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Posttraumatic growth among Turkish-speaking counselling clients in London
a mixed methods exploration of effects of culturally-sensitive therapy provided at a
community counselling service

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Posttraumatic growth among Turkish-speaking counselling clients in London:

A mixed methods exploration of the effects of culturally-sensitive therapy provided at a community counselling service

By

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Abstract

Experience of posttraumatic growth (PTG) (i.e. positive changes) has been reported after different adverse life events, in some cases including migration and acculturating to the host culture. Although some research evidence points to the possibility of facilitating PTG in psychological therapy, there is little research into the effects of the therapy available to migrant/refugee populations in the UK. This research investigates the post-trauma experience of the Turkish-speaking population residing in the UK, and the contribution of short-term culturally-sensitive therapy in a UK city counselling service, with a consideration of positive indicators (i.e. PTG, meaning in life).

A mixed methods research design was employed. Firstly, descriptive and inferential statistics were used in a clinical effectiveness study to analyse any changes in posttraumatic stress, PTG, meaning in life, depression and generalised anxiety in a therapy (N=22) and a waiting list group (N=50), measured at baseline, and subsequently after 6 and 12 weeks. The second study involved an interpretative phenomenological analysis of three semi-structured interviews conducted with three clients who had completed their course of therapy.

No significant change was observed by the quantitative outcome measures in PTG or other outcome variables after therapy, whereas the IPA analysis indicated positive changes through therapy, including some PTG areas that had previously been identified in literature, with the exception of improvements in relationships. Issues discussed include the possible inadequacy of the quantitative outcome measures in accurately reflecting the experience of the current population, as well as the possible limited effectiveness of the available therapy resources in complex cases. The issue of isolation as a minority ethnic group was also raised, which can be addressed by policies targeting immigrant acculturation. Overall, this research contributes to the awareness of the post-
trauma and therapy experiences of the Turkish-speaking minority ethnic groups in the UK, and encourages therapy practice that could be more tailored to take into account the specific context of this particular demographic.
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Finally, I dedicate this thesis to my first sources of knowledge, the Famagustian teachers of the hard times, Vedia and Erol Erozan.
**Reflexive statement**

My interest in migration started in my early ages, as I grew up in a country that has witnessed vast amount of migration and internal displacement of its people, with London specifically being among the prevalent destinations. Then I, myself moved to London for my studies and have gone through the process of adaptation and integration. While this process was initially hard for me, I soon realised when I met my fellow immigrants that my experience of being abroad was not always comparable to theirs, as some of them seemed to have forcibly made the decision to move. Before I undertook my counselling psychology training, I volunteered within IAPT services in those boroughs of London where the Turkish-speaking population lived in large numbers, and because I speak Turkish, my main duty was to carry out screening assessments with the Turkish-speaking clients, the majority of whom were of Kurdish origin from Turkey. I was deeply touched by their traumatic stories and realised that most of them were not only enduring the consequences of highly frightening events they had experienced prior to migrating, but also grappling with adaptation to a foreign country. Later in this decade, the world faced one of the most devastating refugee crises of the century, which produced many tragic stories that all of us read in the press. Subsequently, encountering the phenomenon of posttraumatic growth during my readings on the topic seemed to suggest a positive angle to a multi-faceted experience, a helpful alternative to the dominant narrative of loss and devastation. Therefore, I became curious to explore the way migrants, and in particular the Turkish-speaking clients we meet in various therapy services in the UK experience life after trauma, whether they report any growth, and how counselling/therapy they receive impacts on these experiences.
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Chapter 1 - Trauma, Posttraumatic Growth, and Acculturation

This chapter will provide a theoretical overview of the concepts of trauma, posttraumatic growth (PTG), and acculturation. Accordingly, it will discuss some of the proposed models of posttraumatic stress and growth that have guided the practice and research in this area, followed by some critiques of the validity of reports of PTG. Migration and the process of acculturating in the host country are among events that can potentially cause traumatic stress and growth; therefore, the relevance of migration to mental health will be discussed and theory on acculturation strategies will be reviewed. The chapter will then conclude with the context of the Turkish-speaking population in the UK, in order to provide the reader with background knowledge on the population that is the focus of this research, which would aid better understanding of the discussions in the rest of the thesis.

1.1. Background

1.1.1. A culture of growth

Posttraumatic growth is defined as the “positive psychological changes experienced as a result of the struggle with traumatic or highly challenging life circumstances” (Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018, p.3). The concept of growing out of adversity has its roots in arts, literature, religion and philosophy, most commonly cited alongside Nietzsche’s quote (1888), “that which does not kill us, makes us stronger”. This concept is also closely linked with the fields of existential and humanistic psychology, as seen in the writings of Maslow, Frankl, Yalom, and Rogers.
(Tedeschi et al., 2018), and is embraced by the positive psychology movement (Seligman & Csikszentmihalyi, 2000). Viktor Frankl inspiringly recounted his own experience of survival through finding meaning in a concentration camp (Frankl, 1959). However, during most of the 20th century, trauma research focused only on the negative consequences, until positive effects of adversity also began to be reported, especially in the late 1980s and early 1990s. Similarly, the main aim of psychological therapies traditionally was about alleviating the painful symptoms of trauma. Therefore, recognition and facilitation of any experience of positive changes or ‘growth’ were largely excluded from the field (Tedeschi, Park & Calhoun, 1998).

1.1.2. Terminology

Although the concept is older, the term posttraumatic growth was first coined by Tedeschi and Calhoun (1995). Throughout literature, PTG has also been referred to as stress-related growth and perceived growth (PG) (Jones, Johnson, Graham-Engeland, Park, & Smyth, 2018). Some other terminology used to describe positive changes after adversity has not emphasised the growth aspect, such as benefit-finding, perceived benefits, and thriving (Linley & Joseph, 2004). The term ‘PTG’ is intended to indicate fundamental insights and changes with behavioural correlates, rather than merely a coping mechanism, such as that proposed by Lazarus and Folkman (1984). The present research focuses on the notion of PTG as developed by Tedeschi and Calhoun (2004); however, alongside this term, when explaining the concept to the participants, the researcher used such phrases as ‘positive change after adversity’ or ‘personal development after trauma’, as she found these accessible for the participants. Therefore, the reader may notice that ‘positive changes’ and ‘growth’ are at times used interchangeably with PTG throughout this thesis, as well as ‘trauma’, ‘traumatic event’, ‘stressful event’ and ‘adversity’.
1.2. Models of trauma and coping in its aftermath

Reviewing the models proposed to explain mechanisms of posttraumatic stress and coping revealed that the majority of them draw on a cognitive processing theory, and such cognitive understanding of traumatic stress is the one that is most widely used in posttraumatic growth literature to explain mechanisms of growth. From this perspective, an event is traumatic when it seriously challenges or invalidates crucial elements of an individual’s assumptive world, and their thoughts about their past and future life, causing extreme anxiety and psychic pain (Tedeschi et al., 2018). Traumatic events undoubtedly have many unpleasant emotional, cognitive, behavioural and physiological consequences for the individual enduring them and for the wider system they live in. These events invariably produce shock and numbness in the immediate aftermath of the event. At a cognitive level, they give rise to intrusive thoughts in the form of images and memories which are disruptive when awake or in sleep in the form of nightmares. Emotions that arise in the aftermath of a traumatic event may include guilt, anger, fear, anxiety, and depression, and the individual may experience some physical discomfort as well, including tense muscles, hypertension, gastric symptoms and tiredness (Tedeschi and Calhoun, 2004). As part of a psychosocial model of trauma, Joseph and Williams (2005) viewed the posttraumatic stress condition as a normal reaction to a very stressful event, rather than being a condition arising out of a pathological state.

Cognitive theories of trauma discuss the schemas (Horowitz, 1986) or assumptive worlds (Janoff-Bulman, 1992), which provide us with certain beliefs and assumptions about the world and are utilised to make sense of novel information. According to Janoff-Bulman’s (1992) theory, these assumptions are: 1) the world is benevolent, 2) the world is meaningful and 3) the self is worthy, which are challenged when a
traumatic event is experienced (Ben-Ezra, Hamama-Raz, Mahat-Shamir, Pitcho-Prelorentzos, 2017; Freh, Chung, & Dallos, 2013; Freh, Dallos, & Chung, 2012), causing distress, thus giving way to a reappraisal and review process (Affleck & Tennen, 1996; Joseph & Linley, 2005). Initially, in this process, the representations of the traumatic event are still available to the working memory, which gives rise to phases of stressful intrusions and avoidance (as a defence mechanism). The cognitive process is then thought to lead the individual through the ‘working through’ phase. This phase of recovery - though named differently by different theorists (e.g. Creamer, Burgess, & Pattison, 1992; Horowitz, 1986) - is commonly described to involve making sense of the experience and rebuilding a mental system (congruent with trauma information) through rumination (Janoff-Bulman, 1992; Park, 2010). How well an individual copes with and resolves trauma is argued to depend on several individual background factors such as their pre-trauma psychological well-being, emotional resources, resilience, early attachments (Tedeschi & Calhoun, 1995), available social support (Joseph & Linley, 2005), event’s duration and predictability, historical experience of trauma, intellectual ability, and prior beliefs about the world’s safety (Ehlers & Clark, 2000).

1.3. Posttraumatic growth (PTG)

Experience of PTG began to be reported by research studies in the mid-1980s among individuals such as the bereaved, chronically ill and disabled, heart attack survivors, parents with ill children, road traffic accident survivors and sexual abuse survivors (Tedeschi et al., 1998). It is of importance, however, to be cautious of a fallacy that PTG happens as a natural consequence of a traumatic event (Tedeschi & Calhoun, 2004). Not everyone experiences growth and whether an individual will or will not experience growth would depend on multiple factors including dispositional traits,
nature of trauma (Affleck & Tennen, 1996; Morris & Shakespeare-Finch, 2011) and their social context.

Positive changes are usually reported in the areas of perception of self, relationships with others and philosophy of life (Calhoun & Tedeschi, 2006). Subsequent to the initial categorisation of PTG in three domains (Tedeschi & Calhoun, 1995), factor analysis of the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996) indicated five areas in which growth could be experienced: personal strength, relating to others, new possibilities, appreciation of life and spiritual and existential change.

Positive changes in perception of self usually cover reports of feeling stronger and more self-reliant in the face of potential future adversities, along with a greater recognition of one’s vulnerability and fragility. Individuals may see themselves as the survivor of the event and therefore have faith in other things they can accomplish (Tedeschi et al., 2018), which may then be manifest as a behavioural change such as engaging in studying and learning (Shakespeare-Finch & Barrington, 2012).

Deepening of relationships with close friends and family members is brought about by a sense of being supported by them and an increased willingness to express emotion and self-disclose which is considered to be an integral part of processing trauma (Taku et al., 2009). Besides becoming more open to receiving support from others, an individual who experiences growth through adversity may feel greater compassion towards vulnerable others, or consciously decide to spend more time with their loved ones (Shakespeare-Finch & Barrington, 2012).

Commonly reported positive changes in the domain of life philosophy are listed as an enhanced view of life, changed priorities such as more enjoyment from and easier attitude to life, a greater appreciation of previously taken-for-granted moments, and strengthened spirituality and religiosity (Tedeschi, Cann, Taku, Senol-Durak, &
Calhoun, 2017). New possibilities in life may be identified, be it a new career path, changed lifestyles or becoming more communal (Shakespeare-Finch & Barrington, 2012).

1.4. Models of PTG

Theories of growth usually seek to account for the co-existence of experience of growth and symptoms of posttraumatic stress which broadly involve re-experiencing, avoidance and arousal (Joseph & Linley, 2005). These theories are commonly based on Janoff-Bulman’s (1992) theory of shattered assumptions and also make use of transactional models of coping (e.g. Lazarus & Folkman, 1984; Schaefer & Moos, 1992). Overall, theories on PTG discuss, from a cognitive perspective that, once the basic beliefs about the world and life are challenged by trauma, the individual then embarks on the route of either assimilating the trauma material into their life narrative with existing assumptions, or accommodating it by changing their life narrative and assumptions. The latter process may result in either a sense of helplessness through negative accommodation (e.g. “the world is a dangerous place and I have no control over it”), or growth through positive accommodation (e.g. “bad things may happen randomly, so I must enjoy life to the full”) (Joseph & Linley, 2005; Payne, Joseph, & Tudway, 2007). The most widely used model of PTG was developed by Tedeschi and Calhoun (1995) and has been revised over the years (e.g. Calhoun, Cann & Tedeschi, 2010). The latest revision of the model appeared in Tedeschi et al (2018), which discusses a multi-component process leading to PTG (Figure 1).
The factors belonging to *the person pre-trauma* include demographic characteristics such as age and gender, personality traits such as extraversion and openness to experience, creativity, and attachment patterns, mental functioning, and core-beliefs (Tedeschi et al., 2018). According to this model, *challenges to core beliefs trigger*
cognitive processing as part of an attempt to contemplate what has happened, what to believe about the world and what is to happen in the future. This cognitive struggle initiates intrusive rumination and emotional distress, which is typically managed by emotion-focused coping. Through successful coping, at a later stage, rumination becomes more deliberate, whereby the individual attempts to create a revised assumptive world that accommodates the traumatic event and a new life narrative in which the traumatic experiences are integrated. These processes are considered essential to PTG (Tedeschi & Calhoun, 1995; Tedeschi et al., 2018).

As part of successful coping, self-disclosure may contribute to PTG by alleviating the initial emotional distress, facilitating the cognitive processing, bringing unconscious thoughts and feelings to the surface and eliciting social support. Self-disclosure may also be viewed as a PTG outcome in itself, as one consequence of a traumatic event is reported to be bringing individuals closer, which fosters self-disclosure in the way they never experienced before. Social support has been presented as an integral part of the PTG model as a pre-trauma factor and a mediator during the cognitive processes leading to PTG. Strong social support is thought to help with the ruminative process, as the listeners may be able to offer different perspectives and positive role models (Tedeschi et al., 2018). A process comparable to Tedeschi and Calhoun’s model of PTG was outlined by Joseph, Murphy and Regel (2012) in their ‘affective-cognitive model’ for growth, which pointed out the significance of environmental influences, as well as the importance of posttraumatic stress for initiating growth.

Joseph and Linley (2005) critiqued Tedeschi and Calhoun’s model of transformation by asserting that it did not account for why individuals would move towards growth. Instead, utilised Carl Rogers’ concept of organismic valuing process (Mearns, Thorne & McLeod, 2013) to propose the existence of a tendency that enables the cognitive-
emotional processing of the trauma memory, which may then lead to growth through the positive accommodation of trauma-related information, provided that the social environment facilitates this process (Joseph and Linley, 2005). Although intrinsic to the Rogerian theory, viewing human nature as ever striving to achieve an integrated sense of self is in conflict with destructive behaviour observed in people and such concepts as the death instinct, described in the psychoanalytic theory (Lemma, 2003). The existence of such innate drive for growth is approached sceptically (Wilkins, 2009); moreover, it seems that all PTG models described fall short of taking into consideration what function PTG may serve in the wider social context of an individual in their attempts to account for the PTG experience. That is to say, the social context an individual lives in is likely to influence the construction of a growth narrative through an imposition to focus on the bright side (McMillen, 2004), meanings around coping well and survivorship, or pressures for self-enhancement to maintain a positive self-view (Taku & Cann, 2014).

Models described above conceptualise PTG as attained by means of a cognitive-emotional process that involves the resolution of a state of incongruence between the self and the trauma material. Such a conceptualisation implies a desire for a consistent self, which may not be as strongly emphasised in non-individualistic cultures (Splevins, Cohen, Bowley & Joseph, 2010), and negates the possibility of multiple selves (Bromberg, 1996; Cooper & Hermans, 2007). Alternative to viewing growth as achieved through self-realisation as described in Joseph and Linley’s (2005) organismic valuing theory by attaining a fully-functioning (Rogers, 1959) or a true self (Winnicott, 1960), approaching it with an understanding of self as possessing multiplicity would allow for fluidity of the PTG experience, rather than a concrete outcome. Furthermore, it is possible that different areas of PTG could be achieved in ways alternative to the dominant cognitive processing described in the models. For example, McMillen (2004)
suggested that increased depth in relationships is likely to be caused by receiving regular care from a supportive other, rather than a reviewed schema. Also, some people may experience alternative growth domains other than those commonly cited in literature, for example, a decreased gullibility that may have a protective function against further adversity. Also, by their nature, some traumas may lead to enhanced social relationships, whereas some others may cause a diminished closeness with people such as sexual abuse. The validity of PTG accounts and the PTG phenomenon has also been debated in literature; its illusory aspects have been discussed as possibly serving a purpose of self-enhancement. The next section will review the discussion of the PTG phenomenon as an illusion.

1.5. PTG as an illusion

Some studies failed to find an association between PTG and positive adjustment, and therefore raised doubts that self-reported PTG may not always reflect genuine personal growth. It was reported that, in a study with bereaved spouses and parents, reports of positive outcomes were not in line with their measures of depression, anxiety and somatization symptoms and wellbeing (Lehman et al., 1993). Moreover, those who reported positive outcomes were worse off than a comparison group with no history of a similar loss. The authors, therefore, questioned the credibility of reports of positive life changes, implying that they did not seem to be reliable indicators of adjustment. Similarly, Wortman (2004) argued that cognitive processing and self-disclosure actually led to feeling worse off. However, the experience of PTG may not necessarily tap into subjective well-being measures or be reflected at symptom level; conversely, Linley and Joseph (2004) discussed that growth rather involves greater self-awareness, maturity, wisdom and meaningfulness, which are part of psychological well-being. Therefore,
assessing whether a person is feeling better/worse to evaluate the genuineness of reports of growth may not be an accurate standpoint in this debate.

Many other researchers made a distinction between “actual” and “illusory” growth, and viewed the illusory component of self-reported growth as serving a coping function (e.g. Helgeson et al., 2006), such as through self-enhancement or downward social comparisons (Calhoun & Tedeschi, 2004), although the PTGI showed no association with social desirability measure (Tedeschi & Calhoun, 1996) and there is evidence that the PTGI measures a phenomenon beyond mere coping (e.g. Boals & Schuettler, 2011). Zoellner and Maercker (2006) proposed a Janus face model of self-reported PTG with a constructive/self-transcending component and a self-deceptive/illusory component. They suggested that in some cases, rather than actual thriving, the illusory component of PTG may serve as a coping mechanism to buffer against the negative effects of trauma. Individuals may present with an unrealistic sense of control and overly optimistic thoughts. They, therefore, made sense of some research findings that showed an increase in PTG and no change in distress measures over time as a consequence of this phenomenon. Linley and Joseph (2004) also raised the question of whether PTG is an objective outcome or a coping mechanism, by pointing to the consistent close association between PTG and positive reinterpretation. They suggested that the individuals who report PTG could also be conforming to a cultural script, which may have convinced them that good outcomes can be obtained from adverse events.

The accuracy of retrospective measurements of PTG has also been scrutinised (e.g. Frazier et al., 2009), although error in cognitive reconstruction may be seen as a problem for all self-report measures and not only the PTGI (Calhoun & Tedeschi, 2004). For example, biased recall of a less favoured previous self in order to improve the sense of wellbeing, has been raised as an issue (Ransom, Sheldon & Jacobsen,
Widows, Jacobsen, Booth-Jones and Fields (2005) found that, among bone marrow transplant (BMT) patients, biased recall of pre-BMT distress (recalled distress after the event minus actual distress measured before the event) was significantly associated with PTG, such that more negatively biased recall of pre-BMT distress led to more PTG. A more perceived decrease in distress post-BMT was also associated with more PTG. The PTGI has also been criticised for being biasedly worded and therefore causing illusory reports of growth (e.g. Boals & Schuler, 2018). Frazier et al. (2009) assessed the validity of self-reported growth by measuring perceived growth using the PTGI and actual growth using a reworded PTGI to reflect the last two weeks rather than the change since the traumatic event. They also used other measures that correlated with the domains of the PTGI to measure actual growth, over a two month period. The researchers reported that perceived and actual growth were unrelated and discussed the likelihood that perceived growth could be a self-protective strategy or a negative bias. They pointed out that measurement of PTG is a complex process requiring complex cognitive functions, such that participants are expected to recall their previous level of functioning for each dimension, evaluate their current functioning, compare the two, come to an understanding of the magnitude of change and negotiate how much of this change could be attributable to the traumatic event. However, Aspinwall and Tedeschi (2010) identified some methodological flaws and limitations in Frazier et al’s (2009) study and thus called into question the validity of their argument. They discussed that recall of PTG might not be as complicated as suggested, as typically a traumatic event creates a clear divide in the life narrative between before and after the event. Another critical point Aspinwall and Tedeschi (2010) put forward was that the measures Frazier et al. (2009) used to tap PTGI domains were of unrelated constructs, although Frazier et al (2009) reported medium to large correlations. They also discussed that a two month period used in Frazier et al’s (2009) study might not be helpful to capture growth, as
reports of growth tend to differ temporally, from early reactions in the aftermath of the event to reactions after a considerable amount of time and cognitive processing (Aspinwall & Tedeschi, 2010; Calhoun & Tedeschi, 2004; Helgeson et al., 2006). To replicate Frazier et al. (2009), Boals and Schuler (2018) reworded another quantitative measure of growth, the Stress-related Growth Scale (SRGS) using neutral statements rather than signifying positive change and included an amended response scale to capture both negative and positive change. Although it was not possible in this study to directly compare reported growth rates between PTGI, SRGS and the reworded SRGS (SRGS-R), the authors obtained a pattern in which growth was reported at a much lower rate in SRGS-R than in the other two measures. Unlike Frazier et al. (2009), Boals and Schuler (2018) found that all three growth measures were significantly associated with convergent measures tapping the PTG domains, but with regard to the psychological outcome measures, only the SRGS-R showed significant associations in expected directions. Also, unlike the PTGI and the SRGS, the SRGS-R was not significantly associated with overall coping and was negatively associated with most domains of avoidance coping. Their overall findings led the researchers to suggest that the SRGS-R was less likely to give rise to illusory reports of growth.

Notwithstanding the discussions about a component of reported PTG that seemed to reflect self-defensive functions and biased recall, there is evidence for spontaneously reported PTG, without prompts from researchers (Tedeschi et al., 2014) and PTG that has been observed by others (Calhoun & Tedeschi, 2004; Shakespeare-Finch & Barrington, 2012). It may be extremely difficult and even futile to identify whether an individual’s subjective experience is real or illusory. Individuals may sometimes express PTG-like changes temporarily after a traumatic event in order to preserve pride, feel better, comfort significant others or believe that they have been changed in a positive way; however, what evidence would indicate real PTG is somewhat unclear.
(Tedeschi et al., 2018). Studying individual trajectories of growth experiences longitudinally might be the most helpful way to have more insight into the kinds of PTG people experience (Tedeschi et al., 2018).

1.6. Migration and mental health

One such life-changing and potentially stressful event that can challenge an individual’s beliefs and potentially lead to growth is migration. Migrants (be they refugees fleeing persecution or ‘economic migrants’ escaping material deprivation) choose to migrate as a result of certain socio-political circumstances which make life in their home country unfavourable (Papadopoulos, 2007; Sher, 2010). As there are a variety of reasons and motives for migrating, the experience of migration is highly heterogeneous and will be influenced by several factors such as an individual’s pre-migration experiences, personality, attachment patterns and psychological functioning. As a result, not all those who migrate will experience the same kind of difficulties (Bhugra, 2004), and different groups will interpret the advantages and disadvantages of migrating on their physical and mental health and socio-economic situation in different ways (Toselli, Gualdi-Russo, Marzouk, Sunquist, & Sundquist, 2014). For some, however, the process may involve a distinct level of adversity. The pre-migration period may involve one or more traumatic events such as loss and violence due to political unrest. Afterwards, a migrant’s arrival in the host country is usually followed by problems of living such as adaptation to a new culture, communication difficulties, employment difficulties, coupled with losses such as that of social network, neighbourhood and identity (e.g. most migration occurs from collectivist to individualist cultures) and sometimes discrimination (Bhugra & Minas, 2007; George, Thomson, Chaze, & Guruge, 2015; Kirmayer et al, 2011; Li, Liddell & Nickerson, 2016).
As a result of these pre- and post-migration difficulties, migrants may become more vulnerable to psychological disturbances. Levecque and Van Rossem (2015) found a higher rate of depression among first-generation migrants in 20 European countries, particularly those who emigrated from outside of Europe. This was reported to mainly be related to barriers to integration. Six out of seven studies reviewed by Butler, Warfa, Khatib, & Bhui (2015) also found a higher incidence of a common mental disorder (including somatic, anxiety and depression symptoms) among migrant groups compared to natives in various countries in Asia, Europe and America. Particularly refugee populations are likely to experience stressful events pre- and post-migration (e.g. asylum process), and in line with this, prevalence of PTSD has usually been found to be higher among refugees compared to general population in European countries (e.g. Aragona et al., 2013; Fazel, Wheeler & Danesh, 2005; Li et al., 2016; Toselli et al, 2014). However, Dinesh Bhugra draws attention to the different conceptualisations of these psychological disorders in cultures of the different migrant groups, for example, normative behaviour in one culture being recognised as pathological in the Western culture they reside in, especially in the case of PTSD and coping with trauma, which could potentially cast doubt on the findings about higher rates of diagnoses (Bhugra, 2004).

Acknowledging the adverse effects on mental health and wellbeing aside, it is worth considering that psychological difficulty is not necessarily the sole consequence of migration. While some individuals may experience distress, others may adapt very well (Berry, 1992). Focusing on refugee experience, Papadopoulos (2007) discussed that, besides negative consequences, in the majority of cases, individuals will be able to process the adversity and continue their previous level of functioning, and some will even come out of it stronger, experiencing a transformation and finding a new meaning/appreciation of life. He called this positive change, “adversity-activated
development” (p.306) and noted its similarity to PTG as well as its subtle differences (Papadopoulos, 2007). Similarly, Pan (2015) and Pan, Ye, Chen and Park (2019) identified some positive psychological changes that occur during the process of migration and acculturation among international students in Asia, refugees and other Asian immigrants.

1.7. Acculturation

When different cultural groups come into contact with one another, they experience behavioural and psychological changes, with the minority group, i.e. the acculturating group, usually going through more substantial changes. Traditionally, acculturation of a minority group to a majority group was viewed as a unidirectional process, eventually leading to the assimilation of the minority group (Flannery, Reise & Yu, 2001), which involved shedding one’s culture of origin completely, and acquiring the dominant culture (Berry, 1992; LaFromboise, Coleman & Gerton, 1993). However, biculturalism or integration later came to be viewed as a more favourable outcome of the process of acculturation (Yoon et al., 2013). This view argues for the possibility of dual-identities, where an individual is able to maintain his/her distinct ethnic identity and simultaneously develop an identity of the larger cultural group (LaFromboise et al., 1993; Verkuyten & Martinovic, 2012).

In a bidirectional model of acculturation (e.g. Berry, 2005), the two dimensions of acculturation yield four possible acculturation strategies of integration, assimilation, marginalisation and separation. Integration is defined when the acculturating individual prefers to maintain some of their own cultural values, and at the same time become a part of the larger group by learning new ways of living. Where an individual prefers to completely blend in the new culture and abandon their original cultural identity,
assimilation takes place. Separation is the rather opposite strategy, as it becomes the option when an individual largely reaffirms their own cultural values while not interacting with the dominant culture. Sometimes separation may be a result of an immigration policy rather than individual choice, which would be more accurately called segregation. Finally, in the case of marginalisation, the individual loses participation in their own culture while having little interest/possibility of contact with the larger society, which may be seen in the conditions of pressures for assimilation as well as exclusion by the dominant society (Berry, 1992; 1997; 2005). Which acculturation strategy will be pursued will ultimately be influenced by multiple factors, such as the attitudes of the host culture towards multiculturalism, personal resources such as coping, educational level, social support, the closeness of cultures, and reasons for migrating (Berry, 1997). Therefore, it has been emphasised that acculturation can be best understood as context-dependent and when studied in the specific country, community, time, and with carefully defined domains to investigate (Bornstein, 2017).

1.8. Context of the population in the present research

The Turkish-speaking community of London and England can be divided into three main ethnic groups: Turkish Cypriots, Turks and Kurds. While there is a lack of an agreement on an accurate figure for the numbers of Turkish, Kurdish (Turkey-born) and Turkish Cypriot people in the UK, D’Angelo, Galip, and Kaye (2013) reported an estimated 100,000 Turkish-speaking (comprising Turkish, Kurdish and Turkish Cypriot) residents living in North and East London, and Mayhew, Harper, & Waples (2011) predicted the Turkish community as the third largest group in Hackney. Different estimates of the population suggest that the Turkish-speaking community comprises a significant proportion of ethnic minority population of London, and is a
relevant client group within counselling psychology practice, especially for the practitioners working within diverse boroughs of London.

1.8.1. Migration to the UK

The migration of the each of the three main Turkish-speaking groups started at different points in time and is rooted in distinct historical circumstances. Turkish Cypriots were the first group among the Turkish-speaking communities to immigrate to the UK. They began arriving in large groups following the end of the Second World War due to the colonial relationship between Cyprus and Britain and the rising employment opportunities in the post-war Britain. The Turkish Cypriot immigration continued in significant numbers through between 1950s and 70s, also due to the inter-communal conflict in Cyprus. Migration of the ethnic Turks began in the late 1960s predominantly in search of employment, whereas the ethnic Kurds started migrating from Turkey to the UK mostly during the late 1980s and early 1990s as refugees or asylum-seekers as a consequence of the political unrest and armed clashes with the Turkish military in south-eastern Turkey, where the Kurdish ethnic group reside (Change Institute, 2009).

1.8.2. Socio-economic status

The Turkish-speaking population were predominantly employed in the textile industry during the 1970s. Later, the extinction of jobs in this industry is said to have led to drastic economic consequences and mass unemployment within the community. Findings from survey studies suggest that among the three main Turkish-speaking ethnic groups, Turkish Cypriots are considered by some respondents as the most ‘self-sufficient’ and having more presence in professional settings due to their longer history in the UK. On the other hand, the most socio-economically disadvantaged group is considered to be the ethnic Kurds, mainly linked to their relatively recent arrival in the UK and their refugee status (Change Institute, 2009). It has been argued that the
economic status of the Turkish and Kurdish communities has improved throughout the years and more recently the communities have become economically visible in businesses especially as cafes, restaurants, and supermarkets on Green Lanes of Haringey and Stoke Newington and Kingsland Road of Hackney. Mayhew et al. (2011) estimated that more than 80% of the Turkish and Kurdish community in Hackney received benefits and lived in social housing. According to Department of Work and Pensions, Turkish citizens have been amongst the ten foreign groups who have made the highest number of benefits claims (D’Angelo et al., 2013).

In an attempt to locate the present research within the wider context of PTG research, the following chapter will review the existing literature in the areas of PTG and acculturation, structured around seeking answers to the questions of who is likely to experience and report PTG, and under which circumstances, along with the relevance of PTG and acculturation to mental well-being and whether growth can be promoted within psychological therapy. Therefore, the next chapter will lay out the existing research on the relationship of PTG with different individual variables, posttraumatic stress and acculturation, with a discussion of its methodological issues. Research into PTG and acculturation carried out thus far with Turkish-speaking population will also be outlined. Thereafter, the existing evidence for the association of PTG and acculturation with various mental health indicators will be reviewed. Finally, suggestions made in literature for the facilitation of PTG in psychological therapy will be discussed, followed by the existing evidence from clinical intervention studies. The final three sections of the chapter will introduce the present research, and discuss its epistemological position and the general sampling, alongside presenting an outline of the structure of the subsequent chapters.
Chapter 2 - Empirical Evidence in PTG Research and Methodological Issues

2.1. Correlates and predictors of PTG, and methodological issues

Quantitative PTG research extensively studied and reported associations between PTG and various individual variables, some of which are: the female gender (e.g. Joseph, Linley, & Harris, 2004; Linley & Joseph, 2004; Park, 1998; Vishnevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010), younger age (Butler et al., 2005; Cordova et al., 2007; Linley & Joseph, 2004; Manne et al., 2004; Widows et al., 2005), cognitive factors, the presence of meaning in life, and social support (Helgeson et al., 2006; Linley & Joseph, 2004; Park, 1998; Park et al., 1996; Park et al., 2005; Prati & Pietrantoni, 2009; Rajandram et al., 2011; Widows et al., 2005). In accordance with the theoretical growth models that emphasise the significance of disruptions to the assumptive world, studies indicated a strong relationship between PTG and core belief challenge (Lindstrom et al., 2013), perceiving the event as a threat (Cordova et al., 2007; Helgeson et al., 2006) and as central to one’s identity (Boals & Schuettler, 2011; Groleau et al., 2013). Relationship of PTG with deliberate but not intrusive rumination has also been suggested (Cann et al., 2011; Garcia et al., 2014; Garcia et al., 2015; Linley & Joseph, 2011; Morris & Shakespeare-Finch, 2011; Stockton, Hunt & Joseph, 2011; Taku, Calhoun, Cann, & Tedeschi, 2008; Triplett et al., 2012; Wu et al., 2015). Deliberate rumination may refer to the attempts at contemplating the potential reasons for the adverse event as well as thinking about the impact of it in one's life, both of which were found to be associated with PTG (Manne et al., 2004; Stockton et al., 2011). As an end result of this cognitive process, the presence of meaning has generally been shown to be closely linked with PTG (Grad & Zeligman, 2017; Groleau et al., 2013;
Linley & Joseph, 2011; Triplett et al., 2012), except for Dursun, Steger, Bentele, and Schulenberg’s (2016) study among flood survivors, where an opposite pattern was reported. Again, it can be argued that the PTG research has placed much emphasis on the cognitive processes, with an inadequate elaboration on the influence of social context and culture (McMillen, 2004). For example, while social support has generally been found to be related to PTG (Dursun et al., 2016; Kroo & Nagy, 2011; Linley & Joseph, 2004), its role has been cited primarily as a catalyst for the cognitive process of making sense of and finding meaning in the trauma. The effects from the traumatic event can also be impacted by social factors such as the socioeconomic security. Although traumatic events may have effects on individuals that can be considered universal, every traumatic event is also idiosyncratic (Dursun et al., 2016), meaning that it would have unique personal impact on each individual experiencing it.

These findings are helpful in providing an overall picture for understanding who would be more likely to experience and report PTG. This knowledge can help to guide counselling psychologists in clinical practice and research, for example when devising areas for intervention. However, it is worth being mindful of certain methodological issues embedded in measuring PTG and similar concepts quantitatively, using retrospective self-report measures. Firstly, relying on retrospective self-report measurement compels participants to recall how they felt pre-trauma and how they have changed if at all, after the traumatic event. Time since the traumatic event will also be relevant when measuring PTG, as it is argued that PTG that is measured too soon after the event may indeed reflect an illusory phenomenon (Tedeschi et al., 1998). Moreover, most quantitative research cited is cross-sectional, which limits information on causality and the development of PTG over time. Another limitation of quantitative studies is their approach to measuring variables which are best understood as fluid, and instead assuming that these are constant and unitary concepts which are objectively observable.
without the influence of the meanings attached by the individual experiencing and observing them (Steinmetz, 1998). The next two sections look at the existing research into the association of PTG with posttraumatic stress and acculturation, which inevitably share the same methodological and epistemological issues.

While quantitative studies may allow generalisability and comparisons, qualitative measurement of PTG may be helpful for paying attention to unique growth domains reported in specific contexts (Massey et al., 1998). For example, in an interpretative phenomenological analysis of the role of a physical activity group in experiencing PTG among women with breast cancer, Hefferon, Grealy and Mutrie (2008) reported a growth domain of new bodily awareness, which was unique to their sample’s circumstances. This type of inquiry can also be preferred with more exploratory investigations, for example, when studying culture-specific PTG (e.g. Johnson, Thompson, & Downs, 2009; Shakespeare-Finch & Copping, 2006; Shakespeare-Finch et al., 2014; Woo, Chan, Chow, & Ho, 2007)

2.2. PTG and posttraumatic stress

There has been inconsistency in literature regarding the relationship between PTG and posttraumatic stress. Previous research has suggested a variety of associations, including a positive linear association (Bluvstein, Moravchick, Sheps, Schreiber, & Bloch, 2013; Dekel & Nutman-Schwartz, 2009; Jin, Xu & Liu, 2014; Updegraaff & Marshall, 2005), a negative linear association (Kilic & Ulusoy, 2003), a curvilinear association (i.e. an inverted U-shaped association, with the highest level of growth at moderate levels of stress, as opposed to low or high levels) (Colville & Cream, 2009; Kleim & Ehlers, 2009; Kunst, 2010; McCaslin et al., 2009), or no association at all (Cordova et al., 2007; Helgeson et al., 2006; Morris & Shakespeare-Finch, 2011;
Widows et al., 2005; Wu et al., 2015). Bluvstein et al (2013) argued, however, that their finding of a positive association among heart disease survivors could be attributed to the timing of measurement, as the sample’s traumatic stress levels, measured at admission to a cardiac rehabilitation unit, were still high and PTG might have just started. They mentioned the likelihood of PTG gradually increasing while distress decreasing, leading to a weaker relationship between the two. Some studies reported both a positive linear and a curvilinear relationship, such as Solomon and Dekel (2007) among Israeli former prisoners of war, and Butler et al. (2005) following the 9/11 incident, where the positive association was interpreted as being related to deliberate attempts at cognitively processing the event. Similar to Bluvstein et al.’s (2013) prediction about the high stress levels of their sample, Butler et al. (2005) found at follow up (on average 6.5 months after the incident), that trauma scores for those participants who experienced the highest level of growth had decreased. Frazier, Conlon, and Glaser (2001) also discussed a temporal relationship, where the two variables tend to be positively associated in the immediate aftermath of the event and become negatively associated in the long term when the individual has processed the event, leading to growth and decreased distress.

The studies that have found a curvilinear relationship reported the highest level of growth among those participants with moderate levels of PTS. It has been argued that distress at very low levels may not lead to growth, as it may not cause the shattering and the reconstruction of the world assumptions, whereas too severe distress may inhibit growth. On the other hand, the findings of no association between PTG and PTS may suggest that the two phenomena occur independently of each other, while it is possible for them to occur concurrently (Taku et al., 2008; Zoellner & Maercker, 2006). Similarly, in a meta-analysis, Shakespeare-Finch and Lurie-Beck (2014) found a moderate linear correlation coefficient of .315 and a slightly stronger curvilinear association of .372 and, due to the lack of strength of the associations, the authors
argued that the relationship between them may not be meaningful in practice, and the two phenomena may merely co-exist.

McCaslin et al (2009) argued that the variation in findings could be caused by the lack of a range of distress and growth measurement, for example, involving predominantly either high or low stress levels. As a result, it is possible that only a section of the curve was able to be captured in the studies which reported a linear relationship either in a positive or negative direction. The inconsistent results could also be attributed to variation in trauma type (e.g. studies commonly failed to find a relationship in samples with cancer patients), use of different measures to assess distress or growth, and the time of measurement after trauma.

2.3. PTG and acculturation strategies

There is evidence for both a lack of association and a significant association of both the host and home culture orientations with PTG. Abraido-Lanza, Guier, & Colon (1998) found no association between PTG and acculturation and Cakir and Yerin-Guneri (2011) found no association of acculturation with empowerment among Turkish women, which was a similarly constructed concept to PTG in their study. On the other hand, integrating host and home cultures was reported as most positively associated with PTG among university students from Hong Kong in China (Yu, Liu, & Yue, 2017) and Hispanic childhood cancer survivors in the US (Tobin et al., 2018), whereas Arpawong, Oland, Milam, Ruccione, & Meeske (2013) reported that, among Hispanic cancer survivors, those who spoke English at home more had lower levels of PTG after their treatment. However, language use was the only acculturation variable used in this study, so it may not reflect the totality of the acculturation experience. It seems that orientating with at least one culture was related to some growth, as opposed to not
orientating to any culture at all (i.e. marginalisation) (Tobin et al., 2018). Steel, Dunlavy, and Theorell (2008), for example, found that higher scores in traditions and customs domain of acculturation were particularly associated with higher PTG among refugees from Sub-Saharan Africa who resettled in Sweden.

2.4. PTG in Turkish samples

PTG has not been studied within the Turkish-speaking community in the UK before; however, PTG and stress-related growth have been reported in Turkish samples in Turkey, generally at moderate to high levels. These studies were commonly carried out with university students (e.g. Göral, Kesimci & Gençöz, 2006; Kesimci, Göral & Gençöz, 2005) or patients with chronic illness such as cancer (Bozo, Gündoğdu & Büyükaşık-Çolak, 2009; Karancı & Erkam, 2007; Küçükkaya, 2010; Tanriverdi, Savaş & Can, 2012), rheumatoid arthritis (Dirik & Karancı, 2008) and myocardial infarction (Şenol-Durak & Ayvaşık, 2010). On the whole, in line with literature on predictors of PTG described above, quantitative studies within Turkish samples found significant links with meaning (Dursun et al., 2014; Dursun et al., 2016), social support (Bozo et al., 2009; Dirik & Karancı, 2008; Gül & Karancı, 2017; Karancı and Erkam, 2007; Küçükkaya, 2010; Şenol-Durak & Ayvaşık, 2010; Tanriverdi et al, 2012; Yılmaz & Zara, 2016) and various coping styles (Arıkan & Karancı, 2012; Göral et al., 2006; Gül & Karancı, 2017; Karancı & Acarturk, 2005; Karancı & Erkam, 2007; Kesimci et al., 2005; Şenol-Durak & Ayvaşık, 2010; Tuncay & Musabak, 2015; Yılmaz & Zara, 2016). Contrary to the original PTGI, in a Turkish sample of rheumatoid arthritis patients, Dirik and Karancı (2008) found a three-factor structure to the PTGI, consisting of the relationship with others, self-perception and philosophy of life domains. A study by Kucukkaya (2010) involved a qualitative open-ended question about positive changes
experienced after a breast cancer diagnosis. Content analysis of the data revealed the themes of ‘changes in self-perception’, ‘empowerment’, ‘greater appreciation of life’ and ‘changes in interpersonal relations’. Notwithstanding some cultural differences found in some cross-national studies (e.g. Kehl, Knuth, Hulse & Schmidt, 2015; Taku & Cann, 2014), overall, PTG has been reported as a universal phenomenon (Tedeschi et al., 2018). However, the issues with methodology and context-dependency would apply here.

### 2.5. Acculturation in Turkish samples

The vast majority of the studies on acculturation among Turkish immigrant groups have been carried out in European countries other than the UK. These studies predominantly involved adolescents or mixed samples that included first- and second-generation migrants, which made it impossible to differentiate between the potentially distinct acculturation experiences of the two groups. Overall, research in this area has shown that Turkish minorities in different Western countries tend to maintain their own cultural identity at high levels, regardless of the immigration policy of the country they reside in (Dimitrova et al., 2013; Ersanilli & Koopmans, 2011; Verkuyten and Yildiz, 2007). In terms of acculturation strategies, separation was generally found as the preferred strategy. For example, in London, Şeker and Sirkeci (2014) carried out a study with 125 immigrant women who originated from Turkey and found that the separation strategy was the most preferred acculturation strategy, whereas the marginalisation strategy was the least preferred. They reported a positive correlation between the integration strategy and the assimilation strategy and a negative correlation between the separation strategy and the assimilation and marginalisation strategies. Separation strategy was also found to be the preference of Turkish married couples in Canada.
(Ataca & Berry, 2002). However, the authors also found that those with higher SES preferred integration or assimilation more than those with lower SES. Besides the overall attitude of the Turkish samples to retain their culture of origin, their host culture adoption strikingly varied in different countries with different attitudes to immigration. It is hypothesised that assimilative pressures make host culture adoption more difficult; however, contrary to this hypothesis, a few studies found relatively high host culture adoption in countries that are known to be assimilatory rather than multicultural, such as Bulgaria (Dimitrova, Chasiotis, Bender, & van de Vijver, 2014) and France in comparison to Germany and the Netherlands (Ersanilli & Koopmans, 2011). However, attitudes towards host culture adoption have also been thought to be influenced by accessible citizenship rights, such as in France, or negative attitudes of the members of the dominant group towards the Turkish culture retention, as reported in the Netherlands (Arends-Toth & Van de Vijver, 2003; Arends-Toth & Van de Vijver, 2004). Slightly different from the findings of a more favourable host culture adoption in countries with assimilatory policies, Yagmur and Van de Vijver (2012) reported a higher host culture adoption and lower identification with the Turkish culture in Australia, which is a multicultural country, compared to France, which follows linguistic and cultural assimilatory policies, and Germany, which adopts an ethnic-national approach.

As it can be seen from available literature, findings regarding host culture adoption are mixed, as acculturation attitudes are highly likely to be influenced by the context of the specific sample studied, such as their socio-economic status, reasons for migration and their history in the host country. For example, the social class of an individual both pre-migration and in the country they immigrated to would affect the resources available to them to help in the process of integration, such as their level of education and the skills they have that can be utilised in work life. Therefore, different studies, including the present research, that involve samples of the same cultural group are likely to report
different findings regarding the dominant acculturation strategy of their samples, as this would be laid down by the specific characteristics of each sample, beyond the similarity of their cultural background. Also, most studies cited above included adolescent samples who were the second generation in the host country, sometimes with one parent who was ethnically from the dominant culture of the country they lived in. Therefore, the findings from these samples are not likely to be reflective of the experience of overseas-born individuals.

2.6. Relevance of acculturation to mental wellbeing

Acculturative stress arises where there is conflict during the process of unlearning old cultural behaviours and learning new ones. Out of the four acculturation strategies, integration is thought to result in the lowest level of acculturative stress and marginalisation the highest (Berry, 1992, 2005; Berry and Sabatier, 2011), which may be due to the integrated individual having double the resources and social network (i.e. from both communities) to cope with the pressures of acculturation (Rogler, Cortes & Malgady, 1991). The view that integration leads to lower depression levels was supported by studies in various samples such as international aid workers in Nepal (Ward & Rana-Deuba, 1999), adolescents with immigrant parents in France and Canada (Berry & Sabatier, 2011), Vietnamese in America (Tran, Manalo & Nguyen, 2007), and Turkish immigrants in the Netherlands (Unlu-Ince et al., 2014), London (Şeker & Sirkeci, 2014) and Germany (Morawa and Erim, 2014). On the other hand, two studies with Turkish and Moroccan immigrants in the Netherlands reported that acculturation, measured by the Dutch language proficiency, was associated with depression and distress (Fassaert et al., 2011; van der Wurff et al., 2004), and Beirens and Fontaine (2011) failed to find an association of acculturation with distress among Turkish
immigrants in Belgium, although their sample consisted of working adults only, which may have had a positive impact on their general psychological well-being. A meta-analysis by Yoon et al. (2013) provided support for a positive relationship between positive mental health (e.g. self-esteem, positive affect, life satisfaction) and cultural socialisation to mainstream culture, and negative relationship between negative mental health (e.g. depression, anxiety, negative affect) and acculturation by language proficiency. They also reported a positive association between positive mental health and identity enculturation (retention of home culture), whereas enculturation behaviour was positively associated with negative mental health. The authors, therefore, concluded that most favourable mental health could be obtained through a combination of external acculturation (e.g. through language and behaviours) and internal enculturation (maintaining identity).

2.7. Relevance of PTG to mental wellbeing

There is mixed evidence regarding the helpfulness of experiencing PTG for psychological functioning; nevertheless, a general significant association with positive outcomes has been reported (e.g. Helgeson et al., 2006). Many studies sought to measure the relationship of PTG with positive and negative outcome measures such as depression, anxiety, quality of life, purpose in life, positive and negative affect and physical wellbeing. For example, some studies suggested that experiencing PTG overall predicted lower distress and better wellbeing/adjustment among coronary heart disease survivors (Bluvstein et al., 2013), breast cancer survivors (Ruini, Vescovelli & Albieri, 2013), spinal cord injury survivors (Kunz, Joseph, Geyh, & Peter, 2017) and asthma and rheumatoid arthritis patients (Jones et al., 2018), whereas Barrington and Shakespeare-Finch (2013), Moore et al. (2011) and Cormio et al (2014) failed to find a significant
relationship. On the other hand, Frazier and Kaler (2006) found a limited association between wellbeing and reported stress-related growth, with only small to moderate effect sizes. Boals and Schuler (2018) replicated the lack of association of PTGI with depression, anxiety, global distress and quality of life, but reported significantly lower depression, anxiety, global distress and higher quality of life when growth was measured using their revised SRGS-R, which targeted reducing illusory reports of PTG. A significant curvilinear relationship between benefit finding and several psychosocial outcomes was obtained by Lechner et al (2006), who concluded that overall, women who had low and high benefit finding adjusted better to breast cancer compared to those who experienced benefit finding at an intermediate level. Finally, Park, Mills-Baxter and Fenster (2005) studied experiences of growth from life’s most stressful event among a sample of the elderly. Their findings suggested a continued positive influence of growth experienced many years earlier on current adaptive coping, adjustment, death attitudes and low mood. It is worth noting that although PTG has generally been shown to be associated with quality of life, purpose and lower rates of depression, it has been found to be ineffective with anxiety (Helgeson et al., 2006; Kunz et al., 2017); however, it has been suggested that the experience of anxiety may be accounted for by the increased intrusive thoughts during the cognitive processing that leads to PTG (Helgeson et al., 2006).

There is an argument that PTG may lead to better adjustment through moderating the relationship between posttraumatic stress and mental health, thus acting as a stress buffer (e.g. Bluvstein et al., 2013; Cann, Calhoun, Tedeschi & Solomon, 2010; Kunz et al., 2017; Veronese, Pepe, Massaiu, De Mol, & Robbins, 2017), although not all studies provided support for this role of PTG (e.g. Jones et al., 2018). Moreover, it is worth noting that this finding is correlational, meaning that the relationship between PTG and stress could be in a reversed direction, such that growth might be more possible when
the damaging effect of posttraumatic stress on mental health and wellbeing is weaker (Bluvstein et al., 2013). It has been suggested that the mixed findings on the relationship of PTG with other psychological outcome measures could be due to the different scales used in different studies to measure similar concepts, as well as not testing for the moderating role of posttraumatic depreciation (PTD) as an independent variable, which assesses change in PTG domains in the negative direction (Cann et al., 2010; Kunz et al., 2017). On the other hand, Janoff-Bulman (2004) viewed the mixed relationship of PTG and wellbeing as a natural outcome, considering that the cognitive and emotional processes required for attaining PTG involve painful confrontations, thus reiterating that there are both losses and gains in this process.

Although the bulk of research, especially with patients with physical illness, seems to suggest that experience of growth mostly leads to positive emotional wellbeing, Linley and Joseph (2004) offered an alternative view to seeking a relationship between PTG and subjective wellbeing. They noted that posttraumatic growth is more associated with psychological well-being (PWB), which refers to concepts such as meaning in life, self-awareness, contentment with life goals and purpose, rather than subjective-wellbeing (SWB), which implies feelings of happiness. Ruini et al. (2013) indeed found, among non-illness trauma survivors, a relation of PTG with existential elements, rather than with distress. Also, Durkin and Joseph (2009) reported a finding that partialling out PWB on the Change in Outlook Questionnaire, which measured growth, eliminated the significant association of growth with positive affect, whereas partialling out positive affect had no impact on the association of growth with PWB. The view that growth is associated with PWB over and above SWB may serve as another explanation for the mixed results on the relationship of growth and wellbeing as measured by depression/anxiety symptoms. Therefore, a broader assessment of the effects of growth
on psychological functioning beyond its effect on affect/distress has the prospect to provide a more complete picture (Calhoun & Tedeschi, 2006).

In summary, literature on the relevance of PTG to mental wellbeing is mixed; however, it may still be sensible to think of PTG as a potential target outcome for therapeutic intervention. Overall, experiencing PTG seems to help the trauma survivor individual better adjust to their stressful situation by moderating the effects of trauma on their wellbeing (Helgeson et al., 2006; Veronese et al., 2017), whether its contribution may at times be in the existential area or improving their subjective wellbeing by alleviating distress. There also seem to be findings that PTG’s adaptive role as a stress buffer is accentuated when the negative consequences of trauma are also taken into consideration by the individual (Zoellner & Maercker, 2006; Kunz et al., 2017), which also has the potential to inform practitioners working therapeutically with trauma clients, with a view of facilitating PTG. The next section will review the suggestions in literature on how PTG can be acknowledged and facilitated in psychological therapy with individuals who have experienced trauma.

2.8. Facilitating PTG in psychological therapy

PTG theorists on the whole agree that, while working with counselling and psychotherapy clients, it would be useful for the therapist to be mindful of a potential for growth, listen out for possible growth elements as they manifest themselves and make sure they are discussed (Joseph, 2009). It would also be helpful not to be prescriptive about growth as an outcome of therapy, as this may create unrealistic expectations of having to experience it and put pressure on the client (Tedeschi et al., 2018). They also warn that being mindful of the possibility of PTG must not mean ignoring/downplaying the negative effects of a traumatic event, which are almost
always a natural consequence of trauma (Calhoun & Tedeschi, 2004). Joseph (2009) suggests that clients usually mention positive aspects themselves without needing prompts, and when these are mentioned in therapy, he recommends empathically reflecting these experiences back to the client, which would help put the client at ease about discussing positive consequences of a horrible event.

Particularly in the initial stages of the therapy, if the client is still overwhelmed by the negative consequences of trauma, it would be wise to focus the work on coping and alleviating the psychological distress (Calhoun & Tedeschi, 2004; Joseph et al., 2012) through psychoeducation, reviewing core belief disruption, relaxation or physical exercise (Tedeschi & McNally, 2011), and naming and understanding emotions (Tedeschi et al., 2018). Subsequently, the clinician can be alert to any signs of PTG in the client’s account and gradually choose to bring these to their attention when it is safe and productive to do so. The insight that would facilitate the experience of PTG would be obtained by focusing on the meaning of the event for the person, which could be discussed in sessions by offering different domains of PTG as prompts (Calhoun & Tedeschi, 2004). The therapy space would be facilitating for reviewing old narratives and building new ones, as well as cognitively and behaviourally widening the client’s perspectives on new goals, sources of meaning and roles (Roepke & Seligman, 2015). Tedeschi et al. (2018) define the qualities of a person that would facilitate PTG in terms of an ‘expert companionship’, which requires encouraging disclosure of difficult topics and in turn offering ways to manage difficult emotions, being open to being changed by survivors, being a humble learner rather than an expert, recognising strengths and being present in the room. Such emphasis on the personal and relational factors seems logical given the existing evidence for the importance of the therapeutic relationship for promoting positive outcomes (Horvath et al., 2011; Norcross and Wampold, 2011). The definition of the expert companionship resembles the person-centred approach to
therapy (Mearns & Cooper, 2005). Similarly, a study by Vilencia, Shakespeare-Finch and Obst (2013) found that, among women with a history of childhood sexual abuse, personal attributes of a therapist that were felt helpful were being non-judgmental, supportive, gently challenging, accepting, encouraging, and instilling hope.

Sensitivity to cultural differences would also be important, such as becoming informed about the client’s primary reference group, in order to familiarise with what support and resources are available to them that could facilitate PTG. Familiarising with the client’s cultural norms, such as the cultural rules about self-disclosure, would also be invaluable (Calhoun & Tedeschi, 2013). There might be certain assumptions specific to the group/culture that a client belongs to that are likely to influence their conceptualisations of how therapy can help, as well as the therapist’s role (for example, as an expert in some cultures) or social effects of positive changes (for example, varying reactions to increased emotional expressiveness in different cultures) (Calhoun & Tedeschi, 2013). A few intervention studies have sought to measure the effectiveness of different forms of psychological therapies in facilitating PTG, which was measured as an outcome of these therapies. The next section will review the findings of these intervention studies.

2.9. Efficacy of psychological therapies in facilitating PTG

Some studies have tested PTG as an outcome of a psychotherapeutic intervention, usually for PTSD. These were generally randomised controlled trials (RCTs) (e.g. Antoni et al., 2001; Hijazi et al., 2014; Kissane et al., 2003; McGregor et al., 2004; Pat-Horenczyk et al., 2015; Ramos et al., 2018; Smyth, Hockemeyer, & Tulloch, 2008; Zoellner, Rabe, Karl, & Maercker, 2011), whereas some others were non-controlled (e.g. Hagenaars & Minnen, 2010; Hart, Vella, & Mohr, 2008; Payne, Liebling-Kalifani, & Joseph, 2007). These intervention studies were most commonly carried out with
breast cancer patients, but others also focused on German motor vehicle accident survivors (Zoellner et al., 2011), childhood trauma survivors (Payne, Liebling-Kalifani, & Joseph, 2007), MS patients in the US (Hart et al., 2008) or refugees (Hijazi et al., 2014). Treatments usually involved CBT, exposure therapy, expressive writing/talking or less commonly a psychodynamic group (Kissane et al., 2003) or emotion focused therapy (Hart et al., 2008). However, it seems that most shared many common elements such as exposure, psycho-education, relaxation, and emotional and physical symptom regulation. Overall, previous research provided tentative support for the facilitation of PTG through these interventions. Support was tentative at times, as 1) improvements were reported in different domains of PTG by different authors (Hagenaars & Minnen, 2010; Kissane et al., 2003; Smyth et al., 2008), rather than a consistent support for increased total PTG, 2) some studies lacked a control group (e.g. Hart et al., 2008), and 3) Pat-Horenczyk et al., (2015) reported significantly more ‘constructive PTG’ (where PTG was experienced alongside improvements in positive coping) as opposed to ‘illusory PTG’ (where PTG was experienced alone) in the intervention condition following a resilience-building group, compared to a control condition, which can be viewed as a slightly controversial way of deciding on ‘actual’ PTG experience.

Moreover, Zoellner et al. (2011) found no significant effect of a CBT intervention on PTG among German MVA survivors. Unlike the majority of the intervention studies which generally utilised a structured therapy intervention, Payne, Liebling-Kalifani, and Joseph (2007) tested the effectiveness of a client centred therapy group on facilitating PTG. Their results showed that out of the 6 group members, only 3 perceived the group as empathic, positively regarding and congruent, and those participants were the ones who improved at the end of the treatment. While providing tentative support for the contribution of Rogers’ core conditions (empathy, unconditional positive regard and congruence), the results were inconclusive. It was also noteworthy that the group
facilitators were not trained in client-centred therapy but were clinical psychologists, which may have affected the intended client centred setting. Finally, a meta-analysis with 12 RCTs for PTSD reported overall facilitation of PTG, however, less than half of the studies found significant difference in PTG between intervention and control groups (Roepke, 2015). Again, the results of this meta-analysis were only tentative due to a small number of studies included. Overall, there is some indication of the contribution of psychological therapy to the experience of PTG, although inadequate findings of significant difference between treatment and control groups and some methodological issues as discussed in this section have rendered the results inconclusive. The vast majority of the studies that tested PTG as an outcome measure have mainly included clinical trials that involved standardised therapies such as CBT or exposure therapy, most of the time delivered by therapists trained specifically for these trials rather than in naturalistic settings. Moreover, there is little research into the facilitation of PTG in psychological therapy conducted with immigrant or refugee populations, who are likely to have unique experiences due to potential adverse experience both pre- and post-migration.

2.10. The present research

The present research investigates the post-trauma experience of Turkish-speaking counselling clients, and the contribution of culturally-sensitive therapy\(^1\) in a UK city counselling service that is widely used by this population, with a consideration of

\(^1\) Culturally sensitive therapy means the adaptation of existing therapies not only linguistically, but also by incorporating cultural specific values and beliefs in the treatment (Kalibatseva & Leong, 2014).
positive indicators (i.e. PTG, meaning in life). The other aims of this research include assessing the relationship of PTG with posttraumatic stress and acculturation. As presented in this chapter, research in both areas has yielded mixed results up until now.

The field of counselling psychology places value on promoting growth besides eliminating what is seen as pathological (Cooper, 2009). In accordance with this value of counselling psychology, adding to the current knowledge in these areas will potentially lead to more informed psychological therapy through the awareness of the presence or absence of any PTG experience in counselling sessions, and the effect of therapy on these experiences, specifically with the current population. To date, no research has been carried out with the Turkish-speaking community of London into PTG or the effectiveness of psychological therapies they receive. As discussed in chapter 1, the Turkish-speaking community is among the minority ethnic populations in diverse regions of the UK and is therefore highly likely to work with counselling psychologists. It is the duty of psychologists to have the necessary capabilities to work with every section of society and be aware of the different concepts of health and illness within different ethnic groups, the impact of culture, ethnicity and religion, and also their own ethnocentrism (BPS, 2017). In line with these values of the profession, this research can help counselling psychologists familiarise with and understand the post-trauma and therapy experiences of this population.

Besides individuals, PTG can occur in families, organisations and communities (Tedeschi et al., 2018). PTG in research and practice therefore promise to extend to the healing of groups at a collective level, for example through psycho-education or awareness-raising, and can potentially prompt change in communities that have been struck by trauma (such as violence or natural disaster). Facilitating PTG at a community level may lead to increased sensitivity towards human rights violations and political
participation (Rime, Paez, Basabe, & Martinez, 2010, as cited in Tedeschi et al., 2018) and perhaps assist in conflict resolution and peace building.

The present research employs a mixed methods design with a quantitative and a qualitative (IPA) study, conducted independently. Combining the idiographic approach of IPA with the nomothetic approach of the quantitative component is intended to offer multiple perspectives to answering the research questions. There is some previous research that studied PTG using qualitative methodology (e.g. Hefferon et al., 2008; Kucukkaya, 2010), although the bulk of research in this area utilised quantitative methods. The main rationale for using qualitative methodology to explore PTG experiences is to uncover any unique areas in which individuals experience PTG. Previous qualitative studies in this area mainly focused on the experience of PTG in different domains, and none was identified that inquired about the contribution of individual psychological therapy. It is also among counselling psychology’s values to recognise the subjectivity of a client’s experience (Cooper, 2009). Therefore, the qualitative study is intended to give voice to participants and help the researcher gain more insight into the details of individual experiences of PTG and therapy, whereas the quantitative study is intended to provide a more general indication of the prevalence and trends regarding the predictors of growth and the effectiveness of therapy in the current population.

The following sections of this chapter will discuss the epistemological stance of the present research, followed by some information on the counselling organisation where the sample of this research was drawn from, and the therapists who provide culturally-sensitive therapy within this organisation. Chapter 3 will present the methodology, results and discussion of the quantitative study, whereas the qualitative study with its methodology, findings and discussion will be presented in Chapter 4. Chapter 5 will
offer an overview of the findings from both studies, alongside thoughts on implications for counselling psychology, policy, and further research, and some words on reflexivity and reflections on the process of the current research.

2.12. Epistemology

Several perspectives exist with regard to the choice of paradigms for mixed methods research. The pragmatist paradigm has largely been advocated as the best foundation for mixed methods. Another perspective argues for allowing the mixed methods researcher to use different paradigms and methods under different circumstances depending on their appropriateness, as was implemented in this research (Hanson, Creswell, Clark, Petska, & Creswell, 2005). This view does not favour one purist approach over another; instead it recognises the value of each epistemological position in offering insights into a facet of the phenomena that are being studied.

2.12.1. Critical realism

Critical realism was developed by Roy Bhaskar in the 20th century as a critique of both radical positivism and constructivism. This theory mainly takes an ontological position that advances the independent existence of realities, and yet acknowledges the context-dependency of social structures (Steinmetz, 1998). Therefore, it is different from interpretivism, which suggests the existence of multiple realities. In contrast to the two radical stances of positivism and interpretivism, critical realism concerns with multiple perspectives on a single reality (Healy & Perry, 2000).

The methodology used in the current research project draws on elements from both positivist and interpretivist paradigms and adopt a ‘critical realist’ ontological and epistemological stance. Although some methods used (i.e. validated questionnaires with predetermined questions) are informed by the positivist paradigm, there is an
acknowledgement that the constructs that were measured (i.e. posttraumatic stress, posttraumatic growth, meaning in life, acculturation) are context-dependent; therefore the observations made using these methods are merely a fallible approximation of the phenomena that have been studied (Collier, 1994).

Critical realism sees that causality and prediction are impossible in an open system. It is impossible to accurately ‘observe’ concepts such as PTG in an authentic experiment. Also, meaning cannot be made out of these concepts without the mind of the individual experiencing them. Therefore, the critical realism stance offers the current study a basis to acknowledge the hermeneutic aspect of researching into these concepts, without rejecting that they exist as ‘real’ phenomena (Steinmetz, 1998).

2.12.2. Contextualism

Jaeger and Rosnow (1988) argued for a contextualist perspective, which echoes social constructionist themes of intersubjectivity (intentionality), active engagement of human mind in construction of meaning, active role of the researcher as opposed to an independent viewer and the recognition of the effect of the social context. As suggested by this perspective, the variables measured in this study can also be understood as active, on-going events and too complex to be accurately measurable or draw deterministic causal links between them. Contextualism also recommends the pluralism of theoretical perspectives and methodologies. It argues that no individual paradigm or methodology is adequate in its own right in the pursuit of understanding complex events, which suits well the epistemological stance of this research.

2.12.3. Pragmatism

The pragmatist view allows a researcher to adopt certain theories or approaches and reject others based on the fact that the adopted theories or approaches give rise to more desired outcomes (Cherryholmes, 1992). It asserts that regardless of the circumstances,
competing paradigms and methods can be combined and used in a single study (Hanson et al., 2005). According to this view, when designing a research project, practicality ("what works") is privileged over aligning with a particular philosophical paradigm (Greene & Caracelli, 2003). In accordance with the pragmatist stance, this research combined qualitative and quantitative inquiries in order to achieve a deeper understanding of the phenomena in question.

2.13. Sampling

Participants were counselling service clients of a third-sector organisation, which provides bilingual health advocacy, welfare rights advice service and counselling services to all Turkish-speaking communities (including ethnic Turks, Kurds, Turkish Cypriots and Bulgarian Turks) in a UK city. All participants in the current research were first generation or recent migrants.

In 2017-2018, a total of 452 clients were seen by the Mental Health Services at [XXXX] Counselling Service. Of these clients, 312 were females (71%) and 140 were males (29%). The majority of the clients referred for [XXXX] Counselling Service’s Mental Health Services fell in the age range 50-59 years (36%), followed by 40-49 years (30%). Depression (38%) was the main reason for referrals to the counselling service. The other presenting problems on referral included anxiety, stress, bereavement, panic attack, relationship problems, PTSD, gambling and multiple factors. The referral sources include community organisations, GPs, other projects within the community centre, and hospital-ward or community mental health teams.

All incoming referrals for the general counselling service are reviewed by the mental health team manager for their suitability for the service. As a result of this review
process referrals are either accepted or deemed not suitable due to their being out of catchment area, or in some instances, the service may be considered inappropriate for them, for example in the cases of drug and alcohol problems, psychosis or learning disabilities. The accepted referrals are entered on to the waiting list for initial telephone screening/assessment. After this the clients who are identified as low-intensity are allocated to either group or individual counselling, and are placed on a waiting list. If the group therapy clients also request one-to-one counselling, they can be placed on waiting list for individual counselling after their group intervention. The clients who are identified as complex/high intensity are assessed face-to-face and are placed on the waiting list for individual counselling. Individual counselling lasts between 6 and 12 sessions, after the completion of which the clients are discharged from the service. All clients can be re-referred to the service for therapy if they feel the need in the future, provided that the subsequent referral is made at least 6 months after their date of discharge.

2.13.1. Therapists at the counselling service

A demographic form was given to seven counsellors working within the [XXXX] Counselling Service counselling service (Appendix 2) in order to obtain information about their basic demographic details, their training and the therapy model in which they mainly worked. The majority of the therapists (N=5) identified their principal therapy orientation as integrative. Humanistic, person-centred and psychodynamic therapy influences existed in the approaches of almost all integrative therapists. Some integrative therapists also drew on transactional analysis and cognitive and behavioural orientations.
3.1. Aims

1) To assess the effect of psychological therapy on posttraumatic growth
2) To assess the relationship between posttraumatic stress severity and experience of PTG.
3) To investigate potential associations between acculturation and change in posttraumatic growth and meaning making.

3.2. Research questions

1) Is there a change in posttraumatic growth among clients from pre to post therapy?
2) How is the level of trauma severity associated with PTG?
3) Is acculturation associated with PTG and meaning making?

3.3. Methodology

3.3.1. Design

The quantitative study involved a clinical effectiveness study comparing a therapy group with a waiting list group to allow within and between group comparisons of changes in participants’ experience of posttraumatic stress, PTG, meaning in life, depression and generalised anxiety, analysed by using descriptive and inferential statistics.
3.3.2. Sample size

A priori sample size calculation (Soper, 2016) with a power of .80 yielded 51 in each group (a total of N=102), based on a medium effect size which was expected based on the study by Hijazi et al (2014). Seventy-two participants were eventually recruited, 50 of which were in the waiting list group and 22 of which were in the therapy group.

3.3.3. Inclusion criteria

Participants were recruited among those counselling clients who had been assessed and placed in a waiting list for individual therapy, or those who were invited for their first therapy session in 1-2 weeks. Inclusion criteria which were already in place for receiving therapy at the counselling service were: 1) being able to travel to the therapy place and 2) being above 18 years of age. Exclusion criteria for receiving therapy at the counselling service were: 1) having problems with drugs or alcohol, psychosis or learning difficulties. The counselling service’s clients who had already worked with the researcher in a therapy relationship and those who had already started their therapy at the point of first contact with the researcher were also excluded from the study.

3.3.4. Recruitment

Recruitment took place from January 2017 until May 2018.

The researcher checked on an approximately weekly basis through the waiting list folder and the electronic client monitoring database, which kept the record of the assessment and therapy sessions for each counsellor, to identify the clients who were offered a first counselling appointment and the clients who were on the waiting list. The researcher then contacted the clients via phone to advertise the research project. If a client had been seen by the researcher in the past or at the time of recruitment, he/she was not contacted for the advertisement of the study. Those clients who were interested
in participating in the study were asked to choose from the following methods of participation: 1) meeting with the researcher at the counselling service to complete the questionnaire in person, 2) receiving the questionnaire in post and 3) responding to the questionnaire over the phone at an appropriate time.

The researcher contacted a total of 223 clients to advertise the study (Figure 2). Of these, 81 declined to participate, 49 agreed to participate using the post method but did not complete and return the questionnaire, 15 had already started therapy by the time they were contacted by the researcher and therefore were excluded, 4 were interested in participating but a second contact could not be made and 2 had dropped out of the service by the time of the contact.

In total, 72 completed baseline questionnaires were obtained. At time two, five participants in the waiting list group failed to respond to the second round measures, 3 participants dropped out of the study, 1 left the service and 1 therapy group participant dropped out of therapy and therefore was excluded from time two and time three measures.

At time three, 10 waiting list group participants and 1 therapy group participant failed to respond to the measures, and 3 waiting list group participants were excluded from the third round measures, as they started therapy.
3.3.5. Participant demographics

Participant demographics are presented in Table 1. The majority (83%) of the sample were female. Among all participants, the mean age was 51 (9) and the median was 53. Age ranged from 25 to 67. The mean time spent in the UK in years was 22 (8) and the median was 21. The number of years since arrival in the UK ranged from 1 year to 49 years. Bodily pain (e.g. chronic pain, back pain, knee pain, neck pain) was a common physical health problem mentioned by 27 of the participants. Slipped disc was mentioned by 5 participants. Other reported physical health problems included hypertension, heart disease, diabetes, arthritis, cholesterol, migraine etc. The most
commonly reported mental health problem was depression, mentioned by 29 participants. Other commonly reported mental health problems included PTSD/trauma, panic attack and anxiety. Twenty-six participants reported that they practiced religion, 19 said they did not practice religion and 6 said they practiced religion occasionally, e.g. “on religious days”.

Table 1. Study 1 sample demographics

<table>
<thead>
<tr>
<th></th>
<th>All (N=72)</th>
<th>Waiting List (N=50)</th>
<th>Therapy (N=22)</th>
</tr>
</thead>
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<tr>
<td><strong>Age (mean, SD)</strong></td>
<td>51 (9)</td>
<td>52 (9)</td>
<td>50 (9)</td>
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<td><strong>Years in the UK</strong></td>
<td>22 (8)</td>
<td>24 (8)</td>
<td>18 (8)</td>
</tr>
<tr>
<td><strong>Gender (N, %)</strong></td>
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<td></td>
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<tr>
<td>Female</td>
<td>60 (83%)</td>
<td>40 (80%)</td>
<td>20 (91%)</td>
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<tr>
<td>Male</td>
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<td>10 (20%)</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
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<td>0</td>
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<tr>
<td>Prefer not to say</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Problems reading</strong></td>
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</tr>
<tr>
<td>No</td>
<td>49 (68%)</td>
<td>35 (70%)</td>
<td>14 (64%)</td>
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<td>Literacy problems</td>
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<td>9 (18%)</td>
<td>5 (23%)</td>
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<td>Difficulty understanding text</td>
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<td>6 (12%)</td>
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<td>Dyslexia</td>
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<td>1 (4.5%)</td>
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<td>Other (attention problems)</td>
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<td>1 (4.5%)</td>
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<tr>
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<td>0</td>
<td>0</td>
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<td><strong>Education</strong></td>
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<td>28 (56%)</td>
<td>12 (54.5%)</td>
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<td>Middle school</td>
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<td>5 (23%)</td>
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<td>9 (18%)</td>
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<td>1 (1%)</td>
<td>0</td>
<td>1 (4.5%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
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<td>25 (50%)</td>
<td>11 (50%)</td>
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<td>21 (42%)</td>
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<td>Eastern European Turk</td>
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<td>2 (9%)</td>
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<td>Other (Alevi)</td>
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<td>1 (4.5%)</td>
</tr>
<tr>
<td>Other (From Turkey)</td>
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<td>1 (4.5%)</td>
</tr>
<tr>
<td>Mixed ethnicity</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>1 (1%)</td>
<td>1 (2%)</td>
<td>0</td>
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Table 2 contd.

<table>
<thead>
<tr>
<th>Marital Status</th>
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<th>Counselling Service</th>
<th>Counselling Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>35 (49%)</td>
<td>22 (44%)</td>
<td>13 (59%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>16 (22%)</td>
<td>12 (24%)</td>
<td>4 (18%)</td>
</tr>
<tr>
<td>Separated</td>
<td>10 (14%)</td>
<td>7 (14%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>9 (13%)</td>
<td>7 (14%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Cohabiting</td>
<td>1 (1%)</td>
<td>1 (2%)</td>
<td>0</td>
</tr>
<tr>
<td>Single</td>
<td>1 (1%)</td>
<td>1 (2%)</td>
<td>0</td>
</tr>
<tr>
<td>Civil Partnership</td>
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<td>0</td>
</tr>
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<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>Counselling Service</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term ill</td>
<td>38 (53%)</td>
<td>29 (59%)</td>
<td>9 (41%)</td>
</tr>
<tr>
<td>Long-term unemployed</td>
<td>13 (18%)</td>
<td>8 (16%)</td>
<td>5 (23%)</td>
</tr>
<tr>
<td>Carer</td>
<td>12 (17%)</td>
<td>7 (14%)</td>
<td>5 (23%)</td>
</tr>
<tr>
<td>Working part-time</td>
<td>4 (6%)</td>
<td>3 (6%)</td>
<td>1 (4.5%)</td>
</tr>
<tr>
<td>Retired</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
<td>1 (4.5%)</td>
</tr>
<tr>
<td>Working full-time</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Studying</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Volunteering</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
<td>1 (4.5%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muslim</td>
<td>54 (75%)</td>
<td>37 (75.5%)</td>
<td>17 (77%)</td>
</tr>
<tr>
<td>No religion</td>
<td>12 (17%)</td>
<td>8 (16%)</td>
<td>4 (18%)</td>
</tr>
<tr>
<td>Other (Deist)</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
<td>1 (4.5%)</td>
</tr>
<tr>
<td>Christian</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jew</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>3 (4%)</td>
<td>3 (6%)</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 children</td>
<td>26 (36%)</td>
<td>18 (37.5%)</td>
<td>8 (36%)</td>
</tr>
<tr>
<td>3 children</td>
<td>21 (29%)</td>
<td>16 (33%)</td>
<td>5 (23%)</td>
</tr>
<tr>
<td>4 or more children</td>
<td>10 (14%)</td>
<td>8 (17%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>No children</td>
<td>7 (10%)</td>
<td>4 (8%)</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>1 child</td>
<td>6 (8%)</td>
<td>2 (4%)</td>
<td>4 (18%)</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical health problems</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>56 (78%)</td>
<td>41 (84%)</td>
<td>15 (68%)</td>
</tr>
<tr>
<td>No</td>
<td>12 (17%)</td>
<td>6 (12%)</td>
<td>6 (27%)</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>3 (4%)</td>
<td>2 (4%)</td>
<td>1 (4.5%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health problems</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
<th>Counselling Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>57 (79%)</td>
<td>41 (85.5%)</td>
<td>16 (73%)</td>
</tr>
<tr>
<td>No</td>
<td>10 (14%)</td>
<td>5 (10.5%)</td>
<td>5 (23%)</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>3 (4%)</td>
<td>2 (4%)</td>
<td>1 (4.5%)</td>
</tr>
</tbody>
</table>

The study sample was representative of the general [XXXX] Counselling Service counselling service clients.
3.3.6. Measures

The measures that were administered to participants were: the demographic questionnaire, the Life-events Checklist for DSM-5 (LEC-5) (Weathers et al, 2013), the Posttraumatic Stress Disorder Checklist for DSM-5 (Blevins, Weathers, Davis, Witte, & Domino, 2015), the Posttraumatic Growth Inventory (PTGI) (Calhoun and Tedeschi, 2006), the Meaning in Life Questionnaire (MLQ) (Steger, 2006), Acculturation Scale (Ataca and Berry, 2002), the Patient Health Questionnaire (PHQ-9) and the Generalised Anxiety Disorder 7-item (GAD-7) (Table 3).

3.3.6.1. Demographic questionnaire

The demographic questionnaire enquired about the participant’s date of birth, gender, whether or not they had any reading problems, educational level, ethnicity, marital status, work, religion, whether or not they practice their religion, number of children they had, whether they had any major physical health problems, the nature and the duration of their physical health problems, whether they had any mental health problems, the nature and the duration of their mental health problems and the year they started living in the UK. All questions offered the option of not responding by ticking the box, “Prefer not to say”.

3.3.6.2. The Posttraumatic Growth Inventory (PTGI)

The primary outcome measure was the Posttraumatic Growth Inventory (PTGI), which measures positive outcomes reported by individuals who have experienced traumatic events (Calhoun and Tedeschi, 2006). The 21-item measure consists of a 6-point Likert scale (0 = “I did not experience this change as a result of my crisis”, 5 = “I experienced this change to a very great degree as a result of my crisis”) and the factors of Relating to Others, New Possibilities, Personal Strength, Spiritual Change and Appreciation of Life. Calhoun and Tedeschi (2006) reported a good internal consistency (Cronbach’s α = .90)
and an acceptable test-retest reliability ($r = .71$) for the PTGI. They tested the measure in a sample of college students which, they argued, reflected the general population (Calhoun and Tedeschi, 2006). They found that the measure was not related to social desirability but was related to openness to experience and extroversion characteristics of personality. The total score of the measure ranges from 0 to 105, where higher scores show a greater level of growth after a traumatic experience. The difference between the mean scores of a group who have experienced severe trauma and a group who have not experienced severe trauma suggests that higher levels of growth are reported when people experience severe trauma. The Turkish version of the PTGI used in the current study was translated and validated by Dirik and Karanci (2008), who reported an excellent internal consistency (Cronbach’s α = .94). In the present sample, Cronbach’s α for the PTGI was .92.

Several scales have been developed to measure PTG Changes in Outlook Questionnaire (CiOQ) (Joseph, Williams & Yule, 1993), the Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996), Stress-Related Growth Scale (SRGS) (Park, Cohen & Murch, 1996), and the Perceived Benefit Scale (PBS) (McMillen & Fisher, 1998). It has been argued that the PTGI’s different subscales tapping various areas of positive changes enables researchers to study different areas of growth in a more focused way, which may demonstrate superiority to one-dimensional measures, such as the SRSG (Tedeschi et al., 1998). Amongst these measures, the PTGI also contains the least number of items; therefore was deemed potentially the most efficient way of assessing growth, especially if other outcome measures are also being used concurrently in a study.
3.3.6.3. The Life-events Checklist for DSM-5 (LEC-5)

Life-events checklist for DSM-5 (LEC-5) is a self-report measure that assesses exposure to traumatic events by the participant throughout their life. The measure includes 16 different events all of which have been identified as potentially causing PTSD or distress (e.g. “Fire or explosion”) and another item assessing any other particularly stressful event that has not been mentioned in the first 16 items. The original LEC showed convergent validity with measures screening for exposure to potentially traumatic events. The responses on the checklist include “Happened to me”, “Witnessed it”, “Learned about it”, “Part of my job”, “Not sure” and “Doesn’t apply”.

3.3.6.4. The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)

The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) is a self-report measure of PTSD symptoms. Its four factors correspond to the DSM-5 PTSD criteria. The measure consists of 20 items. Participants respond to the items by rating how distressed they have felt over the past month with regard to the most traumatic event they have experienced, on a Likert scale of 0 (“not at all”) to 4 (“extremely”). Example items on which participants rate their distress include “repeated, disturbing, and unwanted memories of the stressful experience”, “avoiding memories, thoughts, or feelings related to the stressful experience” and “feeling distant or cut off from other people”. In a trauma-exposed college student sample, PCL-5 scores showed a strong internal consistency (Cronbach’s α = .94), test-retest reliability (r = .82), and convergent (rs = .74 to .85) and discriminant (rs = .31 to .60) validity (Blevins et al, 2015). The Turkish-language version of the measure was validated by Boysan et al (2016), who found good reliability with composite reliability coefficient alphas of 0.79-0.92 (re-experiencing), 0.73-0.91 (avoidance), 0.85-0.90 (negative alteration), and 0.81-0.88 (hyperarousal), and temporal reliability with two-week test re-test intra-correlation coefficients of 0.70, 0.64, 0.78, and 0.76, respectively. Strong associations of the total
and sub-scale scores of the PCL-5 with other measures of trauma related symptoms demonstrated construct validity of the measure. In the present sample, the PCL-5 had an excellent internal consistency (Cronbach’s $\alpha = .94$).

3.4.6.5. The Meaning in Life Questionnaire (MLQ)

Meaning in Life Questionnaire (MLQ) is a self-report questionnaire measuring the respondent’s perceived presence of meaning in life and search for meaning (Steger et al, 2006). It consists of a 7-point Likert scale (1= “Absolutely untrue”, 7= “Absolutely true”) and 10 items with two subscales for the presence of meaning and the search for meaning. Each subscale consists of 5 items. An example item for the presence of meaning subscale is “I understand my life’s meaning” and an example item for the search for meaning subscale is “I am always looking to find my life’s purpose”. The two subscales were found to be inversely correlated; pointing to the argument that search for meaning is initiated by a lack of presence of meaning in life, rather than search for meaning leading to a higher presence of meaning in life (Steger, Kashdan, Sullivan, & Lorentz, 2008). The internal consistency for the presence of meaning subscale was found as Cronbach’s $\alpha = .86$ and that for the search for meaning subscale was Cronbach’s $\alpha = .87$ (Steger et al., 2006). The MLQ was translated to Turkish and validated by Dursun (2012) and Boyraz, Lightsey and Can (2013). Both studies reported good internal consistency for both subscales. Boyraz et al. (2013) reported an internal consistency of Cronbach’s $\alpha = .88$ for the presence of meaning subscale, and Cronbach’s $\alpha = .90$ for the search for meaning subscale. The test-retest reliability coefficients were reported as .84 and .81 for the presence of meaning subscale and the search for meaning subscale respectively (Dursun, 2012). In the present sample, the MLQ had an excellent internal consistency (Cronbach’s $\alpha = .9$).
3.3.6.6. Acculturation Scale

Acculturation Scale covers four strategies (integration, assimilation, separation, marginalisation) based on the acculturatio
n model developed by Berry, Kim, Power, Young, and Bujaki, (1989). The measure that has been used in the current study consists
of 40 items with 5-point Likert scales (1 = “Strongly disagree”, 5 = “Strongly agree”). Items ask about respondents’ attitudes regarding friendship, lifestyle, socialising, food, rituals and celebrations, language, house decorating, use of the media, child-rearing styles and teaching children values (Ataca and Berry, 2002). Each acculturation strategy is measured with 10 items. The average score of each strategy reflects to what extent that particular acculturation strategy was the respondent’s preferred strategy. Internal consistencies of the subscales varied from α=.74 to α=.84. The Turkish language version of the measure that has been used in the current study was validated by Şeker (2005), who reported Cronbach’s α=.78, .84, .80 and .74 for the integration, assimilation, separation and marginalisation strategies respectively. This measure was a modified version of the 44-item acculturation scale developed and used by Ataca and Berry (2002) with Turkish immigrants in Canada (did not include the attitude domain of children’s moving out). In the present sample, the internal consistencies of subscales ranged between ‘acceptable’ and ‘good’ (Cronbach’s α = .77, .75, .69 and .63 for the integration, assimilation, separation and marginalisation strategies respectively).

3.3.6.7. The Patient Health Questionnaire 9-items (PHQ-9)

PHQ-9 is a measure of symptoms of depression and consists of 9 items which map on to the DSM-V criteria for Major Depressive Disorder (MDD) (DSM-V, 2013). The scoring of the criteria ranges from 0 = “not at all” to 3 = “nearly every day”. Kroenke, Spitzer and Williams (2001) reported an “excellent” internal consistency with Chronbach’s α = .89 in a Primary Care sample and .86 in an obstetrics-gynaecology sample. They also reported excellent test-retest reliability with the correlation between
the two measures .84. They established the criterion validity of the measure through re-interviewing the participants by a mental health professional. Construct validity was demonstrated by the strong correlation between PHQ-9 and functionality scores, sick days and the general difficulty attributed to the symptoms. External validity was established by replicating the findings of the study with the primary care sample in another study with obstetrics-gynaecology patients (Kroenke et al, 2001). PHQ-9 subscale of the Turkish PHQ-SADS measure had a good internal consistency (Cronbach’s α = .88) in a clinical sample (Güleç, Güleç, Şimşek, Turhan, & Sünbül, 2012). Overall, the Turkish version of PHQ-SADS was found to be valid and reliable (Güleç et al, 2012). In the present sample, the PHQ-9 also had a good internal consistency (Cronbach’s α = .85).

3.3.6.8. The Generalised Anxiety Disorder 7-items (GAD-7)

GAD-7 is a 7-item measure of symptoms of the Generalised Anxiety Disorder (DSM-V, 2013). The scoring of the criteria ranges from 0 = “not at all” to 3 = “nearly every day”. Spitzer, Kroenke, Williams, and Lowe (2006) reported a good internal consistency (Cronbach’s α = .92) and test-retest reliability (.83) for the measure. Correlation of the scores of GAD-7 and the mental health professional administered versions was .83, which demonstrated good procedural validity. The correlation between GAD-7 and functionality scores, sick days, clinic visits and the difficulty attributed to the symptoms demonstrated good construct validity. Convergent validity of the measure was established by demonstrating correlation with Beck Anxiety Inventory (r = .72) and the anxiety subscale of the Symptom Checklist-90 (r = .72). The Turkish version of GAD-7 had a good internal consistency (Cronbach’s α = .85) and test-retest reliability (no significant differences were found between the two measurements). A similar factor structure to the original version of the measure was found and a good structural validity was reported (Konkan, Senormanci, Guclu, Aydin, & Sungur, 2013). Correlations of the
Turkish GAD-7 with other measures of anxiety were significantly high (Konkan et al., 2013). In the present sample, the GAD-7 also had a good internal consistency (Cronbach’s α = .83). The PHQ-9 and GAD-7 are used in the counselling service as outcome measures, and therefore they were chosen to be administered in this study as a measure of depression and anxiety symptoms also due to their familiarity.

Table 2. Measure means and SDs at baseline for WL and therapy groups

<table>
<thead>
<tr>
<th>Measure</th>
<th>WL Mean</th>
<th>SD</th>
<th>N</th>
<th>Therapy Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTGI</td>
<td>26.48</td>
<td>21.24</td>
<td>50</td>
<td>19.09</td>
<td>17.59</td>
<td>22</td>
</tr>
<tr>
<td>PCL</td>
<td>54.10</td>
<td>17.63</td>
<td>50</td>
<td>53.18</td>
<td>22.13</td>
<td>22</td>
</tr>
<tr>
<td>Presence of meaning</td>
<td>19.82</td>
<td>9.39</td>
<td>50</td>
<td>22.41</td>
<td>8.35</td>
<td>22</td>
</tr>
<tr>
<td>Search for meaning</td>
<td>20.70</td>
<td>10.44</td>
<td>50</td>
<td>20.82</td>
<td>10.34</td>
<td>22</td>
</tr>
<tr>
<td>Integration</td>
<td>28.50</td>
<td>9.52</td>
<td>50</td>
<td>28.36</td>
<td>7.58</td>
<td>22</td>
</tr>
<tr>
<td>Separation</td>
<td>33.44</td>
<td>7.58</td>
<td>50</td>
<td>33.82</td>
<td>7.18</td>
<td>22</td>
</tr>
<tr>
<td>Assimilation</td>
<td>18.56</td>
<td>6.57</td>
<td>50</td>
<td>21.91</td>
<td>6.75</td>
<td>22</td>
</tr>
<tr>
<td>Marginalisation</td>
<td>25.02</td>
<td>9.09</td>
<td>50</td>
<td>24.32</td>
<td>5.04</td>
<td>22</td>
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<tr>
<td>PHQ-9</td>
<td>18.90</td>
<td>5.76</td>
<td>50</td>
<td>17.82</td>
<td>7.33</td>
<td>17</td>
</tr>
<tr>
<td>GAD-7</td>
<td>15.44</td>
<td>4.50</td>
<td>50</td>
<td>14.65</td>
<td>6.52</td>
<td>17</td>
</tr>
</tbody>
</table>

None of the measures had means that significantly differed between waiting list and therapy groups according to the Mann-Whitney U test, all \( p > .20 \).

3.3.7. Procedures

Initially, verbal approval to carry out the study was obtained from the counselling service manager following the presentation and discussion of the project with her.

Following this, the researcher joined a counselling service team meeting where she presented the research proposal to the counselling team and obtained their verbal
approval. Written consent was subsequently obtained from the manager (Appendix 3) and individual counsellors (Appendix 4).

When potential participants were contacted, they were told that a research project was being carried out with counselling clients at [XXXX] Counselling Service and they were contacted because according to the [XXXX] Counselling Service records they had recently completed their initial assessment and were on a waiting list for therapy or they had received a letter stating their first therapy appointment. It was explained that this research project was being done as part of a doctorate at University of Roehampton Psychology Department and the aim of this research was to obtain more information on posttraumatic growth among the Turkish-speaking community, and to measure the contribution of the therapy received at [XXXX] Counselling Service. PTG was defined for the potential participants as ‘the positive consequences one experiences after stressful life events’. Potential participants were also informed that the participation involved a questionnaire which asked about the negative and positive effects of frightening experiences, alongside their meaning in life and how they have adapted to the culture in the UK. They were informed that participation was voluntary and not compulsory, and if they wished to participate, they would be required to fill in three questionnaires with a 6-week interval between each questionnaire and this would be done in the most convenient way for them out of the three recruitment options: 1) meeting with the researcher at the counselling service to complete the questionnaire in person, 2) receiving the questionnaire by post or 3) responding to the questionnaire over the phone at an appropriate time. The potential participants were finally asked whether they were interested in participating.

If the participant preferred meeting face-to-face with the researcher to complete the questionnaire together, an appointment was booked at the counselling service,
prioritising the participant’s convenience. The participant was talked through the information sheet (Appendix 5) and it was explained that their data would be treated confidentially, that there would be no identifying information on their questionnaire and that they would be given a unique ID number which would be provided to them at the end of the meeting. They were informed that they had the right to withdraw from the study. Afterwards, their written consent was obtained. If the participant was illiterate, the information sheet was read to them and the participant’s verbal consent was obtained. Both the researcher’s explanation and the participant’s verbal consent were recorded and transferred on to an encrypted USB stick. Questionnaire responses were recorded on a password protected laptop. At the end of the questionnaire they were thanked for their participation and asked how they were feeling. Finally, they were given the debrief form (Appendix 6) with their unique ID number written on top of it. If the participant’s responses to the questionnaire items suggested risk concern, the safety of the participant was assessed.

If the participant opted for receiving the questionnaire by post, their address was obtained on the phone and they were sent a cover page explaining what to do (Appendix 7), an information sheet and consent form, a demographic questionnaire, a research questionnaire, a debrief form and a stamped envelope addressed to the researcher at [XXXX] Counselling Service. If the participant preferred completing the questionnaire on the phone, a convenient time was agreed for a telephone appointment. Informed consent was obtained verbally over the phone which was recorded or an information sheet and consent form was sent to the participant by post prior to the telephone appointment. The participant signed and returned the consent form to the researcher in the pre-paid envelope provided to them. When completing the questionnaire on the phone, the same procedures as the face-to-face meetings were followed. At the end of the call, the participant was debriefed verbally. They were provided with the
researcher’s and the counselling service telephone numbers and their unique ID number. A debrief form was sent by post to those participants who wished to receive a printed copy.

The printed questionnaires were kept in a separate folder from the printed demographic forms and consent forms. Electronic questionnaires were kept in a different folder on the researcher’s laptop from the demographic forms. Electronic demographic forms were regularly transferred on to an encrypted USB stick which was kept at a secure location, and were then deleted from the laptop.

3.3.8. Data analyses

Data were entered on SPSS Statistics 25. The statistical analysis included both descriptive and inferential statistics.

The data were not found to meet the parametric assumption of normality, except for the integration and separation subscales of acculturation and the time spent in the UK. Logarithmic transformations ($X$) were therefore applied to non-parametric data, which failed to normalise the data. Logarithmic transformations only corrected for the distribution of the assimilation and marginalisation subscales of acculturation.

Bivariate correlations of demographic and clinical variables were analysed using Spearman correlations. Friedman’s ANOVA was conducted for both the WL and therapy groups to assess any change in PTG over time, as a non-parametric alternative to the repeated measures mixed ANOVA. Logistic regression models were used to test for predictors of PTG at baseline, as a non-parametric alternative to multiple linear regression models. PTG scores were split into categories of ‘high’ and ‘low’ based on the median value. The cut-off score of 20 for severe depression on PHQ-9 was used to split the depression scores into binary categories (Kroenke et al, 2001), and a cut-off
score of 24 was used to indicate presence of meaning and split the subscale into binary categories, based on Steger (2010). Kruskal-Wallis test was used to measure any curvilinear relationship between posttraumatic stress and PTG. This was carried out by categorising the posttraumatic stress scores as low, medium and high severity, by using the 33rd, 66th and 100th percentile values. Kruskal-Wallis test was then used to test whether posttraumatic growth scores significantly changed depending on scoring low, medium or high on posttraumatic stress.

3.3.9. Researcher’s log

Field notes were taken regarding the observations made during the quantitative interviews. These included some significant content of the participants’ accounts which was not captured in the questionnaire, as well as the researcher-participant dynamics and the participants’ general attitude towards the research process. These notes were typed anonymously in a word document file, which was kept on a password protected laptop.

3.3.10. Ethical considerations

The research for this project was submitted for ethics consideration under the reference PSYC 16/ 246 in the Department of Psychology and was approved under the procedures of the University of Roehampton’s Ethics Committee on 06.12.16 (Appendix 8).

This study later underwent several minor amendments. The most substantial ones were: 1) Changes to recruitment: the option of post questionnaires and telephone interviews were added; 2) Addition of the researcher’s observations, anonymously recorded in writing. Participants were given the chance of opting out of this part of data collection. During telephone conversations and meetings, the researcher endeavoured to be sensitive to participants’ needs. Although the participants were not asked to disclose any
information other than those asked by the questionnaire items, almost all participants 
who met face-to-face with the researcher extended their responses to the items to tell 
their story. It seemed that many of them used the meetings as a space to be heard. All 
material they shared was treated confidentially. Attention was paid to allow time for 
their story to be listened to and respond to their distress with empathy. When a 
participant was distressed, they were given the option to discontinue, although on all 
occasions they preferred to continue and some explicitly said that they had deliberately 
chosen to share the experience, as this made them feel better, indicating that these 
meetings became therapeutic at times (Corbin and Morse, 2003). Where there was a 
concern, risk was assessed by enquiring about any suicidal plans and the protective 
factors. There was no immediate risk that needed to be addressed in any of the cases.

3.4. Results

3.4.1 Descriptive Statistics

Mean PTG of this sample was 24.2 (SD = 20.4), scores ranged from 0 to 94. The most 
endorsed PTGI items were “I am better able to accept the way things work out” (n=48, 
66.6%, 31% endorsed moderate level), and “I better accept needing others” (n=45, 
62.5%, 26% endorsed moderate level). The least endorsed items were “New 
opportunities are available, which wouldn’t have been otherwise” (n=14, 19%) and “I 
developed new interests” (n=19, 26%). Table summarises the mean, SD, maximum and 
minimum scores of the five subscales.

Table 3. Means, SDs, minimum and maximum scores for the PTGI subscales.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>M</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relating to others</td>
<td>7.6</td>
<td>7.5</td>
<td>0</td>
<td>31</td>
</tr>
<tr>
<td>New</td>
<td>4.3</td>
<td>5.3</td>
<td>0</td>
<td>23</td>
</tr>
</tbody>
</table>
Mean posttraumatic stress was 53.8 (SD= 19.0) and scores ranged between 0 and 80. Eighty-nine per cent of the sample (64 participants out of 72) scored 34 or above on the PCL-5, which is considered to be a cut-off point for indicating PTSD. Participants in this sample reported the following as the traumatic events they have experienced themselves: “severe human suffering” (72.2%, n= 52), “any other very stressful event or experience” (66.2%, n= 47) (participants commonly referred to bereavement and immigration/immigrant identity as part of this item during interviews with the researcher), “physical assault” (55.6%, n= 40), “life threatening illness or injury” (44.4%, n= 32), “natural disaster” (34.7%, n= 25), “transportation accident” (26.4%, n=19), “sexual assault” (21.1%, n= 15), “other unwanted or uncomfortable sexual experience” (20.0%, n= 14), “assault with a weapon” (19.4%, n= 14)“captivity” (15.5%, n=11), “combat or exposure to a war-zone” (15.3%, n= 11), “serious accident at work, home or during recreational activity” (14.1%, n= 10), “fire or explosion” (12.5%, n= 9), “serious injury, harm or death you caused to someone else” (9.7%, n= 7), “exposure to toxic substance” (6.9%, n= 5). 18.1% (n= 13) witnessed a “sudden violent death”, whereas 16.7% (n=12) learnt about it. 16.7% (n=12) learnt about a “sudden accidental death”.

It stood out that, sexual assault and other types of uncomfortable sexual contact was reported to be experienced more by the therapy group than the WL group, such that 18% of the WL group and 27% of the therapy group reported having experienced a “sexual assault” and 10% of the WL group vs 41% of therapy group reported having
experienced “other unwanted or uncomfortable sexual experience”. 12% of the WL group reported having caused serious injury, harm or death to someone else, whereas in the therapy group this was 4.5%.

These differences between groups in terms of life events could be due to gender differences, as the vast majority of the therapy group consisted of females (91%) compared to the WL group (80%). Chi squared test showed that the therapy group reported significantly more uncomfortable sexual contact. There was a significant association between group and the experience of unwanted or uncomfortable sexual contact $\chi^2 (4) = 12.25$, $p<0.05$, with a moderate effect size Cramer’s $V .418$.

Mean presence of meaning and search for meaning scores in this sample were 20.6 (SD= 9.1) and 20.7 (SD= 10.3) respectively, both ranging between scores of 5 and 35. Half of the participants scored below 24 on the presence of meaning in life and just over half (53%) scored below 24 on search for meaning, which could be interpreted as around half of the sample felt they had a valued meaning and purpose in life, and yet they were open to exploring meaning and purpose (Steger, 2010).

Mean PHQ-9 and GAD-7 scores, 18.6 (SD= 6.2) (19 after two outliers were removed) and 15.2 (15.5 after one outlier was removed) (SD= 5.0) respectively, indicated moderately severe depression (Kroenke et al, 2001) and severe anxiety (Spitzer et al, 2006). 57.6% of the sample (38 participants out of 72) exceeded the recognised cut-off point of 20 for severe depression, whereas those that exceeded the cut-off point of 15 for severe anxiety corresponded to 61.2% (41 out of 72 participants).

Separation was the most dominantly utilised acculturation strategy by the majority of participants (52%), whereas for 28% of participants, Integration was the preferred strategy, followed by Marginalisation by 16% and Assimilation by 4%. Separation had the highest mean score among all acculturation strategies (M= 33.6, SD= 7.4), ranging
from 19-46 and assimilation had the lowest mean score (M= 19.6, SD= 6.8), ranging from 10-37.

Table 4 shows therapy and waiting list group means for each measure at each measurement point.

Table 4. Therapy and waiting list group means for each measure at three measurement points.

<table>
<thead>
<tr>
<th>Measure</th>
<th>WL Mean (SD)</th>
<th>Therapy Mean (SD)</th>
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</thead>
<tbody>
<tr>
<td>PTGI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence of meaning</td>
<td>19.82 (9.39)</td>
<td>22.41 (8.35)</td>
</tr>
<tr>
<td>Search for meaning</td>
<td>20.70 (10.44)</td>
<td>20.82 (10.34)</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>18.90 (5.76)</td>
<td>17.82 (7.33)</td>
</tr>
<tr>
<td>GAD-7</td>
<td>15.44 (4.50)</td>
<td>14.65 (6.52)</td>
</tr>
<tr>
<td>Integration</td>
<td>28.50 (9.52)</td>
<td>28.36 (7.58)</td>
</tr>
<tr>
<td>Separation</td>
<td>33.44 (7.58)</td>
<td>33.82 (7.18)</td>
</tr>
<tr>
<td>Assimilation</td>
<td>18.56 (6.57)</td>
<td>21.91 (6.75)</td>
</tr>
<tr>
<td>Marginalisation</td>
<td>25.02 (9.09)</td>
<td>24.32 (5.04)</td>
</tr>
</tbody>
</table>

3.4.2. Associations in measures and demographic variables

Table 5 shows the Spearman’s correlation coefficients between scales and age, gender, physical and mental health. The total PTGI score was strongly significantly correlated to each of its subscales. Age had a significant negative correlation with the Presence of meaning in life (r = -.43). The Presence subscale of the MLQ was significantly correlated with the New possibilities and Personal strength subscales (r = .31 and .29, respectively) of the PTGI. Presence also had a strong significant correlation with the
Search subscale ($r = .42$). There was a significant negative association between the time spent in the UK and Presence ($r = -.37$). Depression was significantly negatively correlated with both PTG and presence of meaning ($r = -.34$ and -.35, respectively). It was also significantly negatively correlated with the individual PTGI subscales, except for the Relating to others and Appreciation of life subscales. Anxiety had a significant negative association only with the Personal strength subscale. Both anxiety and depression were significantly positively correlated with posttraumatic stress ($r = .55$ and .52, respectively) and with each other ($r = .45$). In terms of the acculturation strategies, assimilation was significantly positively correlated with both integration ($r = .30$) and marginalisation ($r = .29$), whereas it was significantly negatively associated with separation ($r = -.39$). There was also a significant negative association between integration and separation ($r = -.31$). No acculturation strategy was associated with any of the clinical outcome measures.

A Mann-Whitney U test showed no significant difference in PTG between Muslims and non-believers, $U = 255.50$, $z = -1.14$, $p = .256$. 
Table 5. Spearman’s correlation coefficients between scales and age, gender, physical and mental health.

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<tr>
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</tbody>
</table>

*Correlation is significant at P < .02 level (2-tailed).
**Correlation is significant at P < .01 level (2-tailed).

Physical health = whether they had a physical health diagnosis, Mental health = whether they had a mental health diagnosis, Children = number of children, PCL = total PCL-5 score, PTGI = total PTGI score, Relating = Relating to others subscale of PTGI, New possibilities = New possibilities subscale of PTGI, Personal strength = personal strength subscale of PTGI, Spiritual change = spiritual change subscale of PTGI, Appreciation = Appreciation of life scale of PTGI, Presence = presence of meaning in life, Search = search for meaning in life, Integration = Integration dimension of acculturation, Separation = Separation dimension of acculturation, Assimilation = Assimilation dimension of acculturation, Marginalisation = Marginalisation dimension of acculturation, PHQ-9 = total PHQ-9 score, GAD-7 = total GAD-7 score, Time in the UK = total number of years spent in the UK.
3.4.3. Change in PTG and other outcome measures

Friedman’s ANOVA showed that the PTG level of the therapy group did not significantly change over 6 or 12 weeks, χ²(2) = .26, p = .49. PTG of the WL participants did not significantly change either, over 6 weeks, χ²(2) = .71, p = .62, or 12 weeks χ²(2) = .14, p = 1.00, after being adjusted by the Bonferroni correction for the multiple tests.

The posttraumatic stress, meaning in life, depression and generalised anxiety scores of participants in both groups did not significantly change over 6 or 12 weeks.

3.4.4. Relationship of trauma severity with PTG

There was no significant linear or curvilinear association between posttraumatic stress and PTG.

Table 6 summarises the findings from the binary logistic regression analysis to test whether posttraumatic stress predicted scoring low or high on the PTGI. Posttraumatic stress did not explain a significant proportion of the variance in PTG, Nagelkerke $R^2 = .015$, χ²(1) = .83, p = .36.

Table 6. Logistic regression of PTG on Posttraumatic stress

<table>
<thead>
<tr>
<th>Posttraumatic stress</th>
<th>Unstandardized b</th>
<th>SE of b</th>
<th>Odds ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>-.01</td>
<td>.01</td>
<td>.99</td>
<td>.96-1.01</td>
<td></td>
</tr>
</tbody>
</table>

Model fit, -2 log likelihood = 98.92, Nagelkerke $R^2 = .015$.

Posttraumatic stress was significantly associated only with the Personal strength subscale. However, it did not significantly predict scoring low or high on Personal strength subscale, Nagelkerke $R^2 = .024$, χ²(1) = 1.30, p = .25. Table 7 shows the findings from the binary logistic regression analysis.
Table 7. Logistic regression of Personal strength on Posttraumatic stress

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized ( b )</th>
<th>( SE ) of ( b )</th>
<th>Odds ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posttraumatic stress</td>
<td>-.02</td>
<td>.01</td>
<td>.99</td>
<td>.96-1.01</td>
</tr>
</tbody>
</table>

Model fit, -2 log likelihood = 98.51, Nagelkerke \( R^2 = .024 \).

According to the Kruskal-Wallis test, posttraumatic growth did not significantly change depending on posttraumatic stress severity (low, medium or high), \( H(2) = 3.66, p = .16 \).

3.4.5. Other logistic regression analyses

Table 8 summarises the findings from the binary logistic regression analysis of presence of meaning in life predicting PTG. Presence of meaning in life explained a significant proportion of the variance in PTG, Nagelkerke \( R^2 = .17, \chi^2(1) = 9.85, p = .002 \). The odds ratio shows that more presence of meaning in life was associated with higher levels of growth.

Table 8. Logistic regression of PTG on Presence of meaning in life

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized ( b )</th>
<th>( SE ) of ( b )</th>
<th>Odds ratio</th>
<th>95% CI</th>
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<tbody>
<tr>
<td>Presence of meaning in life</td>
<td>.09*</td>
<td>.03</td>
<td>1.09</td>
<td>1.03-1.16</td>
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</table>

Model fit, -2 log likelihood = 89.91, Nagelkerke \( R^2 = .17 \).

* \( p < .01 \).

Presence of meaning in life and PTG explained a significant proportion of the variance in depression, Nagelkerke \( R^2 = .163, \chi^2(2) = 8.52, p = .01 \). The odds ratio shows that higher levels of PTG were associated with a lower likelihood of experiencing severe depression. Table 9 below shows the summary of findings.
Table 9. Logistic regression of depression on Presence of meaning in life and PTG

<table>
<thead>
<tr>
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<th>Unstandardized b</th>
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<th>95% CI</th>
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<td>.96</td>
<td>.90-1.02</td>
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</table>

Model fit, -2 log likelihood = 81.45, Nagelkerke $R^2 = .163$.
* $p < .05$.

Age and time spent in the UK explained a significant proportion of the variance in presence of meaning in life, Nagelkerke $R^2 = .193$, $\chi^2(2) = 9.82, p = .007$. The odds ratio shows that as participants became older they became less likely to have a high level of presence of meaning in life. See table 10 for the summary of findings.

Table 10. Logistic regression of presence of meaning in life on age and time in UK

<table>
<thead>
<tr>
<th></th>
<th>Unstandardized b</th>
<th>SE of b</th>
<th>Odds ratio</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-.12*</td>
<td>.05</td>
<td>.89</td>
<td>.80-99</td>
</tr>
<tr>
<td>Time in UK</td>
<td>.02</td>
<td>.05</td>
<td>1.02</td>
<td>.92-1.12</td>
</tr>
</tbody>
</table>

Model fit, -2 log likelihood = 77.12, Nagelkerke $R^2 = .193$.
* $p < .05$.

3.5. Discussion

3.5.1. Summary of findings

The present study examined 1) the effect of therapy provided at a Turkish-speaking counselling service in a UK city on posttraumatic growth, 2) the relationship of PTG with the severity of traumatic stress and other outcome variables, and 3) association between acculturation posttraumatic growth. No significant change was observed in PTG or other outcome variables after therapy. There was no significant relationship between posttraumatic stress and growth. PTG was found to be significantly associated with the presence of meaning and depression. Age predicted the presence of meaning. Participants in this sample predominantly used separation from the host culture as an
acculturation strategy; however, acculturation was not associated with the outcome variables.

### 3.5.2 PTG

Mean PTG in the overall sample at baseline (M= 24.2, SD= 20.4) was lower than other samples studied in Turkey. Previously, PTG levels with a mean between 50-60 (which has been described as “moderate”) have been reported in a sample of rheumatoid arthritis patients, (Dirik and Karancı, 2008), spouses of MI patients (Şenol-Durak and Ayvaşık, 2010), cancer patients (Tanrıverdi, Savaş and Can, 2012) and adults who experienced a traumatic event in life time (Gül and Karancı, 2017). One factor contributing to the lower PTG could be that the current sample consisted of counselling clients, who had been referred to this service due to their on-going psychological distress, as opposed to the samples in the previous studies. Lower PTG could also be attributable to additional stressors brought about by being a member of a minority ethnic group. For example, given the finding that the current sample is generally separated from the dominant culture, they are likely to be relatively isolated and potentially benefit from relatively less social support. However, the role of social support was extensively cited by previous research in facilitating PTG (e.g. Dursun et al, 2016).

#### 3.5.2.1. Change in PTG over time

There was no significant change observed in PTG over 6 weeks or 12 weeks in therapy and WL groups. This finding was contradictory to the previous intervention studies, which reported increased PTG post-treatment; although previous studies were predominantly done with other populations (such as cancer patients and Iraqi refugees) who underwent different therapy arrangements from the current service, for example, a psychodynamic group intervention (Kissane et al., 2004), a brief NET intervention
(Hijazi et al., 2014) and CBT (McGregor et al., 2004). The sample size of this study was not large enough to draw reliable conclusions regarding the effectiveness of the therapy. Although a clear explanation for a lack of change cannot be provided under the circumstances, some potential reasons could be discussed. For example, the treatment ranging between 6 and 12 weeks with an unstructured, integrative approach might not have been long enough for most participants to progress along the cognitive and emotional process of making meaning of their traumatic experiences. It is also likely that some elements of growth experienced by some participants in this study along with certain benefits of therapy were not captured by the PTGI and other quantitative measures (discussed further in the ‘Researcher’s reflections’ below).

3.5.2.2. Relationship of traumatic stress and PTG

No relationship was found between traumatic stress and PTG. This finding is in line with some previous research studies (e.g. Cordova et al., 2007; Groleau et al., 2013; Morris & Shakespeare-Finch, 2011; Wu et al., 2015); although research evidence in this area so far is mixed, with some other researchers having reported positive (e.g. Bluvstein et al., 2013), negative (Kılıç & Ulusoy, 2003) and curvilinear relationships (e.g. Kleim & Ehlers, 2009). The present finding of no relationship is more in line with the notion that the two are independent constructs that can occur concurrently (Zoellner & Maercker, 2006).

3.5.2.3. Relationship of PTG with depression and anxiety

There was a significant association between depression and PTG, whereas anxiety was not found to be significantly associated with PTG. Higher levels of PTG were associated with less severe depression. This finding is in line with most previous studies which found an inverse relationship of PTG with depression, but not anxiety (Helgeson et al., 2006; Kunz et al., 2017). Either this could mean that PTG leads to less depression
and therefore contributes to better subjective well-being or that less depression and distress allow more experience of growth (Bluvstein et al., 2013).

3.5.3. Meaning

Mean Presence and Search scores in this sample (M= 20.6, SD= 9.1 and M= 20.7, SD= 10.3 respectively) were slightly lower than a previous study where the MLQ was used with both US and Turkish samples, which reported M= 26.7 (SD= 6.5) for the presence and M= 22.1 (SD= 8.5) for the search in the Turkish sample (Boyraz et al., 2013). However, the sample in Boyraz et al. (2013) consisted of university students and other adults who were recruited on the Internet. The apparent decline particularly in the presence of meaning in the current sample is predictable given that it consisted of counselling service clients in distress. A score below 24 on the Presence and Search subscales is considered as a lack of a valued meaning and purpose in life and a lack of openness to exploring such meaning. Lower scores in this sample probably reflect their experience of emotional difficulties and lack of joy and optimism, as captured by the depression, anxiety and posttraumatic stress measures. It is noteworthy that despite the extreme scores endorsed by the vast majority of participants in such negative outcome measures, meaning in life scores of almost half of the sample suggest a more optimistic result. Nearly all participants who carried out quantitative interviews with the researcher identified their children/grandchildren as their purpose in life.

3.5.3.1. PTG and presence of meaning

The finding that more presence of meaning in life was associated with higher levels of growth was in line with previous research, such as Groleau et al. (2013), Dursun et al., 2016 Grad and Zeligman, (2017), Linley and Joseph, (2011), Triplett et al., (2012). Meaning making is considered an integral part of the process leading to growth (e.g. Park & Ai, 2006).
3.5.3.2. Presence of meaning and search for meaning

Presence was significantly positively correlated with Search, contrary to Steger et al. (2008)’s argument that search is initiated by a lack of presence of meaning in life. For most participants in this study, a lack of presence of meaning did not trigger a search for it either. There seems to be an understanding from previous research that in collectivistic cultures, presence of and search for meaning are usually positively correlated, although in a study with a Turkish sample, the relationship was negative (Boyraz et al., 2013).

3.5.3.3. Age and presence of meaning

Both age and time spent in this country were significantly correlated with presence of meaning, however only age significantly predicted meaning in life in the logistic regression analysis. The finding of a decrease in meaning with older age was in line with a meta-analysis, which reported a negative relationship between age and scales measuring usefulness and creating goals (Pinquart, 2002), although older adults were previously found to have more meaning in life when it was measured by the same scale as the current MLQ (Steger, Oishi & Kashdan, 2009). The current finding could be understood again as a consequence of a lack of goals and isolation, as the older the participants, the less likely they were to be working, socially engaging, able to communicate in English, or be occupied with other duties such as raising children. One could speculate that the less active the participants became in the society they lived in, the less meaning they had in their lives, as one previous study reported that social exclusion and rejection led to less meaning found in life (Stillman et al., 2009).

3.5.4. Acculturation

Previous literature on the relationship between PTG and acculturation has been scarce and vague (e.g. Arpawong et al., 2013). The current study did not find any significant
association of acculturation with PTG, which is consistent with a previous study by Abraido-Lanza et al. (1998). Acculturation was not associated with any of the other positive or negative outcome measures in this study. Participants in the current sample predominantly engaged in the separation strategy, which implies that they preferred to hold onto the values of their own culture and avoided engagement with other cultures (Berry, 2005). This finding is in line with most acculturation studies done with Turkish samples (e.g. Şeker & Sirkeci, 2014). As previously argued by Ataca and Berry (2002), the preference to separate could be influenced by the sample’s socio-economic status. The education levels of the participants in this study were usually low, their primary language of communication was Turkish and for women, who were generally housewives, their contact with the dominant culture for social and work purposes was limited, all of which might have prompted the present sample to employ the separation strategy.

Unlu-Ince et al (2014) reported significant associations of acculturation with demographic variables, whereas in the current study, no significant relationships were found between any acculturation strategies and demographic variables such as age or gender. They also found a significant association between acculturation and having a diagnosis of depressive and anxiety disorders, which was not found in this study. It is intuitive to hypothesise that acculturation attitudes would be associated with psychological symptoms; however the finding of no association of most acculturation variables is in fact not uncommon in literature (e.g. Beriens and Fontaine, 2011; van der Wurff et al., 2004).

3.5.5. Strengths and Limitations

This study has been the first to look into the culturally sensitive psychological therapy available to the Turkish-speaking population in London. This is important in terms of
starting a conversation about the issues addressed in the study, and thus increasing the visibility of the populations that have been underrepresented in research. An increased diversity in research may represent an evolving interest in multiculturalism in the UK. The findings and issues discussed in this study are valuable in informing the work of mental health professionals and service development within this community.

Implications for practice, policy and further research will be discussed in Chapter 5.

Certain limitations of this study made it difficult to draw clear conclusions from the findings. First, the sample size was not large enough for the study to have the necessary power, therefore, the information it can provide is limited to tentative inferences. The before-and-after design of the current project introduced challenges regarding time and the response rates. It has not been possible to have a larger sample within the available time for the completion of the project. Second, it was not possible to randomise participants into the two groups, as the natural assessment and waiting list procedures of the current counselling service had to be followed. As a result, incomparable samples may have appeared in the groups. For example, starting the treatment depended on several factors including the urgency of the client’s needs. Third, these findings are specific to a particular counselling service and its catchment area, and therefore, their generalisability to other types of services available to the current population may be limited. The fourth limitation concerns the measures used in this study. These were translated versions of the original measures, which were developed in Western populations, which may have compromised the accuracy of the constructs assessed. Furthermore, the PTGI did not measure any negative dimensions of the growth items. Therefore it is not possible to deduce whether participants had no change in the PTG domains or if they experienced changes in the opposite direction. Although measuring PTG with the current measures in the current sample should be approached critically, all translated measures used in this study had been validated in a Turkish sample before.
Fifth, it was not possible to control for any events that took place between data collection time points. The scores of some participants may have been influenced by an additional traumatic event experienced during the wait, such as bereavement. Where such change had happened in their lives between time points, this was commonly disclosed by the participants during the interviews. However, it has not been possible to take these changes into account in the quantitative measures used.

3.7. Researcher’s reflections

The following reflections have been derived from the notes the researcher took about her observations of the quantitative interviews carried out with participants. The researcher observed that some aspects of participants’ experiences, including some elements of growth or slight shifts in their mood might not have been captured by the measures. This is a universal issue that applies to every quantitative research. However, in the case of the present research, it seemed that the participants tended to endorse extreme scores, which translated as very high distress and low growth. In a previous study, the Turkish sample was observed to overemphasise their depressive symptoms compared to the British sample (Uluşahin, Başoğlu, & Paykel, 1994), and van der Wurff et al. (2004) later discussed that such tendency to aggravate symptoms might artificially increase their scores. On some occasions during the present research, the researcher noticed that a participant’s endorsement of items slightly contradicted the verbal evidence from their account. For various reasons, participants might have been exaggerating their scores on the distress measures. One possible reason could be a wish to receive on-going care from the service, as the waiting times are long and the treatment ends in 6-12 weeks, or living on income from welfare benefits, which strictly requires a proof of ill health. It was also intriguing to observe that even though some participants verbally reported that they were happy with the therapy they were
receiving, any positive experience they had had was not reflected in their scores. Also, unfamiliarity with form filling of this particular sample may have affected the specificity of their answers.

There may be different correlates of growth experienced by this sample that could not be captured by the current self-report measure, or a possibility that it did not measure the exact same construct as the original PTGI (Splevins et al., 2010), due to the possible differences in the conceptualisation of trauma and growth. For example, the researcher’s observations suggested that, contrary to the closer relationships domain in Tedeschi and Calhoun’s model, the vast majority of the current sample seemed to have moved towards individuality than cohesiveness. This could perhaps be understood as disengagement from the more collectivistic culture the current sample originally had compared to the more individualistic Western culture in which this model was developed. Some participants reported that while in the past they used to “always be there for others”, now they were more inclined to consider their own needs before proceeding to help other people. Although this is contradictory to the items of the PTGI that enquire about an increased trust in others and increased appreciation of close relationships and intimacy, this change described by the current sample taps the correlate of growth reported in other studies, which McMillen (2004) described as a decreased naïveté that can protect against future adversity.

Another possible explanation of the finding of particularly low growth in the current sample could be due to the majority of the sample consisting of women, as it seemed that they experienced distinct difficulties, such as further isolation and less self-sufficiency due to assuming the traditional female roles of childcare/housework, and having more literacy-related issues. We could intuitively assume that isolation could have impeded the ability of most participants in this study to reach the resources they
needed for resilience and growth. Therefore, it is likely that, for the majority of the current sample, traumatic events did not result in a positive accommodation of the new trauma information, but for most they rather resulted in a negative accommodation (Joseph and Linley, 2005), manifested in high levels of posttraumatic stress, depression and anxiety symptoms.

With regard to acculturation, while there were participants who preferred interacting only with people from their culture, who favoured their own values and strictly pursued a similar lifestyle to their home country, some others leaned towards integration in their thinking about the two cultures. However, participants commonly disclosed that the language barriers were the largest factor in keeping communities separate and preventing integration. This implied that, perhaps separation between cultures would not have been to such pronounced degree, if they had more resources to facilitate contact. Nevertheless, it should not be overlooked that less acculturated, and more distressed members of the community were probably overrepresented in this sample.
Chapter 4 - Study 2: An Interpretive Phenomenological Analysis of Turkish-speaking Counselling Clients’ Experiences of Impact of Traumatic Events, and Contribution of Therapy

4.1. Aim

To explore Turkish-speaking counselling clients’ experiences of PTG and the contribution of culturally-sensitive therapy.

4.2. Research questions

1) How do Turkish-speaking counselling clients make sense of their experience of impact of traumatic life events?
2) How have they experienced the therapy they have received and how do they see this to have contributed to any change related to the traumatic life event they experienced?

4.3. Methodology

4.3.1. Design

This study was qualitative in design. It involved an interpretative phenomenological analysis of three semi-structured interviews conducted with three Turkish-speaking clients who had completed their course of therapy.

4.3.2. Rationale for IPA

IPA’s aim is “to explore in detail participants’ personal lived experience and how participants make sense of that experience” (Smith, 2004, p.40). Although PTG has been described as a commonly experienced phenomenon across populations with its clearly defined constructs, it can also be considered as a subjective experience, having unique features for each individual person experiencing it. The current study aimed to
gather detailed accounts of the participants’ subjective post-trauma and culturally sensitive therapy experiences, and make sense of these unique and shared experiences as the participants reflected on them.

The idiographic nature of IPA is compatible with the small sample size of this study. IPA focuses on a detailed exploration of individual cases in specific events and contexts, and is less concerned with generating broader themes with ecological validity, thus supporting a rich bottom-up understanding. This idiographic epistemology distinguishes IPA from grounded theory, which is also an inductive methodology, as grounded theory aims to develop a theory of a phenomenon that is being explored. By using IPA, this study aimed to capture ‘nuances’ of individual PTG experiences and permit unique themes to emerge from each individual case. Also, it could be more difficult to carry out grounded-theory analysis into a well-established concept (Tedeschi et al., 2018). Narrative analysis is another method of inquiry that would be suitable for PTG research, as the process of PTG involves reconstructing life assumptions (Neimeyer, 2006). Yet IPA allows closer access to subjective experience by involving the researcher’s expert knowledge. It also enables cross-analysing in an attempt to find patterns which can capture specific aspects of a phenomenon.

IPA has been used in mixed methods studies previously. To name a few, Rizq and Target (2010) investigated the ways in which counselling psychologists’ attachment styles and experiences of personal therapy converged, by administering the Adult Attachment Interview in combination with semi-structured interviews analysed using IPA. Down, Willner, Watts, and Griffiths (2011) combined outcome measures and IPA analysis of pre- and post-intervention interviews to compare the efficacy of different anger management groups for adolescents. Finally, Thornton, Baker, Johnson, and Kay-Lambkin (2011) used self-report measures with semi-structured interviews which were
analysed using IPA to explore how anti-smoking campaigns were perceived by people with psychotic disorders.

4.3.3. Philosophical underpinnings of IPA

IPA is informed by the three theoretical positions of phenomenology, hermeneutics and idiography.

4.3.3.1. Phenomenology

Phenomenological analysis is the initial descriptive component of IPA, which aims to describe ‘what it is like’ for the participant as they experience a particular phenomenon (Larkin, Watts & Clifton, 2006). Phenomenological philosophy was founded by Husserl, who aimed at reducing a phenomenon to its essential structures by ‘bracketing off’ our taken-for-granted assumptions about the world (Smith, Flowers, & Larkin, 2009). The phenomena, the “things themselves”, are studied as they manifest in consciousness in our everyday experiences, to allow a new look with an open mind (separating out the ways we learnt to make sense of events). This way, a new insight may be gained, which in turn may lead to a novel sense making of these experiences (Crotty, 1998).

From a Husserlian point of view, if a phenomenological inquiry can be done in a way that gives rise to rich and in-depth descriptions of phenomena, the ‘essences’ learnt from this inquiry then have the potential to transcend the particular phenomena being studied and inform the similar other experiences (Finlay, 2009; Smith et al, 2009).

Heidegger was one of the phenomenological philosophers who further developed the original thinking in Husserl’s phenomenology. Heidegger thought of us as living in an already meaningful world (where sense has been made) (Crotty, 1998). As opposed to Husserl’s condition of ‘bracketing off’, Heidegger argued that studying the lived
experience was not possible without a degree of interpretation, i.e. amalgamation with the researcher’s values and assumptions. Therefore, Heidegger added a hermeneutic turn to phenomenology (Smith et al, 2009).

By its attempt to be phenomenological, IPA can be said to ontologically adopt a realist stance, as it aims to reach the participant’s ‘real’ experience (Willig, 2013). However, epistemologically, it recognises the contextuality of both the participant and the researcher, thus acknowledging that the analysed data will have been influenced by the preconceptions of both parties. Heidegger’s hermeneutic phenomenology views the person as always a ‘person-in-context’ and places intersubjectivity at the centre of his philosophy (Smith et al, 2009).

4.3.3.2. Hermeneutics

Alongside generating a phenomenological description, IPA is also concerned with the interpretation of participant data, which links it to the hermeneutic tradition. The interpretation process of IPA aims to fit the descriptive analysis of the first stage into the broader context. With guidance from external theoretical concepts, the researcher attempts to make sense of the meaning of the sense-making performed by the participant in their particular context (Larkin et al, 2006), which is referred to as double hermeneutics (Smith, 2004). Therefore, epistemologically it is not deemed possible to remove the researcher’s prejudices/fore-meanings from the process of trying to find out about some ‘truth’ about the phenomena (Larkin et al, 2006). However, these interpretations should be relevant to the phenomenological description of the participant’s lived experience, which is ‘real’ to them. This process involves making use of intuitions, and aims to exceed the initial explicit account to uncover deeper aspects of the phenomenon. Therefore, the aim is both to bracket off our preconceptions as successfully as possible and to draw on them for attaining a new insight (Finlay, 2009).
Schleiermacher asserted that a detailed, holistic analysis could give the researcher a clearer perspective on the participant’s account than the participant has in their awareness (Smith et al, 2009).

4.3.3.3. Idiography

IPA is idiographic, in that it is primarily concerned with reaching a detailed exploration of the individual case, and only after this has been achieved, can the analysis move on to intending to arrive at generic cross-case themes, IPA is aimed at conveying something about the lived experience of a particular participant (Smith, 2004). This is distinct from a nomothetic approach of a more positivist stance, which aims to establish generalisations for a population. IPA’s focus on the ‘particular’ is manifest in its attention to detail and scrutiny of how a particular individual in a particular context makes sense of a particular subjective experience. IPA moves on to attempting to produce more general themes to reveal a shared experience; yet it permits retaining unique statements from particular cases, thus giving voice to a particular individual (Smith et al, 2009). Considering that unique features of individual experiences emerge from a much more common and shared collective experience, idiographic inquiry has the potential to enhance nomothetic research (Smith et al, 2009).

4.3.4. Participants

4.3.4.1. Recruitment and sample size

Recruitment took place from October-December 2018. Three participants were interviewed. A relatively small sample size is recommended for IPA, since it is an idiographic approach (see ‘Rationale for IPA’ and ‘Epistemology of IPA’). There is not a strict prescription for the ‘ideal’ IPA sample size and more recently very small sample sizes and case studies have been preferred (Pietkiewicz and Smith, 2012). A sample size of three participants was considered appropriate for the current research project, when
the exploratory purpose of the qualitative interviews was taken into account (Pietkiewicz and Smith, 2012). Potential participants were approached by the researcher at therapy/activity groups held at the counselling service. The groups were verbally informed about the aims and the nature of the study. The recruitment process continued until three participants agreed to take part.

4.3.4.2. Inclusion criteria

The inclusion criteria for participation were as follows: 1) having completed at least 6 sessions of therapy in the last year (the counselling contracts at this service are between 6-12 sessions) 2) having experienced at least one traumatic event in their lifetime and this being one of the issues that were worked on in the therapy they received at the counselling service 3) having a good understanding of what research participation will entail (being able to understand the information sheet and give consent without assistance) and 4) being willing to give a detailed account of their experiences.

The inclusion criteria were set in an attempt to both ensure ethical data collection and collection of rich data.

4.3.4.3. Participant demographics

Table 11 presents participant demographics, together with the traumatic events that prompted them to seek therapy.
Table 11. Study 2 sample demographics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Education</th>
<th>Traumatic event</th>
<th>Time since the events</th>
<th>Length of therapy contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayshe</td>
<td>37</td>
<td>Female</td>
<td>Turkish</td>
<td>High school</td>
<td>Financial issues and homelessness, Domestic violence, Divorce</td>
<td>1-2 years</td>
<td>12 sessions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Physical &amp; verbal abuse in childhood</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Infidelity in marriage</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Falsely accused</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Threatened and attacked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bora</td>
<td>40</td>
<td>Male</td>
<td>Kurdish</td>
<td>University</td>
<td>Childhood trauma</td>
<td>12 sessions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celine</td>
<td>43</td>
<td>Female</td>
<td>Mixed Turkish-Kurdish</td>
<td>University</td>
<td>Infidelity in marriage</td>
<td>1-2 years</td>
<td>12 sessions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Falsely accused</td>
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<td></td>
<td></td>
<td></td>
<td>Threatened and attacked</td>
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<td></td>
</tr>
</tbody>
</table>

4.3.5. Interview Schedule

Face-to-face, semi-structured interviews were conducted in the Turkish language. In accordance with the IPA methodology, an interview schedule was prepared (Appendix 9), which consisted of 16 open-ended questions merely to guide the interview. Avoiding strong devotion to the drafted interview schedule facilitates rapport building and allows the interviewer to freely reflect on the experience, enter new areas and thereby produce a richer account (Smith and Osborn, 2003). The interview schedule was translated to Turkish by the researcher.

The interview questions focused on the participants’ experiences of any changes (in any direction) following the traumatic events they experienced, and their therapy experience. In an attempt to be non-directive, have a more comprehensive understanding of the experience of overall effects of trauma, and avoid prior assumption about the traumatic events having caused change in any direction, participants were
asked about their understanding of the general impact of the events, as opposed to specifically about any posttraumatic growth experience in the interview.

4.3.6. Interview Procedure

All interviews were conducted at the counselling service at a convenient time previously agreed with the participant. Similar to the procedure in study 1, prior to the interview, all participants were briefed about the general purpose of the interview, confidentiality, anonymity and the right to withdrawal until after the thesis write-up, and a written informed consent was obtained (Appendix 10). Demographic information was also obtained from the participants (Appendix 1). Following the interview, all participants were thanked for their participation and were given an opportunity for reflection and discussion of any thoughts and feelings that arose during the interview and were provided with a debrief form (Appendix 11). A pseudonym was given to each participant to ensure anonymity and confidentiality. The interviews were audio recorded on a digital recording device and transcribed using an external service due to the time constraints at the later stages of the project. Although the researcher did not make use of transcribing, reading and re-reading the transcripts while listening to the audio recording simultaneously allowed immersion in the participant’s experience, as well as familiarity with their voice for the subsequent readings.

4.3.7. Data analysis

IPA analysis steps recommended by Smith et al (2009) were followed, while being mindful that this was only one way to undertake the analysis. The analysis involved the following process: the transcripts were read and re-read several times and the recording was listened to at the same time. Exploratory comments were made in the margin to the left of the transcript at ‘descriptive’ and ‘interpretative’ levels, using two different colours. More conceptual ‘emergent themes’ were then developed from the notes, which
were still grounded in the text. All emergent themes were typed in a list. Connections were searched for between the themes and those that formed clusters were linked. The analysis of each interview was completed fully before beginning the analysis of the next interview. Once all three transcripts were analysed using this method, integration of cases was sought. The notion of hermeneutic circle asserts that any given part can only be understood by looking to the whole and the whole can only be understood by looking to its parts. This becomes relevant at the interpretation stage of IPA, suggesting a cyclical analytic process. Therefore, care was taken to carry out this process in a cyclical manner by crosschecking with the text, so that any superordinate themes that emerged still represented data.

4.3.8. Ethical considerations

A minor amendment for the addition of the semi-structured interviews for the qualitative part of this research was approved on 27.09.18 (Appendix 12).

Like the procedure in study 1, where there was a concern, risk was assessed by enquiring about any suicidal plans and the protective factors. There was no immediate risk that needed to be addressed in any of the cases.

4.4. Findings

Three master themes have been identified that addressed the research questions of the present study. Table 12 presents the master themes with their corresponding subthemes. This section will explore each theme and subtheme, by drawing on relevant quotes from the transcripts.
Table 12. Master themes and subthemes

<table>
<thead>
<tr>
<th>Master theme 1 - Impact of traumatic events</th>
<th>Master theme 2 - Changes experienced through therapy</th>
<th>Master theme 3 – Elements of therapy that facilitated change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subtheme 1a – Impact on sense of self and self-worth</td>
<td>Subtheme 2a – Stronger self and increased self-worth</td>
<td>Subtheme 3a - Therapeutic relationship</td>
</tr>
<tr>
<td>Subtheme 1b - Avoiding intimacy</td>
<td>Subtheme 2b - Improvements in emotional wellbeing</td>
<td>Subtheme 3b - Techniques to alleviate anxiety</td>
</tr>
<tr>
<td>Subtheme 1c - Emotional distress</td>
<td>Subtheme 2c - Attitude to life</td>
<td>Subtheme 3c - Emotional expression</td>
</tr>
<tr>
<td>Subtheme 1d - Ways of coping</td>
<td></td>
<td>Subtheme 3d - Insight gained through therapy</td>
</tr>
<tr>
<td>Subtheme 1e - Isolation and oppression</td>
<td></td>
<td>Subtheme 3e - Holding onto life: finding a way forward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subtheme 3f - Language and culture</td>
</tr>
</tbody>
</table>

4.4.1. Master theme 1 - Impact of traumatic events

4.4.1.1. Subtheme 1a – Impact on sense of self and self-worth

A weakened sense of self was something that all three participants reported. In the case of Ayshe and Celine this manifested as an inability to make changes or be self-reliant. For example, Ayshe reported being afraid to do things for herself, whilst Celine struggled to find the strength to make personal changes. However for Bora, the weakened sense of self was highlighted by his use of the metaphor of being “crushed” (Bora, 1325) under the derogatory words of his father. This experience was so powerful that Bora recalled wishing to “die there and then” (Bora, 1324-1325). However, Bora also said:

...it taught me how to minimise the damage of an attack against oneself. I mean, just like a warrior, [...] it taught me to defeat- I mean, how to get out of it with minimum harm to myself. So, a bit like a war tactic-. (Bora, 695-705)
Here it is apparent that Bora thinks his adverse childhood experiences strengthened him, although he is referring to defending against “attacks” coming from other people, rather than a generalised sense of personal strength in the wake of life’s difficulties. It is likely that the resilience Bora is talking about stemmed from his learnt ways of managing such interpersonal attacks at a surface level, while the pain and the fragility from being battered as a child were present in his core. Bora reported that his traumatic childhood experiences helped him “stand out tactically and physically” (Bora, 733-734) in the army\(^2\), by strengthening his “decision-making skills” (Bora, 739) under conflict circumstances. Bora’s account of his easy adjustment to military operations along with his use of words such as a “warrior” or “war tactic” indicate his experience of a childhood with a ‘battlefield’ quality, in ‘survival mode’. Bora described his army experience as the only time he felt good after the difficulties of his childhood and feeling suicidal just before joining the army. He went on to say that shortly after the army he took the decision to move abroad, away from his parents in an attempt to be able to “stand on his own feet” (Bora, 1265-1266), and explained that moving abroad gave him a sense of independence, as well as improving his mood. It seemed that his moving abroad was a search for his own self and dreams, independent from what was imposed upon him in his family environment.

As well as affecting participants’ senses of self, it seems that all three participants experienced a decrease in their feelings of self-worth and in the value of their own lives after going through traumatic events. As Ayshe states:

\[I \text{ used to think that I was a useless and incompetent person and I didn’t find myself pretty. I didn’t like myself (Ayshe, 155-156)}\]

\(^2\) while he was carrying out his mandatory military service in eastern Turkey where he participated in armed conflict
Here Ayshe is clear about the impact the trauma she experienced has had on her self-esteem. Celine echoed Ayshe’s feelings of inadequacy. Here Celine talks about how she felt about making changes after finding out about her husband’s infidelity:

\[
\text{I haven’t been able to revolutionise my life. I have to change myself. How do I have to change myself? I could move out of that house. I could divorce the man. Err, or I could leave the house myself. So, who could change those circumstances? Me. However, I cannot seem to be able to find the strength to make a change. I cannot seem to find the courage to make a change. (Celine, 888-900)}
\]

Despite her husband’s infidelity, and the attacks and threats by her neighbour, it is clear that Celine appears to lack the strength to divorce her husband and move out. This seemed to have been caused by a combination of voluntary and forced obstacles. For example, it was apparent that Celine did not wish to make changes to her current order of life and expected her neighbour – who was the wrongdoer - to leave the building instead. Celine also mentioned about her children’s attachment to their father, which was another factor deterring her from a divorce. Unfortunately, she also received verbal threats from her husband upon her thoughts about divorce, which will be discussed further in subtheme 1e.

It appeared during the interview and throughout her account that Celine had a self-concept of an intelligent and competent woman, which she perhaps utilised as a self-preserving strategy. For Celine, it seems that her self-concept was being challenged by the feelings brought about the distressing events she had experienced. Celine’s decreased self-worth was also evident in her discussions of giving up on her dreams of moving back to Turkey to live in a small house with a garden, writing a book and fostering a girl. Celine also reported that she no longer valued her own life. However,
for Bora, a decreased self-worth seemed to have manifested as a compliant self, as he repeatedly talked about not being able to stand up for himself when in disagreement with others, and rather assuming the blame without dwelling on the issue (Bora, 325-327, 370-372, 394-399).

Overall, it can be seen that all participants demonstrated a loss of their sense of self and reduced sense of how they perceived their self-worth, however it seems clear that this manifested differently for the male participant compared to the two women. Bora’s examples included conflict situations in interpersonal relationships and in the army. He discussed experiencing an oppressed sense of self in relation to others despite him mentioning his ability to protect himself against hurt; on the other hand, he held a self-image of an outstanding team leader in the army. The experiences of the female participants not only lacked any benefit of traumatic experiences as described by Bora, but they also felt disarmed in trying to be independent, which was absent in Bora’s experience. Conversely, Bora was able to take the decision for himself to move abroad, away from his family, for a fresh start. These differences in experience could be due to the contextual difficulties the women faced, which may have rendered mobilising change more difficult for them (subtheme 1e). The differences between the possibilities for change could also be related to the participants’ being at different stages of their lives. Bora experienced traumatic events in his childhood and felt able to attempt to start anew when he became a young adult, whereas both Ayshe and Celine experienced the traumatic events in their adulthood, when both already had young children.

4.4.1.2. Subtheme 1b - Avoiding intimacy

A dominant theme among all three participants was a lack of trust in other people, thus maintaining distance in relationships. This was portrayed as self-protection from “danger” (Celine, 658-659) and people who “hurt” them (Bora, 216). Celine
mentioned that since her traumatic experiences she has felt that people are malicious. Here she speaks about her newly developed sense of mistrust:

\[...because I’m scared. I’m scared of people. And if the person you trusted for 8 years can do this to you, you never know about someone you’ve just met. I’ve had trust issues developing within myself, within my personality. I used to trust people a lot, I used to trust and open up easily. There have been trust issues.\]

(Celine, 526-532)

Here it is apparent that Celine’s feelings of “being cheated on” (Celine, 270) led to a generalised lack of trust in her relationships with people. Celine also said that she had withdrawn from her circle of friends in order to avoid having to disclose the events she had experienced, and likened this new way of relating, to “a turtle’s retreating back into its shell in order to feel safe, hiding when there is a threat of danger” (Celine, 656-659). Celine also spoke about preferring to stay at home where she feels safer, due to her fears about being attacked by her neighbour again. While for Celine distance in relationships meant withdrawing from socialising altogether, Ayshe did not seem to perceive any risk in superficial relationships. However, she stated that, although she continued socialising and having conversations with people, she became more cautious about closeness:

\[
I’m not getting any closer, and I’m trying to keep a distance because of the mistrust. Of course, I have this close friend and I call her ‘big sister’ because she is older than me; I share everything with her, but I’m trying to keep a distance with other people that I see, except for my big sister, because of the mistrust. (Ayshe, 534-541)
\]

This quote from Ayshe clearly demonstrates that she has become more reserved in her relationships, apart from her close ‘big sister’, to whom she feels able to reveal more of
herself. The need to keep a distance from people was echoed by Bora, who reported being “selective of people” (Bora, 716):

*Judging who will do harm. I mean, it taught me to keep people at a distance, and not engage with them much (B, 718-723).*

Here it is clear that Bora is wary of being hurt by others, from his concerns about ‘who will do harm’. It seems that, as a result, he makes efforts to keep a distance in his relationships, which can be seen as serving a self-protective function.

Overall, this subtheme demonstrated that all three participants experienced their relations with others to have become more distant as a result of the traumatic events they went through. It is clear that they engaged in such behaviour in an attempt to shield themselves from perceived threats. This can be understood in the context that all participants had experienced traumatic events where someone they had a relationship with was the perpetrator (as opposed to, for example, a natural disaster). Therefore, it is apparent that, for the participants, these events caused a perception of relationships as untrustworthy and potentially harming.

4.4.1.3. Subtheme 1c - Emotional distress

Naturally, emotional distress was a common issue across all participants. Participants mentioned feeling drained/worn down (“yıpranmak” in Turkish) as a result of the adverse events they experienced. For example, Ayshe stated that it was “hard and exhausting” (Ayshe, 87-88) to regularly become homeless and live at unfamiliar accommodations, due to their financial problems caused by her husband’s gambling addiction. Recalling those times when she was confronted with these traumatic events, Ayshe states:
There were lots of things [...] I was in such a convoluted state at the time.

(Ayshe, 45-55)

This quote from Ayshe indicates that perhaps she found these experiences overwhelming, which probably leads to feelings of being drained/worn down. The overwhelming nature of traumatic experiences was also shared by Celine:

I couldn’t accept that my best friend was doing this to me. (Celine, 357-359)

Here Celine is referring to the affair her husband had with her neighbour, who she regarded as a best friend. This quote from Celine suggests that she had been having difficulty processing the events. Celine also stated that she was “shocked” (Celine, 165) as a result of the events perpetrated by her husband and neighbour, which is a common reaction to life events that are experienced as seismic. The experience of shock was echoed by Ayshe:

He became a very different person when we started living under the same roof.

So, he was different, he was rude. I was shocked when he threw a bottle at me for the first time. I was so surprised. (Ayshe, 69-72)

This quote illustrates Ayshe’s first experience of domestic violence as an example of a shocking event. Bora’s immediate psychological response to the traumatic events, or his recall of it is likely to differ from the two women’s due to the differences in both the time since trauma and the developmental stage they were at when they went through the adversities. There was no reference to being shocked or overwhelmed by an attempt to make sense of the events in his account; he rather recalled the exacerbating psychological distress in his adult life, which emerged as nightmares, losing his patience and aggression. He stated that the psychological difficulties then became hard to contain
and led him to seek help. For example, here Bora talks about the nightmares that he started having before he sought help:

\[
\text{It was something that came out at night in my dreams, by having nightmares and waking up with a start. (Bora, 180-182)}
\]

It is apparent that these were the psychological symptoms Bora started experiencing a long time after the original childhood trauma, which had stayed unaddressed until his therapy (explored further in subtheme 3d). In relation to earlier times in his development, Bora remembers having suicidal thoughts throughout his teenage years until he joined the army (Bora, 418-422). Suicidal thoughts were a problem that Celine also suffered from (Celine, 260-263).

In addition to Bora, anger was an experience that was also reported by Ayshe and Celine. As Ayshe states:

\[
\text{I was angry, I was tense. For example, I became so angry when I argued with my husband; I could throw things that were around me (Ayshe, 134-136).}
\]

The above quote from Ayshe illustrates her experience of angry and aggressive feelings during the traumatic events that led to the breakdown of her marriage, whereas Celine expresses her anger in the wake of the breach of her trust by her friend:

\[
\text{What pisses me off the most is, my best friend- I mean my husband wasn’t much of a problem because our relationship was already, you know, we didn’t get married being deeply in love and our marriage wasn’t going very well. [...] I will never forgive the woman upstairs until the end of my life, because I was kinder to her than a sister would be. (Celine, 359-364, 405-407).}
\]

Here Celine is expressing her anger towards her neighbour who had an affair with Celine’s husband, and she is clear that she was more deeply affected by the infidelity of
her friend compared to her husband. It could be that Celine downplayed the value of her marriage, perhaps as a way of looking down upon the pain caused by her husband’s betrayal and emphasised the betrayal of her friend. However, it is apparent that the involvement of a friend who she trusted had exacerbated the difficult feelings in Celine.

Distressing psychological consequences are usually an inevitable outcome of events experienced as traumatic. All three participants reported such negative consequences caused by the traumatic events they experienced. This subtheme presented the most common psychological distress experiences across all participants, which included feeling drained, overwhelmed, angry, shocked and suicidal. These emotional experiences can be understood as responses to the unpredictable, uncontrollable and life-changing nature of traumatic events.

4.4.1.4. Subtheme 1d - Ways of coping

Each participant’s account exhibited conscious and/or unconscious strategies, which he/she utilised to cope with their difficulties. Ayshe’s use of humour to trivialise pain was one example:

*Now, I sometimes jokingly say, ‘wish there was someone who stroked my hair, who loved me and thing’ (chuckles). Even though I might say these words jokingly, sometimes I may actually need this kind of attention... (tears up)*

*(Ayshe, 382-386).*

This quote illustrates Ayshe’s frustrated need to be loved, which seems to be a painful experience that she is attempting to manage by means of humour. Reflecting on her life before the traumatic events of her marriage, Ayshe recalled that she “*did not have a very nice life*”, as she “*was longing for affection*” and “*needed attention*” *(Ayshe, 380-381).* Commenting on the lack of love and affection she has felt since her childhood, Ayshe insightfully added that she tended to “*suppress*” this deprivation:
I’m suppressing this a little. Because at times I feel like I need something, but I move away from that feeling. Maybe in the future this suppression will cause a problem or difficulties for me, but there’s nothing I can do. (Ayshe, 404-408)

Here, Ayshe makes it clear that she resorts to suppressing painful feelings as a way of coping and that it bears the risk of becoming dysfunctional in the future, however hints at her lack of readiness to refrain from this suppression. Her tears while relaying this experience of hers and her surprise at crying after not having cried for a while further suggested that she had not been attending to this painful need, as part of her attempts to think positively and move forward (discussed further in subtheme 3e). Several times during her interview, Ayshe said that she struggled to remember the traumatic events of homelessness and domestic violence she had experienced before seeking therapy, as she was “always adjusting herself to future and forward” (Ayshe, 105-106). Such statements by Ayshe suggest that, similar to her description of suppressing her hunger for love, she perhaps wished to force the recent overwhelming experiences out of her awareness. On the other hand, Bora, who reported growing up in a “patriarchal” environment with an oppressive father (Bora, 153, 161) also talked about his use of suppression as a coping mechanism since his early years. He stated that becoming aware of his “defence mechanisms” (Bora, 87-88, 98-99) was an insight he gained in therapy. Here he speaks about downplaying and ignoring the abuse to which he was exposed to as a child:

_I am someone who has had to minimise the oppression and the violence internally, put them on the back burner, and pretend in my mind that I had never experienced them_ (Bora, 103-105)

Bora stated that he usually managed the minimising and ignoring through distraction, by “being absorbed in work” (Bora, 361-362). The following quote illustrates Bora talking
about his army experience, which also seemed to have helped him cope with the traumatic experiences:

*[the thing that made me so happy] in the army, it was err, being in control. So, being in charge of people and having the weapon (Bora, 1192-1194).*

This seemed to be a distinctive coping mechanism for Bora, which was missing in the female participants’ accounts. Bora’s childhood wish to become a soldier, his description of his possessing control and power as a team leader in the army as euphoric experiences (Bora, 1187-1189) and his excitement about violent movie scenes (Bora, 1152-1157, 1182-1184) suggested that identifying with the violence and patriarchal family environment he initially suffered from was a way for him to tackle the sense of powerlessness these gave rise to. Having had no control over the abuse he was exposed to in his childhood, he became a vulnerable, powerless little boy. It appeared that Bora was also guided by his family members’ minds, as he spoke about not having the chance to pursue his preferred life because of the oppressive family environment. Possessing power and being the mastermind in the army perhaps made those difficult feelings inaccessible.

Celine, on the other hand, had a strong self-concept of a well-read, intelligent woman. This was a dominant theme in her account, exemplified by references to doing well in Maths GCSE, reading psychology books, and thus being an informed client. This self-concept could be understood as serving as a protection against the difficult feelings of shame and inadequacy, which she reported feeling in response to her husband’s affair with her neighbour. It also stood out that Celine repeatedly referred to herself and her family as being decent and moral, while marginalising her neighbour, as she states:

...this is a kind of a woman who stabbed her husband in the leg, whose brother was a murderer, so she is a woman who has no fear, who is dangerous. She is a
woman whose younger son was abusing drugs at the age of 16. I have never used drugs in my entire life, neither has my husband. I have a son who is 15, I have another son who is 8. My sons are successful. They are clever. So, in my entire family life, no member of my family has ended up at a police station. (Celine, 214-227)

Perhaps this was a way of preserving her self-esteem and creating a positive social identity in relation to her neighbour, by engaging in such comparison to show her contempt for the neighbour. Marginalising her neighbour through such comparison could also be serving the function of accounting for her betrayal, in an attempt to make sense of an otherwise unjustifiable event. Overall, this subtheme demonstrated that all participants engaged in certain coping strategies such as distraction, and trivialising or ignoring the pain, which helped them to manage the difficult feelings provoked by the traumatic events they experienced.

4.4.1.5. Subtheme 1e – Contextual difficulties: isolation and oppression

This theme explores the experience of the two female participants, who reported feeling lonely and isolated in the wake of the traumatic experiences. Disadvantages of being a migrant came into play most explicitly in this theme. Both women spoke about having “no support” available, as they did not have family in the UK. As Ayshe articulates:

I have no support or family here. Because I’m on my own and I have to do it, I said to myself ‘I can do this, I have to do this even if I have to do it crying or with lots of difficulties. (Ayshe, 301-304 )

This quote from Ayshe conveys a sense of both vulnerability from having no support network, and perseverance due to having no choice other than being self-reliant.
However, she went on to say that the lack of social support intensified the difficulty of the process:

*It has been so hard. If I had a, you know, a supporter over here, people who would help me or people who I could trust, maybe it would have been easier.*

(Ayshe, 317-319)

Here it is clear that coping with her problems alone became a disadvantage for Ayshe. Despite talking about the lack of her family’s support in the context of being in a different country from them, Ayshe commented that her relationship with her family was a strained one, and that she did not receive much moral support from them while she was grappling with distressing life events, as they became estranged from her because she had a boyfriend after divorcing her husband. This also shows additional difficulties Ayshe faced, that seemed to have stemmed from having a more conservative cultural background. Ayshe’s account of her family’s reluctance to provide support suggests that being a migrant was coupled with her tense family relationships, which both contributed to her feeling of loneliness. Celine shared a similar experience with regard to being away from social support:

*you are alone, you are in a country where you are not fully familiar with the laws, err, you can’t tell anyone...* (Celine, 271-273)

This extract from Celine about not knowing about the legal system in the country hints at the sense of disempowerment that in particular a migrant may feel. The sense of having no support available perhaps originated from not only being physically away from their social network, but also feeling alienated from the larger UK context. It is interesting that the theme of isolation was not present in the male participant’s account, which suggests that gender might have played a role in Ayshe and Celine’s feelings of
isolation. Cultural values about women and marriage, such as the unfavourable attitude towards divorced women or the view of the nuclear family as sacred, might have restrained their ability to cope with the traumatic events. The additional sense of vulnerability in the case of female participants might have stemmed from economical, alongside the social and cultural factors. Here Ayshe talks about her anxieties of being a single mother:

\[
I \text{ had fears and difficulties such as how could I stand on my own feet, how could I look after my two kids on my own when I left my husband. (Ayshe, 285-287) }
\]

This quote depicts the vulnerability Ayshe feels regarding caring for her children without support from her husband. It is not apparent here in what aspects of childcare Ayshe is feeling insecure; however her anxiety could be about missing practical, emotional and financial support, as well as the socio-cultural pressures on single mothers. It was striking that both women talked about being oppressed by their husbands upon their decision/idea of a divorce. As Celine states:

\[
[... I \text{ could not divorce the man. In fact, I offered this, had he accepted, had he been a civilised person, [...] He resisted, he threatened me. He said, like, 'you can't leave me, or I'll ruin your life' [...]. (Celine, 919-925) }
\]

This quote from Celine clearly illustrates the severe oppression she was encountering from a very controlling and possessive husband. It indicates that her husband’s view of the world and relationships is perhaps based on a gender bias, the consequences of which Celine is being made to endure. Such sexist oppression is not dissimilar to Ayshe’s experience:

\[
I \text{ was under pressure by my husband. [...]My husband wanted to take my kids away from me when I wanted to leave him. He made a complaint to Social }
\]
Services about me to take my son away from me. So there were insults and pressures; he wanted me to return on the other hand he was insulting me [...].

(Ayshe, 45-52)

Here it is apparent that, like Celine, Ayshe was experiencing restrictions on her freedom to take decisions for her own future, at the hands of a controlling husband. It seems that the two women were seen as belonging to their husbands or marriages, a mentality that robs them of some of the available opportunities to overcome the adverse effects of the traumatic events. Their culture may have played a part in these experiences of the female participants, although it was perhaps not the sole factor contributing to the development of these experiences.

This theme explored the contextual factors specific to the female participants, which caused additional difficulties in the wake of the traumatic events they experienced. Both the sense of isolation due to being a migrant and the oppression experienced at the hands of male violence were dominant themes in the accounts of both female participants.

Overall, master theme 1 explored the participants’ understanding of the impact of the traumatic events they experienced. Analysis of the transcripts showed that the participants commonly reported negative changes in the areas of their sense of self, relationships, and emotional wellbeing. The only indication of a positive change or benefit found as a result of adversity came from Bora, who reported experiencing distinctive robustness under army circumstances. The discrepancy between Bora’s account, which incorporated some report of growth, compared to the accounts of Ayshe and Celine, where any report of growth was absent, could be due to the difference between times since trauma. Participants also engaged in certain strategies that helped them cope with the adversity, which were also explored in this master theme. Finally,
additional difficulties that arose in the aftermath of the traumatic events, encompassing isolation and oppression in the context of the female participants were explored.

4.4.2. Master theme 2: Changes experienced through therapy

4.4.2.1. Subtheme 2a – Stronger self and increased self-worth

Ayshe and Bora described clear changes in their self-expression along with changes in their relationships with themselves. The accounts of both participants reflected an apparent shift from their description of their sense of self in Subtheme 1a; however, Celine’s account overall did not demonstrate any improvement in her sense of self.

Ayshe pointed out that through her therapy, she had become “more confident” (Ayshe, 589) and self-reliant in terms of “achieving financial and emotional stability” (Ayshe, 284-286). Such improved view of self, seemed to be a significant shift from the sense of helplessness she described having felt in the aftermath of the events she experienced.

The following quote demonstrates this new sense of resilience:

*I’m not desperate. No. I don’t have this kind of helplessness now. I’m not helpless. I have the solution! [...] There’s a remedy for everything. (Ayshe, 855-859)*

This quote indicates an enhanced personal strength, presumably through the positive influence of motivation and an improved ability to soothe herself. Bora’s obedience described in Subtheme 1a seemed to have undergone some transformation. A turning point for Bora was the decision to confront his family with regard to the difficult childhood he had to endure. This step undoubtedly required a stronger sense of self on his part. He reflected on realising the need for such confrontation through the insights
gained in therapy and his therapist’s comments. Here he talks about the experience of confronting his parents:

I confronted my dad, mum and sister last time I was there. I shook up the whole place. There were things I had to tell them. Since my childhood… the things that I held within myself and had not been able to say. […] getting to say the things I hadn’t been able to say, about the things I experienced in my childhood was kind of releasing. (Bora, 444-465)

As demonstrated by this quote, Bora had the opportunity to reveal his true feelings about his upbringing for the first time. It is apparent that Bora’s visit to his family home in Turkey with the aim of confrontation was a pivotal event, and an example of the effects of his therapy at the behavioural level. During Bora’s interview, it was difficult to obtain an understanding of the on-going effects of this confrontation, which had recently happened. It seemed that Bora was perhaps still contemplating this experience, which he described as “intense” (Bora, 473-476). He said that he had had no contact with his parents since returning after the confrontation, and spoke about an emotional numbness. Given Bora’s account of feeling “no such thing as emotion” (Bora, 636), it is likely that this event was so overwhelming that, he was not only grappling with making sense of it in its immediate aftermath, but was also struggling to deal with painful emotions it gave rise to, whether it be hatred towards parents or unbearable sadness due to his childhood experiences.

In addition to an enhanced personal strength, both Ayshe and Bora reported increased feelings of self-worth. Ayshe described that she had learnt to “appreciate herself” and “love herself” (Ayshe, 238-239), and went on to talk about not being concerned about external judgement:
I don’t care even if people say things or even if they think differently in an environment. Because their opinions do not really matter as long as I know the right thing, or I accept myself as I am. Not at all important. (Ayshe, 240-243)

This quote illustrates a decreased social anxiety as a result of a more secure relationship Ayshe has with herself. There is a possibility that Ayshe is overemphasising the unimportance of others’ opinions. It was noticeable that the examples of drastic change in Ayshe’s self-confidence at times contradicted how she presented during her interview, as often during the interview, she worried about not being able to “express (herself) correctly” and feeling as if she “cannot help me” and feeling “embarrassed”, which paralleled her description of her experience of shyness in social situations before therapy. This observation suggested that Ayshe was likely to magnify her experience of positive changes perhaps as a way of coping. Aside from seeing herself in a more positive light, another example shared by Ayshe that demonstrated her improved self-worth was prioritising herself:

My priorities have changed. First of all, I am important. Me first. This isn’t selfishness. I am thinking like, ‘I should be good so that I can help my children.’

(Ayshe, 426-429)

It seems that Ayshe is valuing herself more now, compared to the time before therapy. Her need to emphasise that prioritising herself is not equivalent to being selfish suggests that perhaps in the past she had learnt that it was not acceptable to prioritise self-care. This learnt view of herself perhaps reflects the effects of her difficult childhood experiences, as described in subtheme 1d. Bora shared a similar change in the value he placed on himself. He gave examples of a shift from always assuming the blame, as described in the Subtheme 1a, to standing up for himself. As he states:
...now I am someone who answers people back. I answer back those who mess with me and cause me problems. So, whatever someone says, they get their response. Doesn’t matter if it’s offending them or not. (Bora, 328-332)

Throughout Bora’s interview, learning to stand up for himself, as illustrated by the above quote, was a dominant theme. While at times this new way of relating to himself and others appeared positive for Bora’s emotional wellbeing, his thoughts on its potential risks to his relationships were unclear. It seemed as if difficult emotions were being disposed of or transferred on to another person in Bora’s relationships, rather than a more mature relating to both other people and his difficult feelings. It appeared that he might be leaning towards expressing himself without any withholding, as a way of more manageable coping.

It appeared in Bora’s account that, linked to his increased self-worth was also his new appreciation of seeking help. He described how he used to be rather sceptical about seeking therapy; however it seemed that through his own therapy experiences he became more comfortable about requesting help to meet his own needs. Such optimistic view about personal change was absent in Celine’s account. While relaying her story, she was reproachful of herself several times for being unable to “find the strength” to “revolutionise her life” (Celine, 888-900). It was evident how this – perhaps both voluntary and forced - absence of change created a feeling of being stuck, which is clearly illustrated by the following quote:

_I am cornered. I mean, I cannot even flutter._ (Celine, 1515-1516)

Here Celine’s inability to move forward is powerfully demonstrated. This subtheme overall explored the positive changes in the areas of personal strength and self-worth that Ayshe and Bora experienced through therapy. Perhaps the most important reason for the absence of such optimistic view about change in Celine’s account was the on-
going stress she was experiencing. Celine lived below the flat of the woman who had an affair with her husband and also attacked and threatened her. She experienced further incidents with this woman after the completion of her therapy, and was continually confronted with the reminders of these stressful events, as she said, “it’s like day one” (Celine, 473).

4.4.2.2. Subtheme 2b - Improvements in emotional wellbeing

This theme was shared by all three participants. For Bora and Celine, whose experiences were dominated by suicidal ideation, the most effective emotional recovery through therapy was holding onto life. Here Bora talks about the disappearance of his suicidal thoughts and how this has been possible for him:

I don’t have any [suicidal thoughts] now. But when I say I don’t have them- I let people know what I want and I get out of the situation. This has become the case after therapy. (Bora, 998-1001)

The above quote by Bora indicates that the “release” (Bora, 1011) that came with his newly discovered frankness had a life-saving function. Again, the expression of ‘getting out of the situation’ may imply a disposal of a difficult state rather than staying in and resolving it, a strategy that is concerning, as Bora reported that he was not speaking with two of his colleagues. Like Bora, Celine tellingly highlighted the therapy’s effect on alleviating her suicidal feelings:

I was at death’s door, but you know, I got better with the therapies, with support. (Celine, 1489-1490)

This quote from Celine illustrates therapy’s supportive aspect, which clearly powerfully helped her out of her suicidal ideation. Unlike the narratives of more radical change by
Ayshe and Bora, Celine spoke of only managing survival, yet lacking further change. Drawing on an earthquake metaphor, Celine describes:

_There is a hole, there is light, I can get air. I have neither been able to get out of the earthquake and the wreckage, nor died. [...] I can get oxygen, I can see the light, I can feel it but I haven’t been able to get out._ (Celine, 1619-1628)

Celine’s analogy of allowing the light and the air in through a hole represents the hope she was able to have in therapy. Therapy served as a hole, a way out of the darkness and suffocation caused by the traumatic events, yet it was not large enough to rescue her completely. During her interview, Celine expressed her disappointment about the limited duration of therapy. Her inability to escape the wreckage, among other factors, could be due to reserving herself to be saved by therapy. She was perhaps expecting the ‘hole’ to be expanded for her. Undoubtedly, Celine’s feeling of being deprived of therapy was caused by the reality of limited resources besides her own unique needs. In contrast to Celine’s sense of being stuck, Ayshe’s account held a sense of movement. As she articulates:

_I feel lighter than the old times... I feel lighter now. I’m filled with more energy._

_I’m enjoying life._ (Ayshe, 481-482)

Here it is apparent that Ayshe experienced improvements in her subjective wellbeing, as her description illustrates a lift in her mood. It is clear that overall, therapy helped improve emotional distress in all participants, which has been effective in overcoming suicidal thoughts and symptoms of low mood.

4.4.2.3. Subtheme 2c - Attitude to life

Finding a purpose or meaning in life seemed to be one shared benefit of therapy among the three participants. Participants’ accounts indicated that there had been a positive
change in their approach to life. The following extract from Bora helps illuminate this state of embracing life:

\[
\text{[the thing that I am valuing the most at the moment is] life [...] that life is still worth living even with this illness, by getting psychiatric help. (Bora, 1399-1405)}
\]

This quote clearly demonstrates the significant change Bora underwent, from experiencing suicidal thoughts to valuing his own life. It can also be seen here that Bora seems to have a medical understanding of his psychological predicament. Here Celine also talks about finding a reason to live:

\[
[I have learnt] that one has to find a reason to live. Even in the most stressful moment, no matter how depressed you are, you have to find a reason to live. This has been the most important thing I have learnt from this therapy. (Celine, 1423-1427)
\]

This quote demonstrates a more positive aspect of Celine’s account, one that focuses on hope and resilience, a different outlook that was earned through therapy. It is apparent that learning to find a purpose in life in adverse circumstances was crucial for Celine. Ayshe, on the other hand, talked about appreciating previously taken-for-granted moments; for example, here she talks about noticing surroundings as she walks in a park:

\[
...I never used to look around when I took a walk. As I walk through the park now, I look at everything around me. (Ayshe, 447-450)
\]

Being able to appreciate small or taken-for-granted things such as nature shows that Ayshe is valuing her own life more now. In addition to this example, Ayshe also talked about doing pleasurable activities by herself and with her daughter, and treating herself
to gifts. Comparing her life before experiencing traumatic events and her current life, Ayshe reflected on how her previous life was filled with friends and fun, but that she currently felt more fulfilled, with a sense of achievement and pride thanks to overcoming her struggles. Here she talks about this experience:

I am more proud of myself for being able to stand on my own feet. Back then, I was just having fun with friends. I was happy, there was a lot of craziness, and these things can be fun. Whereas now, I really love my children. I’m so proud that I have been able to stand on my own feet. Now, I enjoy life more because I’m proud for achieving something for my children. (Ayshe, 512-519)

This quote from Ayshe demonstrates an enhanced psychological wellbeing characterised by a new meaning found in life, which surpassed the more euphoric feelings of the past times spent with friends. This subtheme showed that all participants experienced an enhanced sense of value of their own lives. In the case of Bora and Celine this is most evident in their improved ability to have the drive to live, whereas Ayshe was able to reflect on the small changes she has been able to incorporate into her life, and the distinct sense of fulfilment she is feeling compared to her past.

Overall, master theme 2 explored the positive changes experienced through therapy as reported by the participants, which broadly encompassed improvements in personal strength and self-worth, emotional wellbeing, and attitudes to life. While an improved sense of self enjoyed by Ayshe and Bora was presented, possible reasons for Celine’s inability to feel much positive change in this area were discussed. It is also clear that all participants experienced improvements in their moods and an alleviation of suicidal thoughts was achieved with Celine and Bora. Finally, this theme demonstrated that all participants had a more hopeful outlook on their current and future life thanks to therapy.
4.4.3. Master theme 3 – Elements of therapy that facilitated change

4.4.3.1. Subtheme 3a – Therapeutic relationship

The therapeutic relationship emerged as one of the most important vehicles for a facilitative therapy experience. All three participants spoke about feelings of trust and closeness, which enabled them to confide in their therapist, and reveal their deepest emotions. Although they all mentioned the challenge of opening up in therapy, particularly in the initial stages, it was clear that as they gradually developed trust, this felt more natural. As stated by Bora:

*I actually don’t cry much in front of others…In general I used to cry in bed, burying my face into pillow. But I experienced this in therapy.* (Bora, 1291-1300)

It is apparent that Bora felt able to trust his therapist, which facilitated an unprecedented emotional expression in Bora’s experience. Despite Celine’s initial struggle with opening up in her sessions (Celine, 1031-1034), here is what she had to say about her trusting relationship with her therapist, at a time when she hardly trusted anybody else:

*I could tell with trust […] I even told things in therapy that I couldn’t tell my mum and dad.* (Celine, 1585-1586)

This quote from Celine suggests that her relationship with her therapist was comparable to such closeness as can be felt between children and their caregivers, and that perhaps she was able to establish such trustworthy relationship with her therapist, which she was never able to have with her parents. For Bora and Celine, it seemed that the professional quality of the relationship provided the trustworthy environment necessary for therapy. Bora describes his relationship with his therapist as a “*patient-doctor relationship*” (Bora, 1145) and states:
I said to myself, if you cannot share what you know with anyone, maybe talking to someone else, a stranger, could help. Talking to someone else, who doesn’t know about one’s life- who doesn’t know about my life and can analyse my life from what I say. (Bora, 904-914)

It seems that Bora felt as if talking to someone who was positioned outside of the narrative of his past was helpful. Perhaps he needed confirmation of the traumatic nature of his experiences by an objective, uncritical eye. Also for Celine, confiding in someone with whom she did not have any prior personal bond was important, alongside the reassurance gained from the therapist’s confidentiality obligation. Here she talks about the trust she gained from the professional nature of the therapeutic relationship:

Who can I trust? An expert whose job is this, someone who I don’t know, who I’m not dependent upon, and psychiatrists, you know, because they are doctors, they have an oath, and that is confidentiality. This is a rule that they are bound with. As a result of this, I requested therapy, I insisted. (Celine, 1023-1028).

This quote demonstrates that, like Bora, Celine has a medical understanding of psychological therapy, to such an extent that she names her therapist as a ‘psychiatrist’, a ‘doctor’. Although perceiving her therapist as the ‘expert’ was likely to have created a power imbalance in the therapeutic relationship, such medical view of the profession seems to have provided Celine with a sense of trust. Aside from the trustworthy environment enabled by the professional relationship, emotional closeness was also a significant element of therapy, which seemed to have served as a safe space for Ayshe and Celine. As Celine describes:

When I talk to, err Mr Deniz, he is a kind of man who makes you feel calm and safe. A bit like, you know, being at your mum’s, dad’s err house, you know, the
warmth of these is unique. You know the feeling of being at home, for example, I felt that in therapies. (Celine, 1575-1583)

This is a powerful illustration of the warm and caring environment Celine felt in therapy. It is apparent that she felt safe in this therapeutic relationship, as she once again refers to the feeling of being at her family home. This feeling of security is also likely to have been caused by being under the care of an organisation serving her community. As previously illustrated (subtheme 1e), Celine felt lonely and missed the needed support due to being away from her home country. So perhaps the sense of familiarity within the community organisation contributed to Celine’s feeling of being at home. Having found a safe space where she could freely express her thoughts and feelings and felt supported in the midst of her traumatic experiences, Celine discussed how she would have liked an extension to her therapy contract, and feeling deprived of therapy upon its termination was a dominant theme in Celine’s account. She was clear that she felt “let down by the government” (Celine, 1166-1167) due to limited funding for the resources, and expressed her opinion about the necessity of longer-term therapy opportunities. Ayshe echoes Celine’s feelings of closeness to her therapist, as she states:

I was feeling very close to Mr Deniz, I even want to see him now. (Ayshe, 745-747)

This quote demonstrates that Ayshe felt an attachment to her therapist at a personal level rather than perceiving it as a professional relationship, as described by Bora and Celine. It was noticeable in Ayshe’s account that her attachment to her therapist created in her a wish to give something back to him. Below Ayshe talks about her wish to change, motivated by her love for her therapist:

I think I love Mr Deniz so much. Being a person as he described I would be... I know, he may not know about this but inside I’d feel I have made him happy
because I would be able to achieve something by taking on board the advice he taught me during our sessions. (Ayshe, 769-773)

It seems that, this wish to perhaps please a parental figure in the transference motivated Ayshe to make changes in her life. It was also evident that Ayshe had internalised the figure of her therapist, which helped her soothe herself in times of distress after her therapy ended. She described how she initially struggled to make sense of her therapist’s comments in highly emotional moments during sessions, but was able to remember and make use of these afterwards, when the dust settled. Below she talks about this experience:

[…] when you experience another thing or re-experience the same thing you can then remember what the doctor said and it can make you feel better at that moment. (Ayshe, 623-628)

Here Ayshe makes it clear that she was able to use the internalised soothing therapist beyond her sessions, when she experienced similar distressing moments. It can also be seen that, like Bora and Celine, Ayshe refers to her therapist as a “doctor”, suggesting that perhaps she also has a medical view of therapy and sees her therapist as the expert.

This subtheme explored the different ways in which the participants perceived and utilised the therapeutic relationship. It demonstrated that, while Ayshe and Celine became attached to their therapist, which seemed to have allowed them to use the therapeutic relationship in ways that were helpful for them, Bora spoke exclusively about a professional relationship. This could be caused by the fact that, as a man Bora was seeing a male therapist, and societal prejudices about closeness of two men may have impeded Bora’s developing intimacy towards his therapist. However, despite experiencing the therapeutic relationship at different depths, it is apparent that all three participants were able to trust their therapist and be truthfully expressive during their
sessions, which all of them seem to have appreciated. Moreover, although all participants viewed therapy through a medical lens and their therapist as the expert, this did not seem to have impeded the trustworthy relationship they formed with their therapist. Conversely, it seemed to have facilitated it in the current sample.

4.4.3.2. Subtheme 3b – Techniques to alleviate anxiety

Techniques to help alleviate anxiety, such as breathing exercises or distraction, were among the most readily remembered by Ayshe and Celine, in response to my inquiry about the helpful elements of therapy. As Celine recounts:

[…] taking deep breaths, like, when I bump into the woman, I am going on the lift, she enters the building, standing on the side and taking deep breaths when I see her, like, focusing on something else. (Celine, 1190-1196)

Here it is clear that these practical techniques were useful for Celine to help her cope with anxiety, as she was confronted with the cause of her anxiety almost on a daily basis. Below, Ayshe describes the breathing techniques as crucial:

There was a breathing exercise. That’s crucial because when I feel helpless due to being unable to breathe, that exercise is crucial. (Ayshe, 810-812)

This shows that learning these techniques in therapy and applying them outside of therapy perhaps benefitted Ayshe beyond helping her anxiety, as these also guided her out of her helpless state when in distress, restoring her faith in her own capacity to soothe herself. Both Ayshe and Celine, unlike Bora, described a stronger attachment to their therapist. Remembering these techniques taught by their therapist perhaps replaced the therapist for them, in distressing moments. Ayshe and Celine’s report of these techniques as helpful suggests that, alongside establishing a trusting relationship, which was clearly felt as vital for effective therapy among all participants, more practical
techniques taught during therapy were easy to remember and became vital through not only offering practical help, but also providing holding support during distressful times after therapy.

4.4.3.3. Subtheme 3c – Emotional expression

It was evident in the accounts of all participants that establishing a good therapeutic relationship enabled freer emotional expression, which seemed to have been facilitative, through the release of difficult emotions, or an unprecedented expression of the true self. The following quote reflects Ayshe’s experience:

"… after the therapies, talking to Mr. Deniz, the things I told him, which I wasn’t able to tell anyone else, later felt normal to me, you know when I voiced them, you know, there were many things that I could not tell anyone. When I got to voice and tell about these, later on they started to feel normal to me. Ok, that’s what’s happened, and it is over now. Now, I am, like, looking ahead, meaning I am erasing those memories (Ayshe, 108-115)."

For Ayshe, talking about her experiences in therapy seemed to have neutralised the traumatic events and perhaps made their effect less overwhelming for her. This quote also demonstrates Ayshe’s eagerness to leave the events in the past and look to the future. Bora reflected on challenging, emotionally charged moments in therapy, for example, he described, “I had my words stuck in my throat. I had moments in which I cried while talking” (Bora, 1284-1288). However, he added that, “it had to happen that way” (Bora, 1290). Bora went on to say:

I felt release when I cried. (B, 1346-1347)

Bora experienced emotional expression through crying in the presence of another person for the first time, and it is apparent that this experience was therapeutic for him.
Similarly, Celine spoke about having had a “release” in therapy (Celine, 1044), which, she described, was achieved through being “able to express my emotions, to express myself, put myself out there.” (C, 1045-1046) Celine also seemed to have benefited from having a space where she was able to freely be herself, as she states:

[...] He was asking questions, I was telling what I wanted to tell him. There weren’t any limitations to my emotions, my behaviours. I cried if I wanted to cry, I talked about my anger if I was angry.” (Celine, 1347-1351)

This quote demonstrates that, for Celine, who reported feelings of loneliness and isolation (subtheme 1e), having a safe space where she had the opportunity to freely be herself and express her feelings with honesty was crucial. Such an opportunity might be particularly vital for a woman facing intimidation in the context of their gender, as described for Celine and Ayshe in subtheme 1e.

This subtheme demonstrated that all participants benefited from free expression of their thoughts and feelings in therapy sessions. For Ayshe, it seemed that such expression created a feeling of being able to manage the effects of multiple distressing events better. Bora and Celine made use of unrestricted emotional release, which was unique experience for both.

4.4.3.4. Subtheme 3d – Insight gained through therapy

The theme of insight gained through therapy was most evident in Bora’s account. He spoke about how he became aware of suppressing his pain as a defence mechanism, which he developed at a young age. It seemed that the insight gained led to some behaviour change in Bora’s life. His therapist’s suggestions about the importance of revealing his thoughts and feelings for his wellbeing prompted him to be more expressive of his true feelings in his relationships. Bora also specified that his therapist had suggested that confrontation with his family would also be important. This
discussion with his therapist seemed to also have determined Bora’s later actions with regard to deciding to pay a visit to Turkey to carry out this confrontation with his family. Here Bora talks further about the insight he gained:

    [...] my dad, my mum, my aunt used to impose things upon me though. So, I
don’t like impositions. I saw this after I had therapy. I look for a place to hide
when someone imposes something upon me. (B, 1121-1128).

It is evident in the above quote that therapy helped Bora know himself better. Here Bora quite illuminatingly describes therapy as an awakening experience:

    [it was helpful] to talk to someone who didn’t know about my life, becoming
self-aware, and kind of being woken up. (B, 1272-1274)

It is clear that here Bora is talking about the effect of the insight he gained into himself thanks to therapy. Comparable to Bora’s experience of awakening, here Celine is using the analogy of a therapist putting glasses on a client’s eyes:

    Psychiatrists, therapists never say ‘do this, do that’. You find out how you will
be directed into the route in which you will do things. They show you how you
need to do it. It is a bit like, err, the therapy, the therapist putting glasses on
someone who cannot see clearly. He puts the glasses on and you decide how you
will treat [the problem]. (C, 1442-1455).

This analogy implies achieving a greater clarity of mind in therapy, through the therapist’s relevant and useful interventions. Celine also described that she was able to “dig deep” (C, 1353) and speak about her past with her therapist, which she “was able to tell truthfully” (C, 1357). Such opportunity to reflect on her past is likely to have led to increased self-awareness in Celine.
As discussed in subtheme 1d, Ayshe demonstrated good insight about feeling deprived of her mother’s love and attention, and how this is affecting her current life. She was also able to reflect on her current life in comparison to her life in the past, as discussed in Subtheme 2c, which also showed good self-awareness. Here she is being self-reflective:

...I always have a child living inside me, that is different, it sometimes goes crazy. So, I didn’t have a very nice life, I mean, I was longing for affection. I needed attention. I actually ran away from my mother. In fact, marrying my husband was actually trying to escape from my mother. (A, 373-378)

This quote demonstrates a helpful awareness of the effect of her childhood experiences on the choices she made in adulthood. Although Ayshe’s account showed multiple examples of self-awareness, it was not possible to know based on the current interview whether this insight was gained through therapy. However, it is highly likely that at least some of what Ayshe discussed here would have been reflected on in her therapy.

This subtheme explored the insight participants gained into their own lives. It seemed that, through reflecting on his life, Bora has formed a meaningful narrative comprising his past experiences and his responses to these. The more apparent importance of insight for Bora compared to the other participants was perhaps because he experienced the traumatic events that led him to seek therapy a long time ago, in his childhood. Therefore, reflecting on these experiences and making sense of them in his adult mind might have become the central focus of his therapy. It seemed, however, that Celine made good use of the reflections she made with her therapist and compared the experience of being helped by her therapist to find her own direction to seeing more clearly. Ayshe also showed good self-awareness, which was perhaps enhanced by her therapy sessions.
4.4.3.5. Subtheme 3e – Holding onto life: finding a way forward

This subtheme looks at the different ways in which therapy seemed to have helped the participants restore motivation to look forward to living their lives in more satisfying ways for themselves in the future. It was noticeable that hope instilled by the therapist was significant for Ayshe:

Mr Deniz used to tell me that I would be good in the future, that I could achieve things and I was a very strong person. (A, 771-773)

As discussed in the subtheme 3a, Ayshe seemed to have had a transference relationship with her therapist, in which the therapist represented a holding, protecting figure. It seems that in the type of attachment Ayshe developed with her therapist, the therapist’s reassurance about and his belief in Ayshe’s personal strength and her coping capacities was crucial. In Bora’s case, it seemed that therapy identified a pathway for the future, which emphasised the helpfulness of emotional expression and confrontation. Here Bora recalls his discussion with his therapists about the urgency of change:

What was helpful in therapy was seeing that I had to do it - I mean, err, that I had to do it, things would get worse if I didn’t. Seeing that I didn’t have any other choice than change and Mr Deniz’s articulating this, that I would get worse and eat myself up if I didn’t verbalise things, that I had to let my emotions, didn’t matter much if it went down well or not. (B, 1059-1079)

This quote demonstrates that Bora’s new way of relating to others with his new frankness was brought about by his motivation to take precautions against worsening in the future. It is apparent that seeing change as the only way out was the primary drive that brought it about. A similar kind of motivation was also cited by Ayshe as a vehicle for change:
I had to draw a roadmap and be determined and move on on that path I had drawn for myself. I was either going to get lost or be strong and win my kids and move on to live with my kids. (A, 298-301)

Both Bora and Ayshe here share a feeling of being obliged to bring about change in their lives, and having ‘no other choice’, which seems to have been the primary drive that prompted change in both of them and possibly led them to seek therapy in the first place. In both participants’ accounts, the risks of a lack of change are powerfully envisaged. Bora talks about eating himself up, and Ayshe talks about getting lost and losing her children (having been threatened by her husband). It seems that both had imagined quite grim consequences that involved utter destruction.

For Celine, who was struggling with suicidal thoughts for the duration of her therapy, identifying a purpose in life was vital, therefore the theme of holding onto life stood out in her experience of therapy. Accordingly, here Celine describes how focusing on her children with her therapist, as representing a purpose and meaning she had in life, was vitally useful:

Because that was the thing I needed to hold on to, that was my soft spot, and I have been kept away from suicidal feelings by being made to hold on to this. So, ‘you love your children, you have to live for them. They need people who live for them, they need you.’ And we stayed on these feelings a lot in therapy. (C, 1223-1234)

It is shown by the above quote that Celine’s therapist worked with her to focus on her meaning and purpose in life, which was protective against her suicidal ideation. Overall, this subtheme explored how therapy helped participants to proceed from an anxious, helpless position to bearing hope for survival (either literally or psychologically). It showed that better futures were imagined and meanings for life were identified in their
sessions, which seem to have played a key role in the participants’ benefitting from therapy.

4.4.3.6. Subtheme 3f – Language and culture

Regarding the issue of language and culture, participants commonly reported a clear benefit of seeing a therapist who spoke the same first language as them. The participants’ responses once again pointed to the potential concerns about having therapy either in a language in which one does not have enough proficiency, or through an interpreter. Being able to communicate, through language, the exact meaning they wished to convey to their therapist was seen as an important benefit of having therapy in their mother tongue. For example, here Bora clearly states his reason for preferring to talk to a therapist in his first language:

Because he is someone who would understand you the most. It’s good to speak the same language, to know what he’s saying, and to know what he is going to get from a word you use (Bora, 973-976)

Here it seems that Bora felt he could communicate better with a therapist who spoke his mother tongue, as demonstrated by his reference to the importance of a mutual understanding with the therapist of the essential meaning of a word. This is a benefit that may not be enjoyed when working with an interpreter due to the difficulties of translation, in which some meaning may be lost. A similar reference to a shared understanding was made by Celine:

You feel more comfortable when you speak the same language. Because then you are able to make use of some idioms more comfortably, or, I don’t know, some slang words… (Celine, 1276-1281)
Use of idioms in therapy was helpfully pointed out by Celine as something that can foster the therapist’s understanding of the client. On the other hand, Ayshe touched on the importance of culture, as she articulates below:

*I had previously consulted another doctor through an interpreter, but I could not express myself...I think that was because of the cultural differences. They understood what I said in a different way.* (A, 659-665)

Here Ayshe demonstrates that cultural differences, such as differences in meanings of certain concepts, may have as big an impact on communication as language issues, and that generally translation alone may not be enough.

Therefore, this subtheme clearly demonstrated the participants’ understanding of the advantages of having psychological therapy in a linguistically and culturally familiar environment. They felt that speaking the same first language with their therapist and having similar cultural backgrounds contributed vastly to their communication with their therapist and to the benefits they had gained from therapy. Feeling clearly understood by their therapist is certainly expected to contribute to the overall quality and depth of the therapeutic relationship.

Overall, Master theme 3 explored the elements of therapy that were helpful in facilitating positive change for the three participants. Most prominent therapeutic elements that emerged from the analysis were the therapeutic relationship, practical techniques that helped alleviate anxiety, emotional expression, insight gained through therapy, identifying a purpose and a way forward in life, and sharing a common language and culture with the therapist. The quality of the therapeutic relationship was a dominant theme for all participants. All three participants spoke of having been able to develop a trustworthy relationship with their therapist, which in turn enabled them to express their thoughts and feelings freely, and explore their experiences in depth. In
addition, it seemed that trusting that they could overcome challenges in the future became a helpful lesson they learnt from therapy. With regard to the language and culture, all participants pointed out the importance of having culturally sensitive therapy, in their own language, rather than a language in which they struggle to have good command, or through interpreters. It was evident that, while techniques to alleviate anxiety were only talked about by Ayshe and Celine, insight seemed to be critical for Bora. One reason for this divergence between participants could be the time elapsed since trauma. It could be that for Ayshe and Celine, who had recently experienced traumatic events when they started therapy, work in therapy focused on managing difficult emotions that had not been processed. Although Bora also sought therapy due to his worsening emotional states and nightmares, his traumatic experiences were of the past and, perhaps for him, the importance of therapy was more about contemplating the events of the past, to make sense of them in the context of his current life and imagine a new future with a new life narrative that integrated his past and present. This need may have made insight a more helpful element for him.

4.5. Discussion

This section will discuss the main conclusions that can be identified from the findings of this study, concentrating on those that most illuminate the research questions and the focus of the present research, that is, the experience and facilitation of PTG in the Turkish-speaking immigrant population of London. The analysis of the interview transcripts resulted in the creation of three master themes, which were seen as addressing the research questions: ‘Impact of traumatic events’, ‘Changes experienced through therapy’ and ‘Elements of therapy that facilitated change’.
The first master theme, ‘Impact of traumatic events’, explored the counselling clients’ experiences of any kind of changes that happened to them as a result of the traumatic life events they had to endure. Broadly, changes were described in terms of deterioration in personal strength and the view of the self, a distance in relationships, psychological distress, coping strategies triggered, and contextual difficulties, such as isolation and oppression, experienced exclusively by the female participants. The second master theme, ‘Changes experienced through therapy’, explored the areas in which participants reported changes they felt they had as a result of their therapy experience. Positive changes were identified in areas of self, emotional wellbeing and attitude to life. Themes about changes in ‘self’ included feeling stronger and having an increased self-worth. Participants also talked about feeling better through therapy; those with suicidal ideation were assisted in that they could eliminate and move away from acting on such thoughts. Finally, they felt more able to appreciate the value of their own life. The third master theme, ‘Means by which therapy was facilitating’, looked at those elements of therapy that were experienced as helpful and as enabling the positive changes identified by the participants. The analysis of the participants’ accounts suggested that a robust, positive therapeutic relationship was formed between the participants and their therapist, seemingly facilitated by the shared language and culture. The trustworthy space allowed participants to be expressive of their true thoughts and feelings, identify a purpose in life, and engage in useful self-exploration. Gaining new insights was probably the vehicle that was most facilitative for growth experiences. In addition to the more exploratory side of their therapy, it was striking that practical techniques to alleviate anxiety was among the most memorable useful elements of therapy. It seemed that, for some participants such self-help techniques had vital importance, and represented an aspect of self-reliance in distressing moments.
In addition to the psychological distress caused by trauma, findings suggested that the participants in this study experienced posttraumatic depreciation, which is defined as negative changes in the domains identified for posttraumatic growth (Baker, Kelly, Calhoun, Cann, & Tedeschi, 2008). Previous research defined posttraumatic depreciation by means of negatively worded PTGI items, such as having less of an appreciation of the value of own life, a diminished feeling of self-reliance, a greater sense of distance from others, being less certain that one can handle difficulties, and so forth (Oshiro et al., 2019). In line with this, the participants of this study reported a decreased personal strength and self-reliance and little belief in their coping abilities in the face of the events they experienced. Increased distance in relationships was also extensively reported, which can be viewed as representing PTD in the area of relating to others. It could also be argued that, part of this experience represents a decreased naiveté (McMillen, 2004), indicating an enhanced ability on the part of the participant to set boundaries that are protective of their individual wellbeing.

Previous research suggested the possibility of concurrent and independent experience of PTG and PTD after trauma (Baker et al., 2008; Cann et al., 2010; Kunz et al., 2017), meaning that individuals may experience both PTG and PTD in the same domain. Among the participants of the current study, the clearest indication of experience of growth before receiving therapy was cited by Bora as having been strengthened by his early traumatic experiences. This can be viewed as representing PTG in the domain of ‘perception of self’, which encompasses feeling stronger and more self-reliant in the face of future adversity (Tedeschi et al., 2018). It was striking that, for Bora, the positive changes in this area appeared exclusively in the army environment, certain qualities of which resembled the environment he grew up in, and where he had the opportunity to become the one who was controlling, as opposed to the one who was being controlled. Perhaps Bora did indeed present with both PTG and PTD in the same
area of self-perception, as he also spoke about a sense of a ‘crushed’ self, which led to his submissive behaviour in relationships.

As discussed in Chapter 2, the helpfulness of social support in coping with trauma and experiencing growth has generally been supported in literature (Dursun et al., 2016; Kroo & Nagy, 2011; Linley & Joseph, 2004). Two participants in the current study, Ayhe and Celine spoke of lacking social support in this country, due to being away from their immediate family and social network, as well as being an outsider in their present society. This difficulty might not only have exacerbated their predicament after experiencing traumatic events, but it might also have impeded their process of recovery and growth.

All participants in the current study reported mainly positive experience of therapy. The positive changes described as brought about by therapy in the area of ‘self’ tap the ‘personal strength’ domain of PTG (Tedeschi et al., 2018). One participant, Ayshe, also talked about some impressive changes in her self-esteem and self-confidence. The changes in participants’ relationships with themselves seemed to have had some behavioural correlates in their life, such as prioritising own wellbeing or being more assertive. These changes represent the changed priorities and new possibilities described in PTG literature, which tap the ‘philosophy of life’ domain of PTG (Tedeschi et al., 1998; Tedeschi et al., 2018). Here, as necessitated by the ‘phenomenology’ principle of IPA, staying close to and trusting the participant’s experience are important. Ayshe, for example, has experienced concrete changes in her perception of self that facilitated her adjustment in the process of recovery from trauma. At the same time, it is possible to view part of the changes she described as brought about by the illusory aspect of PTG, meaning that it is likely that Ayshe was experiencing some of the positive changes at a heightened level that served as a coping mechanism (Calhoun & Tedeschi, 2004;
Helgeson et al., 2006; Zoellner & Maercker, 2006), perhaps helping her to stay motivated to maintain her process of recovery. Drawing on Zoellner and Maercker’s (2006) Janus face model, such experience of growth could be considered as having both constructive and self-deceptive/illusory components. Similarly, there was a sense of Bora’s new frankness being rather disproportionate, as he spoke on several occasions of not caring about offending other people. This seemed to have the potential to cause him relational problems. Again, the extent to which this self-development represented something of constructive/self-transcending growth (Zoellner & Maercker, 2006) or a rather temporary coping mechanism through avoidance of the difficult feelings that arise in him in his relationships with others is debatable. It seemed that, in Bora’s case, his experience of positive change served to demonstrate to him that it is possible to have a new path and maintain his life despite his difficulties. These findings point to the necessity of taking into consideration the function that reporting growth serves in the specific context of each individual, such as coping or conforming to an expectation of healing with time and therapy intervention.

Positive changes in the area identified as ‘attitude to life’ represent the ‘appreciation of life’ and ‘new possibilities’ domains of PTG (Tedeschi et al., 1998; Tedeschi et al., 2018), through improvements in the view of life for all participants and appreciation of previously taken-for-granted moments especially in the case of Ayshe. Comparing her life before and after her recent adverse experiences, Ayshe was clear that overcoming challenges in life and emerging stronger and more self-reliant out of her struggles provided greater satisfaction to her more than the easier, fun times. This phenomenon is in line with Linley and Joseph’s (2004) alignment of PTG with psychological wellbeing (which encompasses meaning in life, contentment with goals etc.) rather than subjective wellbeing (feelings of happiness). Another dominant theme was identifying a purpose for existence, which can be understood as representing both coping, and perhaps the
beginning of something more than coping, that is, growth in the broad area of life philosophy.

Positive changes reported about personal strength, self-worth, assertiveness, life-style, world view and priorities were in line with the areas of PTG described in a sample in Turkey, following a breast cancer diagnosis (Kucukkaya, 2010). It was noticeable that, participants in this study described deterioration in their perception of self and the value of life and subsequently relayed the improvements in these areas through therapy. However, the deterioration in trust and intimate relationships was not an area they referred to, when they discussed their experience of the contribution of therapy. This is in line with the researcher’s previous observation during quantitative interviews, of participants’ reluctance to cite “positive” changes in this area, as laid down by PTG literature. This finding is contradictory to the findings of Kucukkaya (2010), who reported improvements in close relationships following a breast cancer diagnosis.

Previous quantitative studies with Turkish populations generally focussed on overall PTG, and did not report any absence of PTG in the domain of relating to others. One possible explanation for this discrepancy could be the relatively low levels of social support the Turkish-speaking immigrants would be expected to have in their current contexts, as highlighted by two participants in this study. Previously reported PTG in the area of relating to others usually included reports of realising how much love and support was available from loved ones, resulting in closer relationships with them. Perhaps the unique circumstances related to living outside of one’s home country have produced this result.

Helping the client manage emotional difficulties primarily, especially in the beginning of therapy, has been recommended in PTG literature (Calhoun & Tedeschi, 2004; Joseph et al., 2012; Tedeschi & McNally, 2011). Current findings suggested that
assisting the participants’ coping with overwhelming feelings was achieved by facilitating emotional expression and practicing relaxation techniques. Being able to freely express their thoughts and feelings in the sessions also created the opportunity for reviewing their life narratives and creating new meaning (Calhoun & Tedeschi, 1998). In this regard, therapy provided a space which enabled new insights to be gained, which was experienced by Bora as “being woken up” and by Celine as “the therapist putting glasses on” her. Furthermore, the therapist’s instilling hope not only enabled the participants’ survival in the wake of the most distressing of feelings, but also made self-development possible through identifying purpose for moving forward. In line with this, Roepke and Seligman (2015) previously suggested that the therapy space can widen the client’s perspectives on new goals, sources of meaning and roles.

Current findings also showed that the therapeutic relationship was highly relevant in contributing to the positive outcomes that the participants had after therapy. This is a highly expected finding, as the therapeutic relationship is accepted among the essential elements of therapy that determine positive outcomes (Horvath et al., 2011; Norcross and Wampold, 2011). In relational approaches, particularly the humanistic ones, a more equalitarian therapeutic relationship that bears human-to-human contact is advocated (Mearns & Cooper, 2005), which is usually in disagreement with a medical view of psychological predicament and therapy. However, it seemed that all participants in this study saw therapy through a medical lens, in which perhaps culture played a part. Turkish culture is said to be a hierarchical, high power distance culture (Koc, 2013), which means that the less powerful members of the society and organisations expect and accept that power would be unequally distributed and reliance of the less powerful on the powerful figures would be considered appropriate (Hofstede, 2011; Koc, 2013). Therefore, it is highly likely that the participants in this study more readily saw the therapist as being in a position of power, as an authority, compared to the mainstream
population in the UK. This was a striking divergence from the emphasis on equalising power and seeing the client as the expert, which is dominant in the psychotherapy literature. Perhaps for the current population, the expert position of the therapist is a source of assurance, and most clients may find it unusual or even unhelpful to be seen in the expert position by their therapist.

In addition to the vehicles for positive change that were reported by the current sample, there were some obstacles to change identified in the participants’ accounts, such as the limited length of therapy, and Celine’s difficulty with changing her current circumstances. Besides contextual difficulties she faced, Celine seemed to be reluctant to make changes in her life perhaps because she felt that as the sufferer of the events, she should not be forced to have further disturbances in her current life, and perhaps wished to keep her resentment with her neighbour alive. The social identity theory (Tajfel, 1981) states that individuals tend to categorise other people in social groups and attach positive stereotypes for their in-group in an attempt to boost their self-esteem. Not severing all ties with her neighbour and engaging in social comparisons with her might be serving to maintain Celine’s self-esteem. On the whole, the findings indicated that all participants’ overall experience of therapy was positive. At the same time, all participants talked about certain unresolved issues which seem to have the potential to be worked through in further therapy, be it the early and current relationship with parents, complications of recent behaviours, or unresolved feelings from recent traumatic events.

4.5.1. Strengths and limitations

This is the first qualitative study that sought to give voice to Turkish-speaking therapy clients in London, to illuminate their lived experience. It has been possible to capture the details of lived experiences of the current sample, which were not captured by the
pre-determined quantitative questions. The small sample size enabled the exploration of each participant’s experiences in more depth than a larger sample size would have allowed. Interviewing participants in their first language added further strength to the study in terms of participant understanding, involvement and interaction within the interview stage. However, there are certain limitations to the inferences that can be drawn from this study.

First, divergences in the sample existed, especially in the time that had elapsed since trauma. Bora’s experience was developmental trauma, whereas the two women experienced traumatic events in their adult lives. They may have also experienced a traumatic event in their past, however the focus of the interviews was the issues they worked on in therapy. As a consequence, a long time had elapsed since Bora’s traumatic experience, whereas for Ayshe and Celine it was a recent event. The data could have been different if all participants had more homogeneous experiences, for example a recent, single traumatic event.

Related to the previous limitation, a second limitation was the possibility of each participant being at a different point in their own trajectory of post-trauma experience (Tedeschi et al., 2018). It is difficult to ensure homogeneity in this regard, as every experience is unique. It could be argued that if more time had elapsed for Ayshe and Celine before their therapy, they would have perhaps processed some of the traumatic experience with their own means and experienced growth in some of the areas described. Equally, it is likely that, in the future, some illusory aspects of growth could give way to ‘actual’ growth, or they could experience further growth, or in other areas. A less optimistic picture would also be conceivable.

Finally, while having the opportunity to interview the participants in their first language was a strength of the study, this meant that their quotes later had to be translated to
English. Carrying out the data collection in Turkish and the analysis in English posed a challenge in terms of conveying the original meaning communicated by the participant, because of the differences between the two languages.
Chapter 5 - General Discussion

This research sought to explore the Turkish-speaking therapy clients’ experiences of the impact of trauma and contribution of culturally-sensitive therapy. It also sought to assess the effectiveness of therapy in promoting PTG in this client group. This chapter will present an overview of the overall findings of this research. It will then conclude by providing thoughts on reflexivity and reflections on the research process and outcome.

5.1. Overview of findings from studies 1 and 2

The study 1 sample had a relatively low mean PTG, as measured by the PTGI. PTG was found to be significantly associated with presence of meaning (positive association) and depression (negative association). Findings about meaning in life suggested that age predicted the presence of meaning, in that older participants reported less presence of meaning in life. No significant change was observed in PTG or other outcome variables after therapy, and there was no significant relationship between posttraumatic stress and growth. This could suggest that the two phenomena occur independently of each other, although it is difficult to draw inferences from the current findings. Participants in this research predominantly used separation from the host culture as their acculturation strategy, and it has been discussed in Chapter 3 that this could be influenced by the language barriers and isolation due to the gender roles or the relatively low education level that applied to the majority of the participants. The study 2 participants’ overall understanding of their experience of impact of traumatic events indicated that negative consequences prevailed in the aftermath of the traumatic events they experienced. These negative consequences were experienced in the areas of their sense of self and self-
worth, relationship with others, emotional wellbeing, and additional context-dependent difficulties, arising particularly for women. However, the participants viewed their therapy experience in a good light, and recognised some positive changes it facilitated. Positive changes that were brought about through therapy included some growth experiences that have been described in PTG literature, broadly in the areas of perception of self and philosophy of life. Discussion raised the possibility that these positive changes were also serving a function of helping the participants cope and instilling hope for further healing. In addition to these positive changes, it was clear that alleviation of distress and suicidal thoughts was also achieved through therapy. Contrary to previous research, a theme of greater intimacy in relationships did not emerge as a change in the area of relating to others. It has been discussed that this could be due to cultural differences, as well as the isolation and lack of social support that the current population might be experiencing. A trustworthy therapeutic relationship emerged as an essential element of therapy, which enabled free emotional expression, exploration of life events leading to insight, and identification of purpose and meaning of life in the sessions. Sharing the same language and culture seemed to have contributed a great deal to the development of the trustworthy and productive therapeutic environment. It was also indicated by the study 2 findings that, probably due to cultural values, the current sample viewed the therapist as a respected expert, from a more paternalistic viewpoint.

Findings also suggested that, although individual participant accounts seem to indicate benefits from therapy, the length of treatment might be too short for most clients to truly embody the benefits gained or achieve deeper-rooted changes. Deeper-rooted outcomes might be hard to achieve especially in terms of PTG, as it requires cognitive change through reviewing old and new life assumptions. Another relevant point here is the issue of client readiness and the time needed for therapy benefits to materialise. The account of one study 2 participant, Ayshe, showed that the effects of therapy were noticed after
some time had passed. Therefore, outcome measures administered immediately after the therapy’s ending may fail to capture all of its effects.

The quantitative study result of no change in PTG and other outcome variables by the end of therapy was a rather unexpected finding, and was in disagreement with the qualitative study findings. Some possible reasons that may have caused this result have been discussed, such as a possible aggravation of scores for various reasons, a deliberate or unconscious hesitation to report improvement due to concerns about losing income from welfare benefits, a limitation of short-term therapy especially in complex cases, study limitations and limitations of quantitative outcome measures in reflecting any felt change. While the qualitative study presented the details of participants’ felt experience more clearly, it is also worth bearing in mind that the participants who came forward for the qualitative study were willing to talk about their experiences and were likely to have left the service with a relatively positive experience.

5.2. Implications for counselling psychology practice

The inconclusiveness of the findings of study 1 brings to the fore questions about the accuracy of quantifying clients’ distress and outcome of therapy, and reminds us that while the use of outcome measures may sometimes be helpful for the purposes of monitoring change, they should not be presumed to be a correct reflection of client experience, the subjectivity and uniqueness of which are emphasised in counselling psychology. The findings of study 1 nevertheless suggest a relationship between PTG and meaning and depression. They provide tentative support for the suggestion that depressive feelings may be seen to improve with experience of growth, and also for the close association between meaning in life and PTG. Although these results are tentative
and cannot imply any causation, they point to potential implications of recognising and promoting PTG in counselling sessions. The study 1 results also suggested a decreased meaning in life with age, which underscores the importance of working on existential issues within counselling with the older generation. The findings regarding the acculturation strategies of the present sample suggest that counselling psychologists working with this client group should also be aware of the difficulties they face with regard to integration to the UK, and the psychological impact the additional complications of this isolation cause.

The findings of the qualitative study suggest that Turkish-speaking clients can benefit from receiving culturally-sensitive therapy. Experience of posttraumatic growth in the areas of the perception of self and the philosophy of life through therapy was evident, and the exploration of the elements of therapy that helped the participants make progress overall reinforced the universal factors of therapy that were found to be helpful in previous research. It suggested that creating a therapeutic environment in which new insights can be gained through the exploration of old and new life narratives alongside working to alleviate emotional distress would be fruitful in promoting growth related experiences. The specificity of the underlying functions of the experience of growth for each individual’s unique circumstances also became relevant in the study 2 analysis, which demonstrated the supportiveness of the perception of growth in some cases. Therefore, being mindful of the possibility of PTG (Joseph. 2009) and acknowledging it with the client as it manifests in the account of the client may raise their awareness of the positive ways in which they may have changed. This would instil hope for new possibilities for the future, which can be of vital importance for the client’s current functioning. The helpfulness of the mother tongue and the convergence of cultural backgrounds within therapy relationships was emphasised. Finally, the findings demonstrated that the clients from this population tend to look up to their therapist as
the expert and expect to be directed by their therapist. This is generally at odds with counselling psychology’s emphasis on an egalitarian therapy relationship (Cooper, 2009); therefore practitioners working with this cultural group may notice a discrepancy between the client’s and their own expectations from the therapeutic relationship. However, adapting to the client’s needs rather than favouring a single approach to therapy is also advocated by many theoretical models within counselling psychology (e.g. Cooper & McLeod, 2007; Faris & van Ooijen, 2012), and therefore recognising cultural differences in the understanding of psychological therapy would be important for a helpful therapeutic relationship.

5.3. Implications for policy

The findings of the present research may have some implications at the policy level. Study 1 showed that the current sample was quite separated from the rest of the society in the UK. In order to further promote multiculturalism in the UK, policies – such as the ‘Integrated Communities Action Plan’ (HM Government, 2019) - should address participation of immigrants in the larger society by promoting work opportunities with members of the larger group and language learning (British Future, 2019). It is known to the counselling service staff that many service users have issues with literacy, and the majority of them, especially the elderly, have had little formal education. Therefore, although language barriers appear as the most significant problem, interventions in this area hardly become fruitful for most service users. Moreover, psychological problems affect concentration of many of them, impeding their ability to acquire a new language. Peer learning could perhaps be a more effective method. The language barriers and issues with integration also emphasise the necessity of the provision of psychological
interventions in their mother tongue, especially for the most isolated members of this population.

Also considering that Turkish-speaking therapy is not readily available in statutory services, it seems that the opportunity of longer-term therapy and therapy within specialist services is limited for this client group. Furthermore, some experiences of the participants in this research, and experience from practice show us that resources of community counselling services such as the one in the current research are usually limited in meeting the needs of more complex cases. Perhaps different arrangements of therapy, for example the possibility for a limited number of cases to extend up to one or two years based on the joint decision of the client and the therapist, or provision of specialist services (e.g. for trauma) should be made available in such community counselling services.

5.4. Implications for further research

Further quantitative research may be carried out into the same phenomena in a larger sample to obtain a more generalisable result. As an alternative method, ethnographic research may be carried out to explore the constructs measured in this study with a bottom-up approach, which could yield more population-specific domains to be studied (Hughes, Seidman & Williams, 1993). Findings obtained from such ethnographic research can then be used to develop new scales specific to this population, as an alternative to culturally-adapted measures.

To address the limitation around different trajectories of growth process, a second semi-structured interview could be carried out a year after the first one to gain more depth in to the individual processes, beyond a snapshot view of the participants’ experiences.
Similarly, a quantitative follow-up questionnaire could be administered to investigate participants’ developmental process over a longer period of time, for example a year after therapy. Such further quantitative and qualitative research would also help identify any further benefits of therapy that might arise in this time.

As the sample interviewed in study 2 comprised a relatively young and educated section within the general client group, experience of older and less educated counselling clients within the current client group could also be investigated by further IPA. In addition, experience of clients who have received therapy in English via an interpreter would be useful to investigate via semi-structured interviews, to illuminate any divergences from the experience of the current sample.

5.3. Cultural context & reflexivity

Starting from the problem definition stage of a research study, a researcher holds a specific cultural perspective from which she constructs research questions. Culture and research intersect not only at the early stages of research but also throughout the methods employed to collect data and create knowledge. Therefore, the cultural perspective of the researcher should be compatible with the culture of the population studied in the research (Hughes et al., 1993). Being a researcher from a similar cultural background to the sample in the current research and speaking the same language provided benefits in rapport-building and adjusting to the ethnic-cultural needs during the research process. I observed that some participants had a particularly warm attitude during data collection due to appreciating someone from their cultural background carrying out research in the community. On the other hand, having a western educational background and holding such assumptions as the appropriateness of studying concepts defined in the Western world in an ethnic minority group using the
same methods as they have been studied in Western populations have posed some challenges. Although I was an insider in the broader cultural group i.e. Turkish-speakers, I was not truly part of the community, as my reasons and process of moving to London were distinct from theirs. I also had a different historical and geographical background from the majority of the participants (Cyprus vs. Turkey), which naturally gives rise to some differences in cultural values and the lived experience.

I think the differences between the participants’ and my lived experience contributed positively to my engagement with particularly the qualitative data; in terms of bracketing off my own pre-existing assumptions about the world, and staying true to the participant’s experience. Although IPA aims to provide a first-person picture of a participant’s experience, the researcher always takes part in the construction of that account (Larkin et al., 2006). Therefore, I acknowledge that I brought my preconceptions and prior knowledge into the interviews and analysis, on the areas of PTG and the characteristics of helpful therapy relationships that are commonly reported. My assumptions about the world and interests may also have influenced which themes were accentuated in the analysis and the write-up, such as the attention to the gender issues. It is inevitable that another researcher would ask different questions in the interviews, and create different themes from the data.

5.4. Reflections on the methods and outcome

Alongside the knowledge obtained from the findings, paying attention to the methodological process of this research has offered me valuable knowledge about the benefits and challenges of different data collection methods. During study 1, those participants who found self-completion difficult preferred meeting face-to-face with me for the opportunity of a verbal discussion of the questionnaire and its verbal
administration. Presenting questions verbally has obvious benefits over a visual presentation of questions on paper in assisting those with literacy problems (Chang and Krosnick, 2010). On the other hand, some participants merely preferred discussing about the sensitive topics raised by this study in-person, in a confidential environment. An evident drawback of this method was its time-consuming and laborious nature. Although in-person interviews were not an efficient mode of data collection in this study, they were necessary in the current context, as eliminating this method would have led to excluding a significant number of participants who did not feel able to participate without the help of the researcher. Participants who preferred the post option were generally those who could confidently complete a questionnaire by himself or herself (or with assistance for a friend or a family member). For this group of participants, the post option provided convenience, as they did not have to leave their own comfortable settings for the purpose of participating in this study (Trier-Bieniek, 2012). In addition, they had been able to respond to the questions without the researcher being in between by directing the questions at them and recording their answers; thus moderating the power of the researcher. For the telephone interviews, participants needed to find an available time and space where they could have privacy (e.g. Trier-Bieniek, 2012). This posed the initial challenge for this mode of questionnaire administration, as it meant that most of the time I was not able to interview participants at the first call attempt. Overall, these challenges in recruitment and data collection, and administering questionnaires at three different time points extended the time required for the study 1 data collection.

This research also contributed to my knowledge as a therapist. The qualitative accounts of the participants in study 2 cemented for me the importance of a robust therapeutic relationship and also cherishing the hope even when the client is very distressed. In addition, the findings of both studies showed me that the ‘outcome’ of therapy may not
always be readily observable at a desired time, via common methods. As I am nearing my qualifying, I am negotiating my professional identity and the ways of doing meaningful work in the field of counselling psychology, and for me, this research once again brought forward the challenge of adapting to work with limited resources.

5.5. Summary and conclusion

This research is unique in investigating posttraumatic growth and effects of psychological therapy among Turkish-speaking therapy clients in the UK, which comprise a considerable proportion of ethnic minority populations. It used a mixed methods design, with a quantitative study that compared a therapy group with a waiting list group over three time points, and an IPA study. This research found that, overall, this population’s response to trauma was not dissimilar to other populations and that this population can benefit from culturally-sensitive psychological therapy, in ways that are comparable to other populations reported in previous literature. Unexpectedly, the quantitative measures showed no significant changes in posttraumatic stress, PTG, depression and anxiety scores post-therapy or between groups, providing an inconclusive picture which the qualitative findings subsequently contradicted. It is likely that the qualitative therapy experience of the current sample were not accurately reflected by the quantitative outcome measures; however, the limitation of this type of short-term therapy with some more complex cases has also been considered, which may be an issue that can be addressed at the policy level. The qualitative study reported positive changes through therapy, including some areas of PTG that had previously been identified in literature, with an exception of improvements in relationships, a finding that has been discussed in the specific context of the population in this research.
Nevertheless, caution must be taken against unquestioningly adopting these accounts of positive change as reflecting PTG as an objective and concrete notion, as growth out of adversity can be seen as a subjective, fluid, and time dependent experience, embedded in wider context. The issue of isolation emerged as a prominent feature of the current population’s experience, both through their preference of acculturation strategy and their accounts of posttraumatic experiences in qualitative interviews. Future interventions can potentially target the specific issue of isolation within the current cultural group and perhaps in other minority groups. A further finding was the specific perception of the therapist and the therapeutic relationship from a more paternalistic perspective by the current sample. This is something that practitioners should take into account when working with this client group, as it would assist them in working more collaboratively with their clients. This research can perhaps contribute to the awareness within the counselling psychology field of the Turkish-speaking clients’ experiences within the therapeutic scene; and being more informed of the unique contexts of minority ethnic groups, which can be both similar to and different from the dominant Western culture, would encourage psychologists to work ethically, productively and without ethnocentric biases.
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Appendices

All participant-facing documentation were translated and presented to participants in Turkish language

Appendix 1. Participant demographic information form

Demographic information form

Thank you for agreeing to take part in this study. We would like to ask you to respond to the following questions about yourself because we would like to understand whether people with different life situations may have similar posttraumatic experiences and attitudes to cultural adaptation.

What is your DoB:

......................................................................................................................................................

☐ Prefer not to say

What is your gender?

☐ Male

☐ Female

☐ Transgender

☐ Other (please give details): ..........................................................................................

☐ Prefer not to say

Do you have any reading problems?

☐ No

☐ Dyslexia

☐ Difficulty understanding texts
☐ Other (please specify) ____________________________________________________________

☐ Prefer not to say

What is your highest level of education?

☐ No education

☐ Primary school

☐ Secondary school

☐ College

☐ Higher education (Please specify)
________________________________________________________

☐ Other (Please specify) ____________________________________________________________

☐ Prefer not to say

What is your ethnicity?

☐ Kurdish

☐ Turkish

☐ Turkish Cypriot

☐ Eastern European Turk

☐ Mixed ethnicity

☐ Other (Please specify)
________________________________________________________

☐ Prefer not to say

What is your marital status?

☐ Single

☐ Married

☐ Divorced

☐ Separated from partner
☐ Widowed
☐ Civil Partnership
☐ Cohabiting/partnered
☐ Other (please specify)
........................................................................................................................................
☐ Prefer not to say

Are you working?
☐ Working full-time
☐ Working part-time
☐ Studying
☐ Doing voluntary work
☐ Retired
☐ Long-term unemployed
☐ Long-term ill
☐ Not working for other reasons (e.g. taking care of children or relatives)
☐ Prefer not to say

What is your religion?
☐ No religion
☐ Muslim
☐ Christian
☐ Jew
☐ Other (Please specify)
........................................................................................................................................
☐ Prefer not to say

If you have a religion, do you practice your religion?
........................................................................................................................................
......
Do you have any children?

☐ Yes

☐ No

☐ Prefer not to say

If yes, how many children do you have?

☐ 1

☐ 2

☐ 3

☐ 4 or more

Do you have any major physical health problems?

☐ Yes

☐ No

☐ Prefer not to say

If yes, what is it and for how long?

........................................................................................................

Do you have any mental health problems?

☐ Yes

☐ No

☐ Prefer not to say

If yes, what is it and for how long?

........................................................................................................

Year you started living in the UK:

........................................................................................................
# Counsellor Demographic Form

What is your age?

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Other (please describe)</th>
</tr>
</thead>
</table>

3. What is your ethnic group? (Choose one option that best describes your ethnic background)

| 1. Kurdish |   |
| 2. Turkish |   |
| 3. Turkish Cypriot |   |
| 4. Eastern European Turk |   |
| 5. Mixed ethnic groups |   |
| 6. Any other ethnic group, please describe |   |

4. Your training programme(s)

4a. What was the title, institute, start date and end date of your principal professional counsellor/psychotherapy training programme?

Title: .................................................................

Institute: ..........................................................

Start date [mm/yyyy]: ............... End date [mm/yyyy]: .................

4b. At what level was this training? (please tick one only)

| Level 5 (Dip. HE/FE) |   |
| Level 6 (Bachelor’s degree) |   |
| Level 7 (Master’s degree) |   |
| Level 8 (Doctoral degree) |   |
| Other (please describe) |   |

4c. What was the orientation of this training? (please tick one or more)

| Humanistic |   |
| Person-centred |   |
| Gestalt |   |
5 Your practice

5a. For how many years have you been qualified as a professional therapist?

5b. What is your principal professional identity? (please tick only one)
- Counsellor
- Psychotherapist
- Counselling Psychologist
- Clinical Psychologist
- Other (please specify)…

5c. What is your principal therapeutic orientation? (tick one only)
- Humanistic
- Person-centred
- Gestalt
- Transactional analysis
- Integrative
- Eclectic
- Pluralistic
- Psychodynamic/analytic
- Cognitive
- Behavioural
- Cognitive-behavioural
- Systemic
- Other (please specify)…

5d. To what extent is your current practice influenced by each of the following orientations?

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Not at all Influenced</th>
<th>Greatly Influenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Humanistic</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]</td>
<td></td>
</tr>
<tr>
<td>Person-centred</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]</td>
<td></td>
</tr>
<tr>
<td>Gestalt</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]</td>
<td></td>
</tr>
<tr>
<td>Transactional analysis</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]</td>
<td></td>
</tr>
<tr>
<td>Integrative</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]</td>
<td></td>
</tr>
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Appendix 3. Counselling service CEO’s information sheet and consent form

[XXXX] COUNSELLING SERVICE INFORMATION SHEET AND CONSENT FORM

Posttraumatic growth and meaning making among Turkish-speaking immigrants before and after receiving culturally sensitive psychotherapy

Thank you for taking the time to read this information sheet. It will explain the aim of the current research project and what will be involved for [XXXX] Counselling Service.

The research project

The aim of this research is to investigate the effects of psychotherapy on posttraumatic growth (PTG) and meaning making in a sample of Turkish-speaking immigrants. PTG is defined as positive psychological changes experienced as a result of a struggle through experiencing a traumatic event. It is also referred to as thriving or stress-related growth. Immigration can be a difficult and life-changing process. Most immigrants may go through at least one traumatic event. So far, research has shown that populations such as refugees or assault survivors may also experience PTG.

This project will also investigate the acculturation strategies of the Turkish-speaking population and the association between these strategies and PTG. Acculturation is the social and psychological changes that two different cultural groups experience when they come into contact. Ways in which the individuals in the immigrant group acculturate can be associated with their mental health and PTG experience.

We hope that being able to add to the current knowledge in these areas will potentially lead to more informed and effective psychotherapy with immigrant/refugee populations that go through adverse life events. Findings of this study may bring a clearer understanding of positive outcomes of psychotherapy such as PTG and meaning making that have generally been ignored, in addition to alleviating the negative indicators, which has traditionally been the only focus of psychotherapy. As a result, counselling psychologists and trainees will be encouraged to consider addressing these issues as a focus in therapy. Current and future clients of this organisation will benefit from this study’s findings, as the service they receive will have been validated and informed by research, which can lead to more helpful outcomes.

Participants, procedure and [XXXX] Counselling Service involvement
This research is looking to recruit [XXXX] Counselling Service clients who are starting / on the waiting list to receive therapy. Clients who wish to participate in this study will be asked to complete a questionnaire which will be comprised of the following measures: PTSD Checklist (PCL-5), Life Events Checklist (LEC-5), Posttraumatic Growth Inventory, Meaning in Life Questionnaire, PHQ-9, GAD-7 and Acculturation scale. Following the completion of the questionnaire, participants will be debriefed and encouraged to discuss any thoughts and feelings that have arisen for them. The completion of the questionnaire will take around half an hour to 45 minutes.

The researcher will liaise with [XXXX] Counselling Service staff on a regular basis to obtain a record of the clients starting their therapy and the clients who are booked in for an assessment session. The researcher will then phone these clients to advertise the study. The details of the study (i.e. aims, procedures, confidentiality, right to withdraw) will be explained to the clients on the phone. Those clients who wish to participate in the study will be offered one of the following options: 1) meeting face-to-face with the researcher at [XXXX] Counselling Service to give written informed consent and complete the questionnaire, 2) receiving the information sheet and consent form, questionnaire and the debrief form in post and returning the completed consent form and questionnaire in a stamped envelope with [XXXX] Counselling Service’s address, which will also be sent to the participant, 3) giving written consent and completing the questionnaire at [XXXX] Counselling Service in the presence of [XXXX] Counselling Service staff in the office, without the researcher present, 4) receiving the information sheet and the consent form in post OR collecting it at [XXXX] Counselling Service to sign and return, and booking a telephone appointment with the researcher to complete the questionnaire at a later time, 5) giving audio-recorded verbal consent and completing the questionnaire on the phone there and then. Written consent will also be sought afterwards where possible, by means of one of the above methods.

All participants will complete measures at baseline and then after 6 weeks and 12 weeks (except for the acculturation scale which will only be completed at baseline). Clients who contract for 6 weeks of therapy will only complete questionnaires at baseline and at 6 weeks.

Potential risks to participants

Participants will have to give up some of their time to take part and can feel distressed remembering the traumatic event they went through. They will not be asked to tell about the event in detail. They will be informed that if they feel uncomfortable at any point, they can choose not the answer a question, or to stop taking part in the project. They will also be informed that they would not need to give us a reason for leaving the study, and it would not affect any services they are receiving/will receive at [XXXX] Counselling Service.
Potential benefits to participants

There is no incentive / a direct benefit to taking part in this study. However, participants may find it useful to think about the positive ways in which they may have developed through their struggles, also think about their meaning in life and relationship with their own culture and the culture in the UK. The information obtained from this research will contribute to the current knowledge about PTG, meaning making and acculturation among Turkish-speaking immigrants in London.

Confidentiality

All information provided will be kept confidential and only accessible to members of the research team. All collection, storage and processing of data will comply with the principles of the Data Protection Act 1998, and has been approved under the procedures of the University of Roehampton Ethics Committee. All of the information provided will be stored securely and all questionnaire data will be anonymised. Under no circumstances will identifiable responses be provided to any third party. Limits to confidentiality will apply in situations where research participants disclose information that they or someone else is at risk of harm. In such situations, [XXXX] Counselling Service’s usual safeguarding procedures will be followed. In such situations, where possible, this will be discussed with participants before a suitable course of action is taken.

Data storage

Anonymised data (completed questionnaires) will be stored for an indefinite period of time following the study and may be used for publication, presentation or for subsequent research project or data analyses. Personal (non-anonymised) data (consent forms, demographic information, audio-recorded verbal consent on a USB stick and SPSS spreadsheets with identifying characteristics i.e. demographic information such as age) will be kept for 10 years, in which time they might be used for other research projects and data analyses (at the discretion of the researcher).

Dissemination of findings

The results of this study will be written up in partial fulfilment of the requirements for the Doctorate in Counselling Psychology from the University of Roehampton. The results of this research may be published in academic journals, or presented at conferences.

If you have any further questions, please contact the investigator: Diva Ulucay

Department of Psychology Roehampton University Whitelands College
Holybourne Avenue London, SW15 4JD ulucayd@roehampton.ac.uk
If you have any concern about any aspect of your participation or any other queries please raise this with the investigator or the Director of Studies. However, if you would like to contact an independent party please contact the Head of Department.

**Director of Studies Contact Details: Head of Department Contact Details:**

Dr Elias Tsakanikos  
Roehampton University  
Whitelands College  
Holybourne Avenue,  
London, SW15 4JD, UK  
Elias.tsakanikos@roehampton.ac.uk  
+44 (0)20 8392 3080

Dr Diane Bray  
Roehampton University  
Whitelands College  
Holybourne Avenue,  
London, SW15 4JD, UK  
d.bray@roehampton.ac.uk  
+44 (0)20 8392 3627

**Consent Statement**

I have read the information sheet and understand the purpose and procedure of this research. I understand that I may request further details and information should I wish. I agree to take part in this research, and am aware that my participation is voluntary. I understand that I am free to withdraw from the project without giving a reason. I agree for the research data to be used in preparation of a thesis and accompanying papers and presentations. I understand that the consent forms, demographic information and SPSS spreadsheets with identifying characteristics i.e. demographic information such as age will be destroyed after ten years, in which time they may be used for other research projects and data analysis (in the discretion of the researcher). I understand that the information participants provide will be treated in confidence by the investigator, and that participants’ identities will be removed in the publication or presentation of any findings. I understand that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University of Roehampton’s Data Protection Policy.

On behalf of [XXXX] Counselling Service: …XXXX – Chief Executive Officer……………………………

Signature: ……XXXX…………………………

Date: …..15 February 2017…………………………………….
Appendix 4. Counsellor information sheet and consent form

[XXXX] COUNSELLING SERVICE COUNSELLORS’ INFORMATION SHEET AND CONSENT FORM

Posttraumatic growth and meaning making among Turkish-speaking immigrants before and after receiving culturally sensitive psychotherapy

Thank you for taking the time to read this information sheet. It will explain the aim of the current research project and what will be involved for [XXXX] Counselling Service.

The research project

The aim of this research is to investigate the effects of psychotherapy on posttraumatic growth (PTG) and meaning making in a sample of Turkish-speaking immigrants. PTG is defined as positive psychological changes experienced as a result of a struggle through experiencing a traumatic event. It is also referred to as thriving or stress-related growth. Immigration can be a difficult and life-changing process. Most immigrants may go through at least one traumatic event. So far, research has shown that populations such as refugees or assault survivors may also experience PTG.

This project will also investigate the acculturation strategies of the Turkish-speaking population and the association between these strategies and PTG. Acculturation is the social and psychological changes that two different cultural groups experience when they come into contact. Ways in which the individuals in the immigrant group acculturate can be associated with their mental health and PTG experience.

We hope that being able to add to the current knowledge in these areas will potentially lead to more informed and effective psychotherapy with immigrant/refugee populations that go through adverse life events. Findings of this study may bring a clearer understanding of positive outcomes of psychotherapy such as PTG and meaning making that have generally been ignored, in addition to alleviating the negative indicators, which has traditionally been the only focus of psychotherapy. As a result, counselling psychologists and trainees will be encouraged to consider addressing these issues as a focus in therapy. Current and future clients of this organisation will benefit from this study’s findings, as the service they receive will have been validated and informed by research, which can lead to more helpful outcomes.

Participants, procedure and [XXXX] Counselling Service’s involvement

This research is looking to recruit [XXXX] Counselling Service counselling service clients who are starting / on the waiting list to receive therapy. Clients who wish to
participate in this study will be asked to complete a questionnaire which will be comprised of the following measures: PTSD Checklist (PCL-5), Life Events Checklist (LEC-5), Posttraumatic Growth Inventory, Meaning in Life Questionnaire, PHQ-9, GAD-7 and Acculturation scale. Following the completion of the questionnaire, participants will be debriefed and encouraged to discuss any thoughts and feelings that have arisen for them. The completion of the questionnaire will take around half an hour to 45 minutes.
The researcher will liaise with [XXXX] Counselling Service counseling service staff on a regular basis to obtain a record of the clients starting their therapy and the clients who are booked in for an assessment session. The researcher will then phone these clients to advertise the study. The details of the study (i.e. aims, procedures, confidentiality, right to withdraw) will be explained to the clients on the phone. Those clients who wish to participate in the study will be offered one of the following options: 1) meeting face-to-face with the researcher at [XXXX] Counselling Service to give written informed consent and complete the questionnaire, 2) receiving the information sheet and consent form, questionnaire and the debrief form in post and returning the completed consent form and questionnaire in a stamped envelope with [XXXX] Counselling Service’s address, which will also be sent to the participant, 3) giving written consent and completing the questionnaire at [XXXX] Counselling Service in the presence of [XXXX] Counselling Service staff in the office, without the researcher present, 4) receiving the information sheet and consent form in post OR collecting it at [XXXX] Counselling Service to sign and return, and booking a telephone appointment with the researcher to complete the questionnaire at a later time, 5) giving audio-recorded verbal consent and completing the questionnaire on the phone there and then. Written consent will also be sought afterwards where possible, by means of one of the above methods.

All participants will complete measures at baseline and then after 6 weeks and 12 weeks (except for the acculturation scale which will only be completed at baseline).

**Potential risks to participants**

Participants will have to give up some of their time to take part and can feel distressed remembering the traumatic event they went through. They will not be asked to tell about the event in detail. They will be informed that if they feel uncomfortable at any point, they can choose not the answer a question, or to stop taking part in the project. They will also be informed that they would not need to give us a reason for leaving the study, and it would not affect any services they are receiving/will receive at [XXXX] Counselling Service.

**Potential benefits to participants**

There is no incentive / a direct benefit to taking part in this study. However, participants may find it useful to think about the positive ways in which they may have developed through their struggles, also think about their meaning in life and relationship with their own culture and the culture in the UK. The information obtained from this research will contribute to the current knowledge about PTG, meaning making and acculturation among Turkish-speaking immigrants in London.

**Confidentiality**

All information provided will be kept confidential and only accessible to members of the research team. All collection, storage and processing of data will comply with the principles of the Data Protection Act 1998, and has been approved under the procedures of the University of Roehampton Ethics Committee. All of the information provided will be stored securely and all questionnaire data will be anonymised. Under no circumstances will identifiable responses be provided to any third party. Limits to confidentiality will apply in situations where research participants disclose information
that they or someone else is at risk of harm. In such situations, [XXXX] Counselling Service’s usual safeguarding procedures will be followed. In
such situations, where possible, this will be discussed with participants before a suitable course of action is taken.

Data storage

Anonymised data (completed questionnaires) will be stored for an indefinite period of time following the study and may be used for publication, presentation or for subsequent research project or data analyses. Personal (non-anonymised) data (consent forms, demographic information, audio-recorded verbal consent on an encrypted USB stick and SPSS spreadsheets with identifying characteristics i.e. demographic information such as age) will be kept for 10 years, in which time they might be used for other research projects and data analyses (at the discretion of the researcher).

Dissemination of findings

The results of this study will be written up in partial fulfillment of the requirements for the Doctorate in Counselling Psychology from the University of Roehampton. The results of this research may be published in academic journals, or presented at conferences.

If you have any further questions, please contact the investigator: Diva Ulucay
Department of Psychology
Roehampton University Whitelands College Holybourne Avenue London,
SW15 4JD
ulucayd@roehampton.ac.uk

If you have any concern about any aspect of your participation or any other queries please raise this with the investigator or the Director of Studies. However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details: Head of Department Contact Details:
Dr Elias Tsakanikos
Roehampton University
Whitelands College
Holybourne Avenue,

Dr Diane Bray
Roehampton University
Whitelands College
Holybourne Avenue,
Consent Statement

I have read the information sheet and understand the purpose and procedure of this research. I understand that I may request further details and information should I wish. I agree to take part in this research, and am aware that my participation is voluntary. I understand that I am free to withdraw from the project without giving a reason. I agree for the research data to be used in preparation of a thesis and accompanying papers and presentations. I understand that the consent forms, demographic information and SPSS spreadsheets with identifying characteristics i.e. demographic information such as age will be destroyed after ten years, in which time they may be used for other research projects and data analysis (in the discretion of the researcher). I understand that the information participants provide will be treated in confidence by the investigator, and that participants’ identities will be removed in the publication or presentation of any findings. I understand that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University of Roehampton’s Data Protection Policy.

Name of the counsellor:  
..................................................................................................................  
Signature:  
..................................................................................................................  
Date:  
..................................................................................................................

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PARTICIPANT CONSENT FORM

Posttraumatic growth and meaning making among Turkish-speaking immigrants before and after receiving culturally sensitive psychotherapy

We would like to invite you to take part in this research project which is organised by the Department of Psychology at the University of Roehampton. Please read carefully the information about this project before deciding to participate. It is important that you understand why we are doing this project and what we are asking you to do.

Why is this project being carried out?

The aim of this project is to find out more about how receiving therapy after a very frightening/distressing event may change your life in positive ways by which you feel that you have grown as a person. These positive changes experienced following very frightening/distressing times are called Posttraumatic growth (PTG). Immigration can be a difficult and life-changing process. Most people who leave their home country to live in a different country may go through at least one very distressing event (traumatic event). A traumatic event is a very frightening experience which can cause physical or emotional distress or harm. It is experienced as a threat to one’s safety. So far, research has shown us that people who go through different traumatic events may also experience personal growth.

We are also looking to find out more about the social and psychological changes that the Turkish speaking population in London may experience while they are trying to adapt to their life in the UK. The modifications you make in your life in order to adapt to a new culture may influence your physical and mental health.

Who can participate?
Anyone who is starting / is on a waiting list to receive psychological therapy at [XXXX] Counselling Service can take part in this study.

What will the participation involve?
We are aiming to recruit 102 participants in total. Participation will involve completing a set of questionnaires on paper, which would take between 30 and 45 minutes depending on individual variation in responding time. We will ask you to complete questionnaires at three different time points: before you start your therapy, when you finish your therapy and at 12 weeks after the end of your therapy. If you are on a waiting list to receive therapy, we will ask you to complete questionnaires now, after six weeks and towards the end of your waiting period. The questionnaires will ask you about the changes you experienced (if any) after the traumatic event you went through, the meaning you find in your life and your interest in the UK’s and your home country’s culture. The recruitment will take place while you are at [XXXX] Counselling Service. After the end of your therapy, you will be contacted to complete the last set of questionnaires after 12 weeks. You will be invited to come to [XXXX] Counselling Service. If this is not possible, you may be contacted by the researcher via phone and respond to the questionnaires on the phone. Assistance will be available if you experience literacy problems. A convenient time can be arranged so that you can meet with the researcher.

Do I have to take part?
No, it’s completely up to you. Taking part in this research is voluntary, which means you don’t have to take part if you don’t want to. If you agree now you can still change your mind later.

What are the possible disadvantages of taking part?
There are not many risks involved. You will have to give up some of your time to take part, and might feel uncomfortable remembering the traumatic event you went through. Please note you will not be asked to tell about the event in detail. If you do feel uncomfortable at any point, you can choose not to answer a question, or to stop taking part in the project. You would not need to give us a reason for leaving the study, and it wouldn’t affect any services you are receiving/will receive at [XXXX] Counselling Service.

What are the possible benefits of taking part?
You may find it useful to think about the positive ways in which you may have developed through your struggles, meaning in life and your relationship with your own culture and the culture in the UK after you have moved here. By taking part in this study, you will be helping to improve the current knowledge about posttraumatic growth, meaning making and acculturation among Turkish-speaking immigrants in London. This knowledge may help us improve the psychotherapy received by this population in the future.

Will anyone else know about my responses?
Your responses are confidential, which means that they will not be passed onto anyone else (such as your therapist, doctor or family members). However, if you tell us that you or someone else might be at risk of harm, we will have to pass this on so that we can get help and make you safe. Your questionnaire paper will not contain your name.

**What should I do if I want to withdraw from the study?**
Your questionnaire paper will be coded with a unique ID number which you will be given to take away if you choose to participate. It is important that you keep that ID number so that you can provide us with it if you wish to withdraw from the study and we will destroy your questionnaire paper. If you withdraw, your data may still be used in the analysis in an aggregate form.

**What will happen to the results of the research study?**
The results of this study will be written up in a report, and might be published. Anonymised questionnaire responses may be used for other research projects and data analyses.

**Who has reviewed the research?**
This project has been approved under the procedures of the University of Roehampton’s Ethics Committee.

**What if I experience a problem / emotional distress?**
If you feel something is wrong, please talk to us about it as soon as possible. This can be before, during, or after your participation in the study. You can also contact [XXXX] Counselling Service or the investigator whose details are below if you wish to discuss any problem about the study. If you feel emotionally distressed, you should call your GP or the crisis services numbers that we will give you.

**Investigator Contact Details:**

Diva Ulucay

Department of Psychology
Roehampton University
Whitelands College
Holybourne Avenue,
London, SW15 4JD, UK

ulucayd@roehampton.ac.uk
07850757534
Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University’s Data Protection Policy.

Name ..............................................

Signature ......................................

Date ..............................................

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Head of Department.

Director of Studies Contact Details:       Head of Department Contact Details:

Dr Elias Tsakanikos       Dr Diane Bray

Roehampton University
Whitelands College
Holybourne Avenue,
London, SW15 4JD, UK

Elias.tsakanikos@roehampton.ac.uk       d.bray@roehampton.ac.uk
+44 (0)20 8392 3080                   +44 (0)20 8392 3627
Appendix 6. Debrief form (Study 1)

Thank you for taking part in this study.

Our aim in asking these questions to you was to find out more about any negative and positive changes you may have experienced through trauma and how you are adapting to the UK culture. We are interested to find out whether the psychological therapy you have received here at [XXXX] Counselling Service has had an effect on the negative and positive changes you have experienced. The reason for doing this research is to investigate whether culturally-sensitive psychotherapy may facilitate growth following a trauma with the aim of providing more effective psychotherapy for immigrant populations in the future.

I appreciate your contribution to this research, and hope you enjoyed taking part.

Participating in this study and responding to the questionnaires may have raised some questions or concerns for you. If you would like to share any thoughts or feelings, or ask any questions, please contact me:

Diva Ulucay
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Phone: 07810352307 Email: ulucayd@roehampton.ac.uk

If you feel distressed at any time after participating in this research, contact [XXXX] Counselling Service 020 7XXX XXXX or your GP to ask for further support.

If you are worried about any aspect of this study, or have any other questions please ask Elias Tsakanikos (the Director of Studies). However, if you would rather talk to someone at the university who isn’t directly involved in the research, you can contact the Head of Department.

Director of Studies Contact Details:
Dr Elias Tsakanikos
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
Elias.tsakanikos@roehampton.ac.uk
+44 (0)20 8200 2080

Head of Department Contact Details:
Dr Diane Bray
Department of Psychology
Whitelands College
Holybourne Avenue
London, SW15 4JD
d.bray@roehampton.ac.uk
Dear ..........,

Thank you for your interest in my research.

As we agreed during our phone call, I have sent the information sheet, consent form and the questionnaire.

At the bottom of the information sheet and consent form, you can see the consent statement. If you agree to take part, please sign this and complete the questionnaire.

Please return the completed questionnaire and the signed consent form to [XXXX] Counselling Service in the stamped envelope I have sent. Please keep the thank you note.

Thank you very much.

Diva Ulucay
Trainee Counselling Psychologist
Department of Psychology
Roehampton University
Whitelands College
Holybourne Avenue,
London, SW15 4JD, UK

ulucayd@roehampton.ac.uk
07810352307
Appendix 8. Ethical approval

Ethics Application
Applicant: Diva Ulucay
Title: Posttraumatic growth and meaning making among Turkish-speaking immigrants before and after receiving culturally sensitive psychotherapy
Participant documentation: Investigating personal growth seen after traumatic incidents / (frightening experiences)
Reference: PSYC 16/246
Department: Psychology

Many thanks for your response and the amended documents. Under the procedures agreed by the University Ethics Committee I am pleased to advise you that your Department has confirmed that all conditions for approval of this project have now been met. We do not require anything further in relation to this application.

Please note that on a standalone page or appendix the following phrase should be included in your thesis:

The research for this project was submitted for ethics consideration under the reference PSYC 16/246 in the Department of Psychology and was approved under the procedures of the University of Roehampton’s Ethics Committee on 06.12.16.

Please Note:

- This email confirms that all conditions have been met and thus confirms final ethics approval (it is assumed that you will adhere to any minor conditions still outstanding, therefore we do not require a response to these).
- University of Roehampton ethics approval will always be subject to compliance with the University policies and procedures applying at the time when the work takes place. It is your responsibility to ensure that you are familiar and compliant with all such policies and procedures when undertaking your research.
- Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.

Many thanks,

Jan

Jan Harrison
Ethics Officer
Research Office
University of Roehampton | London | SW15 5PJ
jan.harrison@roehampton.ac.uk; www.roehampton.ac.uk
Tel: +44 (0) 20 8392 5785
Appendix 9. Interview schedule

Thank you very much for volunteering to participate in this interview. I understand that you came forward for the interview because you have experienced a life-changing, traumatic event and sought help from [XXXX] Counselling Service for your psychological difficulties. Without a doubt, people experience some negative consequences after a traumatic event and most also go on to experience more long-lasting changes, be they negative or positive. With the interview today, we will aim to understand how you have been affected by the distressing experiences you have had in the long-run. Therefore, the interview will be more about the impact of these experiences, rather than the specific details of the event, also with your wellbeing in mind.

I would like to remind you that, if at any time the interview becomes distressing for you, you can let me know and we can stop. Similarly, if a question is difficult for you to answer, we can move on. If you want, we can always come back to continuing with the interview and answering the questions. Is there anything you would like to ask me before we start the interview?

1) To begin with, could you tell me about how you came to [XXXX] Counselling Service for therapy?  
   Possible prompt: How the referral happened

2) Could you briefly describe the events you experienced that led you to [XXXX] Counselling Service, for example, what happened and when? There is no need to go into the details of the event?

3) Thank you for sharing that. Now, can you describe for me how you were affected in the immediate aftermath of the event?  
   Possible prompts: emotionally, physically, beliefs about self, life.  

PTG

4) As a result of struggling with these events (distressing ones), now that some time has passed can you tell me about any experience of longer-term changes in yourself as a person?  
   Possible prompts: How do you see yourself as different from before you went through this event? Some people talk about a sense of vulnerability, a sense of strength, overcoming hardship

5) Can you tell me about any longer-term changes you experienced in any aspect of your life since this event / these events?  
   Possible prompts: relationships, work, social, family, personal

6) Can you tell me about whether your attitude to life has changed now, compared to before the event? If so, how has this changed?  
   Possible prompts: new priorities, a changed appreciation of life
   If negative – Why do you think/feel there has been no change?

7) And what about your relationships with people, can you tell me about whether you have experienced changes in these now, compared to before the event?
Possible prompts: closeness/intimacy, relying on others, seeking help, compassion
If negative – Why do you think/feel there has been no change?

8) What lessons do you feel you have learnt from this experience?
If no lessons learnt – what makes you think that?

9) Can you tell me about any experiences of behaving differently since the distressing event?
Possible prompts: What behaviour change have you noticed? How would you say the things you do on a day-to-day basis have changed? Behaving in a new way in a particular situation (for example, how do you act in response to hardship/negativity / when you see others in need/vulnerable others, how do you behave towards loved ones, as compared to before the event), spending your days differently (for example, what new activities do you engage in, if any?)
If no change – why do you think/feel that is the case?

Therapy experience
10) Thinking about the therapy you have received, can you tell me about your experience of receiving therapy at [XXXX] Counselling Service?
Possible prompts: How was it like for you to have therapy sessions at [XXXX] Counselling Service? Lingual and cultural similarities with your therapist. Any benefits you found? Any challenges/limitations?

11) Considering the experiences you talked about earlier, how do you see therapy having helped you experience these positive changes, if it helped at all?
(If they have only had negative changes How do you see therapy having helped change any of these difficult thoughts and feelings, if it helped at all?)
Possible prompts: awareness of the changes, experiences being validated, relationship with therapist, therapist as a person, therapeutic space.

12) Can you describe any obstacles in therapy that might have prevented you from experiencing any growth / positive changes?
Possible prompts: was there anything unhelpful? Might anything related to therapy have stopped you from growing through your traumatic experiences?

13) Can you describe the most important lessons you have learned from your experience of therapy with [XXXX] Counselling Service

Ending Questions

14) What do you most value about yourself now?

15) Is there anything else you think I should know in order to understand your experiences here?

16) Is there anything you would like to ask me?
Appendix 10. Participant information sheet and consent form (Study 2)

PARTICIPANT CONSENT FORM

Posttraumatic growth and meaning making among Turkish-speaking immigrants before and after receiving culturally sensitive psychotherapy

We would like to invite you to take part in this research project which is organised by the Department of Psychology at the University of Roehampton. Please read carefully the information about this project before deciding to participate. It is important that you understand why we are doing this project and what we are asking you to do.

Why is this project being carried out?

The aim of this project is to find out more about the contribution of culturally-sensitive psychotherapy to the experience of posttraumatic growth among immigrants. Posttraumatic growth (PTG) is defined as positive psychological changes experienced as a result of a struggle through experiencing a traumatic event. It is also referred to as thriving or stress-related growth. Immigration can be a difficult and life-changing process. Most immigrants may go through at least one traumatic event. A traumatic event is a very frightening experience which can cause physical or emotional distress or harm. It is experienced as a threat to one's safety. So far, research has shown that populations such as refugees or assault survivors who go through different traumatic events may also experience posttraumatic growth.

Who can participate?

Anyone who

1) has received and completed a course of therapy from [XXXX] Counselling Service
2) has experienced at least one life-changing, traumatic event in their lifetime and addressed the issue in therapy they received at [XXXX] Counselling Service
3) can understand what research participation will entail and give consent
4) is willing to give a detailed account of their experiences

can participate in this study.

What will the participation involve?

We are aiming to interview participants about their experiences of growth following adversity and experiences of receiving therapy at [XXXX] Counselling Service. The interview will take place at [XXXX] Counselling Service at a time that is convenient to you. The interview will be audio recorded. Following the interview, you will be given chance to discuss any thoughts and feelings that have arisen from the interview process. The interview and debrief should take no longer than an hour and a half.

Do I have to take part?

No, it's completely up to you. Taking part in this research is voluntary, which means you don’t have to take part if you don’t want to. If you agree now you can still change your mind later.

What are the possible disadvantages of taking part?

There are not many risks involved. You will have to give up some of your time to take part, and might feel uncomfortable remembering the traumatic event you went through. Please note you will not be asked to tell about the event in detail. If you do feel uncomfortable at any point, you can choose not to answer a question, or to stop taking part in the project. You would not need to give us a reason for leaving the study, and it wouldn't affect any services you are receiving/will receive at [XXXX] Counselling Service.

What are the possible benefits of taking part?

You may find it useful to think about the positive ways in which you may have developed through your struggles, meaning in life and your relationship with your own culture and the culture in the UK after you have moved here. By taking part in this study, you will be helping to improve the current knowledge about posttraumatic growth, meaning making and acculturation among Turkish-speaking immigrants in London. This knowledge may help us improve the psychotherapy received by this population in the future.

Will anyone else know about my responses?

Your responses are confidential, which means that they will not be passed onto anyone else (such as your therapist, doctor or family members). However, if you tell us that you or someone else might be at risk of harm, we will have to pass this on so that we can get help and make you safe. Your interview recording will not have your name attached to it.

Your recorded interview may be transcribed and/or translated to English by an independent party, who will also be under the confidentiality obligations mentioned above.

What should I do if I want to withdraw from the study?
Transcribed data will be anonymised (meaning all identifying information will be removed), to ensure that individuals are not identifiable. The interview data will be coded with a unique ID number which you will be given to take away if you choose to participate. It is important that you keep that ID number so that you can provide us with it if you wish to withdraw from the study and we will destroy your data. If you withdraw after the writing up of the thesis, your data may still be used in the analysis in an aggregate form.

What will happen to the results of the research study?
The results of this study will be written up in a report, and might be published. Anonymised data generated from this study may be used for other research projects and data analyses.

Who has reviewed the research?
This project has been approved under the procedures of the University of Roehampton’s Ethics Committee.

What if I experience a problem / emotional distress?
If you feel something is wrong, please talk to us about it as soon as possible. This can be before, during, or after your participation in the study. You can also contact [XXXX] Counselling Service or the investigator whose details are below if you wish to discuss any problem about the study. If you feel emotionally distressed, you should call your GP or the crisis services.

Investigator Contact Details:

Diva Ulucay

Department of Psychology
Roehampton University
Whitelands College
Holybourne Avenue,
London, SW15 4JD, UK

ulucayd@roehampton.ac.uk
07850757534
Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University’s Data Protection Policy.

Name …………………………………

Signature ………………………………

Date …………………………………

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Deputy Head of Department.

Director of Studies Contact Details:               Deputy Head of Department Contact

Dr Diane Bray                             Dr Janek Dubowski
Roehampton University  Roehampton University
Whitelands College               Whitelands College
Holybourne Avenue,              Holybourne Avenue,
London, SW15 4JD, UK              London, SW15 4JD, UK

d.bray@roehampton.ac.uk            j.dubowski@roehampton.ac.uk
+44 (0) 20 8392 3627            +44 (0)20 8392 3214
Appendix 11. Debrief form (Study 2)

Thank you for taking part in this study.

Our aim in asking these questions to you was to find out more about any negative and positive changes you may have experienced through trauma. We are interested to find out whether the psychological therapy you have received here at [XXXX] Counselling Service has had an effect on the negative and positive changes you have experienced. The reason for doing this research is to investigate whether culturally-sensitive psychotherapy may facilitate growth following a trauma with the aim of providing more effective psychotherapy for immigrant populations in the future.

I appreciate your contribution to this research, and hope you enjoyed taking part. Participating in this study may have raised some questions or concerns for you. If you would like to share any thoughts or feelings, or ask any questions, please contact me:

Diva Ulucay  
Department of Psychology  
Whitelands College  
Holybourne Avenue  
London, SW15 4JD  Phone: 07810352307  Email: ulucayd@roehampton.ac.uk

If you feel distressed at any time after participating in this research, contact your GP or [XXXX] Counselling Service 020 7XXX XXXX to ask for further support.

If you are worried about any aspect of this study, or have any other questions please ask Dr Diane Bray (the Director of Studies). However, if you would rather talk to someone at the university who isn’t directly involved in the research, you can contact the Deputy Head of Department.

**Director of Studies Contact Details:**
Dr Diane Bray  
Roehampton University  
Whitelands College  
Holybourne Avenue,  
London, SW15 4JD, UK  
d.bray@roehampton.ac.uk  +44 (0) 20 8392 3627

**Deputy Head of Department Contact:**
Dr Janek Dubowski  
Roehampton University  
Whitelands College  
Holybourne Avenue,  
London, SW15 4JD, UK  
j.dubowski@roehampton.ac.uk  +44 (0)20 8392 3214
Appendix 12. Minor amendment for the semi-structured interviews approval

Ethics Application (Amendment 04.18)
Applicant: Diva Ulucay
Title: Posttraumatic growth and meaning making among Turkish-speaking immigrants before and after receiving culturally sensitive psychotherapy
Participant documentation: Investigating personal growth seen after traumatic incidents / (frightening experiences)
Reference: PSYC 16/ 246
Department: Psychology
Original Approval Date: 06.12.16

Under the procedures agreed by the University Ethics Committee I am pleased to advise you that your Department has approved the amendment to your above application dated 07.04.18 and confirmed that all previous conditions relating to this amendment have been met. We do not require anything further regarding this amendment.

Please Note:

- This email confirms that any conditions have been met and thus confirms final ethics approval for this amendment (it is assumed that you will adhere to any minor conditions still outstanding, therefore we do not require a response to these).
- University of Roehampton ethics approval will always be subject to compliance with the University policies and procedures applying at the time when the work takes place. It is your responsibility to ensure that you are familiar and compliant with all such policies and procedures when undertaking your research.
- If this project involves clinical procedures or administering substances it is a condition of Ethics approval that all relevant SOPs published on the department communities pages are fully complied with.
- Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.

Many thanks,

Jan

Jan Harrison
Ethics Officer
Research Office
University of Roehampton | London | SW15 5PJ
Jan.harrison@roehampton.ac.uk | www.roehampton.ac.uk
Tel: +44 (0) 20 892 5785
Appendix 13. Ayshe translated transcript

Interviewer: Well, slowly. No need to get nervous. We'll just chat. My aim is to get to know you and also to think and discuss your experiences together. Well, you can start talking slowly—

Ayshe: The words do not come to my mind when asked, and they come to my mind afterwards.

Interviewer: Well, we have time. Even if you cannot think about anything at that moment and the words come to your mind later, you should just consider this as a conversation. So this is not a question and answer process. And also considering your mental health, I will just ask you to describe me any stressful traumatic event that you have experienced rather than descending to the particulars of such event. It will be more about the effects of this event in your life. And lastly, I want to remind you that we can suspend the interview process, if you have any trouble, we can also stop and take a break. If you feel distressed or if you are very affected by some questions. Or we can just skip that question. So, you should just let me know in case of any negative situation. We can come back and complete the conversation later. Do you have a question before starting?

Ayshe: No, I don't have.

Interviewer: All right, I'll start with the first thing. What events brought you to [XXXX] Counselling Service? How did you get here for therapy?

Ayshe: When I first came to therapy, it was two years ago. 2 years, I'm not sure but it should be 2 years and I met with Mr. Deniz. One year later, I came back again and I met with Mr. Deniz again. I came through GP. I applied to GP.

Interviewer: Ok. You applied to the GP, and they referred you here. Well, maybe you could tell us about any traumatic events that brought you here? Could you tell what kind of things you experienced without going into details?

Ayshe: Well, I've experienced a lot of events. I was always homeless. Because, my husband was gambling. We always had financial problems because of his gambling problem. When I came to [XXXX] Counselling Service, I had changed a total of 12 addresses. So, how in many years? I believe I've changed 12 or something in 5 years. My husband had beaten me a few times. They were things that constantly recurring in my memory. I was under pressure by my husband. There were lots of things. My husband wanted to take my kids away from me when I wanted to leave him. He made a complaint to Social Services about me to take my son away from me. So there were insults and pressures; he wanted me to return on the other hand he was insulting me, so I was in such a complex state. I left my husband, but I was too scared to do anything. Well, I was afraid to do something by myself. I was afraid to go somewhere and talk about my problem. I had no self-esteem. Well, I mean, I was in something very complicated at that time.

Interviewer: Yes. So this is about two years ago?

Ayshe: Yes, 2 years ago.
**Interviewer:** Well, you said you changed 12 addresses in 5 years--

**Ayshe:** I had changed 12 addresses.

**Interviewer:** So, in other words, all these things were approximately experienced five years ago or so?

**Ayshe:** Yes, being thrown out of house, getting beaten up by my husband were experienced in 5 years.

**Interviewer:** In general, how was your situation before that?

**Ayshe:** When I first came to this country, I was already very frustrated. I had married my husband before even knowing him and he became a very different person when we started living under same roof. So he was different, he was rude. I was so shocked when he threw a bottle at me first, I was so surprised. And then I thought I didn't love him. My love and respect for him died. I had a second child. I don't know why I did that. (laughs). Well.

**Interviewer:** When did you get married?

**Ayshe:** I got married in 2008. I came to this country in 2009. I had a son in 2010.

**Interviewer:** A lot of events took place in a short period of time.

**Ayshe:** One thing led to another within a very short period of time. Lots of different things. I had learned that my husband was a gambling addict. Well, we were always being thrown out of the houses we lived in. We were being taken out of our places. Then we were applying to the council, and they were arranging a hostel for us, we were moving to a hostel. Such different environments which I had never been accustomed to. It was hard, it was exhausting. So, the council gave us a temporary home after that. My husband gambled with benefit amount deposited to housing benefit account of the council. We were thrown out there as well. We were completely homeless. I went to the mother of my son's school friend. I stayed there for 3 days. At that time, I realized that my children were a little active. Well, I understood that the lady was uncomfortable from this. I wanted to leave the house. When I called my husband he told me 'Don't leave. Stay there.' And when I left the house, I was slightly insulted. I mean, she acted differently towards me. In other words, she closed the door so hard and then said, 'They messed up my house.' Such words made me feel sad. So many things. When I am talking, it's a bit complicated, but it is also because I don't want to remember too much all those things...

**Interviewer:** Yes

**Ayshe:** You know, I'm always thinking of adapting myself to future and forward and now I can forget things that I've gone through. I mean, after the therapies, talking to Mr. Deniz, there were things that I could not tell anyone else; and the thing I told him sounded normal to me afterwards and there were also other things that I could not tell anybody ever. I mean, these things started to sound normal to me when I spoke out such events later on. Okay, that's what happened and it is past now. Now, I am looking ahead in other words I am forgetting all these things.
Interviewer: I see. So, could we say that talking about those experiences has reduced the terrifying characteristics of what you experienced?

Ayshe: I guess.

Interviewer: When you have the opportunity to talk about-- So in general, you have experienced very stressful events within this short period of time, in 5 years.

Ayshe: We have been separated for three years.

Interviewer: You've been separated for the last three years.

Ayshe: It's going to be almost three years.

Interviewer: Can you tell me a little bit about how you have been affected immediately after these events? So, now it's been a while, but how did those times affect you when you experienced these events in the heat of the moment?

Ayshe: The period after I left my husband?

Interviewer: Well, no in all these five years--

Ayshe: I've been crying in those five years. I was crying for everything. I was angry, I was nervous. For example, if I felt very angry when discussing with my husband, I could throw the things around me. I was constantly cleaning. Uhm, the kids were young, it was exhausting.

Interviewer: Emotionally you--

Ayshe: I was crying a lot.

Interviewer: You have been affected.

Ayshe: I was very angry.

Interviewer: Have you been physically affected?

Ayshe: I had a lot of headaches, but I didn't have any other physical discomfort.

Interviewer: And how did these things affect your thoughts about yourself or life?

Ayshe: Well, I was thinking that I couldn't do anything. I mean, I was thinking, uh, mmm, I was incompetent or something. I thought I was a useless person, I wasn't beautiful. I didn't like my appearance. Don’t know how this was relevant (laughs). I don't know right now. Actually, there were a lot of things.

Interviewer: Like a sense of worthlessness? You know, the idea of inefficiency--

Ayshe: I mean, I was thinking that I was a useless and incompetent person, and I didn't find myself beautiful. I didn't like myself. I was always judging myself as if am I doing everything wrong? And so on... I couldn't know.

Interviewer: I see. Thank you for sharing. Now let's move on, after a while a little time has passed now from what you have experienced; you have been separated in the last
three years which is also a very traumatic and stressful event. Have you noticed any long-term, fundamental changes about yourself after struggling with these as a result of this period?

Ayshe: Of course, I changed a lot; lots of things have changed about me. Actually, it has happened like this. After I left my husband, I felt remorse. Uhm, for a period, I hesitated if I loved him or if I pitied on him. Because I saw him like that, he was living with another woman but I had no love for him when he was living with that woman. I knew that, but I was seeing him as desperate and because of that I was judging myself. I was feeling remorse, wondering whether I loved him or not; this thing lasted for a long time. Then I had another traumatic event upon this. This was even more severe last year. I had another boyfriend after my husband. He was my first childhood love from my childhood. We saw each other for a year or so, and he left me one day at the end of one year and he did this by insulting me. Later he returned to Turkey after 15 or 20 days. He married a girl that had never married before in Turkey. Now I have heard that they are separated. It was a great devastation for me, because after leaving my husband I trusted and believed in this boyfriend so much and I already had no love and respect my husband. When this person left me by insulting me, I felt so ashamed and I was ashamed in front of my children as well. I can mix it up a bit. (Laughs) But these things are in the past now. I am confused now where have we been now?

Interviewer: After these events, is there anything that you have realized as a person--

Ayshe: At the moment

Interviewer: What are the long-term changes?

Ayshe: I've changed a lot, I'm calmer, I can make more logical decisions. I'm more self-confident. I can do things. I'm participating in social environment. I can make a lot of new friends. I used to be cut off from people a lot. I used to withdraw from people; on the other hand I could not stay in the house on my own for an hour or something. Now I can go anywhere. I can make new friendships. I'm doing a lot of things. I did voluntary work for a while. I'm going to college now. I mean, I am able to do everything that I used to say I couldn’t do, so I can stand on my own feet now. I've got two kids, and if you ask me what's changed; I can say lots of things have changed (laughs)

Interviewer: Yes, it is very positive and

Ayshe: I can always say positive words to myself such as I can do this, I can achieve this. At first, I thought it didn't have much effect, but then later, I have seen that it really works.

Interviewer: So, as a person, do you feel much stronger?

Ayshe: I'm much stronger, so I'm doing everything that I used to say I couldn’t do, so I'm much stronger and I have more self-confidence. But I believe this is also related to the fact that I'm using this tablet. This also has an effect. It is a kind of a

Interviewer: Medicine

Ayshe: It makes me feel calm, because I gave up using it for a while. Then I started again now. I've started again for five or six months. When I gave it up, I was always in a
weeping state. Now I have started again and I feel much better. I'm not afraid of anything anymore.

**Interviewer:** How, for example, what kind of things are you not afraid of?

**Ayshe:** For instance, when I was about to go somewhere, I would feel stressed and panic wondering how would I talk and what would I tell? I was embarrassed when I met someone new, I was afraid. I felt like there was something wrong with me, and I used to wonder did they notice or feel this problem I have. Then I used to feel shy about this. Wish I could talk about this (chuckles). I was wondering if it really looks like I have a problem from the outside and I used to feel shy, I used to blush; I was ashamed of everything.

**Interviewer:** OK, now you're feeling that it's not the case anymore?

**Ayshe:** Yes, I'm not ashamed of anything. I appreciate myself. I love myself. I'm talking to everyone. [Very good.] I don't care even if people say different things or even if they think differently in an environment... Because their opinions do not really matter if I know the right thing or if accept myself as it comes. Not at all important. Do you understand what I mean?

**Interviewer:** Yes, I understand very well and it is very positive.

**Ayshe:** (laughs) It sounds like I can't express correctly and then I feel like I cannot help you in this work and I feel embarrassed.

**Interviewer:** No, please don't think so. You've really helped a lot.

**Ayshe:** In fact, there are lots of things and there is too much variable in this regard. It may not be coming to my mind, I mean it does not.

**Interviewer:** No, you have actually mentioned a lot of things, so you mentioned a lot of areas, for example the social area (clears throat) in your life. You can talk to people more comfortably. You can maintain friendships with people. Uhm, you've said you are going to school, you know, education ...-

**Ayshe:** Last time, I was attending college and this year also I am attending the college. I go to the same class, I'm learning from the same teacher. I was embarrassed when I entered the classroom last year. I couldn't say the thing that I already knew. Because I was embarrassed, I mean I felt like everybody was looking at me. I didn't like my face, I wasn't looking at anyone. I'm much better this year, much more comfortable. I was afraid to sit down somewhere, now I can sit anywhere I want. I want to do it, I want to sit, and I’m sitting, so I am doing everything that I want.

**Interviewer:** So it sounds like you're more comfortable in social situations.

**Ayshe:** Yes, I'm much more comfortable. I used to blush, feel uncomfortable, I used to be out of breath; I don’t feel any of these anymore.

**Interviewer:** Maybe there has been a change in the value you put on yourself.

**Ayshe:** Definitely, definitely.
Interviewer: Well, some people talk about overcoming difficulties or understanding that you could overcome difficulties more comfortably. Did you have such feelings?

Ayshe: So, I had fears and difficulties such as how could I stand on my own feet, how I could look after my two kids on my own when I left my husband. But now I can overcome them all so I can achieve all the material and emotional stability, I can do all of them on my own.

Interviewer: You have understood that you can do more, your self-confidence has increased. In your relationships with others, social and--

Ayshe: It's completely changed.

Interviewer: and you have leap forward in the field of education. How do you think your experiences may have affected these? Obviously your life has changed a lot, the way you look at yourself, your perspective on your life. How could all these bad experiences have led to all of these things?

Ayshe: (8s) Well, I don't know, but I had to do it because I was on my own. I have no support or family here. Because I'm on my own and I have to do it, I have said to myself 'I can do this, I have to do this' even though I cry or have lots of difficulties. My children, for example, I used to feel that I have to do more as I see my children and I used to force myself to do it even though I had to crawl out of bed. I really do not know how I succeeded (chuckles).

Interviewer: When you look back, do you feel like you've achieved the impossible? I mean, how you succeeded...

Ayshe: It's because I was really exhausted. I was very weak, fatigued, always tired, constantly crying, and sleepless and I was not eating anything. I started to weigh 49 kilos. So, I was doing everything while weeping at the beginning because I was very weak, I achieved by crawling I guess (laughs). I mean by being-

Interviewer: With having difficulties...

Ayshe: It was very difficult. Maybe it would have been easier if there was someone who could support me or someone I could trust.

Interviewer: Were your family in Turkey?

Ayshe: Yes, in Turkey. It would be a lot easier, I guess.

Interviewer: Have you experienced a change in your relationship with them?

Ayshe: About my relationship with them, they first rejected me because I met someone else after leaving my husband, because they didn't want me to see him. They knew this person because he was coming from the same place as my family so they rejected me. They never talked me for a year. My mother and brother, I still don't see my brother, but I am talking to my mother now. I just talked to my sister. So there's not a lot of emotional support.

Interviewer: This is a very sad situation.
Ayshe: Not much has happened actually. I was seeing my sister. But they didn't offer moral support. But now I'm talking to my mother, and I'm not offended by them. I just accepted everything as it is. [You accepted ...] I just accepted them as they are.

Interviewer: Hmm.

Ayshe: Because I have no other choice. Because she's my mother. Even her asking how I am doing could be enough sometimes.

Interviewer: I see. Sad, of course.

Ayshe: Yeah.

Interviewer: Being in this situation with your family which you had very close relations in the past. So, as far as I can tell from what you say, it's like you always say “I had to, I had no other choice.”

Ayshe: I had no other choice.

Interviewer: I've come to this situation by crying and being forced to. So I've come to this more positive situation, and I'm much stronger. So it is like all your options were closed, there was no other option for you and so you know the only thing to do was to look forward and move on-

Ayshe: I had to draw a road map and be determined and move on that path I had drawn for myself. Either I was going to get lost or I was going to be strong and win my kinds and move on living with my kids. Because, I could have lost my kids. I could have lost my children when my husband had made a complaint to Social Services to take my son away from me. I could have ended up in much worse situation in psychological terms. I pushed myself by saying "I love my children, I love myself".

Interviewer: Yes. Well, could you say that; the situation you are in now is much better compared to your life before you experienced all these events? Or is this not the case?

Ayshe: You mean my life in Turkey before even experiencing all these events--

Interviewer: Yes, you have come out of this crisis stronger but how do you compare this with your previous life?

Ayshe: In fact, I didn't have a great life. My mother was an uncaring person. I believe, I have a much more organised life right now. Because, when I met my husband, I was a child who had been raised unhappy and stony-hearted by my mother. I am saying I was a child but I was 27 when I was married, but I regarded myself as child (smiles) because I always have a child living inside me, that is different, sometimes it goes crazy (laughs). So I didn't have a very nice life, I mean I was longing for affection. I needed attention. I actually ran away from my mother. In fact, marrying my husband was actually trying to escape from my mother.

Interviewer: The fact that you are aware of this actually suggests you are at a good point. So you have awareness of yourself and about your feelings.

Ayshe: Now I sometimes jokingly say something like this; 'wish there was someone who caresses my hair, who loves me or something (chuckles). Even though I say these words jokingly, sometimes I might actually need this kind of attention, but ... (tears up)
Interviewer: Of course.

Ayshe: I do not trust.

Interviewer: Yes.

Ayshe: I don't really trust people around me.

Interviewer: Did this lack of trust come to existence after you've been through all these things?

Ayshe: hmm-hmm. I haven't cried in a long time (becomes tearful). I've never been crying for 3-4 months, but I think I'm suppressing this issue of affection. That's why I think--

Interviewer: It seems that this issue of missing out on love is a big wound.

Ayshe: I'm suppressing this a little. Because at times I feel like I need something, but I'm moving away from this feeling. Maybe in the future, this suppression will cause a problem for me or it will cause difficulties for me, but there's nothing I can do.

Interviewer: The sense of a lack of love?

Ayshe: (Nods) It has been a very long time since I cried last. I was even asking 'Why don’t I cry?' (tearful)

Ayshe: [Crying]; For me (clears throat) - It is.

Interviewer: I believe it is painful for you to speak about these issues.

Ayshe: Well, sometimes.

Interviewer: So, considering the things you have said, it seems that you are now in a better state compared to your previous life.

Ayshe: Yeah. (Grabs a pen) [Clearing throat]: I feel better when I play with something.

Interviewer: Are you feeling a little nervous? How are you feeling?

Ayshe: I feel like I'm a little tired.

Interviewer: Yes. Should we continue?

Ayshe: Yeah!

Interviewer: Can you tell me if your perspective on life has changed or not? I mean, in terms of priorities--

Ayshe: My perspective on life ... it has changed, everything has changed.

Interviewer: Well, have your priorities changed? Do you have new priorities?
Ayshe: My priorities have changed. First of all, I am important. Me first. This is not selfishness. I am thinking like 'I should be good so that I can help my children'. Priority is myself, then my children.

Interviewer: Is there a change on the value you have placed on your life?

Ayshe: The value I place on my life? I don't know. Could you give me some example, like a point that I could understand it?

Interviewer: Well, you have already mentioned that you value yourself more. Have you ever thought that your life was more valuable?

Ayshe: I value my own life, of course, I sometimes buy myself gifts (laughs) to treat myself, I buy myself coffee and a present and so on.

Interviewer: Are these your new habits compared to previous life?

Ayshe: Of course, these are my new habits. Buying myself coffee or tea. Special, I go to the bagel seller for myself.

Interviewer: Doing something for yourself.

Ayshe: For instance, I never looked around when I used to take a walk. As I walk through the park now I'm looking around all over the place. It's irrelevant, but it's just come to my mind.

Interviewer: No, it is not irrelevant, actually. So, you are also engaging in different behaviors. Like looking through, looking around and doing something for you. What do you think this act of looking around is related to? So you didn't use to look around at all, why are you looking now?

Ayshe: I didn't have time to look around in the past. Kids are very young; you're always taking care of kids. I am having problems with my husband as I take care of the children. There's always a problem. You're always thinking about problems. (2s) I wasn't looking, I wasn't able to look around. Now, perhaps I am looking around because I've spent more time on my own, for taking some private time off for myself. For having a special time for kids. I mean, time for myself ... Now I can spare a certain amount of time for myself as a special time. What can I do during this time? I can walk around ... I can walk in the park, or it's the simplest. So, when I'm walking, I'm looking around. In the past, I didn't have such time. My special time was in fact my children's special time... There could not be a time for me. Even if I had time and tried to take the children walking outside, I could not notice the things around me, such different people, trees, flowers, birds and so on. Because, there was always a problem in my head or because I always had issues with my husband.

Interviewer: I think your mind is clearer now.

Ayshe: Yeah, yeah

Interviewer: So this experience, focusing on the trees and flowers around rather than dealing with problems inside your mind when you are walking outside. How does this experience make you feel?
Ayshe: I feel lighter than older times; I'm filled up with more energy. I'm enjoying life. Well, this is how I feel compared to that time because I was always tired, tired, tired, tired, and tired. I feel lighter now.

Interviewer: This, in fact, sounds like enjoying life more than ever. [Ha, ha] And do you ever feel that way compared to your life before struggling with all these problems? Do you feel much lighter, more able to have fun or is this not the case?

Ayshe: My life five years ago?

Interviewer: Yeah. So, comparing the old you and present you

Ayshe: At that time, I was very happy in my circle of friends. I had a very nice friend’s environment. At that time, my family was the missing part in my life; on the other hand I was very happy with my friends. Now, my missing part is actually (laughs) lack of being loved, attention. Now I can enjoy life more. Yes.

Interviewer: So you can actually see things internally. What you were missing then and what you are missing now.

Ayshe: Yes, I know those missing parts and I can see them.

Interviewer: They are actually rather similar, I mean they do not differ greatly but still do you enjoy life despite this?

Ayshe: Yes, because I feel more proud of myself for being able to stand on my own feet. Back then, I was just having fun with my friends, I was happy, there was a lot of craziness in it, and these things could be enjoyable. Whereas now... I really love my children. I'm so proud that I could stand on my own feet. Now, I enjoy life more because I feel proud for achieving something for my children. Because I believe that experiencing my kids are so different, it is very nice to hear them saying "morning" after they wake up in the morning, it is also nice to hug them or seeing them mess with each other and so on. I think these things give me more happiness.

Interviewer: Okay. So, you have also mentioned about your friend's circle; has your relationship with them or new friends changed compared to previous years?

Ayshe: Friends from five years ago? I have friends that I'm still seeing. We're still seeing each other.

Interviewer: When you were talking about relationships with others, you said, you said that you can actually make friends more easily; on the other hand you also stated that you do not trust people. So, I believe the things you have experienced and your struggles might have an effect on your relationships with other people.

Ayshe: Yes, they have had effects on my relations.

Interviewer: Like what, so can you comment on this? What do you feel is different now?

Ayshe: I feel mistrust against people, I mean I am seeing them, I talk or have conversation with them but I'm not taking any further steps in my relations. I'm not getting any closer, and I'm trying to keep the distance because of the mistrust. Of course I have this close friend and I call her 'big sister' because she is older than me; I share
everything with her but I am trying to keep the distance with other people that I see apart from my big sister because of mistrust. I am talking, seeing everyone and all of them are my friend and I like them all.

**Interviewer:** You're not becoming intimate and you are just keeping the distance. Well, has your relationship with that person you are close with (whom you call big sister) changed compared to your previous life? Your intimacy, your sincerity?

**Ayshe:** I've been seeing her for, like, three years. Of course, I've become distant from this person as well for a month, two months or so.

**Interviewer:** So you're also feeling mistrust against people you're feeling close?

**Ayshe:** Yes, I do.

**Interviewer:** What kind of lessons did you learn from all these experiences?

**Ayshe:** (4s) What lessons have been learnt.. Well, uhm... In fact, the lessons I've learned is my present situation, well... uhm...

**Interviewer:** What have you learned; what have your experiences taught you?

**Ayshe:** I couldn't tell what they've taught me but I already said a lot of things. What I have inside this (laughs)? [Yes, actually-] What have I learned?

**Interviewer:** [You have said a lot of things]

**Ayshe:** I have learned to esteem myself. Well, uhm.. (9s) Nothing comes to my mind now.

**Interviewer:** We have actually said a lot

**Ayshe:** We have said a lot

**Interviewer:** About yourself

**Ayshe:** I have learned to esteem myself, and also I have learned to spare time for myself. Uhm, I started to have a reading habit, well...

**Interviewer:** Does reading books help?

**Ayshe:** Yeah, I mean, it makes me feel calm and it's nice, I enjoy reading some things. I am watching series, in the past I never watched TV or series; now I have started watching. I can stay home for hours (laughs)

**Interviewer:** In fact, you're staying by yourself.

**Ayshe:** I couldn't stay, I couldn't do that in the past, I mean, it's like sparing time for myself

**Interviewer:** Yes, yes.

**Ayshe:** I didn't have the habit of cooking too much, and I always used to cook appetizers such as soup and stuff and sometimes we used to spend pleasant time with
Fatma (my daughter's name is Fatma) by cooking pastry. I don't know, lots of things have changed in parallel with lots of habits.

**Interviewer:** Yes, it sounds very interesting to me, they seem very positive as well.

**Ayshe:** I've become more confident.

**Interviewer:** And I think they have had a direct effect on your life because your habits have changed as you say.

**Ayshe:** Totally, everything has changed a lot. It's completely changed.

**Interviewer:** Very nice. OK, now let's move to the second part. Let's talk about your therapy experience. Can you talk a little bit about your experience of receiving therapy from [XXXX] Counselling Service? How was it for you, what kind of experience did you have?

**Ayshe:** At first, it was difficult, I can say it was frustrating to tell the same things all the time, to talk about the bad events I had been experiencing or something like that. You come here and keep crying and crying [laughing].

**Interviewer:** Yes.

**Ayshe:** At first, it sounds annoying. But somehow, for example, you cannot understand the doctor's advice or the words said by the doctor at the time, but then you can remember those said words or advice when you experience something similar and this feels very good. Uhm. I am not able to talk [laughing] I can't tell.

**Interviewer:** But you are telling everything very nicely.

**Ayshe:** Am I? I don't think so.

**Interviewer:** You're panicking?

**Ayshe:** What the doctor said at that moment does not happen. You know, it doesn't matter much, but then I'm doing something by remembering those words said by the doctor. Something changed.

**Interviewer:** I think I understand. I mean, maybe there are not lots of things during the session; maybe it doesn't make much sense. [Overlapping speaking] Maybe you can't internalize them very much.

**Ayshe:** It doesn't make much sense, uh huh.

**Interviewer:** But in your own time after you leave there--

**Ayshe:** When you stay calm, [yes], you think or when you experience another thing or re-experience the same thing you can remember what the doctor said and it can make you feel better at that moment. Because, you can feel a little panicked when you're listening to the doctor at that moment. You're getting a little tired because you cry and you can't understand. After that--

**Interviewer:** Do you have an example in your mind? An example of this moment you've described? A moment that has changed you?
Ayshe: Uhm-, (3s) For example, I would be very breathless, could not breathe. Like, I'd sob my heart out-- Mr. Deniz showed me some exercises that could help me breathe more easily. Then, I would try to practice those again when I felt so bad, or try to feel the place I'm sitting on or quitting the work I am doing at that moment and focusing on another work or something like that, uhm

Interviewer: Hmm.

Ayshe: Uhmm. I'll remember those later- uhm well (Laughs) Oh! Let me start again (laughs). For example, when I finished talking with Mr. Deniz, I used to follow the advices given by Mr. Deniz when I experience some problems again in my daily life. If I'm doing something, I'm trying to do something else by focusing on doing something else or you know, by doing breathing exercises or something like that--

Interviewer: Okay. So what were the challenges of the therapy sessions you received?

Ayshe: If I was to talk about the things that I did not like or the challenges, I can say I did not like constantly repeating all the bad memories that I did not want to remember at all. It was tiring.

Interviewer: Let me ask this, does speaking the same language or coming from same cultural background have an effect?

Ayshe: [Overlapping speaking] Definitely, very much. Because, I had previously consulted another doctor through an interpreter, but I could not express myself. Of course, I cannot express myself from time to time in Turkish perhaps because of the situations I have experienced, I might feel confused or panicked, but I think that was because of the cultural differences. They understood what I said in a different way.

Interviewer: Hmm.

Ayshe: Mm-hmm.

Interviewer: So you felt more comfortable to express yourself.

Ayshe: Mm-hmm.

Interviewer: Well, let me ask this way. We have just talked about what has changed in your life. So have talked about many positive changes such as; you feel more powerful, you have learned to appreciate yourself more than usual and you spare more time for yourself or you keep a distance in your social relationships. So how do you think therapy has helped these positive changes, if so?

Ayshe: (6s) How the therapy helped, well - Mr. Deniz gave me advices such as finding activities that I could enjoy more. Or read a book, exercise and also he was showing me how to thing but I that time I used to feel like not doing anything because I was tired and those things sounded boring to me. But later, I kept constantly trying and trying--

Interviewer: Well. OK. Have you ever discussed with Mr. Deniz about these changes that you have experienced such as appreciating life more or the ones that we have just discussed or have you ever realized these during your therapy process? So, your life after the worst events you've experienced [overlapping speaking]

Ayshe: When I have moved on to this new era ...?
Interviewer: Yeah, I mean when it was better.

Ayshe: Unfortunately we haven't discussed yet. Not yet.

Interviewer: So during the therapy, you didn't feel those changes.

Ayshe: I didn't like anything, I didn't feel like doing anything.

Interviewer: But did you think that the transition from the therapy had an effect?

Ayshe: I certainly do, I think, definitely.

Interviewer: Well. Mm-hmm. Uhmm--

Ayshe: Because, I wanted to rise up after a moment. I wanted to do something. When I start thinking what can I do, I started to remember (as I said previously, you start remembering the words said during therapy when you start to feel calm.)

Interviewer: Yes, I see. I mean...

Ayshe: Maybe it's about this: because I wanted to do it. Because that suffering starts to decrease, you're looking for a way out when that suffering is gone. I believe doing something starts with wishing.

Interviewer: Hmm.

Ayshe: When doing something starts with wishing, you start to remember those advices.

Interviewer: It comes to your mind. Yes, very interesting indeed. Because, those advices may not be so useful at the beginning. Maybe you don't feel ready.

Ayshe: It makes no sense, it sounds ridiculous what the doctor says. But after that time of suffering, that thing is-- Maybe I think that the suffering period is under my control. Uhmm--

Interviewer: Hm, how?

Ayshe: But maybe my children have a lot to do with it. Well, for instance, a bear hug of Fatma is a reason for stating that I need to get stronger. Because she is giving me a bear hug sincerely.

Interviewer: How old is she?

Ayshe: Umm, 5 years old but she is about to be 6 years old.

Interviewer: so sweet.

Ayshe: I know, I know. [Laughing]

Interviewer: In other words, the love of your children and your relationship with them has been the biggest thing that gives you strength and contributes to your positive changes.

Ayshe: Uh, huh.
Interviewer: And with the therapist--

Ayshe: In other words I am thinking like this; I think that the people who are in such a difficult situation, who feel very bad about their lives, can succeed with all the sincerity of those who hold their hands with love. I don't know if I am right thinking this way.

Interviewer: Hmm. It makes sense. Do you think that you have felt this kind of relationship in therapy?

Ayshe: Umm about Mr. Deniz, I was feeling very close to Mr. Deniz. I even want to see him now. Even though I wasn't able to do certain things I tried to do them just to look good to Mr. Deniz (laughs) because I was feeling very close to Mr. Deniz. But I love Mr. Deniz very much. I wanted to do something because I liked him.

Interviewer: Well, your relationship with Mr. Deniz has affected you in some way as well.

Ayshe: Oh, because I wanted to talk to Mr. Deniz for a second time and I continued seeing Mr. Deniz for a second time.

Interviewer: Hmm.

Ayshe: I mean, I felt very close to him. Mm-hmm.

Interviewer: How do you think this helped you later? I mean, it did not help at that time, I know, but when you decided "I need to do something now", after getting over the difficulties and reducing the pain you felt inside. What was the effect of your relationship with Mr. Deniz during the process that you decided "I need to do something in my life"?

Ayshe: Mr. Deniz used to tell me that I would be good in the future, I could achieve things and I was a very strong person. Well-- I used to think or I am thinking, one day I wanted to be a person as Mr. Deniz described me. (Laughs). Uhm, this is just because, I think, I love Mr. Deniz so much. Being a person as he told me, I know, maybe he will not know about this but inside I'll feel I have made him happy because I will be able to achieve something by using the advices he taught me during our sessions. I couldn't describe this perfectly please put these words together (laughs).

Interviewer: (laughs) Yeah I guess, yeah you're right, so giving him something back

Ayshe: Maybe he will not know about this but I can feel that this will make him happy. Just like that. Are we finished?

Interviewer: Are you tired?

Ayshe: Yeah

Interviewer: We're almost finished. It's about to finish. Well, have you felt anything that might have prevented you form experiencing a positive change during the therapy apart from crying and feeling bad? Could you tell me anything like this?

Ayshe: No

Interviewer: Never happened?
Ayshe: Is it something that would stop me from telling anything?

Interviewer: Like any obstacle that could prevent you from coming out of crises stronger

Ayshe: No, I did not experience anything like that...

Interviewer: You've never experienced any negative side

Ayshe: That negativity was already related to me, disliking everything was already my problem

Interviewer: So you feel like there was nothing that's blocking you and holding you back.

Ayshe: There was nothing like that.

Interviewer: Well, we are in the final part now. Can you describe the most important lessons from your therapy in [XXXXX] Counselling Service? Tell me the most important things and the things that you have learned.

Ayshe: The most important thing I have learned

Interviewer: You mentioned the advice of Mr. Deniz, I believe you mentioned his belief that you could be a strong person in the future; do you think there are other things that you have learned?

Ayshe: There was a breathing exercise. It's very important because when I feel helpless without being able to breathe, that exercise was very important so I can say that's the first one. And then two minutes of thinking, what was that? I was constantly becoming obsessed with something and started to think about that thing. Even though I say to myself I will not think about this, I couldn't help but thought about it. So there was the two-minute rule.

Interviewer: Yes

Ayshe: I practiced that rule a lot. At the beginning it didn't work. Same thoughts would still come to my mind and I started to think about them but the rule of two minutes became helpful over time

Interviewer: You limit your thoughts

Ayshe: It's like a punishment (mutual laughter). When it's a punishment you give up following that after a while... I think it is becoming a habit and changing. You impose the rule of two minutes [uh huh] At first, it does not work out when you start to impose this rule but then it starts to work out fine like a habit. You just say to yourself "I have the rule of two minutes."

Interviewer: So after a certain point it is becoming a habit, you get used to it. [Uh huh] You talked about breathing exercises, a feeling of helplessness, of course, not being able to breathe and feeling panicked are very bad feelings

Ayshe: It was very intense back then, and now I feel panicked and I can confuse and forget what I'm going to say during a conversation. For instance, if I think about
something, I can confuse and forget those things very easily. This happens today as well but not as severe as before, everything could crumple up so easily in the previous times. Now it goes in a much more controlled manner.

**Interviewer:** The feeling of helplessness that you mentioned may have changed in your general life or the feeling of helplessness in those moments of inability to breathe. Well, is there a change in general, I wonder if you feel helpless, how desperate you feel

**Ayshe:** In general terms

**Interviewer:** In other words, the helplessness in life, does it mean that you are feeling less helpless in general and not in moments of failing to breathe.

**Ayshe:** At this moment?

**Interviewer:** Yeah

**Ayshe:** I'm not desperate. NO. I don't have this kind of helplessness right now. I'm not helpless, I have the solution! [Interviewer: hmm! (impressed). Ayshe: hmm!] I have the solution, so there is nothing helpless. I don't think there's anything helpless. There is a remedy for everything

**Interviewer:** Very good

**Ayshe:** I'm just doing this; If I enter into a mood and feel very desperate, I let those things slide because I should think and remain calm. I can do wrong things at that moment or I can say wrong things and I can follow up a wrong path at that time. I have to let that things slide for one day or so

**Interviewer:** Hmm, this also sounds like a good method (mutual laughter). Did you learn that later as well?

**Ayshe:** So I started to do this so much later, like starting from this summer

**Interviewer:** What is the thing that you most appreciate about yourself currently?

**Ayshe:** What do I appreciate about myself... Aww.. Like what? In terms of appearance?

**Interviewer:** Anything, it doesn't matter, [mutual laughing]. It could be either appearance or emotional things

**Ayshe:** Well, I could not know. Could you give me an example? I like myself, I mean, I adore myself

**Interviewer:** Tell me about your appearance then

**Ayshe:** My body, because everybody likes my body and this makes me feel like a cool person [laughing] because a lot of people want to lose weight and they always ask me the same things like "how do you lose weight?" I'm not losing weight, I'm not doing anything. I even eat too much in the evening, but I am also walking a lot, I'm consuming a lot of water, yes, I like my body
Interviewer: Great very good. [Mutual laughing] Well, lastly is there anything you want to tell me or anything that you think I should know so that I could know and understand you better. Any topics that you did not mention about

Ayshe: I'm a very good mother, I'm perfect, I don't know, I just wanted to say this.

Interviewer: Maternity is very important for you

Ayshe: Yes, it is important.

Interviewer: I see

Ayshe: Yeah

Interviewer: Well, is there anything you wanted to ask ...

Ayshe: I am so strong

Interviewer: Yes

Ayshe: Yeah Of course, I'm strong

Interviewer: Well, to be strong and to be a good mother for your children. These are important values for you.

Ayshe: Important, very important

Interviewer: Well, thank you very much, is there anything that you want to ask me before finishing?

Ayshe: No, thanks.

Interviewer: OK. Thank you very much, you’ve been very helpful

Ayshe: I am happy, if I could help and explain

Interviewer: Very much. It's been very good.