through the same stressful situations. I had problems too. No one in the world can live without having problems unless – I don’t know where he would be living [laughing]. It is impossible”. Another, talking about his daily struggle to get from his place of work to the

community center said “This is normal, everyone faces challenges in life. If you want to deliver information to someone, you must face challenges. We must be able to overcome these challenges”.

Conclusion

This study is a valuable addition to the main research project investigating the therapeutic outcomes of this community based lay counseling intervention. Although previous studies (Alexander, Mollink & Seabl, 2010) have specifically examined the effect of lay counseling on the counselors, this is the first study that looks at the effect of providing therapy on lay counselors from the Sudanese refugee community of Egypt. It appears that the experience of providing therapy to refugees by lay counselors, themselves refugees from the same country, is a positive experience for the lay counselors. The results of this study suggest that appropriately trained lay counselors can benefit immensely from the processes of training and providing therapy. It is an enriching experience that allows lay therapists to emerge empowered with new knowledge, skills and an improved ability to manage their own stress and difficult emotions, while simultaneously increasing their ability and potential to provide effective and needed services to their community.

This study fills an important gap in the literature on the use of trained lay counselors from refugee communities to provide therapy to their traumatized peers in the community; and is the first study of its kind in Egypt. Despite its limitations, this study provides a basis for further research. Future research into the use of lay counselors from the Sudanese refugee community to meet a mental health treatment gap can build upon the findings of this study. Ideally, future research would utilize quantitative methodology in addition to qualitative. Quantitative methods would allow an assessment of incidence and prevalence rates of psychopathology in the

community. Furthermore, future research would ideally have a larger, more gender balanced and ethnically diverse sample. In addition, if future research employing a community member who has undergone the training as the NET trainer reveals positive results, this would also be a helpful step toward sustainability of this intervention in the community and eventually its replication in other communities as it would no longer be dependent on a clinical psychologist from the American University in Cairo

Finally, in addition to future research, the data and results of this study will help inform the direction of future community based lay counseling interventions in Egypt by providing guidance on the selection of trainees now that this study has provided better idea of the characteristics of successful lay counselors such as a commitment to help, a strong sense of community and the general characteristics required of a Narrative Exposure Therapist. It will also help in tailoring interventions to make it them more culturally appropriate by taking gender into account.

Limitations

This study had a number of limitations. The sample was obtained from the cohort of trainees by convenience; those who were available and willing to volunteer their time met criteria for inclusion, in addition to being a small sample of only four. Furthermore, it was not possible to obtain a sample larger than the four trainees interviewed due to time limitations and since three of the original cohort of ten trainees dropped out after the training phase and did not go on to provide therapy. Only one of the four lay counselors was a woman, raising the possibility that results may have been different had the sample been more gender balanced. However, similar studies (Alexander, Mollink & Seabl, 2010) using an exclusively female sample of a similar size of five lay counselors revealed similar results. Another possible

limitation is that because all counselors were recruited from one community center, they were all from the same tribe. Perhaps the strong sense of community that emerged in the analysis would not have been as strong had the counselors been more ethnically diverse.

Another concern is that it is likely that the trained lay counselors did not fully appreciate the ethos of NET and adhere to the training manual. Lay counselors spoke of their desire and duty to “advise” their clients; while one spoke of more forceful encouragement of his client to “move on” and “forget the past”. While this was largely benign, it is recommended that future interventions and research emphasize to trainees that the purpose is not to solve the client’s problem or help them forget past trauma, but rather to weave a meaningful, coherent narrative and in the process correct cognitive distortions and maladaptive responses to stressful stimuli.

Finally, there are the ethical problems of working with a vulnerable population such as refugees. The possibility that the unequal power dynamic between the interviewer and the lay counselors affected their responses cannot be excluded. For example, they may have been reluctant to express a negative opinion of the training due to the researcher’s association with the trainer. On the other hand, the fact that one lay counselor did actually express his reservations about the training, and the consistency of the other themes that arose which were unrelated to the training; minimize the likelihood of this having been a problem.

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Appendix A**English and Arabic Informed Consent Forms****Documentation of Informed Consent for Participation in Research Study**

Project Title: Lay Counselors Experiences with Counseling their Peers; The Impact of Being a Lay Counselor and Providing Therapy to Traumatized Sudanese Refugees in Cairo

Principal Investigator: Baher Ibrahim, baheer.brahim@aucegypt.edu, +20 01221295475

*You are being asked to participate in a research study. The purpose of the research is to examine the effect of providing psychological counseling to your peers in the community on yourself, the counselor, and the findings may be published or presented. The expected duration of your participation is one hour.

The procedures of the research will be as follows: A one hour interview will be conducted with you, during which you will be asked about your experience in providing psychological counseling to other refugees. The interview will be audio-recorded. After the research is over, you will be provided with the results if you wish.

*There may be certain risks or discomforts associated with this research. Discomfort is unlikely, however you may become distressed during discussion of certain details. If this happens, I will be available for help. If you are still concerned or distressed, you may contact Dr. Kate Ellis who will provide assistance.

*There will be potential benefits to you from this research. These include an opportunity to reflect on your experiences as a counselor and identify areas for improvement when providing future therapy as well as to identify areas for improvement in future training courses for counseling within your community.

*The information you provide for purposes of this research is confidential. Only Dr. Kate Ellis and I will have access to the recording. The data will be kept in an encrypted file in a locked file cabinet in Dr. Kate's office for a period of four years. Quotes from the interview may be used for publication, however they will be anonymized.

*Questions about the research or your rights may be directed to the principal investigator, Baher Ibrahim, at 01221295475 or by email at baher.ibrahim@aucegypt.edu. You may also contact my advisor, Dr. Kate Ellis by email at kate.ellis@aucegypt.edu.

*Participation in this study is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue participation at any time without penalty or the loss of benefits to which you are otherwise entitled and your data may be removed from the study at any point.

Signature _____

Printed Name _____ Date _____

الجامعة الأمريكية بالقاهرة 

استمارة موافقة مسبقة للمشاركة في دراسة بحثية

عنوان البحث : تجربة المرشد النفسي الغير محترف أثناء تقديم الإرشاد النفسي لأقرانه – تأثير تقديم الإرشاد النفسي لللاجئين السودانيين

المصابين بصدمة نفسية على مقدم الإرشاد نفسه

الباحث الرئيسي: (باهر إبراهيم – طالب ماجستير في برنامج علم النفس المجتمعي بالجامعة الأمريكية بالقاهرة)

البريد الإلكتروني: baher.ibrahim@aucegypt.edu

الهاتف: 01221295475

انت مدعو للمشاركة في دراسة بحثية عن تجربة المرشد النفسي الغير محترف أثناء تقديم الإرشاد النفسي لأقرانه مع دراسة تأثير تقديم الإرشاد النفسي للاجئين السودانيين المصابين بصدمة نفسية على مقدم الإرشاد نفسه

هدف الدراسة هو دراسة تأثير تقديم الإرشاد النفسي لأقرانك في المجتمع عليك كمرشد نفسي

نتائج البحث قد تنشر في دوريه متخصصه أو مؤتمر علمي أو ربما كليهما

المدة المتوقعة للمشاركة في هذا البحث حوالي الساعة

اجراءات الدراسة تشتمل على: اقامة مقابلة لمدة ساعة معك اثنائها سيتم سؤالك عن تجربتك كمقدم للإرشاد النفسي للاجئين الاخرين. هذه المحادثة سيتم تسجيلها صوتيا. بعد انتهاء البحث سيتم موافاتك بنتائجه إذا رغبت.

المخاطر المتوقعة من المشاركة في هذه الدراسة: قد يكون هناك مخاطر أو مضايقات بعينها و لكنها غير محتملة. قد تتعرض للحرج أثناء مناقشة بعض التفاصيل. في حالة حدوث ذلك سأكون متواجد للمساعدة وإذا لم يكن ذلك كافيا يمكنك مخاطبة د. كيت للمساعدة.

الاستفادة المتوقعة من المشاركة في البحث: قد تمنحك الدراسة فرصة لتقييم تجربتك كمقدم للإرشاد النفسي وتحديد الجوانب التي يمكن تحسينها في حال تقديمك إرشاد نفسي مستقبلا وايضا في حالة عمل تدريب على الإرشاد النفسي للعمل في مجتمعك.

السرية واحترام الخصوصية: المعلومات التي ستدلى بها في هذا البحث سوف تكون سرية. فقط أنا و الدكتورة كيت اليس سوف يتاح لهم الإطلاع على هذه المحادثة. المعلومات ستحفظ في ملف مشفر موجود في خزانة مغلقة في مكتب الدكتورة كيت اليس لمدة اربع سنوات. فقط اقتباسات من المحادثة يمكن استخدامها في حالة النشر ولكن لن يتم تحديد هوية قائلها.

أي أسئلة متعلقة بهذه الدراسة أو حقوق المشاركين فيها يجب ان توجه الى باهر إبراهيم على رقم هاتف 01221295475 أو عن طريق

البريد الإلكتروني baheer.ibrahim@aucegypt.edu أو د. كيت عن طريق البريد الإلكتروني kate.ellis@aucegypt.edu

ان المشاركة فى هذه الدراسة ماهى الا عمل تطوعى, حيث أن الامتناع عن المشاركة لايتضمن أى عقوبات أو فقدان أى مزايا تحقق لك.
ويمكنك أيضا التوقف عن المشاركة فى أى وقت من دون عقوبة أو فقدان لهذه المزايا وسيتم ازالة البيانات المختصة بك.

الامضاء: اسم المشارك :

التاريخ:

Appendix B

Interview Questions in English and Arabic

- 1) Can you please describe your experience while you were receiving training?
- 2) Can you please describe your experience while you were providing therapy?
- 3) How did the training you received enhance your knowledge and skills?
- 4) What do you feel you did well as a counselor?
- 5) How do you feel that you have been affected by the experience of being a counselor?
- 6) In your opinion, what makes an effective therapist?
- 7) How effective do you think you were as a counselor?
- 8) What difficulties did you encounter while providing therapy?

1) من فضلك هل يمكن ان تصف تجربتك أثناء تلقيك التدريب؟

2) من فضلك هل يمكن ان تصف تجربتك أثناء تقديمك الإرشاد النفسي؟

3) كيف ساعدك التدريب الذي تلقيته في زيادة معرفتك و مهاراتك؟

4) في رأيك ماذا تعتقد إنك اتقنته أثناء عملك كمرشد نفسي؟

5) في رأيك كيف تعتقد ان تجربتك كمرشد نفسي اثرت فيك؟

6) في رأيك ما هي مميزات المرشد النفسي الناجح؟

7) إلى أي مدى ترى نفسك مؤثرا أثناء عملك كمرشد نفسي؟

8) ما هي الصعوبات التي واجهتك أثناء تقديم الإرشاد النفسي؟

Appendix C

Thematic Analysis 6 step guide as cited in Braun and Clarke (2006).

1. Familiarizing yourself with the data

Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.

2. Generating initial codes:

Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.

3. Searching for themes:

Collating codes into potential themes, gathering all data relevant to each potential theme.

4. Reviewing themes:

Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.

5. Defining and naming themes:

Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme

6. Producing the report:

The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Appendix D

A 15 point checklist of criteria for good thematic analysis as cited in Braun and Clarke (2006).

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
Analysis	6	Themes are internally coherent, consistent, and distinctive.
	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
Overall	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as <i>active</i> in the research process; themes do not just 'emerge'.

Appendix E

Evolving guidelines for publication of qualitative research studies in psychology and related fields, as cited in Elliott, Fished and Rennie (1999).

A. Publishability Guidelines Shared by Both Qualitative and Quantitative Approaches

1. Explicit scientific context and purpose
2. Appropriate methods
3. Respect for participants
4. Specification of methods
5. Appropriate discussion
6. Clarity of presentation
7. Contribution to knowledge

B. Publishability Guidelines Especially Pertinent to Qualitative Research

1. Owning one's perspective
 2. Situating the sample
 3. Grounding in examples
 4. Providing credibility checks
 5. Coherence
 6. Accomplishing general vs. specific research tasks
 7. Resonating with readers
-

Appendix F**Example of full interview transcript**

Baher: Alright, you already told me that you have attended the training with Dr. Kate-

Interviewee: Yes

Baher: On how to provide therapy. First of all, I'd like to speak with you about your experience during the training itself. Tell me about your experience during the training

Interviewee: The, the clients I met?

Baher: No, at the beginning

Interviewee: The course?

Baher: Yes, the course itself. What was good? What was bad? Everything.

Interviewee: I learned a lot from the course. The first thing I learned is to help people. There are a lot of people who are suffering. There are mental problems (*halaat nafsiyya*), especially the Sudanese, who spent a long time in war

Baher: What? [I could not understand the last phrase]

Interviewee: We spent a long time in war in Sudan

Baher: Yes

Interviewee: I mean, most Sudanese have mental problems (*mashakil nafsiyya*). You see friends at work, they all have problems. Like, there was one person who lost all his family in the war...lost his children, lost his mother, lost his father

Baher: Yes... [I must have appeared confused as I was trying to understand the Sudanese dialect]

Interviewee: You understand Sudanese Arabic?

Baher: I understand, you're telling me he lost his father, lost his mother. I'm trying-

Interviewee: I'll try to speak Egyptian [laughing]

Baher: OK

Interviewee: I benefited from the course, and I've thanked Dr. Katie... [10 seconds of unintelligible speech due to noise]. I benefited, I learned how to help anyone who has a problem, who faces a problem. We Sudanese, we came to Egypt, but the commission's office [UNHCR] does not help, the commission does not help

Baher: The commission's office does not help?

Interviewee: It does not help, uh, on the contrary, there is someone who came with some mental problems, they increase here. He came from Sudan with a problem, when he went to apply [to the UNHCR] so they could solve his problem, the problem got bigger. One sometimes says "I wish I had stayed in Sudan, it would have been better". When we approach someone with a problem to solve it, it becomes bigger. This is the problem of most Sudanese. The other thing [changing subject back to the training] is that she delivered the lecture in a very good way. A smooth way, a simple way, a way...like, I was able to understand a lot from her

Baher: Um-hmm

Interviewee: I was able to understand a lot from her because her method of teaching is very good. A method that is slow, not just fast fast fast, no. She would deliver the information to us step by step, until we could finish the five or six weeks of training in 2 months

Baher: Um-hmm

Interviewee: -and it was good. The third thing, I learned how I can help anybody who is suffering who can do nothing for himself; I can help him even with my limited experience. With my limited experience, not a lot of experience, I mean these are limited experiences, but the principle is how can I help anybody in need?

[Door opens, brief exchange of words between interviewee and the person who enters, noise]

Interviewee: OK, I benefited by knowing how I can help anyone in need, like a simple person who comes for help and he's not able to do anything

Baher: Um-hmm

Interviewee: The fourth thing, the course was very enjoyable with Dr. Katie. It gave me a good chance to learn from her the English language through the Arabic language translated. I was able to benefit

Baher: Um-hmm

Interviewee: I have always wanted someone to speak English while I listen and someone translates at the same time, he speaks English and someone translates, while giving us the information. I benefited from both the information and the language

Baher: Um-hmm

Because I'm still a beginner in English and my English is basic and I want to develop my English. The lecture would be delivered in English, and Mr. Ahmed would give a good translation in the Arabic language. I benefited a lot.

Baher: OK, so, in total-

Interviewee: In total-

Baher: -the experience in the course was, uuuh, was good?

Interviewee: It was a very good experience

Interviewee: And the attendance was light [training sessions were not too much, so they were not a burden]

Baher: The training was a month?

Interviewee: No, two months

Baher: Two months...OK great. OK, now we've spoken about, we've spoken about your experience during the course

Interviewee: Um-hmm

Baher: Now I'd like to ask you about your experience while providing therapy. Tell me...First of all, how many clients have you seen?

Interviewee: I have seen 2 clients. The first client is the one I told you about earlier [we had chatted a little bit in the hallway before another interviewee arrived, but all the info is repeated here]. I had 2 sessions with him.

Baher: Um-hmm

Interviewee: On the 2nd session, he got upset at me and said he did not want to continue.

Baher: Why didn't he want to?

Interviewee: He actually wanted material help

Baher: Yes...

Interviewee: So his understanding was that maybe somebody would give him money, maybe somebody would help him materially. When he realized that this was not the case, he withdrew and told us not to tell anyone what he had said [in the sessions]

Baher: Um-hmm

Interviewee: I told him you are free to withdraw, he withdrew. After two times, he withdrew. He told us don't write anything, don't write any information about me, and he withdrew. I told the doctor about this, and she said it was OK. The second client, she is continuing with me, and I will meet her after those leave [pointing to the door, indicating the massive noise from the children outside the room] – the hours here are until 9.

Baher: Yes...

Interviewee: Today it's until 9 o'clock. Now, it is the last session and *inshallah* I will write the report.

Baher: You will what?

Interviewee: I'll write the report when I am finished with the client.

Baher: Ah yes, the report

Interviewee: Yes, the report of the last session [referring to the written narrative and possibly the post-therapy assessment as well]

Baher: What about your experience in general, what do you uhm, how do you feel?

Interviewee: Uhhh, well it needs time, to be able to deal with and manage the client, it needs you to be prepared. When you are coming from your work which is a bit tiring, and then the counseling session itself is long, one hour and twenty minutes, or 90 minutes. So it needs someone who has a bit of a laid back job.

Baher: Um-hmm

Interviewee: Because when you come to sit with the client, you need to be in a good psychological state, so that you can help in every way.

Baher: Um-hmm

Interviewee: Because the counseling session requires that you ask about everything, everything. Who were you with? What time was it and what day was it? Who were you with and what exactly did what? Who was the reason for this?

Baher: Um-hmm

Interviewee: I mean it, it needs someone who has time and whose job is laid back. Now I work as a [??]

Baher: Working as what?

Interviewee: Um, uh, housekeeper [saying it in English]

Baher: Ah, OK

Interviewee: Housekeeper

Baher: So it is a tiring job?

Interviewee: Yes, the work is a bit tiring. But in a way I am doing this [counseling] because someone needs it.

Baher: Um-hmm

Interviewee: I put in more effort, I leave home early to get to work early and be able to leave work early, so I can come meet the client

Baher: Yes

Interviewee: These are some challenges, for, for, challenges for the person [the counselor]

Baher: Um-hmm

Interviewee: Because I work as a housekeeper, so sometimes you get exhausted

Baher: Um-hmm

Interviewee: These days I try to leave home early...

Baher: Um-hmm

Interviewee: First of all I go to bed early, so I can wake up early to go to work, then get permission to leave early

Baher: Um-hmm

Interviewee: I work in Zamalek. To come from Zamalek, there is a lot of traffic. These few simple things are the challenges

Baher: Uh huh, yes

Interviewee: This is normal, everyone faces challenges in life. If you want to deliver information to someone, you must face challenges. We must be able to overcome these challenges. I tried to, tried to, uuuuh, to prepare myself [for the counseling]. First of all, I go to bed early...

Baher: Um-hmm

Interviewee: And wake up early

[Knock on door, interruption, I pause the recording]

Baher: OK...

Interviewee: The second challenge is, as you can see now, the center is crowded. The center is very crowded and doesn't provide comfort. You can't get very comfortable because of the children [referring to the children outside the room making noise]

Baher: Um-hmm

Interviewee: And we are constrained by a time limit. If someone comes [to use the room], we are forced to cut it short [the session]

Baher: Um-hmm

Interviewee: One must, for example, I come early, so no one cuts off some of my time, which is the 1 hour and 20 minutes, or 90 minutes

Baher: Um-hmm

Interviewee: I must come early so they don't take my time

Baher: Um-hmm

Interviewee: This is the challenge number two. But overall, there were many good things. I honestly enjoyed it. I enjoyed it and discovered new things about people

Baher: Um-hmm

Interviewee: I discovered many things about people who are coming from a war

Baher: Um-hmm

Interviewee: The person coming from a war has been through many problems. There is rape, they can be [??], or [??]. There are fractures, they can break your hand-

Baher: Sorry, there is just something I didn't hear. You said at first that there was rape, what was the second thing you said?

Interviewee: Rape...

Baher: Um-hmm

Interviewee: And possibly life threatening challenges. Like, you can escape death by a miracle from God

Baher: Uh-huh

Interviewee: But they can threaten to break your hand, break your fingers, pull off your nails, these are all things that cause mental problems [*halaat nafsiyya*]

Baher: Um-hmm

Interviewee: There are people whose nails can be pulled off, there are people whose hands can be broken...The client with me, her hand was broken...

Baher: Uh-huh

Interviewee: They broke her hand to extract information

Baher: To do what?

Interviewee: To extract information

Baher: Uh-huh

Interviewee: They broke her right hand to get information...She was innocent of everything. You understand? Also, if someone loses his father, or if someone loses his children, he can lose

his family, he can lose his wife, these are all mental problems [*halaat nafsiyya*] that cause challenges for people

Baher: Um-hmm, yes, OK. OK, when you were listening to the stories, like the clients that you saw who told you about arms being broken and nails being pulled off, did this affect you in a particular way?

Interviewee: No [emphatically]. The doctor taught us that even if you hear something that affects you [in a negative way], it should not show on you

Baher: Uh-huh

Interviewee: It shouldn't show on you. I was kind of affected, yes, but I didn't show it on my face. I don't show that I am affected. I personally went through some of these experiences, but not all-

[Interruption, noise, stopped recording]

Interviewee: Uuh, because I was with the people who came from the war, I saw some of these experiences myself. There were things I experienced myself. There were other things that I did not experience myself, but others did.

Baher: Um-hmm

Interviewee: Any person coming from a war is definitely coming with a lot of stressful experiences. There is a lot of stress on any person coming from a war.

[Interruption, noise, stopped recording]

Baher: We were talking about war and experiences...

Interviewee: Yes

Baher: You went through some experiences, they went through other experiences

Interviewee: Exactly, and I learned, like I told you, I learned how to listen to any difficult problem a person has been through...like a person who was innocent of any wrongdoing. The normal citizen is usually innocent of everything, but he can also experience psychic trauma. You can say “I didn’t do anything” but they can still cause problems for you.

Baher: Um-hmm

Interviewee: This was a cause of problems for a lot of people. Because sometimes...I know that sometimes there are people who have really done something [wrong], and deserves it. And really, the innocent person who has nothing to do with anything happening, he can be caught and they can kill him, they can hit him, they can break his hand, they can pull his nails, and he hasn’t seen [witnessed] anything. And really, a person, a normal person, who has done nothing, the authorities can come and say “you saw something, you did something”

Baher: Um-hmm

Interviewee: And these are very dangerous things, I hope that any authorities in the world or the state or in any particular place try to.....I mean, not all people are responsible for crime

Baher: Um-hmm

Interviewee: Not all people are criminals. Yes, I agree with the authorities that a criminal person deserves it, but an innocent human citizen...

Baher: Um-hmm

Interviewee: It is hard, it is hard, it is hard and it causes them psychic trauma and it causes them problems

Baher: Yes. Um, OK...OK, now we’ve talked about your experience while providing counseling

Interviewee: Um-hmm

Baher: Uh, I want to ask you; the training, the course you took at the start

Interviewee: Um-hmm

Baher: Did it help you or give you information or skills that you were able to u-

Interviewee: Definitely. It gave me a lot of information. It taught me how to listen to a client and stop writing to listen to the client. After the client narrates the whole problem, I can go back and make records. I memorize and pay attention and keep things in my memory. For example in the course they told us when the client is talking, we shouldn't write. To concentrate with what the client is saying and what other people [that the client is talking about] said and what exactly happened, and then the client wants to say more and talk again, I have to stop everything. Just listen to the client. This is a thing I learned in the course. Because sometimes, if a person does not take a course and the client is talking, you might blame him and say "No, it should be like this. It should be like this". In the course I learned that I should let the client say everything. Even if there are difficult things, I don't do that. Even if it gets to the extent of crying, like if someone is crying

Baher: Um-hmm

Interviewee: I can't cry with him, even if it is very hard. I control myself so I can help.

Baher: Uh-huh

Interviewee: For example if the client cries, and I cry, then both of us are sick.

Baher: Uh-huh

Interviewee: Exactly

Baher: And you, you, were you able to-

Interviewee: Yes. To control myself. Because they taught us in the course that one must take control of his nerves, no matter how hard the words or the trauma of the client are. They taught

us how to control, how to do “control self” [said these words in English] in situations where you might hear difficult things.

Baher: Um-hmm

Interviewee: Exactly, I learned that. It [the course] taught me a lot. It taught me to pay attention, to pay attention to what exactly the client is saying, how far we’ve reached, when I should ask him something, when I should ask, all this I learned in the course. The course taught me a lot. The course was very very beneficial.

Baher: Um-hmm. OK, there was a time, you were talking about clients that reached the point of crying. Were there times when you felt like you wanted to cry and....did you ever feel like that?

Interviewee: No. I actually did go through difficult periods but I controlled myself. I remembered the course and how we were told to “control self” [said these words in English]

Baher: OK. OK, uuuuh, since we’ve now talked about this point, you told me that you learned for example, you learned in the course that you had to control yourself and you applied this [while giving counseling]

Interviewee: Yes

Baher: And this is something- What are other things that you learned in the course that you feel you did well?

Interviewee: The thing that I felt I performed well was my timing. If I agree to a time with the client, I must arrive early, before the client. He should come and find me ready. The sick person, if the sick person finds that the therapist is not available, he may completely change his mind [about receiving therapy]. He may not come again. He will feel that he is not cared for. I wanted to care. Like I told you, I go early, I wake up early to go to work, and get permission to leave work-I say that I have something today-I have to leave two hours before my appointment

Baher: Um-hmm

Interviewee: It takes two hours because of the traffic, because I work in Zamalek, and the way from Zamalek to here in Nasr City is difficult. You have to plan for at least two hours to get here

Baher: Um-hmm

Interviewee: I plan for at least two hours-

[doorknock, interruption, paused recording]

Interviewee: This is all because of [??]

Baher: I'm sorry what?

Interviewee: I'm saying this is all because of [*name of another participant*], she took up some of my time [She was scheduled for an interview before (*interviewee's name*), came a little bit late and so by the time it was time for this interview the center had gotten crowded – this is what he is referring to, jokingly]

Baher: Yes, I'm sorry, it's OK

Interviewee: Truly, the course, I cannot thank the doctor enough. The doctor gave us a course that we all benefited from. I am also saying this on behalf of the others who are not present, all of us benefited from this course, and this course helped a lot of people.

Baher: Um-hmm

Interviewee: You provide therapy for one hour only, and we have started to help a lot of people. We've helped maybe more than four people

Baher: Um-hmm

Interviewee: And we were able to help. If there is time maybe we can help a lot of people

Baher: And, yes, you told me that one of the good things is timing, you told me that you come before the appointed time

Interviewee: Yes I come before my time so that when the client comes he finds me present in the center

Baher: OK

Interviewee: I can't be at home while the client is here

Baher: So you come on time-before time?

Interviewee: Exactly

Baher: OK, what else do you think you performed well in?

Interviewee: I worked hard on everything and I will try to do more than this, so this can help my skills and also help a person in need.

Baher: OK. Was there a particular thing...you told me for example that in the course they told you to control yourself when the person before you is crying

Interviewee: Yes

Baher: And you did this. They told you, for example, when someone is talking, you have to stop writing

Interviewee: Exactly

Baher: And you did this.

Interviewee: I did this

Baher: What else did you do well?

Interviewee: I also did well...with the first client whom I met and could not continue with, I used to go bring him from his home. I brought him from home. I would come here and not find him, and he does not have a telephone, I go and look for him inside and outside the center

Baher: Um-hmm

Interviewee: The second thing is that I wanted to continue with him with the same effort. I wanted to bring him every time until we could finish the five sessions, but I was not lucky enough. Also, I think that when I try to bring someone and try to sit with him, even if we did not speak, this gave me motivation, taught me how to care, how to care for the patient

Baher: OK. You learned to care

Interviewee: Exactly

Baher: OK, OK. OK, I'd like to ask you now, you as a counselor, did this affect you in any way? To be a counselor and provide counseling to people who are troubled or coming from a war, did this affect you?

Interviewee: No, on the contrary [emphatically]. I-

Baher: No, I mean did it affect you either in a positive or negative way?

Interviewee: Positive. It affected me in a positive way because wherever a person is present in this world, he must help. He must help in any way he can, even if in a small way. This is something from God to help other people [interruption, paused recording]. It gave me a positive motivation, not a negative effect. It gave me a positive motivation to help others.

Baher: Could we please say that last bit again, sorry? [I was distracted by the interruption]

Interviewee: OK, I'm saying the course gave me positive motivation. It gave me very positive motivation to help people in need. There was no negative effect. It was very positive, 100% for me.

Baher: Um-hmm

Interviewee: The course gave me 100% motivation. I used, one used to be afraid of certain things that happen, but I found motivation in the course, to be able to control yourself, so you can be able to help a sick person in front of you who has had a psychic trauma

Baher: Um-hmm. OK, so there was no...it was all a positive effect?

Interviewee: Yes

Baher: OK, OK, I'd like to ask you; we spoke about this before but I just want to ask you a bit more about it. You have now told me that there were several things you learned in the course and applied.

Interviewee: Um-hmm

Baher: Well, in your opinion in general, for a counselor or therapist to be successful, what attributes should be present in him?

Interviewee: A successful counselor must be attentive. He must pay attention to every word said by the patient. He has to pay attention and to be punctual, and number two his appearance [clothes]

Baher: The what?

Interviewee: The appearance. I mean your clothes

Baher: Ah, OK

Interviewee: You have to dress well. Because the client, you can see the client-I mean, the client can come and be dressed poorly. If he comes and sees that you also are poorly dressed, this can give a negative impression. The therapist should be well dressed in clothes that suit him. For example, I met a client who was poorly dressed and did not shower often, so I learned that I must be well dressed in clothes well suited to my position. This can even help the client's mental state [*hala nafsiyya*]. He will see that you are well dressed, while he is not well dressed. He may change his mind and decide to dress better, he may take a shower. When he sees that you are clean, he may take a shower. I met a client who did not shower, doesn't shower and doesn't care for himself, so I learned that I have to wear respectable clothes, clean clothes, my face should

look clean [pointing at his clean shaven face], to look respectable and well suited to what I am providing

Baher: OK. This will make him [the client] care for himself more?

Interviewee: Exactly

Baher: OK. What else may need to be present [in the successful counselor]?

Interviewee: Attendance. Attendance, and your punctuality also provide the client with motivation. Attendance and sticking to your appointed time. If someone says I am not coming today, if you are working with a client and for example call and say you are not coming today, this is not good. You must continue the five consecutive sessions with the client to not forget anything. Number two, if you cancel, he might [??]

Baher: Might what?

Interviewee: Might change his mind

Baher: Yes

Interviewee: He'll say "no, there's no care". If the cancellation comes from the client, this is something else. I mean if the client himself says he is not coming because I have something, no problem. But for the therapist himself, to call and say "I'm not coming because I've got something else" - He must continue all five sessions to be able to connect the whole problem and everything together.

Baher: OK

Interviewee: So you can write the report, because there are things you may miss

Baher: OK, are there for example any skills or special things *during* the session itself that you must do, or not do because-

Interviewee: Yes, of course there are skills. When you see the client at the beginning, let him feel at ease and be comfortable. What do you need, do you need water, or go to the bathroom?

Baher: Um-hmm

Interviewee: These are all skills one can use with the client, because if the client is crying and you are trying to talk to him, no. Leave him to cry and finish completely. Ask him do you want to go to the bathroom? Do you want to drink something? Do you want to uuh, rest a little? If someone is a smoker, do you want to smoke? Do you want something, do you want tea? All this I think is a skill one must have, to allow the client to find what he needs in the therapist.

Baher: OK, uuh, OK, now we've spoken about the things that make a counselor or therapist successful or effective

Interviewee: Um-hmm

Baher: I want to ask you, for you personally, do you feel that you were, or at least up till now, with the clients you sat with, do you feel that you were an effective therapist?

Interviewee: Um, of course I'm not going to really answer you because I cannot talk about myself, but I hope that I was effective with the people that I met, but I can't give you a complete answer, I don't know if I really was effective or not. There is a client, the client I talked with, that got much better. He got better

Baher: There is one that got better?

Interviewee: He got much better. There was a client I met who had suffered a trauma; I was able to show her that there is life and there is a good future, a sunny future, today is not like tomorrow. Yesterday is not like today. Today is different because if you go through hard things today, tomorrow you are prepared.

Baher: Uh-huh

Interviewee: Tomorrow is definitely sunny and tomorrow is definitely good. There are good things in the world and the future no matter how many bad things we've been through.

Tomorrow can be better

Baher: So, there *are* some things that you feel you did well?

Interviewee: Yes, exactly

Baher: OK, OK. OK, is there something you did that you thing was not done well?

Interviewee: No.

Baher: OK. Alhamdulillah [smiling]. You are confident.

Baher: OK, OK. Alright we have talked about your feelings as a therapist. I want to ask you now; were there any difficulties? What were they? And if there was a difficulty, what was it and how did you manage it?

Interviewee: No, uuh, there truly were difficulties but I could not control them. It is difficult because we have time constraints. In the center here there is no quiet, there is no way to be completely comfortable. And also, the client I saw in the beginning, his name was [*name of client*], he was difficult.

Baher: Um-hmm

Interviewee: It was difficult to deal with him. I was able to have 2 sessions with him, with difficulty. I had to persuade him to come and continue. But I could not continue with him. This is something

Baher: OK

Interviewee: But, I thank God. All is good inshallah.

Baher: OK. Were there any other difficulties you faced?

Interviewee: No there were difficulties, but just the ones I told you. In work, the therapist himself must be in a high “form” [he said this in English] to be able to deliver information to the patient

Baher: Uh-huh

Interviewee: He must be in a high “form”, not be exhausted, not upset by anything. You have to be complete so you can give all information to the patient

Baher: Sorry, did you mean by “high form- please explain the word to me

Interviewee: I mean you must not be upset from anyone

Baher: Uh-huh

Interviewee: If you are upset from someone, and then meet someone else and they talk to you, they can make you more upset- you understand?

Baher: Yes

Interviewee: There must be devoid of any upsetting feelings, your psyche [*nafsiyyitak*] should be open, to say good things, to find a solution for the person in front of you

Baher: OK, OK. Uuuh, ok these were difficulties regarding the venue and regarding someone not wanting to continue. What about during the session itself, were there any other difficulties?

Interviewee: No, no other difficulties, alhamdulillah

Baher: OK, you feel you did well throughout. Um, ok, um, I thank you very much, I’m done with the questions, thank you for your time

Interviewee: Thank you Mr Baher

Baher: Ok, I will stop recording now.