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"This is a wound of the soul" – examining experiences of lay therapy as trauma treatment in northern Uganda

Mattias Norlinder & Jenny Pein

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Handledare: Lars Gunnar Lundh
Examinator: Håkan Johansson

Abstract

Background: This study explored the experiences of clients, therapists and supervisors in regards to lay therapy as trauma treatment in Northern Uganda. The participants' experiences of what is important in the implementation, planning and context for such treatment setup to be successful, as well as the potentials and limitations are explored. **Method:** A total of 14 semi-structured interviews were conducted with 13 participants, consisting of two clients, nine therapists and two supervisors. The contributions from the participants were analysed using thematic analysis resulting in a total of 18 themes across four groups. **Results:** The main results showed experiences of initial suspicion from the clients towards the therapists, distress in connection to the clients' stories, a lack of resources combined with extensive needs, and the importance of a supportive organization in a lay therapy setting. **Discussion:** Shared aspects in the background of the client and the therapist is stipulated to play a role when forming an alliance. An integration with other support systems, clearly defined boundaries and ongoing supervision and training are put forward as important considerations for future lay therapy interventions.

Keywords: Lay therapy, Lay counselling, PTSD, Task sharing, Treatment gap, Trauma

Sammanfattning

Bakgrund: Denna studie utforskar klienter, terapeuter och handledares erfarenheter av lekmannaterapi som traumabehandling i norra Uganda. Deltagarnas erfarenheter av vad som anses vara viktigt gällande implementering, planering och kontext utforskas tillsammans med vilka möjligheter och begränsningar deltagarna ser gällande detta behandlingsupplägg. **Metod:** 14 semistrukturerade intervjuer genomfördes med 13 deltagare varav två klienter, nio terapeuter och två handledare. Deltagarnas bidrag analyserades med hjälp av tematisk analys och resulterade i 18 teman i fyra grupper. **Resultat:** Studiens huvudsakliga resultat visade på erfarenheter av en initial misstro från patienterna gentemot terapeuterna, bristande resurser kombinerat med omfattande behov och pekade på vikten av en stöttande organisation för en fungerande lekmannaterapi. **Diskussion:** Gemensamma aspekter i bakgrund mellan klient och terapeut kan ha en betydelse för alliansbyggandet. En integration gentemot stödsystem, tydligt definierade gränser samt pågående utbildning och handledning läggs fram som viktiga faktorer att ha i åtanke för framtida interventioner med lekmannaterapi.

Nyckelord: Lay therapy, Lay counselling, PTSD, Task sharing, Treatment gap, Trauma

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Table of Contents

Introduction

Post Traumatic Stress Disorder (PTSD) is a worldwide issue and cause for suffering, the prevalence of which is higher in lower-income countries and post-conflict settings (Atwoli, Stein, Koenen & McLaughlin, 2015). Uganda, a country burdened by civil conflict for decades, has a high level of PTSD, combined with a lack of effective public mental health services to address the associated needs (Mugisha, Muyinda, Wandiembe & Kinyanda, 2015).

Treatment Gap is a term which is used to describe the gap between the number of people who are in need of treatment compared to the number who receive treatment (Wright & Chiwandra, 2016). When it comes to PTSD treatment in low and middle income countries, WHO recommends "an approach that balances (a) strengthening the availability and capacity of specialists to train and supervise and (b) shifting to the delivery of psychotherapy by non-specialists...". This is a strategy that is described as one of the most important ways to be used in the work towards closing the treatment gap (Tol et al., 2014).

> Building the capacity to train and supervise psychotherapeutic interventions in non-specialist settings will be crucial to ensure that such services [treatment of trauma related mental health issues] are sustainable and of sufficient quality [31]. This is likely to require a balanced approach in building capacity of both specialist supervisors and non-specialist health workers in community and primary health care settings (p.4)

The term *lay therapy* was first used in 1950 as a term to describe a treatment method for alcoholism where the treatment was performed by "laymen" who had experiences of alcohol addiction themselves and had gone through a specific treatment method (Mann, 1950). This thesis will examine experiences regarding lay therapy as trauma treatment. In this study the term will be defined as a person who does not have a therapist degree, goes through a brief education of conducting therapy and a treatment method, potentially along with the treatment itself, in order to work as a therapist (Woods-Jaeger, Kava, Akiba, Lucid & Dorsey, 2017). An example could be that a person who is or has been a refugee and has suffered from issues in regards to trauma, later can become a therapist and work with people who are suffering from similar issues as those the therapist themselves has experienced. The terms *task sharing, task shifting, lay counselling, community health worker, non-specialized health worker* among others are sometimes used as synonyms to lay therapy and in this thesis the

term lay therapy will be used throughout the text except in quotations or when referring to specific articles.

Evidence from psychotherapy research shows that it is not just the specific therapy method that is important for the outcome of psychotherapy. The characteristics of the therapist, and the relationship between the therapist and the patient, as well as cultural adaptation are important for the outcome, something that is sometimes referred to as *therapist effect* and *common factors* (Martin, Garske & Davis, 2000; Wampold, 2015). Other research shows that shared experiences between the therapist and patient, such as a shared structural position in society, have an importance for therapy (Goode-Cross, 2011; Hultqvist & Berg, 2015). Some studies show how self-disclosure by the therapist, or sharing of personal information to the client, can improve therapeutic relationships and therapy outcome (Hill, Knox & Pinto-Coelho, 2018). Taken together, this points to the importance of investigating the different experiences of lay therapy further.

Lay therapy is often used in emergency settings and the Inter-Agency Standing Committee (IASC) describe in their text *Guidelines for Psychosocial Support in Emergency Settings* (2007), what they call *the intervention pyramid for mental health and psychosocial support*. This is a way of describing the differences between general interventions and specialized interventions and is divided into four tiers ranging from basic services to specialized services. Lay therapy interventions would here be classified as being on either layer three depending on the circumstances. If used with basic mental health or such as psychological first aid, this would be classified as layer three, and if conducted in a more specialized manner such as trauma treatment that would be an example of layer four. This classification can be helpful in order to know what considerations should be taken when implementing and planning a certain intervention.

The civil war in Northern Uganda

This thesis is examining experiences of lay therapy as trauma treatment in Northern Uganda. In order to understand the context in which this treatment is taking place, a short description of the recent civil war will follow.

Northern Uganda was engulfed in a civil war from 1986 to 2006, with fighting lead between Government forces (UPDF) and the Lord's Resistance Army (LRA). During the conflict, gross violations of human rights were committed as well as serious violations of

international law, including war crimes and crimes against humanity (UNHCR, 2013). In Acholiland, which was most affected by the conflict, nearly two million people were internally displaced, amounting to 90-95% of the population (UNHCR, 2011). The UN High Commissioner for Human Rights (UNHCR) published a study in 2011 wherein 2,302 victims of the conflict were interviewed. This report found serious violations in terms of killing, torture consisting of cruel, inhuman or degrading treatment, abduction, slavery, forced marriage, forced recruitment, mutilation, sexual violence, serious psychological harm, forced displacement, and pillaging, looting and destruction of property. Although this report describes how the UPDF participated in illegal executions and use of undue force, it describes how the violations conducted by the LRA were more widespread and systematic. The following excerpt from the report is attached in order to get an idea of the atrocities that occurred, some of which experienced by the participants of this study.

> In addition to killing civilians during attacks, the LRA also killed civilians they had taken into captivity, often in particularly brutal ways, including beating, hacking, pounding or crushing them to death, dismembering them, cooking or burning them alive, or breaking their limbs and putting them in pits that they could not crawl out from. LRA acts of torture or cruel, inhuman or degrading treatment included the raping of women and girls, the cutting and burning of women and girl's genitals and breasts, castration of males, dismemberment, cutting body parts, and severe beatings.[...] In addition, the LRA perpetrated torture, cruel or inhuman treatment of civilian populations and abductees by forcing people, in particular children, to harm and kill loved ones, family members, friends, and other community members or captives (UNHCR, 2011 p.12).

One particularly targeted group during the conflict were children, of whom the LRA abducted and forcefully recruited as soldiers. In order to do so, their strategy included three main components: remove the children of all hope of returning home, make them participate in the act of murder, and finally, reconstruct a new persona through the use of superstition and ritual (Storr 2014). To this day the government has offered very little in terms of repairment to the communities and there are still conflicts in the communities as remnants from the past war (UNHCR, 2011). The aftermath of this conflict has left a substantial portion of the population suffering with PTSD (Mugisha, Muyinda, Wandiembe & Kinyanda, 2015).

Previous research

A meta-study by Gwozdziewycz and Mehl-Madrona (2013) indicates that trauma treatment performed by refugees within lay therapy, can be more effective than therapy delivered by professional therapists who were not themselves refugees. One proposed explanation is that both parties share important life-experiences and that the relationship to the therapist becomes more equal, which may facilitate a stronger alliance, as indicated by the above mentioned research and other studies, which points out that different structural positions of therapist and client may be an obstacle in therapy (Berg & Hultqvist, 2015; Skau & Ganuza Johnsson, 2007). This could also be viewed from the perspective presented by Papadopoulos (2007) who writes about *Adversity-Activated Development* (AAD), that is described as the experiences gained from living through (or in) adversity and its associated positive, "growthful" developments. Papadopoulos (2007) considers the potentially positive outcomes of adversity to generally be neglected by professional theories and practices. This presents the hypothesis that therapists who have encountered similar adverse experiences as their clients, in some ways, can be more effective in conducting treatment. AAD is described as finding a part of oneself which didn't exist before the adversity (Papadopoulos, 2007), which may contribute to a greater understanding between people who has lived through similar adversities.

In a study conducted in Malawi by Wright and Chiwandira (2016), lay counsellors within the primary health care system were used to reach out to parts of the population that were hard to reach for the normal mental health care system due to long distances and stigmatization of mental illness, among other reasons. They conclude that the lay counsellors had played an important part in both responding to the needs of the communities and giving an explanatory model which the population deemed credible and giving the mental health care system a greater reach. A greater reach of lay therapy compared to previous mental health care initiatives was also concluded in Tol et al. (2014). Furthermore, WHO describes lay therapy as being of utmost importance for meeting the needs of treatment posed by the high prevalence of PTSD and acute stress symptoms over the world (World Health Organisation, 2007).

Previous research indicates positive outcomes of lay therapy in regards to trauma treatment (Ertl, Pfeiffer, Schauer, Elbert & Neuner, 2011; Neuner et al., 2008; Padmanathan & De Silva, 2013; Van Ginneken et al., 2013; Woods-Jaeger et al., 2017; Wright & Chiwandira, 2016). In a review by Van Ginneken et al. (2013) the outcomes are generally

positive, but they do however claim that the studies they found were mostly of low or very low quality. They conclude the review by pointing out the need for further research.

In a review by Padmanathan and De Silva (2013), the picture seems to be rather complex. This review explores users' satisfaction with lay therapy, along with factors related to acceptability and feasibility. It concludes that although satisfaction with services was relatively high, there were contradictory results regarding satisfaction of needs. This means that even though users were satisfied with the service itself, it was not always the case that the treatment had met their needs of help. The personal characteristics of the person delivering the intervention were considered important in regards to the acceptability of the intervention. In the studies included by this review there are results showing both an acceptance and a lack of acceptance from other professions in the workforce regarding lay therapists. This seems to be an important factor for therapist satisfaction and self perceived competence. There are examples where acceptance from the rest of the workforce increased or was assumed to be increased by different measures taken in the organizations. These examples include ensuring that lay therapists reported to psychiatrists regularly (Balaji et al., 2012), doctors receiving positive feedback about lay therapy from patients (Pereira, Andrew, Pednekar, Kirkwood & Patel, 2011) and clarifying the meaning of counselling to the staff and formalizing the role of counsellors (IASC Jordans, Keen, Pradhan & Tol, 2007).

The previously conducted studies vary significantly in several aspects, both regarding the self-perceived competence of the lay therapists as well as in the amount of training and supervision. The stated length of training was between five months in some studies and two days in others. The amount of supervision varied between weekly professional supervision to a daily peer review group to no supervision at all. More than half of the included studies received no supervision. The self-perceived competence of the lay therapists did not necessarily correspond to the amount of training they received but seemed to bore related to other factors, such acceptance by the workforce. The WHO guidelines for task shifting point towards the importance of regular supervision, advanced counsellor training and networking opportunities with other counsellors, which is in line with the results of this review (Padmanathan & De Silva, 2013; World Health Organization, 2007). The following passage is an excerpt from the conclusion of Padmanathan and De Silva (2013).

> For task-sharing to be successful and sustainable a number of factors need to be considered: distress experienced by the task-sharing workforce; their self perceived level of competence; the acceptance of the workforce by other health care professionals; and the incentives provided to ensure retention of the workforce. As the

> main barrier to addressing these is a lack of resources, it is clear that in order to ensure the acceptability and feasibility of task-sharing interventions, an increased investment in mental health care is essential. (p. 86).

The studies found during the database searches conducted in connection to this thesis mainly used quantitative methodology. They focused largely on either the efficacy of the treatment such as Ertl et al. (2011) and Neuner et al., (2008), or the macro-level such as global or national implications of lay therapy and experiences regarding macro-level change such as in Mendenhall et al. (2016) and Wright and Chiwandira (2016). Very few qualitative studies concerning longer treatments were found. Most studies concerned a low number of therapy sessions (four or less), psychoeducation or referring the person somewhere else. One of few qualitative studies which was directly concerned with lay therapy as trauma treatment and the experiences of participants is Woods-Jaeger et al. (2017), focusing mainly on how the lay therapists have been able to adapt a treatment method which has been developed in a different cultural setting to the needs of their community.

In a study by Naved, Rimi, Jahan and Lindmark (2009) about paramedics in Bangladesh performing mental health counselling for abused women, qualitative and quantitative methods are combined. The study does not concern treatment exclusively for trauma, but rather short counselling consisting of one to four sessions (the absolute majority of the clients came for one session only). The counselling focused on managing stress, improving coping and enhancing well-being. The results show that most women considered the session(s) useful. Primarily, the women considered the session(s) to be useful in terms of the relief attained after talking about their experiences, something that many had not done before. The respect and politeness of the counsellors was something that a lot of the women described in the interviews and that seemed much more valued than the technical competency. Several of the women expressed concerns regarding personal information leaking out, and the privacy that most of them eventually experienced was something that seemed highly appreciated (92% “rated efforts at maintaining privacy as good or very good” (Naved et al., 2009, p. 484). While the women were included because of their experiences and not a trauma diagnosis, PTSD is one of the most prevalent mental health consequences of intimate partner violence (CWF, 2011).

In the review written by Van Ginneken et al., (2013) some recommendations for future research are provided such as providing better descriptions of interventions, for example in terms of training, supervision and incentives as well as investigating potential

adverse effects or unintended consequences. They find it important to develop an extensive typology of lay therapy and its variation in implementation.

There is a need to further develop our understanding in regards to what the therapists and others involved have experienced concerning the actual therapy and what has been difficult, helpful, limiting or overwhelming in their experience, as well as their needs in terms of education and supervision, or other factors concerning the implementation and the context. It is important to further investigate potential risks and issues indicated in previous studies. These risk include *vicarious traumatization*, which is when a therapist working with trauma experiences symptoms of PTSD after hearing the clients' stories (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). Other risk factors include over-identification in terms of the therapists and clients sharing similar experiences, limitations of having a shorter education and acceptance by the community, family and other health care workers (Goode-Cross, 2011; Padmanathan & De Silva, 2013; Wright & Chiwandira, 2016).

The previous studies of lay therapy have focused on shorter counselling, quantitative evaluation, or lay therapy as a tool for treating issues other than trauma. There exists therefore a gap in the literature in regards to qualitative evaluation of lay therapy for treating trauma, which is a gap which this thesis aims to explore.

In addition to what has been stated above, it can be pointed out that lay therapy could have an empowering function, not just on an individual but also on a regional level. It could potentially counteract human capital flight, through strengthening local communities, spreading and decentralizing knowledge and skills, which reduces the risk of people with education leaving the region. A well functioning lay therapy system could therefore have the potential of making low income countries like Uganda less dependent on foreign expertise.

The above mentioned potentials and positive aspects of lay therapy as trauma treatment are mainly hypothetical, or just partly confirmed, and the potential negative experiences or limitations have not been thoroughly described in the literature examined. This is strengthening the reasons as to why it is important and relevant to further explore the potentials and limitations of lay therapy.

A well-functioning and sustainable lay therapy system could be one way of addressing some of the core issues in the developmental issues affecting countries like Uganda, such as centralization of economic and educational resources on both a global and regional level (Tol et. al, 2014; World Health Organization, 2007)

Finally, in a world where many people are unemployed and others are overworked, the class-differences are increasing and the paid labour generate extremely different wages and

circumstances, there is a need for a greater division of labour (Marmot, 2007). We see a need for a division of both high and low status tasks and tasks that are intellectually and physically demanding. Hence we see a need to develop the possibilities of sharing a physically non-demanding and high status task such as psychotherapy. This then becomes an opportunity for power sharing or power spreading since the professional roles and tasks we have are crucial for our position in society (Crompton, 2012).

Aim

This thesis is an exploratory examination of experiences regarding lay therapy as trauma treatment where the experiences of clients, therapists and supervisors are examined. A qualitative analysis of experiences of lay therapy as trauma treatment is deemed to be of high relevance both since WHO recommends this as for future research directions in order to work against the treatment gap (Tol et al. 2014), and since there were no such studies found in the database searches conducted in connection to this study. The ambitions of the authors are for the insights and perspectives given by the participants' experiences to give a useful perspective regarding what could be important in the use and distribution of a well-functioning lay therapy. This thesis aims to gather information about participants' experiences of the limitations and potentials of lay therapy, what is important to think about during the implementation and what the participants think would be beneficial to share with other lay therapy projects. By interviewing clients, therapists and supervisors, this thesis aims to shed light on the experiences of both the receivers of lay therapy, the people conducting the therapy as well as the perspective of the implementation of the training, supervision and planning.

This is an exploratory study and intends to examine experiences that could be of use for further understanding of lay therapy as trauma treatment in order to guide future research directions. In order to answer question number three, as posed below, the results will be compared to the factors proposed by Padmanathan and De Silva (2013) as important for increased acceptability and feasibility in lay therapy settings.

Research question

1. How do clients, therapists and supervisors experience lay therapy as trauma treatment?

2. What is experienced as important in the implementation, planning and context, and what should be avoided?
3. What is experienced as the limitations and potentials of lay therapy?

Method

Participants

A total of 14 interviews were conducted, out of which two were with clients, nine with therapists and three with two individual supervisors.

The recruitment of supervisors was conducted via e-mailing various authors of articles on the topic as well as through contacts of one of the participants. One of the supervisors works in the same organization as the therapists and one works in a different setting. In order to get a deeper understanding of the experiences of the supervisor that works with the participating therapists, two interviews were conducted with this person. Both of the interviewed supervisors work by having a team of lay therapists, whom they provide with training and supervision, as well as providing trainings for members of external organizations.

The therapists as well as the clients were recruited through the out-patient treatment centre where one of the supervisors work. All nine participating therapists work in the same clinic where there are a total of 17 therapists and one supervisor, of which the supervisor also participated in this study. The work-experience of the participating therapists range from one year to ten years. The therapists receive supervision twice a week if they are junior counsellors, and once a week if they are senior counsellors. This is conducted within supervision groups of between three and four people. The therapists have been through an initial theoretical training of between two and four weeks and a practical training for a few weeks after that. This has been followed by ongoing training in related topics to their work as well as refresher trainings. All of the therapists work with a specific treatment method for the treatment of PTSD, while some of the senior counsellors also provide other interventions such as family mediation.

The interviews with the clients were conducted after their treatments had finished and in connection to post-tests approximately eight months after the end of the treatment. Both clients had been abducted by the LRA which was not discussed during the interviews for reasons discussed further in the section "*Ethical considerations"*. An interpreter was used

during the two interviews with clients and the remainder of the interviews were conducted in English.

Interview guide

The foundation for the interview guide was based upon examination of available literature as well as personal interests. Three electronic databases were searched using terms such as: *Lay therapy, Lay counselling, Task shifting, Task sharing, PTSD* and *Community counselling.* The articles deemed relevant were selected and amongst these were Padmanathan and De Silva (2013) and Woods-Jaeger et. al (2017) found to be the most useful for purposes of the interview guide (for a full account of the interview guides see appendix A).

This study was conducted through the use of semi-structured interviews. Each interview finished with a discussion regarding the contents of the interview and suggestions regarding additions or changes for future interviews. Different interview guides were used for the clients, therapists and supervisors respectively. All interviews started with a discussion regarding consent, confidentiality and the purpose of the study, as well as an opportunity to ask questions regarding the meaning of these terms. Further ethical considerations are discussed in the section "*Ethical considerations"* and later under "*Discussion"*.

The interview guide for the clients contained questions regarding background information and experiences of getting in contact with the therapy services or previous experiences of therapy. The interviews also contained questions regarding the relationship with the therapist such as "How is your relationship with the therapist and how has it changed since the therapy started?", or "Do you feel safe in terms of what you tell your therapist will not be told to other people?". The guide also consisted of questions regarding experiences of the therapy in itself, and regarding the satisfaction of needs such as "Has the therapy been helpful to you, if so in what ways? Is there anything that could be improved?" or "Do you remember any specific part of the therapy that was especially helpful? In what way? Do you remember anything as being harmful?".

When interviewing therapists, the interviews contained questions regarding background and what experiences the therapists had found useful or not useful in their work as therapists. This included questions such as: "What experiences in your personal background do you find important/relevant to you in your work as a lay therapist?" or "Have

you ever experienced any hardship separating between the roles as a professional and private person?". The interview guide also consisted of questions regarding the training to become a therapist, the contents of the training, what was considered useful at the time and what was still of use today. The next section of the guide focused on the actual work as a therapist. It contained questions both about what it was like to start working as a therapist and what it is like today, as well as hopes for the future. It also contained questions regarding support from the organization or colleagues, strategies for handling the job when it is demanding or difficult and what needs the therapists have in strenuous situations and everyday life. This included questions such as "Do you remember what you thought/felt when beginning to work as a therapist?" and "How has working as a lay therapist affected you?". The interviews also contained questions regarding the organization of a clinic and what the participants thought could be helpful for other lay therapy projects to keep in mind, as well as what they found important to be able to work as a lay therapist for a longer period of time.

The interview guide for the supervisors contained questions regarding the experiences of starting to work as a supervisor in a lay therapy setting and what the participants had learned from that as well as questions regarding how the work had changed over time and how that has been experienced. The interviews also involved a discussion about the organizational setup, how that has changed over time and other organizational issues regarding being a supervisor in a lay therapy setting. This involved questions such as "In what ways, if any, do you think the organization has to be different when it comes to lay therapy compared with other forms of therapy?", "What purposes does supervision need to fill? How, if in any way, does the supervision with lay therapists differ from supervision with other therapists?" and "How do you conduct the training of the therapists?". The interviews with supervisors also contained questions regarding experiences of recruiting clients and therapists as well as the limitations and opportunities of working with lay therapy. It also consisted of questions regarding what the supervisors had learned from their time as supervisors as well as what has been the main challenges.

Preconceptions of the authors

The authors first became interested in the topic of lay therapy after reading a meta-analysis by Gwozdziewycz & Mehl-Madrona (2013) where the lay therapists obtained better results, when treating PTSD, compared to university-educated professionals. This was seen as

both a possibility of providing more treatment to the people with the greatest needs, at the same time as it was seen as a way of promoting power sharing and a more equal labour market.

The preconceptions of the authors were documented before conducting any interviews. Amongst these preconceptions was that the expectations and attitudes regarding lay therapy and the interviews were largely positive. They anticipated that the therapists sharing a similar background to the clients would improve the understanding and empathy for them. Furthermore, it was speculated that this would in turn cause the client to feel more kinship towards the therapists, providing the client with a better experience of therapy. In their documented preconceptions, one of the authors expressed a hope that "the clients will feel that the therapists really understand them, that they do a good job and that it has helped them."

Concerning the supervisors, there was an expectation that they would have a different perspective than the other groups of participants, in terms of being able to make comparisons of lay therapy with other forms of therapy, for example. This was thought to possibly result in more negative opinions from the supervisors. Additionally, it was expected that "supervision will be very important" and that "the more the better."

In terms of expectations of negativity, the documented preconceptions contained ideas of "difficulties in regards to limitations in education of the therapists", such as "that it's hard to handle complex cases and problems [...] and that you are really dependent on much supervision of good quality."

Procedure

The interviews were conducted in Northern Uganda between the 15th of March and the 10th of May 2018 in connection to an out-patient treatment centre for the therapists, at various places for the supervisors and in connection to post-tests in a village nearby for the clients. The length of the interviews varied from 45 minutes to three hours.

Part of the transcription was carried out in Uganda in 2018 and the remainder was done in Sweden in 2019. Due to time restraints, only six out of the nine interviews with therapists were transcribed and parts of the final three were instead analysed through listening

to the audio files and compared to the codes from the previous therapist interviews. Relevant data from these final three interviews was transcribed, coded and added to the the data-set.

Qualitative analysis

This thesis has explored what the participants have experienced as useful and problematic, and how the implementation and therapy process itself has been experienced. The analysis therefore had a phenomenological focus. At the same time, the nature of the participants' experiences are treated as something real and hence this thesis method and truth claims will be working within a realist framework (Healy & Perry, 2000).

Thematic analysis has been used throughout the analytical part of this thesis. This method differs from other qualitative methods such as Narrative Analysis or Interpretative Phenomenological Analysis in that it is a flexible method that is not theoretically bound to any epistemological or ontological presumptions, but leaves it to the researchers (Willig, 2014). One of the reasons for using thematic analysis for this thesis was the freedom of being able to focus on both the details and the experiences as a whole. This mixture was considered important in order for the results to be able to provide a general picture of the participants experiences as well as details that could be of use in future implementation of lay therapy interventions. The data from the therapists, clients and supervisors were first analysed separately, in order to later be put together into a theoretical map containing the full data-set in order to compare the experiences between all three groups.

In the analytical process the six steps described by Braun & Clarke (2006) was followed. These include familiarizing yourself with the data, generating the initial codes, searching for themes, reviewing themes, defining and naming themes and finally producing the report.

The authors familiarized themselves with the data by first conducting the interviews and later transcribing them.

When generating the initial codes, the data, the two authors first coded the same interview in order to compare and discuss the codes. This was done in order to avoid blind spots and increase coding reliability. This process was repeated for all three groups and a total of 172 codes were generated. When selecting codes and themes, there was a semantic focus in the selection process rather than a latent one which means that the focus was on what the participants were saying directly rather than detecting underlying themes or ideologies. The generation of codes was done without consideration to the research questions or any theory.

When searching for themes, the selection of codes were narrowed down, with combined regards to predominant themes and our research questions. Thus, a code that was just registered once and did not seem to contribute to answering the research questions was excluded. Through general discussions an initial 24 themes were generated across the three groups.

After the initial themes were created, the themes were reviewed. This was done by going back and forth between the codes, the transcriptions, the proposed themes as well as mind-maps while discussing and analysing the contents of the interviews. After this the themes were either adapted or excluded, if they did not seem to contribute to the research questions. Themes that were excluded range from themes focused on experiences that were limited to the practice of a specific treatment method to themes focused on statements that were not directly related to the experiences of the participants. This process reduced the number of themes down to the 15 themes which are now found in the results.

The final codes and themes were mainly included because of their perceived contribution to the research questions. However, some degree of consideration was also taken by giving more emphasis to predominant themes than what was only mentioned once. Consideration was also taken to the more general implications of the data-set with all three groups as well as what was deemed relevant in the separate groups.

Since the material was coded freely and thereafter gathered in themes and connected to theory and research questions, there were elements of inductive reasoning in this process. However, since the authors started the reading of the material with their research questions in mind and since the interview-guide was generated from both personal interest and previous research, there were also elements of deductive reasoning in the analytical process.

The authors acknowledge that it is unavoidable to be influenced by theory and personal background in an analytical process such as this. Hence, during this process the aim has not been to be value-free, but rather to not be value-ridden as well as to be informed about our values and theoretical standpoints as interpreters of the data (Haley & Perry, 2000). As Hugman, Pittaway, & Bartolomei (2011) writes: “all research is undertaken from a standpoint” (p. 1276). In order to improve the transparency of this thesis, the authors wrote a thorough description of each of the authors expectations and preconceptions before conducting any interviews were described, the content of which is described above. These were later compared to the data-set in order to look for biases.

When analysing the whole data-set combined, the results of which are found in the section “*General themes”,* a less formal analysis method was adopted. This was due to both

restrictions in time combined and a vast material. At the time of analysis, the authors were familiar enough with the data-set to provide themes in a less formal manner. This did not follow the procedure described by Braun & Clarke (2006), as implemented on the rest of the material, and are therefore of a broader nature. The three themes generated through this process were added after the thematic analysis making a total of 18 themes.

Ethical considerations

Since clients of psychotherapy are a vulnerable group, interviewing them raised several ethical issues. It was deemed crucial to take their experiences into consideration, since it is the clients who have the first hand experience of lay therapy, from the point of view of whom the therapy is aiming to help. Thus, it could be argued that it is the clients who have the most valuable information regarding the limitations and potentials of a certain kind of therapy.

This being said, the ethical questions posed by conducting these interviews are of great importance. One of the major concerns is the risk of evoking traumatic memories by making interviews about the therapy process (Gusic, 2017). Therefore, the interviews with clients were strictly focused on the response from, and the relationship with the therapists, and the benefits and limitations of the therapy process itself. The content of the therapy, such as the traumatic experiences of the clients, was avoided. These boundaries regarding the content of the interview were clarified before the interviews started and brought up during the interviews when needed.

In order to make the experience of the participants as safe as possible, all clients were recruited after recommendations from the therapists and the supervisors. This was done after having made an agreement with them about it being possible for the clients to discuss anything troubling being raised in our interviews with the therapists. The fact that the therapists expressed an agreement to talk about any difficult emotions or memories brought up by the interviews, was pointed out both within the written consent form and orally during the interview. The interviews with clients were conducted in connection to the post-tests being conducted by the therapists. This setup was accepted by therapists as well as supervisors and clients with an informed consent.

In a similar way, an agreement was made with the supervisors that the therapists in their turn would be able to talk to their supervisor(s) about any possible difficult emotions brought up by the interviews.

The informed consent included participants being given both oral and written information (see appendix E-G) about the study, the aim of the study and the meaning of consent. This was discussed in the beginning of each interview and in the cases where any confusion or misunderstandings seemed possible, this topic was addressed again.

Hugman et al. (2011) points out the importance of a relational approach (where the needs of both the researcher and participants are acknowledged and paid attention to equally) where one, for example, considers what is offered to participants, and not solely how the researchers benefit from the research. This was addressed by having the interviews with the therapists and the supervisors during their working hours as well as trying to give information back that could be useful for developing the organization and by shining a light on the experiences expressed by the participants. As part of the process of trying to adapt a more relational approach to the research, the interview guide was adapted during the interview process in accordance with alterations and additions from the research participants. After some of the interviews the authors and the participants discussed the topic of the study, or any other questions brought up by the participants.

As for the clients, it is not easy to say what is an appropriate way of making the relationship mutually beneficial without complicating the power differences further by creating a relationship of dependency. To balance the impact of the compensation with the perceived benefit to the participants, the compensation was adapted after discussions with the local contact person regarding what was considered a standard compensation. It was decided that the participants were given small gifts as thank you for the participation, as well as compensation for transport in accordance to what was considered standard. The supervisors did not receive any compensation for transport since the authors came to meet them where they were situated. All confidential information has been stored in a locked cabinet which only the researchers had access to. All recorded data has been stored on an encrypted USB-drive, which also has been stored in a locked cabinet when not being used. The USB-drives has only been used on computers that has not been connected to the internet.

All content of the quotes that has been considered identifiable information such as age, names, city names and the name of treatment methods have been retracted for the sake of confidentiality and replaced with a description within brackets []. When being uncertain regarding the accuracy of the transcription of a word, that word has been replaced by [?] in the results.

This study was financed by Olof Palmes minnesfond as well as SIDA within the framework of *Minor Field Studies*.

Before being conducted, the study proposal was submitted for examination by the local committee of scientific ethics in Uganda (the Lacor Hospital Institutional Research and Ethics Committee), however without response to the submission. The study was approved by the Regional Ethics Board at Lund University (dnr 2017/1009).

Results

This section is divided into four separate sections. First the results from the clients are presented, followed by the therapists and the supervisors. These three groups are then compared to one another in order to discuss themes ranging across the data-set. In this way, a narrative has been established where it is possible to grasp the participants' experiences ranging across the whole span of a lay therapy organization. The narrative follows, as much as possible, an order of stemming from the base of the organizations with the clients, through to the therapists and finally to the top with the supervisors. A chronological order from the client's initial contact with the therapist and onwards has also been taken into consideration when establishing this narrative. The results are followed by a discussion and a summary. In order to provide context to some of the results, external sources have been used in this section at points where this was deemed necessary.

A total of seventeen themes and eighteen sub-themes have been examined across the three separate groups of participants, as well as the whole data-set. Out of these themes, three stem from the clients, seven from the therapists, five from the supervisors and three general themes ranging across the groups. Table 1gives the reader an overview of the themes and sub-themes.

In order to preserve the voice and the intentions of the participants, as much as possible of the results are accompanied by quotations. When presenting an interaction in quotes, the abbreviations IL for interview leader and IP for interviewee has been used.

Table 1. Overview of the themes and subthemes.

Group	Theme	Sub-themes
Clients	At first I was afraid: Building trust	
	I really needed counselling, and it helped	-Helping is about the community – not just the individual
	What happens now?	-Follow-up -We have more needs
Therapists	Connecting when the trust is low: building alliances	
	Working with the whole community	
	Sharing a background with the clients: Advantages and obstacles	
	I'm proud of what we do	
	Endless needs: the limits of what we can do	-Endless needs:we can't do enough -How can I help more?: Limits in competence or therapy in itself
	Learning is ongoing: growing with the work	-Training was both demanding and fulfilling -Ongoing learning: developing through experience -Carrying the pain of the clients: learning to cope
	Working as an organism: learning and supporting	-The therapists supporting each other -The therapists learning from each other -Supervision is crucial for both learning and emotional support
Supervisors	The supervisor has a complex role	
	Training: deep and focused or broad and spontaneous?	-A broad training: more spontaneity, less focus -A narrow training more focused and less flexible
	The therapists sharing a background with the clients	
	Creating an organism	-Learning is ongoing: training is more than a course -Building a supportivie organization
	Endless needs: few resources	-Doing what we can under the current conditions -Lay therapy as a necessity -What we can offer and how we can reach out -Navigating the aid industry -Limitations of what we can offer

Themes from the clients

A total of three themes were identified in the data from the clients.

The first theme is titled "*At first I was afraid: Building trust"* and discusses the clients' initial experiences of receiving therapy.

The second theme, "*I really needed counselling and it helped",* includes one sub-theme titled *"Helping is about the community"*. This illustrates the effects that therapy has had on the clients as well as their views in regards to the impact of lay therapy in the society.

The third theme, "*What happens now?",* includes two sub-themes" *Follow-up"* and "*We have more needs."* The clients' concerns in regards to further needs for support are raised here, as well as their thoughts regarding their futures.

The interviews with the clients were conducted with the assistance of a translator. At some points in the interviews, the translator used pronouns in third person to describe what

the client had said. In order for the quotes to be less confusing, these pronouns have been exchanged to the first person pronoun "I".

At first I was afraid: Building trust. The initiation of a therapeutic relationship and a therapeutic process can be an intricate process. During both of the interviews with clients, they described experiencing difficulties in this phase of the treatment, both in terms of trusting the therapist and in terms of the symptoms getting worse before they would get better.

> On my first day when I came I was not ok. Because it was reminding me of what happened a long time ago when I was still in the bush.

> I was worried at first because I knew that they may first increase the pain and then later on you change your mind.

When it comes to trusting the counsellor, both interviewees mentioned being afraid of being reported to the police or the government and what that could lead to. In other words, the clients described that it took some time to establish a relationship to the counsellor where the clients felt like they could trust that the confidentiality was being upheld.

> That [treatment] was at first a secret because the information would not go to any other person other than me or you people. That's why I stand firmly to say that this training is ok. Because the secret is now between the people who have participated in it.

The fear of being reported is said to have been strengthened by the LRA's practices towards abductees, where they warned people of counselling.

> At first I was having fear. It was from the bush because from the bush what they told they need the people who have left their home. They start by [saying] that they want to counsel you, and as you come they punish you. So I was having quite fear. But when I got in contact with this organization I got to learn a number of things from them and now I don't fear and I feel good about that

In order to build trust towards the therapists, the interviewed clients described several factors that had been important for them. One described how having the telephone number to the supervisor felt reassuring and both interviewees described home visits as being of importance. One client described that a sense of trust towards the therapist started to build up as the therapy began to take effect.

When they came they said people should not fear them and should stay freely with them. When then at the end, when they[/we?] also copied what they were doing, we realized that they were doing something great. So they just made the growth and we began to work

IL: And how did you know that what they were doing was something good?

IP: Through the advice that we were given

One of the of the clients described how the relationship to the therapist changed with the home visit.

The relationship is quite good, because after the counsellor came here again they came from here and took me to town, and even slept at the place. We interrupted it not and from there the counsellor also came to here and they came to my place and I gave the counsellor a chicken so the relationship is quite good. [...] [After that] there are some difference where we could just ask each other. When I asked him he could also do the same and we got to share a number of things.

This could be interpreted as how sharing that experience made it possible for the client and the therapist to take part in more equal conversations. This client also described an instance of self-disclosure from the therapist and how that was received.

Even the counsellor could tell me some painful memory that we passed through, and we shared and also I told the counsellor the same thing and the experience I went through. So in the end we came to the conclusion that this made me feel good because the counsellor would have now hit the point[?] and have healed the wound now.

The implications of such self-disclosure will be discussed further in the section "*Summary and discussion"*. These examples of what happens in the client-therapist relationship, where a client and a therapist sleep at each others' houses, share food and where the therapist share their difficult experiences, may seem rather different from the therapeutic frames commonly embraced Western psychotherapeutic settings. The indications that these approaches have been experienced as helpful by the client, may challenge some of these common norms about therapeutic framework.

I really needed counselling and it helped. Both clients expressed appreciation towards their former therapists for helping them as well towards the organization who provided them with the opportunity to attend this treatment.

> What I have is appreciation only. I want to appreciate it so much for coming in so much

During both of the interviews it was mentioned that therapy had helped the clients in managing their everyday life.

> There's hope in that I could not now think of but things like killing, running every day because at first if she's walking she could have bad visions but now it's gone she's ok. She can walk when the visions are clear and she can go and do anything that she wants

Furthermore, the therapy helped to put the past behind them.

> Before the training I was using the old version of doing things. But now after the training, I could now have good visions and has made it into the past and I am now in the present

Additionally, one client described how it helped to break social isolation.

> Before counselling I used to not go where people are. Only sitting alone and not wanting to share with other people I can come among these people, share, play and do a number of games with people.

Helping is about the community - not just the individual. Both clients talked about therapy as something that could help not only individuals, but also improve relationships and even help entire communities.

> If they could also tried to [...] extend the training the some of the colleagues around it would also be better both for them and their friends so they could be a happy society.

> The old version of life would go. Not only for the people who have been trained today or a few months ago but it would be for the whole people who live in that society and then you should not think again that you should kill your neighbour or think about the negative things about your neighbour. We shall always focus on the positive things that can develop and make the society into a better place

In one of the interviews a client pointed out that by continuing to provide therapy in the community, this could be more normalized and understood as a treatment method.

> Continue with the counselling, because first of all counselling would help [one]self alone to stand against any trouble that may come. Secondly it will expose you to the community and people will get to know that this one can help us

One client spoke specifically about how therapy could improve their ability to support others.

> So [we] were now sharing and counselling each other and I also learned through that. I also learnt how to counsel and comfort somebody[...]then when you see your friend in trouble you can have a clue about how to stop. Like if you do this that might happen so you better leave this like that. And like that I can enter in that gap and help a friend.

What happens now? When discussing their views on the previous therapy, the clients suggested improvements both in major and minor fashions. One suggestion was about adjusting the time of the therapy, so that there would be more time to make a living by working on the fields. That client also remarked that the therapy felt long, so they asked if it could not have been done in a shorter period of time. However, the main points both of the clients made, regarding their experiences and possible improvements, circulated around the future of them and their communities.

Both clients also requested more support for their communities after seeing others in need of similar treatments or other types of help. These statements were divided into two sub-themes; *Follow-up* and *We have more needs*. The sub-theme called *Follow-up* contains requests, statements and questions regarding lack of information or contact after the end of the therapy. *We have more needs* contains statements regarding the unmet psychological and material needs of the community and how they think one could go about meeting those needs.

Follow-up. Both clients expressed a wish for more contact after the therapy had ended and when doing so, one of the clients requested that this could take place in a recurring fashion.

> Since they have now reminded us of what has been happening in the past I wonder if they could come every now again to see how the people who have been trained to see how are they doing in life because they need the attention

Furthermore, there were questions about what plans the therapists or organization had for the clients after therapy was finished.

> Now after counselling, where are they going to put me, or what are they going to do to me? [...] What visions do they have for the people they have already helped?

Such requests for more contact suggest that the clients have further needs. This topic, as well as the rest of this quote, have been explored in the following sub-theme and in the section "*Discussion and summary"*.

We have more needs. When discussing the needs of the clients and their communities they both emphasized that the need for therapy is substantial and that more people need help.

> Because as there is more people and others that are coming back, they still need the same counselling. So I pray that you don't stop today or tomorrow, you should be coming again and again, also to help other people.

One client even advocated for education of local therapists in the communities in order to be able to meet the needs for more therapy.

> One or two people could come back, one or two or three could come with them and they could go and train them also to be counsellors. This would be very important in that even though when they are not there, these people they have trained, they could be help for other people

The clients also expressed a wish for support regarding matters that are outside the limits of what therapy can provide, such as interventions addressing material needs or livelihood interventions. One client highlighted that the organization could provide the names and contacts of the clients they have treated to other NGOs.

> The organization has the names of the ones they have trained [conducted therapy with]. So the point of this question is if the organization could bind these names together and if the organization could get back to one of the other NGOs around. So if one of those organizations could really come in and help the children and those people it would be much better. Because it would also serve their life and they would be okay, with great joy.

When interviewing the clients, it was pointed out by the researchers, as part of the informed consent, that the interview and the organization that provided the treatment were unrelated and that participation in the interview would result in a discussion and

compensation for transport but nothing more. There is a chance that this may not have been communicated clearly enough. This was noticed in the following passage.

> IP: Now my question is, after this organization has trained me and given me counselling. Now after counselling, where are they going to put me, or what are they going to do to me?
>
> IL: I'm not sure I understand the question
>
> Translator: Ok the question is...
>
> IL (2): I think I understand the question, or I think I can understand. We are now with this organization to learn to work with this, or something similar in the future. So we are new with this organization so we are not the best people to answer this question.
>
> Translator: So first of all [the client] said, "you are students and you are here to conduct research and this question you might not be the appropriate people to answer"

This interaction is discussed further under the section *Ethical discussion* under "*Discussion and summary"*.

When hearing some of these statements from the clients, they were interpreted as an expression of worry regarding the future of the participants and their communities as well as a way for them to state a need for more information about these matters. Since the interviews were conducted on the same day as the therapists were conducting post-tests, it was possible for the clients to ask their questions to people who had more answers regarding future contacts as well as tips regarding referrals of other clients.

Themes from therapists

The data from the therapists has been divided into a total of seven themes.

The first theme is titled "*Connecting when the trust is low"*, whereby the therapists' attempts and strategies to build an alliance with the clients are examined.

Second, titled "*Working with the whole community"*, highlights therapists' experiences of work in the local communities in order to reduce the stigmatization of individuals with trauma.

Third, the theme titled "*Sharing a background with the clients: advantages and obstacles"*, considers the views of the therapists who have personal experience similar to their clients.

The fourth theme titled "*I'm proud of what we do"*, focuses on the motivational factors to the therapists' efforts.

Fifth, titled "*Endless needs: the limits of what we can do"*, has two sub-themes "*Endless needs: we can't do enough"* and "*How can I help more?"* Here, the various challenges of the therapeutic process are raised, as well as the burden of being unable to address all the needs of the clients.

Sixth, the theme "*Learning is ongoing: growing with the work"* contains three sub-themes: "*The experience of training; Learning is ongoing"* and *"Carrying the pain of the clients: learning to cope".* In this theme, the therapists describe their experiences of growing and evolving through their work. The sub-themes focus on the therapists' experiences of their training, the development of their careers and skills, as well as insight into their coping strategies. Each sub-theme begins with a short summary of the findings within them.

Lastly, the theme titled *"Working as an organism: learning and supporting"* includes three sub-themes: "*Supporting each other", "Learning from each other"* and "*Supervision is crucial for both learning and emotional support".* The therapists' experiences regarding the role of their colleagues and the organization are explored; first in regards to their emotional well-being, followed by their learning process, and finally in regards to their experiences of their supervisor and supervision.

Connecting when the trust is low: Building alliances. In a similar manner as to how the clients described having difficulties with trusting the therapist in the beginning of the treatment, the therapists also described frustrations and a great need for patience and persistence when attempting to establish an alliance with the clients. They point out factors that can prevent a trustful relationship.

In a similar manner as what the clients spoke about, the therapists acknowledged that many clients fear being reported. Additional factors affecting the therapists experiences of trying to establish an alliance to the client included the client arriving intoxicated to sessions and the therapists having difficulties trusting some clients. They also stressed that factors outside of therapy sometimes hinder the relationship, such as stigmatization or fear of stigmatization or the client having an abusive partner who prohibits them from attending the treatment.

Within this theme the therapists described their experiences of working when the clients are unwilling to share their experiences as well as their strategies to try and establish a relationship of mutual trust. Several counsellors pointed out the importance of being understanding and patient as well as emphasizing the confidentiality agreement at several

occasions. This is described as being of great importance when working with traumatized people, since many clients in this group can be very suspicious and careful.

> They really want always assurance and assurance. In terms of like for example just this week, this week on Tuesday, and someone asked me like, "Why is it that you come?" - because I went for a follow-up - and then someone was like, "Are you people not going to report us or take us to International Criminal Court?". So I think I really reemphasize the confidentiality which we really have been doing before, and I think that is one thing that a person that handle people like that should never get tired of doing. Yeah reassurance is very important.

In many of the interviews the therapists emphasized the importance of being patient and empathetic when trying to establish a trusting relationship towards a traumatized client.

> This kind of work is like dedication to me, because the first impression you get like the first thing you get to treat a client is not what you get afterwards. At times it is very hard for someone to build trust, at times it is not easy for you to believe what you are saying. Even if you explain the psychoeducation everything very well someone might not believe you at first, and that means that it requires a little bit of patience for you to be able to help people, and also it's also good to understand that people have they have and what they went through, that really helps to be able to treat them properly, because you need to understand them you need to really go down to understand in depth of their problems

Some of the therapists described that they gained an understanding of how difficult it can be to open up due to their own personal experiences of attending therapy. Others gained an understanding through the practical sections of the training, where they had the role of clients. This will be discussed further in the section "*Learning is ongoing: growing with the work".* Most of the therapists emphasized that in order for the treatment to be successful, it is essential for the client to open up and trust the therapist.

> Sometimes we might find a client who will never trust you at all. And the client will not be open up. I know with our kind of treatment if a client is not open up he's trying to avoid or hide certain things from you. It will be very difficult for that client to heal. So when the client is not open that is number one challenge.

Some therapists pointed out how it can sometimes take until the post test for the clients to have gained trust in the therapists not reporting them. Since it can take a long time to build a trustful relationship between the therapist and the client, and since this is key for a successful treatment, several therapists highlighted the importance of offering the clients a second treatment in some cases.

> Maybe when this period, the period to wait for the post-test to reach, they might have a kind of rethought about, or they have waited for any bad news and looking for them and nothing came up. No one came to trace them for whatever they said it out. So that will give them a positive feeling like "Ok next time they come back, I have to tell them the things I have left so yeah". After waiting this period of eight months no leaders went after them you know. [...]Then they start thinking that I think that these people are alright.

Several therapists pointed towards the importance of repeated psychoeducation, in order to build an alliance with the client. This is where the clients are given information regarding what the therapy process may entail as well as information about PTSD and their symptoms. In this example, a therapist described how they try to explain that the symptoms may first get worse before they get better.

> We have reactivated what they went through. But later on we tell them it's like you have a [?] and you go to the doctor. You will not only address it or put antibiotics, but first of all if it makes a sense removing this one out of there with the puss, then press it to remove the puss, then when it is clean you can now press it. So it is the same with the counselling. It reactivates those emotions and those fears that you went through. Then you begin dreaming again, acting as if you are there again but later on slowly it will vanish. The only thing that during that process, I think they kind of can withdraw from certain work, because you have reactivated their fear networks [...] I dreamt that that day that happened, so she will withdraw from farming for some time until that fear or those thoughts have gone down. So it kind of affects their productivity and their lifestyle.

In some of the interviews, the therapists described feelings of frustration when working with clients where they didn't feel like they could trust the client in telling them the truth. In some cases, this could be because of the clients' fear of being reported. It could also be because of some clients having been highly regarded in one of the armies and thus not

wanting to share experiences with civilians or what they considered low-ranked people. Here is an example where a therapist described conducting therapy with a client who was a high ranking officer or general in the LRA and was therefore unwilling to share truthful experiences with ordinary people, since they were considered below him.

> It is discouraging and it makes you get less interested in doing the therapy, but I just go and do it for the sake of doing. [...] I do the session, but I don't trust him anymore. I just take in what he is saying the way it is and I always assure them that it is important to open up, if you feel like you can't it is ok.

In some cases, the therapists described feeling personally responsible for getting the clients to trust them and having feelings of inadequacy when being unsuccessful in doing so.

> For my case, what sometimes makes me feel like that some of the clients' relationship are not quite ok with me maybe. Like if I try best like maybe for this difficult client and I really feel like want to help them and they don't want to open up, even after sessions and sessions and sessions. There you kind of feel "now what am I doing?" or "why is he or she not opening up?". So you feel like, there is this feeling that you feel that maybe the clients' kind of don't trust me or you know. You just kind of feel like joking yourself. And there you feel like maybe the relationship is not very ok, there is that feeling that you will have. But once someone is open to you you just know the relationship is ok she is free you know.

Other factors hindering a working relationship between the client and the therapist included clients arriving intoxicated to their therapy sessions.

> I don't want to use the word good but, there are those that are cooperative during the counselling sessions and there are those that show some not or some element of not being in a good relationship during the counselling process. For example, you are giving counselling to a client, then the client the next time comes drunk and you tell the client that in counselling try to avoid drinking or if you drink you can not to stop it completely at a go. Or if you are to drink and you know that we are going to meet the following day, can you come when you are not drunk so that you are sober and we can handle these things very well. That is helpful both on your side and on my side because if you are intoxicated you will not understand what I'm saying clearly or even the way you are expressing yourself. There will be a disconnection in your speech or your thinking and then they say yes. And then the next session the client comes drunk.

Several of the therapists emphasized that the clients fear of being stigmatized by their communities also plays an important role in why it can be difficult to build a trusting relationship to their therapist, or to even reach out to some clients at all.

> Some of this clients, might not come when they really have problems, because they fear stigma. Because in the field, there or in the villages there, they know that okay, these people are working with trauma people. People who have maybe experienced war, so some of them, you know some of them they don't want anybody in the community to know that they were formerly abducted for example. Or they have been in the bush with LRA. So when they, they fear to come to you, because if they come, [?] will say, "Oh, Mr so and so has gone there, so he was formerly abducted", then they start stigmatizing the person.

One of the clients described it as being important that the treatment was a secret, judging from the above statement it is possible that that client was describing a fear of being stigmatized in that instance rather than a fear of being reported as have been discussed before. When addressing the clients fear of being reported, the therapists described how their main tools are psychoeducation and patience. However, in regards to stigmatization, those tools may not be very effective and in the following section we establish a deeper understanding of what therapists do to address this issue and how they experience those interventions.

Working with the whole community. One topic that many of the therapists returned to was the individual and the community as being intertwined in regards to the mental health of the clients. As mentioned above, one important factor that can prevent clients from building a trustful relationship to the therapists or even receiving treatment at all can be stigmatization or fear thereof. Being stigmatized can make the lives of the people affected extremely burdensome and in relation to this theme the therapists discussed their views on this issue as well as what they do in order to try and prevent it. Several therapists described how a fear of stigmatization can be a factor in preventing the clients from applying for treatment.

> Sometimes the community spread rumours that discourage our clients from coming to meet us, they begin to stigmatize our clients. That's why we tend to do a lot of community sensitization and trainings.

The therapists described an intervention they refer to as *Community sensitization* where they gather the community in order to introduce themselves and address issues related to the whole community. This intervention was described as a way of addressing the history and aggressions tied to the past conflict as well as stigmatization of mental illness. It was also described as providing a chance for the people in the community to explain themselves to the other members of the community either during the community sensitization or after the treatment when the trauma-related guilt often has decreased.

> Before we go to the community and start to do our treatment, we first of all do the community training where we talk about stigmatization, we talk about trauma we talk about all that. Almost all those things are affected and we talk about what the organization does. Yes, so that they know. Because also in the community there are those ones who were not abducted, see. And there is this way they look at the others in the other way around, they think ok, this one is the one who killed my brother and whenever you come from the bush they hear that ok you have just come from the bush so you are the one who killed my brother. Because they were not there in the bush so they don't know exactly who did what. So if it is to make sure that they know that whatever amount of things that were done, they are already done and they are in the past. But there was actually no way of avoiding it, because it was a violent act and there was no way of avoiding it, so we try to talk to them. And that's also when we try to put forward that we´re doing our treatment. So we go through all that and you know, all these signs and symptoms, and some of them can come for the [diagnostic] interview.

During the community sensitizations the therapists described how they try to begin the process of normalization of trauma and mental illness. They also illustrated how they try to broaden the concept of stigmatization, both regarding the meaning of the term as well as regarding who is the recipients of stigmatization.

> We gather the whole community, or sometimes if we feel that the stigmatization is only within the family, we go and do a family mediation, we talk to the whole family. We don't specify that we have come to talk because Mr Jones has been in the bush so, we just talk about the stigma in general. We look at the, mostly the disadvantages of stigma, what it could cost, and tried to tell them how they can avoid it, ways of handling, how they can cont- stop stigma not control stopping it, then if that we train them like that they will realize that, oh, this is bad. Because, there is one question we

> normally ask them that, “Let me see how many people who feel they're stigmatized” or “How many people have ever- who has never been stigmatized in future?”, so we find that, when you explain stigma and tell them, in which [?] you can be stigmatized, they will realize that all of them in the community have been stigmatized. And, which it is not good, because for them they know first of all that stigma is only when you are like maybe formerly abducted, it can only update into formerly abducted people, and people with HIV. That is what I know of my people in the local areas there, but when [we give examples of other factors causing stigmatization] they will realize that “oh, if we do this if we do this it can really help and stop stigma”. So you find that, if you even go and ask the client, since there are the training, this thing has reduced, nobody now talks about you directly or points at you and say that, that one is from the bush [...] even some communities, they again requested and requested that if you could come back and again train us. because other people were not there the other day. Sometimes we go back and again rearrange and train them, so that is how we are trying to handle and deal with stigmatisation.

One of the therapists gave an example of how they explain the concept of trauma during Community sensitization. It was an example from this quote which gave this thesis its title.

> You just explain according to how we know, how can trauma comes. First of all, how the war causes trauma, we start with that. […] You tell them this is something which can cause lots of fear, but it’s an experience, because excessive fear to a person where a person feels that there is nothing he can do about it and later it starts. Or you can say this is a wound of the soul. Then when we explain that you, you make them know what causes trauma. That is when a person experience something which is so terrifying, or witness something which is so terrifying. […]. So if they know that, then they will say “Oh, so, so and so is behaving like this, it is true that this person has experienced very many things”. It is not what we think.

Another way in which the community is involved in the therapy is when recruiting new clients or finding participants for diagnostic interviews. One therapist described using what they call a mobilizer, which is someone who is known and trusted by the people in the community and is the therapists main contact in the village.

> We always have specific community mobilizers to connect us in every place that we go. We always have one mobilizer because we believe the mobilizer knows the people.

In a similar manner as to how one of the clients requested training local people in basic therapeutic concepts, this was also brought up by one of the therapists. This therapist suggested training people in the community in matters of suicide prevention and stigmatization.

> We should get some local people, we train them in the community there, whom they will always be, you know, talking to this people, once like somebody discriminated, stigmatize, they can go and talk to that person and because sometimes we could be very far. Or if somebody is suicidal, they can as well to the person.

Much like the clients, many therapists also described how they believe that therapy can play a transformative role in society. They spoke about what kind of society or community they would like to have, what opportunities they believe should be in place and how therapy can play a role in building that future. One therapist described that if there were more therapists working in the communities, that could be an important step in the right direction help the people in the communities put their past behind them.

> By reaching out to people of course even the relationship in the community will be a little fairer you know. Because first of all you'll kind of let people see for themselves that despite my experiences, I can still be a productive person. So once we reach out to those people and we are many counsellors, even life in the community would be much easier. Things would be nice and friendly you know. That harmony will be a little bit of higher percentage than few counsellors reaching too few of them.

One therapist illustrated how they believe that a personal change for the clients could lead to more peaceful and harmonious communities.

> First of all, these clients who have been traumatized, most of them they have this revenge feeling. Some of them are scared, they are fearful, they don't feel loved by the community. So with that feeling of anger in them they will see you as a stranger, they will have no pity on you, they just do whatever they feel like on you because they want you also to be like them yeah. They want you also to be to experience whatever they also experienced. So by that of course that's, that harmony would not be there.

> Instead there would be a lot of, a lot of fighting in the community, hatred you know. So because most of them they are not they feel worthless you know. But once the counsellors have done their best those things are good in that. And they also start now that feeling of being worthless will no longer be there and that feeling of revenge will not be there. Then peace will be in the community.

Sharing a background with the clients: advantages and obstacles. In a related fashion as to how the therapists spoke about the difficulties when trying to establish a trustful relationship to the clients, many of the therapists described how being from the same culture, area and sometimes having similar experiences to the client can be both an obstacle and an advantage. An obstacle when the therapist gets too affected by hearing the stories and an advantage when conveying an understanding towards the clients' experiences or when trying to give the client hope. One obstacle described in one of the interviews was how in the end of the war, it was harder for the clients to trust locals than foreigners, since they did not know what role they had had in the war and what their alliances were. There and then, establishing trust was easier with the foreign therapists.

The therapists did however put more emphasis on the advantages, since most of the therapists mentioned some kind of advantage while only two mention any obstacles. When one of the therapists described how they think sharing some background with the client impacts the relationship, it is described as a strength. The term *mzungu* which is used in the following quote is an East African term referring to Caucasians/Europeans.

> It is very good strength, because you even, the client thinks that I'm talking to a person who is knowledgeable about my environment and my culture and what went through and my experience. Because if it was a mzungu from somewhere now counselling, him or her think now this one does not even know my culture she'll never even know what I went through [...] at least the client is confident that at least I'm talking to someone who knows my culture yes. It is a very good strength.

Many of the therapists described having experiences of the war without having been abducted or having spent time with any rebel group or army. One example brought up by several therapists was how sleeping in the town together with other children was a safety measure in order to avoid being abducted.

> Those experiences because most of the clients are war victims, so during that war period of time I think though I was young but I also went through that experience of the war. You know hearing the bombs here I did not sit so close. So part of it part of that clients' experience is also part of my experience, like concerning the war, like related. This kind of going to sleep - you go and sleep in town and then in the morning you go back home and when you hear them coming you again have to leave home, so that one also I experience it yeah.

Some of the therapists use self-disclosure as a technique in therapy. According to one therapist, to share their own personal experiences with the client can in some cases be a way of both providing hope and building trust.

> To a few clients I've shared with them my experience. I opened up and tell them like look at me I went through a lot, but because I believe in god and you know and I remained strong and now I'm here. [...] So I can see that the few clients I shared with them, my experience some of them were surprised because they say "I thought it's only me". So I tell them very many people out there and some of them have even gone through worse experiences than me and you but they are still appreciating life today. So it has helped.

This is in line with how one of the clients described their experience of the therapists' self-disclosure as being helpful. In a related manner, one therapist recalled how a client asserted that the self-disclosure had helped her manage suicidal thoughts.

> One time I spoke to a young lady and she was suicidal and she was telling me that she has suffered since childhood and the rebels abducted her, she does not know why she escaped from captivity and came back home, she should have stayed with the rebels. So when I talked to her she told me, after maybe a few days later, she told me that what you shared with me I reflected on and I felt like you removed a big burden from my heart. I thought I was the only person who has experienced that.

Some of the therapists described that living in a conflict prone area for so long has made them more familiar or habituated to the content of the clients' stories.

> I think most things that much of us were not abducted but at least what our clients tell us their experiences in the bush we've already had before which to me is not something new and to make me put in a lot of effort and do my best when doing

> therapy to ensure that they come out of this situations because we have relatives who've been abducted we have got a lot of friends who've been abducted who've been yelling what takes place when abducted so to make me really because to me it is not something very new so when I go to do therapy and what clients tell me it is not very new.

In one interview, this habituation or familiarity is described as having helped in knowing when a client may be avoiding to share certain parts of their experience.

> When you know like the client could also be avoiding to talk about certain things or expose a bit of it and the difference is that for me who has been within the environment would really know that. [..] when I'm treating somebody and I know maybe someone is avoiding, it is much easier for me to know because many people already maybe told me similar stories on how maybe rebels did a similar thing so the difference between me who lived in the environment and you who came from far is that I would notice when the client is maybe trying to lie to me or try to avoid certain things because I have already heard similar stories from somewhere else and then try to compare.

Many therapists described finding motivation to carry on their work in their past or their circumstances in one way or another. Not all the interviewed therapists had been directly affected by the conflict and some of them described how they find motivation in curiosity about the past and in wanting to know what happened.

> I was not affected directly but indirectly because I had relatives who were abducted and others were also killed and at first when I joined this organization I couldn't have a precognition of exactly what happened and what was the brain behind it because when you aren't there, the information is mixed up. You know somebody is saying you know the government had a hand and this is a rebel you know. But when you get out there and you get from the people who were there you get to know exactly what took place and who was the brain behind it and that one helps a lot to clear you know the doubts.

Sometimes it can be difficult trying to pinpoint exactly where one's motivation come from as it is often not just one source. One thing that the interviewees kept coming back to however was that they found motivation in helping people they identified as their own.

> I felt like I got to know more about the suffering of my people. Because I come from this region only that during the insurgence I was already in Kampala. So when I started work I felt like I am doing something for my people. Other than getting to know the challenges or their plights I felt like I am also at least supporting them by listening to their stories.

One therapist described how this motivation had made them want to stay with this job for the ten years that they have been working there.

> I could tell you that I love very much to help people who have affected by this war of Northern Uganda, the war which has taken over twenty years. I, my dream was really to help this people, because when I was still also in school I could see how some of this formerly abducted people were suffering after like coming back from the bush. you see, our [?] go through, so, I felt, if there was any way I could get and help this people it would really be very good.

All of the therapists described influences from their past as a factor in their work. Some therapist described how disclosing parts of their past to some of their clients has been a way of providing hope when they client doesn't have any. Others illustrated how their knowledge about what has happened in the area has given both tools for knowing when the client is avoiding parts of their story as well as a curiosity regarding the clients and their experiences.

I'm proud of what we do. As could be seen in the previous theme, many therapists find motivation in helping their people or from finding out what happened in the past. This theme centres around the therapists' statements regarding finding motivation in seeing the results of their work, as well as taking pride in what they do and what they can provide. This is something that all of the therapists described in one way or another.

> I'm actually very happy that this organization has made an effort to help those who were affected like the victims because if you go to the field you find that what we're doing as an organization it's really helping a lot. Because many people they are really traumatized even up to now because you find in the village almost each and every one, even if they were not abducted they were made to do something. Maybe their children were killed maybe their husbands or like that or their huts were burned, so you find it that in the village each and every one was affected. And what this organization has

done is to bring hope into those lives and also during the war so many people were forced to do things that they didn't want to do.

Most therapists described how they find motivation or meaning in seeing the change or the results of their work. Several therapists emphasized that the direct experience of seeing a client's life change, as being an important motivational factor.

I wanted to work as a therapist more because you really see the real change in somebody. It's not like you're going through third parties or fourth parties it's just you and the victim. So you see that by the time you talk to them the more you go you are able to see and monitor someone's changes and body reactions maybe signs and you know. So it makes me want because you're always happy when your work shows a good result.

Some therapists recounted how they became interested in working as a therapist after having worked as a translator throughout trauma therapies and seeing the results for themselves. The experiences of working as translator is discussed further in the section "*Learning is Ongoing: Growing with the work".*

I was together with therapist even times when going back even to check on the clients which we call post-test I was there I was still translate and I could observe the difference the first time we met the client and now after three months how the client appears, represents him or herself yeah. So I felt like I am interested in this job if there is any opportunity.

Some therapists discussed how this motivation from seeing results also can become a pressure or a great sense of responsibility for helping every client they meet.

I really want what I've done to be successful. So that on really it's like my personality, I just feel like what I did should really make someone 80% or not if they are less than 50% that means I have not done so much for such a person. Yeah so that is my personality kind of concerning the job.

In some cases, the therapists described seeing that the lack of results can be caused by other negative events in the lives of the clients.

They come and appreciate, even those who did not fully benefit from the therapy still come and tell us and they give us reason why ok they give us reasons to us that those

> are reasons but for them they don't know that, those are reasons as to why they still have the symptoms. To us we understand that it is the environment and more negative events that is happening in their lives.

Endless needs: The limits of what we can do. Managing the limits regarding who you can help and what you can do has been a dilemma discussed by all the participating therapists. These discussions were often centred around their experiences of trying to handle the limitations in how many clients they can treat or how they experience not being able to help all clients they do treat. The limits of therapy were also brought up when the therapists described their experiences of meeting great social and material needs amongst their clients while not being able to being able to help in that regard. Perhaps deriving from those experiences, many therapists emphasised the need of social support as a complement to undergoing therapy.

The following sub-themes explores the therapists' experiences of the seemingly endless needs for both the services they can provide as well as needs that cannot be met by therapy. The two sub-themes consist of statements regarding how these limitations have been experienced in regards to the needs that can not be met by the treatment followed by experiences of limitations in the meeting with their clients.

Endless needs: we can't do enough. One therapist expressed that the lack of therapists makes them unable to reach everyone who is in need of therapy.

> It would really help so much if many of the trauma counsellors are there. Just to help reach out to anyone who has been traumatized or depressed and doing that. Of course you know once you feel however much you try, your effort you can not reach everyone.

The large need for treatment can be both intimidating and a source of motivation. One therapist pointed out that they can see this motivation, while simultaneously having to limit oneself for the sake of their own well-being.

> My thoughts or feeling about work at the moment is that I should continue with the work, because there are so many people still out there who would need this support. [...] Sometimes I feel like we should handle like maybe three[clients], but you will not

manage because you will be exhausted. I still feel like there are really many people that are out who we have not reached.

Many of therapists described how they can see these pressing needs amongst their clients and their communities and that they often lie outside the boundaries of therapy.

Much like what one client requested, they also stressed how collaborating more with other service providers could help in meeting those needs. One therapist pointed out that these unmet needs can have a negative impact on both the well being of the client and the therapeutic progress.

> When we are helping these clients apart from the psychosocial problem. Like they have also other family needs. So in addressing the psychosocial problems and you disregard the other family needs and yet they play a key role in kind of developing the mental status of the client. So if you come to the client and you think he or she is ok but then when they go back they can have a husband who is torturing or beating for domestic violence her and there is no food in the house and children are not going to school, it kind of rewinds her back, kind of washing away what maybe you have tried to do because of that. Maybe the only thing that is lacking is the network, the linkage and linking yes you have done the psychosocial part but can you link this client to other service providers to deal with the rest of the problems and other problems.

Some therapists appreciated the collaboration that is already taking place and one of them specified the benefits from an ongoing collaboration with a torture centre.

> The supervisor has gone ahead to connect with another organization which is a torture centre I think for victims something. So now also help because it makes our work now easier. Because sometime you're talking to someone, maybe was being wounded or still has those splinters from the bomb and they still have a molded[?] effect. Now at least our supervisor helps us to refer those people to [another organization] at least to help them medically.[...] The supervisor has helped us so that now we are in position to link up to those people. Many times we bring victims there.

Additional suggestions were made in regards to how the organization could develop in order to meet the needs outside of therapy. A suggestion from one of the therapists was that teaching a skill set, such as a weaving or tailoring, after the therapy ended could be one way of addressing those needs.

> Because you're dealing with people that has been affected so much you know maybe some of them now they don't have anything. [...] To me I would think that apart from doing the therapy itself, that if therapy could work hand in hand with like some kind of social support[...] Psychologically now you start feeling better, but for you to be completely ok, what position are we leaving you in? I would think they should put aside some kind of social support whereby you know that, ok after finishing maybe the ladies who have done the counselling with us, maybe you give them something to grow, maybe you provide them you know kind of tailoring, maybe knitting, or even weaving baskets or even making bags, you know. Whereby you are providing for them a way of living. However much they don't have to depend on anyone they can start on their own. Even if it's just a kind of small income, it is able to make them make ends meet. Because most of the people put there, they don't have school fees for their children[...] If you open up this kind of organization, you should at least think of also the social part of it. Not only, because somebody's wellbeing also comes up to you, how you think, how you stay. Because if you're not living well you cannot think well, if you're not eating well you cannot reason well. So all the things work hand in hand.

How can I help more?: Limits in competence or in therapy itself. Seeing how their clients or communities suffer from factors where the therapists can't offer any support, is described as difficult by many of the therapists. In the meeting with the clients this can become very immediate.

> Working as a counsellor, I think one of the challenges is like not being able to solve every problem for the client [...] you tell the client that them to talk and it's confidential I am only offer you psychological support I don't offer you material benefit and then someone tells you know "I have this orphans" or "I have this sickness" or maybe "I have been raped and that has cost me to be HIV positive or maybe because I was raped by very many soldiers it has affected my uterus it may require operation" so that really pains me. Because I feel my work is only limited to addressing the psychological well-being of the client

Both gender-based violence and alcoholism is brought up by many of the therapists as factors that can get in the way of a successful treatment. In regards to this, one therapist

described the need to be able to handle limitations in terms of what they change or affect in the behaviour of the client.

> With those who drink, of course there are those who you cannot stop him in a matter of days or weeks because even after you've finished the client is gonna remain in the community and remain drinking. So you do your part and you leave him to do his part. Other than carrying all these clients baggage it comes with it that "oh no, he's drunk and I don't know whether I helped him or not"[...] I've done my part to make you reach somewhere or rehabilitate you to a certain level but you also has to do your part. It is just like a treatment and they give you tablets and they say twice a day. The doctor has done his part and given you the treatment, so the rest of taking is upon you.

Some of the therapists described how clients with such great needs keep asking them for help. This is another reason why many of them emphasized the importance of repeating the process of psychoeducation and establishing the concept of the treatment at multiple occasions. One therapist described feeling frustrated with having to stress to the client that the organization does not supply material support, during every session with some of their clients, and how some of the clients still seemed to come to therapy hoping to get material support.

> I realize I am talking to a mature person, but some of them you realize that they have different interests. Some of it I understand, like ok they can annoy me to some point but on the other hand I also understand that it's because of poverty that this person keeps on asking me.[...] So each and every day it feels like they want me to reassure them that you know we are not paying you for this there are other benefits. So sometimes it annoys me, because I am not talking to a child I'm talking to an adult but in the long run I understand that this poverty makes them keep their hopes high and they believe that all NGOs give support, that they give material support to people. So maybe they expect, I get the feeling that even the psychoeducation I did where I clearly told them what we do they it's maybe they still feel like they could expect something more[...] there are still more needs so we give psychological support, but they also wish that somebody had given them financial support or other materials, I think that's why they keep on asking over and over.

A couple of the therapists expressed further limitations in their role, in particular regards to possessing a limited skill-set. One therapist described how this can occasionally be problematic during therapy sessions.

> Sometimes you get some a little bit of difficulties down there with the client. Then sometimes handling it might become a little bit also difficult for you as a counsellor. [...] some things are similar scenario might happen very close to you, where we stay in the community, and you might feel that, ah, I really wish learned more, psychology than what I learned. I could have done much better than what I'm doing now[...] I could say basically that, although, I've experienced that this method works, but I feel I could have learned more ways of treating traumatic people. Because I know that different approaches and ways of treating trauma which people are using, but to me, I feel this one only is not enough

Sometimes it may be the case that a limited skill-set is a part of the explanation as to why the therapist felt like they couldn't help the client. In some cases, this also seems to be related to the sense of responsibility for being able to help every client as described in the theme "*I'm proud of what we do"*.

> Sometimes I get puzzled like how to help some of the clients. Some clients really, ok they can share with you a story or they are in a condition that even if you talk like you use all the counselling skills, you feel like you still have not supported them enough. I feel like, what other skill is missing so that I can know how to help this client? But I think it all comes back to the heart. You know the feeling that humans feel like, I wish I could give more but I can not give. Because I know our ethical work ethics and you know the limits and you know. And sometimes those stories they can disturb you and come and share with our supervisor. And I also know they answer that "you know we can not go beyond this" or "there is nothing we can do about the client's situation" and "you know you did your part and you talked". So that is still what I think what is missing.

Learning is ongoing: growing with the work. The initial theoretical training received by the therapists can last for two to four weeks followed by an "on-the-job training" where they follow a senior therapist for a few more weeks. With such brief introduction to the profession, it is unavoidable that there will be limitations in comparison to a psychotherapist degree. This theme focuses on therapists' descriptions of what it was like to learn the profession and start working as a therapist as well as the things they have learnt along the way. It has been divided into three separate sub-themes; "*The training was both difficult and*

fulfilling", "*Ongoing learning: developing through experience*" and "*Carrying the pain of the clients: Learning to cope*".

Training was both demanding and fulfilling. One component of the training which was considered of great importance to many of the therapists was the experience of being in the clients' position. One therapist recalled the practical teachings from this exercise.

> The practical part prepared us like it, like we got the real life experience. If you can hear from a colleague their real life experience and myself also, I could give my real life experience. So the training really worked[?] us because we were given the chance to truly narrate our life experiences because that is what also the clients are going to share with us.

Furthermore, several of the therapists emphasized that the practical training taught them the required techniques to be able to conduct a professional therapy session. One therapist described how this training taught them to set aside their own personal experiences.

> There is a training that we go through and in that training we discuss all the challenges that we went through in our lives. This helps us when we go now to help others. When a client is talking and narrating the same event as you went through, you are not so connected emotionally so that you forget you are counselling yes. You discuss it in the training and even when the client mentions it, you are just concentrating on what the client is saying and kind of forgetting about you. You're [gone through treatment yourself]. So that helps us not to entering into the clients' world. Getting into the story too much and forgetting that I'm a counsellor. So that training helps us to discuss that and put it aside.

When training to become a lay therapist, this includes having to learn a new profession or a new method in a concentrated period of time. When discussing their learning process and the contents of the training, several therapists emphasized the importance of learning diagnostics and a theoretical framework together with practical exercises.

> We started training in how to diagnose, PTSD, depression, and aggression. We went through that training for a shorter period of time. Then after that, after that training of diagnosis, that is when they started training us in [the treatment method]. So after that training, now that is when we went down to the field, and started like giving therapy to formerly abducted youth and adults.

Some therapists described experiencing difficulties understanding the psychological concepts and the theoretical framework in the beginning of the training.

> When we started the training, in the beginning it was little bit, complicated a little bit because there were some concepts which we did not understand, [...]it was really some psychological words [...] So when we started in the beginning it looked like it was a little bit complicated, it took us some quiet time with the hard work [...] They made sure that when they were explaining something to us they will use any possible means of making us to understand the context of the question, what it means and we understood. That is how we started open up and found it at the end it wasn't all that difficult.

Several therapist described how the training in a manualized method, they felt prepared them to conduct the treatment.

> With me I think I went through like a two-month training on how to do [the treatment method] with our supervisor and you know everything is about learning and besides that what we do is majorly about [the treatment method] and you're trained exactly how to do it. And I don't think you'll get difficulties, like it's not something very broad that you're supposed to do. Just this basic thing, so it's even like maybe if it was at University it would be maybe just a course unit and you would have still other things besides it. It's not something very broad, so I don't see it as a problem there. Because each of us here are doing it perfectly well and it's showing great results.

When given the possibility to make additions to the training that the therapist felt would have been helpful, the majority did not have any suggestions. One therapist did however request adding a component about how to deal with flashbacks and dissociation.

> If maybe I could add one thing in the training, well I could say, I could like maybe feel like adding, mostly like, dealing with somebody who really goes into flashback or I could say dissociation, because really, according to my experience, that thing really happens, in different ways, but sometimes how to deal with it is really complicated, cause the little I was told, how to handle, sometimes it fails to work, so if really I could get, a very concrete like training on that

As explored in this sub-theme, it can be concluded that the general view of the therapists was that the training was both difficult and demanding. This was mainly attributed to a lack of previous experience in the field and having to grasp many new concepts. The therapists also expressed satisfaction regarding the training and stress that the training gave them the tools they needed for their work. Most therapists emphasized the practical components of the training which enabled them to get a practical understanding of the theoretical concepts, practise their skills and allowed them to become more proficient over time.

Ongoing learning: developing through experience. As highlighted in the previous sub-theme, a majority of the therapists described how practical experience was an important component in enhancing their understanding of the theoretical concepts. This therapist described their experience of receiving a foundational training and then starting to work and pointed out how ongoing training is important in order to keep the knowledge up to date and relevant.

> I think the training was a little comprehensive and when we were given because each time we were given refresher trainings, like time and again. Like always doing refresher trainings and always new things always keep on coming in like [a training in a method focused on treating perpetrators suffering from PTSD] we had on to that and also I think also just last week we had some other trainings. Because you know the complexity involved in treating the clients. So I think our supervisor that they gave**[**?] us with a lot of relevant literature and also doing routine trainings and refresher trainings to ensure that we are also up to date and well packed with the knowledge.

For some therapists their first practical experiences of working with trauma treatment was when working as translators to foreign therapists. One therapist recalled how that gave a different understanding of the treatment and how that was helpful when learning to put the theoretical concepts into practice.

> The way I translated it really made me an insight in learning in how [treatment method] therapy takes place. It's not from theory to the practice alone. It's not just the supervisor who carries out the therapy but also me as a translator so it really helped me a lot and it was so nice for me.

Several of the therapists highlighted their personal development as a result of work experience. One therapist described the various skills they have learnt and how they are able to use these outside of the work environment.

> I've learned actually it has changed my life a lot. I have learned how to be patient a lot, even with my family members, and I've learned how to tolerate many situations. So my family has not really commented directly on my face but I think, ok the trust that they put in me. Like if there's any misunderstanding or there's a conflict among family members, they tend to call me to be around. So I think my counselling skills, I know how to cool the situation[...] I've learned how to deal and to be patient and listen to people. I've learned not to be judgemental. And I've also learned how to be patient and also to keep my words. Not to give empty promises. [...] I've practiced this for long, so I realize that how to interact with people and handle situations matters a lot.

The therapists highlighted that the practical experience and regular training sessions had been important parts of their learning process. Some of them also expressed that the lessons they learnt from their work has influenced many parts of their lives.

When the therapists were asked whether they would have any recommendations to someone opening a trauma clinic several responded that it is not easy to work with trauma treatment, especially not in the beginning. Many said that in order to get through those difficulties you need to have empathy as well as interest in both the field and the clients. Another factor stressed by the therapists was the importance of learning how to deal with the difficult stories and your own emotions in connection to hearing those stories. In the following sub-theme, the therapists' experiences in regards to that is explored further.

Carrying the pain of the clients: learning to cope. Several therapists described that they had been personally affected by the clients' stories. As several therapists described, this was more difficult in the beginning of their careers.

Several therapists described experiencing nightmares in the beginning of their careers. This could be a symptom of experiencing vicarious traumatization which is further discussed in the section *"Discussion and summary"*. The following therapist also mentioned how they received counselling from the supervisor in order to handle to manage their reactions to the clients' stories. The support from the supervisor is explored further in the following theme under the section "*Supervision is crucial for both learning and emotional support".*

So it was really scary in the beginning and I remembered when we started [the treatment] our supervisor could offer us counselling and even up to now. Because you go to the field and you meet a very very difficult story that you have nightmares at night, so you will not sleep well. [...] Sometimes you feel afraid and sometimes you can even at night you can even have this thing. So it was not easy for me at the beginning because that adjustment that kind of life it's like a reality that is so painful. But I adjusted and now[...] because you keep on hearing so many stories. [...] So for all this time now I'm ok with it.

Several therapists described it as being harder to cope when hearing stories involving children. One therapist described having such difficulties and how these experiences became easier to deal with over time and stresses the importance of learning to cope.

Back then I, ok I already had the skills I knew what to do, but I think my heart was still weak that clients' stories affected me a lot. But now as time went on the more clients I met I feel like there are many events that I can handle, no matter how bad it is. And I also think that time has changed because back then most of the clients then were very young people, child murderers, young children and like the past three, four years we started meeting with you know, much older older people much older victims. Yeah, so I think time helps people to grow stronger and now I feel I am stronger though there are still events that make me feel a bit weak but I know how to cope. At least I share with my colleagues or I come and share with my supervisor.

In order to cope with such painful stories and emotions, one therapist described what they see as common ways of coping and shared their personal coping strategy.

They come to you, they want to leave their burden with you. They want to go back home and then feeling better. And after taking their burden, you also have to know how to deal with yourself so that afterwards you can still come back and meet them, so it's not easy. [...]

We share or you do something that will keep you, that will take your mind away from the stories that you've heard. You do something that you love. Some of us - like for me, I go home, I just throw my handbag and start cleaning the house, I cook food you know, I spend time with my family. If I'm to go home and just do nothing, I'll become sad and keep on thinking about the negative stories I've heard. By the time I go to sleep I'm already tired, I just sleep yeah.

Many of the therapists illustrated how they have different ways of taking their mind away from work and the clients when they go home. The most frequent coping strategy brought up was how talking and sharing with their colleagues and their supervisor. Many of them expressed that this support is essential when trying to cope with the painful emotions and stories carried on from the clients. In the following theme, the therapists' relation to the others in the organization is in focus.

Working as an organism: learning and supporting. As apparent in the previous themes many therapists found it challenging to both learn how to conduct trauma therapy and to cope with the difficult emotions that the work can give rise to. One component that all the therapists emphasized as being of great importance is an organization which is supportive, promotes learning and curiosity as well as takes care of and values the experiences obtained within the organization. They described in different ways how the different members of the organization have become interdependent, both in the way they support each other as well as playing different roles in order to keep the organization functioning and developing. As some of the therapists pointed out, both the support from the fellow therapists as well as the supervisor(s) play an important role in building such an organization. This section describes the ways in which the therapists support each other, how they learn from one another as well as how important supervision is considered to be. One therapist described their experience of how the support from both the fellow therapists as well as the supervisor work together.

> I think our team spirit of all the teamwork is quite ok because we really feel for ourselves you know? And besides feeling for ourselves or supporting each other also sometimes[...] the supervisor is also kind of supportive towards ourselves. Besides ourselves the supervisor is always there. So our relation is quite ok. Because we feel for each one of us.

Another therapist highlighted how a supportive environment makes an organization more sustainable and play an important role in avoiding vicarious traumatization.

> With the colleagues and during the supervision. And that one helps us a lot and it doesn't make you have secondary trauma because you handle it yourself, among yourself.

Related to how the therapists described it as being a more prominent issue in the beginning that they would carry the pain of the clients, many therapists also described how the support from the organization was of greater importance in the beginning.

> I think time helps people to grow stronger and now I feel I am stronger, though there are still events that make me feel a bit weak, but I know how to cope. At least I share with my colleagues or I come and share with my supervisor.

The therapists supporting each other. When focusing on the relationships between the therapists in the organization, most of them described that they support and help each other in different ways.

> I must say that the relationship among the counsellors I'm working with is really very good, and we are all really so cooperative. Everyone is there for another any time. Any day.

One of the therapists described how it had been possible to build such a supportive culture, they stressed that by spending a lot of time together and learning the methods together, a mutual trust had been established between them.

> Most of us who are here, we started together. with the training together. We got to know each other very well, we started working together, we normally always, go to the field together, we are in a car driving like for two hours [...] and share, even things outside. Like, outside the workplace we normally share. [...] When we are in the office, we are always together. So that culture just came because, we, me, ourselves, each one knew each other better very well, and developed that trust. [...] We try also to go to get what we call our self help by ourselves, you know. Sometimes you need to help one another because you know the work we are doing also is not very easy work.

One of few times any of the therapists mentioned any negative statements regarding the culture amongst the therapists was when one of them described how there can be conflicts in the workplace. At that same time, the therapist also emphasized how they still remain supportive during conflicts and how they often manage those conflicts amongst each other:

> So sometimes people could have little conflict yeah. That is, I would say maybe I would say that some six years back or seven years, where people could have those misunderstandings. Like people could have misunderstandings in high school

> sometimes people exchange words, they quarrel but it doesn't affect work. People still support each other when it comes to work. [...] We manage to deal with such situations. So we support each other also when two people are having conflict. Someone is much more mature can go and talk to those two people, but it doesn't need to, they don't always have to come to the office to resolve their difference. We manage that. So because we know how to handle each others you know relationship, that's why we can support each other also. When you have a difficult client you can share among each other you share the problems and you talk about it.

One of the therapists stressed the importance of being able to tell their colleagues when they disagree with how they conduct their work.

> If you know in any group, there will always be challenges. Challenges maybe in the way people think, or the way people do things, the way people talk, yes. When not satisfied with someone's behaviour or the way you are talking, then tell me that you know, that practice is harmful as a person. As a counsellor you don't need to say like that, that is not the proper word. Don't call them mad, so I feel like I've supported them a lot.

The therapists learning from each other. Aside from supporting one another emotionally, the therapists also described how they support each other by sharing professional advice and techniques. One therapist illustrated this process.

> We share each and every thing we get from the field and each of our colleagues are able to comment, and in case you don't know how to go about it, somebody is able to give you a way forward. So we have that teamwork and you know.

In a similar way, one therapist highlighted how the more experienced colleagues can fill the role of the supervisor when the supervisor is not available.

> We work as a team and there are things that we do share, for example we have supervisions on Thursdays but also [...] we do have each other even, right from the field. Like for example we have people - maybe two colleagues in the organization - they have experience enough.

In order to exemplify this further, one therapist described the function and occurrence of collegial supervision.

> Even after supervision when we are going out back to our respective homes. You know, not everyone will feel free to discuss anything with the supervisor. [...] I discuss with my supervisor, maybe [they] will feel that I'm incompetent. So when we are walking back someone can say you know, "I have this challenge and I try to do anything and I don't know whether that was the correct way". Say "yes, that is one way of doing it but if it fails you can also do 1, 2, 3 and the other one. I also tried and it worked". So it can be in the car when we are going or when we are coming back, or even when we come from supervision or after supervision and say you know I encountered this, I only didn't want to ask the supervisor the explain then.

Supervision is crucial for learning and emotional support. Several of the therapists detailed the advantages of supervision, particularly how it enabled them to gain new perspectives regarding situations with their clients.

> Sometimes we are learning through experience, after experiencing something and we felt. I mean, like we had a challenge or difficulties, we come back to our supervisors, we tell them what happen, then they get another way of like telling us what to do in case such a scenario happen like that.

During the early days of the treatment centre, the support system for the therapists was described as not being very strong. One therapist described their experiences of this period, as well as their strategy to overcome the difficulties associated with this period.

> I think that the organization had not yet built a very strong support system for staff I would say. Like supervision we call it now, and so we basically shared among the counsellors. Like when we were driving back from field we can share, you can tell your friend today I had my client shared with me a very terrible story, so we could talk about it. But you really did not get enough support, so we could go out to listen to music or some people go to church or go to visit friends you know to disrupt, where you can charge, laugh, and it can help you to relax.

One therapist described how the support system has changed since then.

> The biggest difference is that now we ok we meet regularly in the office. Ok now I would say our supervisor told us that whoever feels like they want to talk can [the supervisor] a call and we come to office. Even when it's not the day for the general meeting in the office. So any time something is really bothering you and you feel like you have shared with your colleagues and it has not really supported you, which rarely happens because now we really support each other. Yeah so regular you know meetings and support has made the big change

Several therapists explained that as the team has gained more experience, they have become more independent, resulting subsequently on less reliance on the guidance of the supervisor.

> I feel like I am more experienced and conversant now. But back then when I started out - because back then I would need too much of my supervisors then. Nowadays I think I can do much 90% of the work without the supervisor that is all I can say. But back then I would have to be so close to the supervisor because I would do things and then go to the supervisor. [...] But I think I can do more work independently at least compared to those days

Many therapists expressed how they see a major difference in how they experienced supervision in the beginning of their careers compared to how they consider it now. This therapist first experienced supervision as being controlling and also described being nervous and tense in relation to the supervision.

> In the beginning I think the supervision was so strict. I know when you are teaching a child how to walk, the way you hold the child you release just a little bit and the you hold back. And when the child gets bigger and now walks and walks for some minutes and then hold and that was exactly what they did in the first supervision. They were very strict. [...] So we were kind of tense in ourselves when we were doing it. Very tense. And then you'd wish that they would postpone that supervision because in yourself you are so tiresome. Like what are they going to say that I didn't do correctly? Those are some of the questions that go in our mind. But supervision today is like when you are learning to drive a car, the way you hold it and then after you can use one hand like this (showing) and one elbow out and supervision these days are like yes, challenges are always there but they are relaxed because we know the concept.

> [...] [Now] I look forward to it and I think "When will Thursday come? I want to meet my supervisor and discuss this". You know "First of all I think you did it correctly but maybe you need some small thing to correct it".

This therapist also mentions being afraid of what failure could entail.

> It wasn't easy with the first client because first of all we were given video cameras. [...] Because you you are torn about am I reading the right thing, am I asking the wrong question, what if the recording shows that I'm left so many important things. [...] Something like that and at the end of it, they kind of give you supervision to fill the gaps where they need to help you address. But for us it was like in case I fail anything am I going to be sent away?

Even though many of the therapists described how the need for supervision and support was the greatest in the beginning, some of them also remember having difficulties sharing with the supervisor during this period. One therapist described feeling a pressure to prove oneself and not make mistakes in front of the supervisor, since the supervisor is Caucasian/Western (mzungu).

> Six years ago wasn't an easy task because remember, we are still learning to do something, and then your supervisor is next to you and the supervisor is a mzungu like you, and not your friend hehe yes. Then you have now declared that you are now something bad and are now panicking about doing it correctly even though when left alone with how to begin you kind of, did I ask the right question, did I leave out something then you then you[...]yes you want to be perfect and perfect yourself.

In a similar way to how the previous therapist pointed out that the ethnicity of the supervisor caused them to feel uncertain during supervision, one therapist highlighted the difference in academic background as a further cause for uncertainty.

> The person who was a supervisor was a doctor, I think in psychology, and then remember I had done the diploma. Now you are being supervised by someone who has the PhD. [...] You know when you are being supervised by a person by a higher education, there is a way you feel small. The esteem is a bit low. [...] You feel like you are too small to be supervised by this person and maybe he or she are supposed to be supervising maybe university, and here it's supervising who has not yet gone far in their education. It's just an inner feeling and knowing the esteem. I think it has not to

do with the character, just feel small because of the education. This high person supervising this small person.

There seems to be some important similarities with how the therapists describe these experiences of supervision, and the situation of being interviewed for this study. They describe wanting to be perfect as well as being fearful of not doing the correct thing. The implications of this will be discussed further in the section *"Discussion"*.

In one of the interviews, one participant described what they find important in order to build an honest relationship with a supervisor where they feel like mistakes are accepted.

> Some of us that are from smaller education were too friendly, very helpful, very parental. Do you know even if you make a small mistake they don't harass you, even the way the give the technical advice it is very parental. They talk to you in a way so that it is ok to make that mistake. But you will not feel you know, when they are some people that when you make a mistake they are very (makes angry sounds and punch a hand in the table) but here the person is very cool and calm. It's like if that was done, the other alternative of doing it was this this and this. And then you feel very comfortable in your heart.

Despite the therapists described being cautious of supervision in the initial stages, they began to appreciate its function in the organization once they became used to it. Consequently, several of the therapists highlighted characteristics they believe are important in a supervisor, particularly someone who is understanding and mindful of their needs. One therapist stressed how crucial the support and the empathy from the supervisor is in order to be able to carry the stories from the clients and to be able to keep going.

> For the supervisors I think the best thing you can do is to be supportive to the staff and to let this also have that feeling for the staff because no most of these experiences we will carry it a lot on us. We carry them for those other clients - over twenty clients for seven years ago - and I've been carrying now for how many clients, it is now our supervisors to have that support feeling for us. To let us also keep on going. Once someone is there those are the feeling that ok I can go on with the job or with the work. So it is very good to be supportive to your staff once you are a supervisor. And it is better also to tell them in advance that in case things do not work out well, please just come you know. Yeah that one will give you that feeling that ok someone is there for me

Furthermore, one therapist illustrated how having a good relationship with the supervisor and receiving support has made it possible to stay with the job for a long time.

> I think one is the good work relationship with the supervisor. Because some of our colleagues also left. They misbehaved and they were terminated. So I stayed this long because of the good relationship, my conduct and I love the work. [...] [It] is exceptional in the sense that your supervisor greets you "Morning do you have anything you want to maybe discuss with me or any challenge that you personal or work related?". [The supervisor] doesn't want you to go and work when you are stressed. If you say yes, I have this challenge that maybe I need some money to send home. Ok maybe I give you now or when you come back from the field. In other organizations you only wait for your salary at the end of the month. Anything that affects you is none of their business. But here it is different. I wish if all organizational managers were to come and see how our manager handles people. I think we would live in a very good world.

As evident from the previous sections, the supervisor and supervision plays an important role in facilitating the learning experiences for the therapists as well as in providing new perspectives and emotional support. As the therapists described having a certain reluctance to sharing negative or potentially shameful parts of their work experience to their supervisor, then the importance of the colleagues providing both emotional support and in facilitating the learning process for their fellow therapists becomes evident.

The therapists described being proud of their work and the results, as well as being troubled by the scale of needs that can't be met by their organization. Several of the therapists as well as the clients requested further interaction and collaboration with other organizations in order to meet those needs.

Some of the therapist expressed appreciation towards their supervisor for the collaboration and referrals that are being conducted at the same time as they stress that it isn't enough. In the next section the experiences of the supervisors are examined.

Themes from supervisors

In the analysis of the three interviews with the two supervisors, a total of five themes were identified.

The first theme is titled "*The supervisor has a complex role"*, and examines the responsibilities of the supervisors and their experiences in regards to that.

The second theme titled "*Training: deep and focused or broad and spontaneous"* contains two sub-themes: "*A broad training: more spontaneity, less focus"* and "*A narrow training can give more focused knowledge, but less flexibility"*. Here, the focus is on how the supervisors presented their preferred method of training of the therapists, as well as the potentials and limitations within these.

Third, the theme titled "*The therapists sharing a background with the clients"*, highlights the supervisors' perspective in regards to the relationship between the therapists and their clients.

Fourth, the theme *"Creating an organism"* contains two sub-themes: "*Learning is ongoing: training is more than a course"* and "*Building a supportive organization"*. This theme examines the supervisors' strategies for maintaining an organization based upon training people to become lay therapists.

Finally, the theme "*Endless needs: few resources"* contains five sub-themes: "*Doing what we can under the current circumstances", "Lay therapy as a necessity", "What we can offer and how we can reach out", "Navigating the aid industry*" and "*Limitations of what we can offer".* Within this theme, the supervisors discuss their experiences of providing lay therapy in a context with limited resources and support structures.

The supervisor has a complex role. As we have seen, the supervisor plays a very important role for the therapists. In this context the supervisor has a very large responsibility and can become close to indispensable when there are so few other psychologists to employ, as the following sub-theme will explore.

Both supervisors described how being a supervisor in a lay therapy setting can differ in some ways from what it's like in other therapy settings. Both in that it comes with a greater focus on training the lay therapists, and in other responsibilities. The supervisors described their role as involving a wide range of responsibilities.

> At the moment it's just me as a clinical psychologist and as a supervisor and I do all the logistics and admin and finances and taxes which is the most fun part of all (laugh)

When discussing the experience of having many different roles simultaneously, one of the supervisors described how being both a supervisor, a friend, management, as well as other roles can be a challenge. The different roles each come with separate tasks, which combined

together result in a heavy workload. One supervisor described that the lack of resources prevents them from hiring another person to ease that workload.

> That's one of the trickiest part, because I'm management and the one who tells them, "payback your advance now" or "hand in those documents", or "you did this wrong" or, so and at the same time I'm supposed to be the psychological supervisor they're trusting and open to. There is definitely, this double role has been there for years, and we never manage to change that because we never had enough funding to to split up the two of them. So I think it was on both sides, on the counsellors' side and on my side, a learning process, and basically I, from the very beginning, those people don't work with us, I even had two three who were really close friends to mine, we became friends. And they actually managed, they never had, they could really separate. I meet [IP] in the afternoon and we're friends, and we share even personal details. But then the next day we're in the office or we have supervision, or we, we work and [IP] tells me something from a management perspective.

Furthermore, the same supervisor described how having insight into the private lives of the therapists can make it difficult to implement the rules that accompany the management position. The same supervisor illustrated how that manifests itself when the therapists ask for an advance on their salary.

> You know and that is of course the most challenging. It's basically every second week somebody has a special problem which is much more special than any other problem. And it's true, they never ask for money for stupid things. It's always something difficult. And then they always want to say, but only this time, the maximum advance, can I get more. And then it's of course for me, of course the point is as management I would say no, strictly no, because if I say once yes to this, then it becomes this, yeah. And of course, as a human being, and problems being difficult, of course I sometimes do it. But technically not, you know. And it's really, that is again this role because I know about maybe private problems, and I just, I cannot ignore them, I mean I'm a human being as well, but technically as management I have to say no. So maybe I try to find other ways, [?] I say, okay I can't give you this advance, but I have some extra work, which I could pay and then through that you get money you know. So of course there could be other ways. [...] So what of course the problems they're having are real problems, but if I would say yes to everything than I would go bankrupt and then we couldn't run the NGO anymore. Its really, it's a very difficult balance.

Both supervisors described how there are very few local psychologists or psychotherapists and how that can make them feel a responsibility for teaching the profession to others. One supervisor described how the lack of local psychologists makes if difficult to find local people to employ who can be work as supervisors.

> In all the years I've done three - four times, there were never more than one or two [people belonging to the same ethnic group as the clients of the clinic] amongst them, because we always keep on thinking, oh, they are psychologists, and of course if they are [people belonging to the same ethnic group as the clients of the clinic] maybe we can even employ them with us. It would be so cool we have a psychologist, you know, Ugandan psychologist, they could maybe even become supervisors one day, you know if you have psychology studies as a background,

The supervisors described a role that comes with a large responsibility and a complex set of tasks, which sometimes even seem conflicting. This seemed to be due to both a lack of funding of the organizations, which makes them unable to employ enough staff, and limitations of availability of Ugandan psychologists. That makes this theme similar to the theme *Endless needs, few resources,* further on in the results (as well as the themes *"What happens now?"* and "*Endless needs - the limits of what we can do"* from the therapists).

At the intersection of the conflict between "Endless needs, few resources", and "*The supervisor has a complex role*" is the aid industry - a complex system that the supervisors can be left to navigate if there are no one else with that role. This challenge will be further explored in the subtheme "*Navigating the aid industry"*.

Training: deep and focused or broad and spontaneous? The one topic where the supervisors' opinions and perspectives differed the most, was regarding how to train lay therapists. They had differences in opinions in regards to what the training should contain, and whether it should be focused on one or a few manualized methods (as received by the participating therapists), rather than several different perspectives. These two sub-themes will go more into depth regarding what the supervisors considered in regards to these standpoints. Both supervisors described how they aim to educate lay therapists into experts in their field, but with two different ways of getting there.

When comparing these different perspectives, the focus is not whether to have a long or a short training, since they both discuss an ongoing learning, but rather how wide the scope of the training should be.

One of the supervisors contrasted the view about ongoing learning, with some studies that describe how their training ended after just one week.

> That's also one of the things if you read sometimes the paper and then it's like they did the training and, it's ok, they received a one-week training and it's like ah are you kidding me? How could they know that in one week? That's just not possible. Or a diagnosis or something, you know we took more than three weeks to teach them the diagnosis and PTSD, and that was just the theoretical part. It's really intense. It's not that easy to just do a diagnosis

A broad training: more spontaneity and less focus. One supervisor described how possessing an academic background or more experience can allow for more spontaneity in the therapy.

> I do work and train people that say with not say a rich background, and in my experience I would say that the richer is best. Like the same actions because you could teach moment by moment what to do yeah, but my vision of therapy intervention or counselling intervention is there really the best is to have the capacity to decide in the very moment - moment by moment, client by client. Through the moment in a session what is the best to do.

When describing the aim of a broader training, this supervisor focused more on promoting a set of values, such as curiosity and enthusiasm.

> People who are curious about it are those people who are maybe more effective with more people around. Because they don't apply simply a pre-organized set of rules but they can see every situation as a new one, always pays on the experience with everything that you are doing [...] I have a given time so my time is in the training time I feel that enthusiasm and every emotion is contagious so if you are sincerely enthusiastic, there is more chance for a person to get interest in what you are sharing.

One supervisor had an alternative point in regards to the broad perspective in training, and claimed that having knowledge of several different perspectives can promote a healthy criticism in terms of not believing that one perspective has all the answers.

> [I'm] always trying to promote in this teaching this critical position. Like what I'm presenting is according to this approach or according to me personally, and I don't believe that - I don't know exactly why counselling is effective, yet I have thousands of clients that I've seen change so I can see the if I can tell you I know exactly why I don't know [...] to be more doubtful and I feel like to be more doubtful is a crucial position which you need to have in therapy.

One supervisor meant that when introducing many new theoretical concepts, it is important to try and simplify and remove as much of the technical jargon as possible. That was to prevent the new words being in focus rather than the new perspectives.

> This is the same when you are introduced to CBT. The year after you do it again and you think of other things, and you think the first time was maybe only a struggle to understand the language. I'm trying in my training to remove as much technical language as possible. But I'm not achieving much like the cluster of memory if it's occupied with new words can not be occupied with new concepts. And I wish I could remember the intervention or the idea even if I don't remember technical terms.

One of the supervisors highlighted a potential risk in a broad-style of training, whereby the therapists learning too many different techniques may cause them to be unable to separate them when necessary. Consequently, the therapists may mix up techniques that should not be mixed up. At the same time however, the supervisor pointed out that a broader set of techniques may allow for greater flexibility, as different methods can contain more universal aspects, which are good to use generally across methods.

> You know it's always a balance, like you want to mix some. Because all of them have some basic rules which apply for everything, and some have some good techniques which you could even use in another kind of setting. But you don't want to mix up everything at the same time. Especially for [our trauma treatment], you can't in the middle of [our trauma treatment] do something completely different, that would be harmful even[...] I am a bit worried about having all these different skill sets and then you actually need to know like what is the specific of each and what is the boundaries of each. Where can I mix it and where not and for some like [our trauma treatment] it's very specific where you couldn't mix and for other things [...] different things and also different levels of being affected you know you might have people who need counselling, up to who need treatment intervention, people have problems versus

highly symptomatic mental health disorder, so you also have a bigger range in terms of what they work with.

One supervisor expressed insecurity about whether or not they ought to narrow down the training in order to be able to go into more depth with a narrower focus.

I ask myself every year it would be better maybe to simplify and instead of giving all these range, vision or different approaches maybe select two three approaches and deepening them, could be as well maybe better I'm not sure

A narrow training: more focused and less flexible. One supervisor talked about how a narrow training focused specifically on trauma, trauma treatment and related areas, enabled the therapists to become experts in their field, "comparable to a psychologist who is a trauma specialist", without them having an academic background in psychology studies.

Of course you could say you have lay personnel who have no background in terms of psychology study, but they will not stay lay personnel. You have to make them expert in that field. You know they are not psychologists but their field you turn them into experts, and that is not easily possible. That cannot be done in a one-week training. And of course we train them in [a treatment method] and in diagnosis but they also learn about suicidality, about general counselling skills, solution focused counselling, depression, suicidal intervention, trauma guilt and how to deal with shame, how to deal with aggression. […] That training is not like because maybe lay personnel sounds kind of like we just teach them a bit or so. And yeah a bit in a sense like not the whole variety of mental health disorders, like they don't need to know anything about schizophrenia but they need to know about depression since that can be also trauma related. So you have to see what is in that field and then they have to become experts in that field, comparable to a psychologist who is a trauma specialist. They basically need to have in that field the same knowledge. I think maybe the term lay-personnel can be then sometimes confusing because they are actually experts like we have made them experts through the training and their experience.

One of the supervisor discussed experiencing difficulties in training people who have used different methods in their previous professions.

I think maybe they are more focused because they only know [treatment method], that's one of the things we have, sometimes in [the supervisor's country of origin]

> when we do trainings with therapists, it's actually more difficult because [treatment method] is different. It's more, you know normally you would say if a therapist is talking too much, you know then you are doing something wrong. [...] So [experienced therapists knowing different methods] is always very difficult and we always try to tell them like ok, try to put that aside for a moment because right now you want to practice [this treatment method] so try to do that protocol and it sometimes very difficult for them.

Similarly, one of the supervisors described an instance of where they tried to train lay therapists who also knew a different method, and how it became mixed up. They described how a smaller palette of treatment options can make you more focused.

> People had learned something else and then they kind of mixed up. It was lay therapists, but then they mixed up two different therapies and it didn't work well. So our experiences are also my senior colleagues sometimes say it's so much nicer to train psychology-students in [treatment method] because they are more open to that and they don't have all the other background of all kinds of other therapies, than to train psychotherapists who has been working 20 years in a different field and never has tried [this treatment method]. Because I think that's the thing like you have your other things in your mind, but for [this treatment method] it's special, like you have to focus on something and if you're a lay therapist, that usually means that's all you know and then you actually don't have anything to confuse you, like you know exactly what you have learnt and you're doing that.

The therapists sharing a background with the clients. Both supervisors stressed, which was also mentioned by the therapists, that having been in the client's shoes can help to see the client differently and relate to the client in a different way.

> Another aspect to me important is the counsellor themselves to have their own experiences from other areas as a starting point, their own experiences of counselling in the role of clients. They will not be able for a maybe five-year psychoanalysis or four years, but have as well the experience of being in their shoes of the person so they can as well help a lot in terms of relationship. To not see the other like someone different to handle.

One supervisor emphasized how the therapists originating from the affected area and sometimes even going through treatment themselves can be beneficial for the therapist, both in understanding and motivating the client.

> When it's lay personnel it often means that it's the people from that affected area that you're working with and then to a certain degree understanding really what those people are going through. Like that experience we made in a different setting. Like once people who are affected themselves overcome their trauma they become really good counsellors because they really, they have the empathy is simply there because they really know what it means to be affected and what it means to go through the therapy - the combination of the two. Of course everyone in a war area knows what it means but to overcome it and realize what it takes to overcome it - it's really a valuable lesson that can really help you to also motivate the client when they say I don't wanna talk about the past, and you say I really know what it means for you to say no now, but I also know how good it is if you do it. So to have that experience is I think very valuable.

As we have seen in the quotes from the clients and the therapists, there are ways in which they see both similarities and differences in one another. One supervisor described that for some clients it was difficult to trust the local therapists at the end of the war since they did not know what part they had played in the war. They described that in that sense, it could be beneficial how the clients also see the therapists as being different, in order to reduce negative connotations.

> Of course they consider them clearly as town people and there's a huge difference between village and town people. So like the women they wear trousers, that is like sometimes confusing to the people in the village. Like I don't think you would ever see a woman in trousers in the village. So I think that helps them also to like, the expect them as professionals, so that I think helps.

Creating an organism. The therapists and the supervisors described how the supervisor has a role that is central to the organization and how it is organized. In this theme the supervisors described different ways in which they try and build a learning and a supportive culture within their organizations.

Learning is ongoing: training is more than a course. Just like what the therapists described, the supervisors also stressed that an ongoing training and development is necessary. As will be discussed under the theme *Navigating the opportunities and limitations of the aid industry,* this can sometimes be a challenge in a donor- driven industry where many interventions are based on short term projects. Both supervisors did however stress that training therapists is a continuous process and not something that can be finished after just a course or a training.

> I think also to realize it really needs that effort and training and follow up it's not done. Even if it would be a one-year training, then you cannot just say we´re leaving now. Since it's trauma it has to be a continuous effort. We still do catch up training we teach other things from time to time.

The practical part of the training, involving elements of role-play and following senior therapists, was portrayed by many of the therapists as the most important component of the training. They described it as a way to both gain motivation and insight about themselves as well as the perspective of the client. One supervisor illustrated the intention of this part of the training.

> There's always this part where it is required that every trainee is once a client themselves and once a counsellor themselves. [...] We do small group exercises and rotate where everybody gets a turn, everybody gets a chance, and if they have a traumatic event, in their life - even if it's not showing PTSD now but if they have any traumatic event, we encourage them to talk about it or to talk about the worst one they had. If they had several - if they didn't have a traumatic event - then maybe take something which is quite severe, maybe an accident which was severe but maybe not life threatening, for example. So that at least they really get this experience of what it's like and at the same time they give a learning opportunity to a counsellor who then practices in a small group, and then the other one has to be the client. So that is part of all the trainings. [...] So to have this experience, how much talking in detail about it and then from the past - how much you bring it back to now, how much your whole body and memory comes back - it's quite an experience. If you understand that, then you also understand when your client talks about a really severe traumatic event, how difficult it is for them.

One supervisor described how how the practical aspects of the training can play an important role facilitating an understanding of your own past and your own avoidance as a therapist.

> We really want to encourage people in the training you know to really learn about who they are, what they have been through themselves, how it might affect them and that it might be easier to avoid some things. You know avoidance generally is a bad thing, all of us have some things were avoiding [...] So we try to encourage them to see. If you want to be a good trauma counsellor you, you need to know yourself what happened to yourself.

When discussing the recruitment process, both supervisors described focusing on both the theoretical knowledge and practical skills of the applicant, as well as determining whether they would be able to handle the clients' stories and the strong emotions accompanied with hearing them. One supervisor described the different ways the therapists can ease into the work by gaining some practical experience in a controlled way. Throughout the interviews, different ways were mentioned in regards to this, such as translating therapy sessions, accompanying a senior counsellor through a therapy, or even being accompanied themselves. One supervisor described the recruitment process as a process of narrowing down until the most suitable candidates are employed.

> If I have a choice is basically say I train ten people and I employ the five best. And the five best in terms of there's a theoretical written exam, so that the basic knowledge is there. If people just got the concepts, plus how is my impression in the small groups. So, and of course people have different learning speeds, so it could be that maybe, like we had that sometimes that I had the counsellor in the training, and maybe the theory was very good but then I still realize in the practical exam there's still a lot lacking, but I never had the feeling they're ignorant, or you know, I really felt like they want to do it and then I, it's also good to say, we had that with counsellors before, that we would say, okay why don't you first maybe work first as an interpreter, you get some bit more experience.[...] But the basic idea is that it's not for everybody. [...] I mean counselling already is a kind of special profession plus being a trauma counsellor is special. [...] I'm very open in the training, I really try to give them very accurate examples of what it would be like, because there's no need to hide it. And then you know, pretend they know and then they don't. To really be open about it, because they also have to be open to the client and they have to name the ugly details. There's no

way around it, and also to kind of give them a feeling of what that feels like and that they also you know realize what it makes with themselves. Also making them understand if there's any relation to their own past that could be an obstacle. But if they overcome it, it can be a benefit. So that they're not trying to avoid it or so, that they're also trying to be open.

One supervisor described the importance of having foundational experience and knowledge in the organization in order for that knowledge to trickle down: both in terms of theoretical knowledge and so that the lay therapists have a therapist role-model. This supervisor described how an academic background in psychology is not enough to fill that role.

I think it's important to model the service. Often a psychologist is called to supervise service provider in the field but the psychologist herself has no clinical experience. She is coming from the university organization as is this for her she should be a coordinator or a manager of psychosocial services. This one will work. Should be hired someone with clinical experience who provide service and can model. Modelling is an important aspect of learning and all these supervisors who don't have clinical experience the problem start from the project [...] I feel this co-therapy component is important. Then the counsellor will develop their own way [...] But consider that the psychologist that you engage make sure that he she knows about client service, not just theoretical knowledge. Because it's a different thing. [...] there is a difference. I mean I rejected a number of psychologists who applied to my organization [...] You know in therapy the tool is the person itself, so my evaluation is as a person first and beside the level of education. It's true that's having a background in psychology or philosophy gives you a way to think as well in abstract terms, which to me is very useful, rather than to just know what to do. [...] Again it can be very much related to the, let's say characteristic of a therapist, which some of them may not be taught in any university course.

One supervisor described how lay therapists who later attended university gained new experiences and perspectives which were able to broaden the scope of what the organization can achieve.

I have some counsellors who have now over the years on weekends university or so the other counselling degrees so that definitely also has helped a bit more their general

> understanding. And those counsellors are more able to work with like family mediation and so on because they understand a bit of that. That one has definitely also helped like maybe not with [treatment method] specifically, because that is something that we have trained and that is there as it is. But in terms of general counselling and also family mediation that has also helped more. Yeah but that is usually things they have acquired as they have kept on working with us and they gave us also some top-up training. We can tell if you do also some other training they say ok, but I have also learned this, and then you realize ok, they had other areas and then they can combine it and you tell ok this is now an actual benefit and they have added more things to their skill set which is very good.

When the organization is able to maintain and utilize the experience within the organization, this relieves some responsibility from the supervisor and builds a learning organization.

> I think it's really nice to have the junior counsellors because they can also learn. Since we then have the senior counsellors that makes also the training easier if you can rely on their experience also. And also it's good that you know that they go together to the field so whenever they may be a difficult client, I know already that the senior counsellors are there and they can already share in the field. So in the beginning of course we used to always drive with them out to the field, which now is not necessary anymore since they've gained all this experience and they can now support the junior counsellors[...] I'm not doing the therapy, it's just the counsellors, but then they can learn also by sitting in with the senior counsellors

The expanded responsibility for the senior counsellors can be seen as a way of making a career ladder within the organization, which will be discussed further in the section "*Summary and discussion*".

Building a supportive organization. When discussing how it had been possible to continue to work as a therapist for such a long time, one of the therapists described the relationship to the supervisor as the most important factor. In a similar way, both supervisors emphasized the importance of supervision and a support system. This is in order to build a functional lay therapy organization where people want to stay for a long time. One supervisor described how their organization has kept most of the therapists over time and voiced

frustration at how the training of staff in external organizations can be of no use when they have a high staff-turnover.

> We have trained organizations and then a year later all the counsellors are gone and they employ completely new staff and it's like, but we trained those. [...] You know for more than ten years we our, employment rate has been stable like - of course we had counsellors who left us and we trained some new ones, but it's not like that every year its completely new. Like I have that with other organizations, I know them for long and every time I go to their office they have a new program manager, a new secretary, everything. And I m like I'm starting over [...] So actually our organization has been quiet stable in that, in terms of sustainability we have a very, very sustainable. If you compare to other organizations where also staff- turnover, I think it's called, is quiet high.

One of the supervisors described how a flawed organizational structure can compromise the effectiveness of the training for the participants. This poses a further problem when training people who have a wide range of work assignments when not getting the appropriate amount of scheduled time for therapeutic assignments.

> One of the biggest obstacle is we would train people from other organization and then they would very much not change their job description. Maybe we had nurses in health centres and then actually they would need to say; 80% you're a nurse and you really need to work less so you have maybe 20% to do some counselling. But they wouldn't do that and they were already overrun with work and we also thought that this is actually ridiculous we are putting more work on them. But of course the government would have to employ more people but they are already hardly paying the ones they have, so you struck a lot with the structural things[...] It's often a problem if you train other organizations or staff from government hospitals or something, they usually have already a full job description.

One supervisor described how some of the therapists are not accustomed to the function of supervision. This can be related to how some of the therapists described feeling a lot of pressure in connection to the supervision in the beginning of their careers.

> Therapist in [the supervisor's country of origin] they have more awareness, they've grown up with all supervision, they know, and they can actually say it for themselves, which is good if you can be honest to yourself. It's better somebody tells us I really

can't or don't want to, then somebody who's maybe hiding that and then it kind of backfires. But of course if you have lay personnel they don't have that awareness, they don't know what supervision is, they don't know what reflection is, knowing yourself

Furthermore, one supervisor highlighted the importance of making sure that the therapists feel safe during supervision, in order to promote an honest and open climate.

If we had like some client who's a bit more aggressive, who's kind of more challenging the counsellor, and then the counsellor might feel like, okay I'm not scared, but it's still a bit weird, our therapeutic relationship. So we would already say, okay first of all if you're scared you can't do therapy, so you need to sit somewhere with your client where you're not alone, but you see other counsellors close by so you feel safe. Because you can't be a counsellor if you're scared, yeah. And then we would also say then, tell the other counsellors, keep an eye on her, you know, if she feels safe she can do a good therapy. And also ask her afterwards, how did it go.

This supervisor is aware that the therapists do not always feel comfortable during the supervision sessions. On such occasions, the supervisor encourages the therapists to share between one another.

What very often works very well, what I'm also encouraging a lot is that maybe if they feel like they can't share it with me because I'm also management that they use the other counsellors. And they also say they do that a lot. Like whenever I here about, like what I heard now about the child or so, I already realize a few other counsellors know about it, and then I'm also encouraging them, why don't you call her you know, you know her best, check on her how she's doing, but also in terms of [the treatment method], you know, If I know a junior counsellor has a difficult client I would even talk to some senior counsellors maybe two of them - and I know they're in the same car, they go in the same direction, so I would say you know on Monday she has a difficult session, why don't you go check on her right afterwards and see how she's doing [...]So I'm also glad that the team has each other. So I feel like that also compensates for me maybe not being able to do all the roles because I already have so many kind of yeah. And maybe it's not ideal, the problem is we don't have another choice.

Additionally, one supervisor highlighted the importance of laughter as a coping strategy.

> Of course with fellow counsellors they can always talk. They know these stories and they can even laugh about it. You know sometimes you need this sarcastic laugh to get it out of the system, and I also do that with colleagues, you know. Sometimes we laugh about some clients who are not laughable at all but sometimes some stories are so horrible and then getting even absurd that you think this can't be happening, and you know what has happened. So much violence at once that you actually can only laugh about it because otherwise you're going crazy. So things like that like can also be sometimes like Catharsis you know.

One therapist explained how the supervisor sessions are not only to discuss the clients, but also on the mental health of the therapists, which they refer to as psychohygiene.

> And sometimes we have special supervision meetings. Like where we discuss other things, more like, like we did a special supervision meeting on social support. Because social support one thing that is psychohygiene for counsellors or therapists all over the world [...] you know the main point of psychohygiene for psychologists, therapists, counsellors is knowing yourself.? Knowing where are your limits, what are your signs of early burnout something. And what resources do I have in my self, in my social system

Endless needs, few resources. This theme contains the supervisors' descriptions of how they are handling shortages of resources while providing therapeutic treatment. They described a context where the social support systems are lacking while there are vast material, social and psychological needs amongst in the communities. They expressed how this situation often leaves the supervisors (and therapists) in the difficult position of having to leave clients in a better psychological state, but remaining in a very difficult situation.

Doing what we can under the current conditions. As discussed in the theme *The supervisor has a complex role*, there are very few local psychologists in Northern Uganda. The care structures generally are also described as insufficient.

> The work opportunities given as well by money invested in these services. Money invested in these services almost is not here in North Uganda or Uganda in general. There are no psychologists in any health structure.

There are some services that the NGOs are just doing now but it's not in terms of building capacity for the whole country so to say it's not in that sense. It's more like trying to fill the huge holes which are there.

Because of this, providing therapy poses some additional challenges. One supervisor described the difference in dealing with suicidal clients in Uganda compared to how it can be handled in a country with a better-functioning psychiatry.

First of all, suicide trying to kill yourself is a criminal offence, so that is a huge problem because you can technically go to prison for that, which of course we don't want to our clients to happen. And then the other problem is probably the police wouldn't do anything, if there's, only if something happens but not in advance. And also there's no closed psychiatry here. There's an open psychiatry so they can leave again which would not help. So what we basically have to do is to adjust to what is there. So we basically tell the counsellors, if the client is completely not cooperating and doesn't talk to you anymore and simply leaves the room and says "I don't care I'm gonna kill myself now or tomorrow or whenever", then you have to break confidentiality but again be careful. It doesn't mean tell everybody. It means maybe you already know the client is close to the brother, so maybe you talk to the brother, or maybe to something like a cousin[...]it doesn't mean you tell everyone.

Another example of how lacking these fundamental governmental structures can affect therapy work, comes up when discussing how to deal with ongoing trauma.

Well generally in research there are two opinions. One is basically like if you want to talk about an ongoing trauma, you first need to establish security. So basically in Europe that means taking out the child out of a sexual abuse environment, for example. And of course there it might work because you just call the police and there's an arrangement for that but also in some places also in Europe you just can't do it - you won't get the court order to take somebody out. So that is sometimes difficult, but of course here, in most cases the women cannot leave their husbands because of traditional reasons. It's a very patriarchal society. Financially they won't they are not independent, they have many kids and they can't take care of them. So like our opinion is if you wait for someone to be out of the trauma and then talk about the trauma it can be already too late.

Lay therapy as a necessity. When the needs are as great as what has previously been described and the resources are few, then the traditional ways for the health care system of tackling mental health issues - with long education and governmental support - seem far fetched. In regards to that, both supervisors described how working within a lay therapy setting was a necessity.

> There is not enough of anything not even therapists or psychologists or anything. So it was pretty much clear to them from the beginning that we need to develop something that can be taught to lay therapists because otherwise you can not provide the help those people often need and you can not wait or it to be finished [...] So that was really also something where the point was that treatment needs to happen and people need this help and at the same time realizing but who is going to do that? There is no one around who can do that and of course you can not constantly fly in experts or so you know, or work with interpreters. That could be a short term solution if there's something immediate like in an emergency situation but that is not a long term solution [...] so it had to be lay therapists and that also means they're usually affected themselves so you had to take basically victims and also make them so to say therapists so they can help their fellow victims.

When discussing this and comparing what would have been different if working with psychotherapists, one of the supervisors said that in the current therapy situation, as in when conducting a manualized treatment, the difference wouldn't be too substantial. They did however describe how the scope of what kinds of treatments offered by the clinic could be increased. Supervision and training are two aspects in where psychotherapists could contribute. As discussed in the theme *The supervisor has a complex role*, that would also mean that the responsibilities for upholding the organization would be more spread out.

> I think it would've been more that they would also provide more training and supervision maybe to other organization, I think that would be different. That maybe they are working in the field would be more diverse instead of only doing [a manualized treatment] and counselling, they could probably do more trainings and maybe also supervise other organizations more. Then you would have basically more capacity of the people I think that could be a different thing. I mean when I do trainings still the counsellors support me like the senior counsellors would also have

> small groups where they are practicing talking about one event and then in the training so they are already supporting, but I still do it in the most part of the training. Maybe you could have a system in place where you train like training of trainers, so that you have people in position that keep on. […] so that could be good that you don't only train but you also establish a system so that even when you are gone it can keep on going and even that's what we did in [another country]. We trained psychology students we made a trainer of trainees and they are also now supervisor which worked of course with psychologists. That one I think might be too much for lay personnel because I think you need a bit more background in that.

What we can offer and how we can reach out. Both the clients and the therapists described how building a trusting relationship between the client and the therapist can take time and it requires patience and empathy. As previously mentioned, many therapists emphasized how the clients fear of getting stigmatized by their communities can be an obstacle to establishing a relationship between the therapists and the clients. When the supervisors described how the organizations can reach out and build trust as well as capacity in the communities one of the supervisors described how they use the community sensitization as a way of both introducing the organization and the community to one another, as well as a way of addressing stigmatization and conflict stemming from the past war.

> We basically say this is an entry point and we explain who we are, but not so much on trauma, that comes a bit later. We first do like more of an introduction meeting of who we are. But basically explaining everything about trauma and who we're looking for [...] and also to inform we do it about trauma background and stigma. Stigma is a big problem, so we could also talk about that and inform the community about that, like what is stigma and why are people stigmatizing, also to say those who are stigmatizing are not the bad guys, because then you kind of push them further away - But more like explain that stigma often comes from people not knowing or being scared, so it might be a good reason why someone stigmatizes. It doesn't mean it's good but maybe understanding it it helps.

That way the community sensitization can be a way of recruiting potential clients and finding mobilizers.

> So we basically say we can start with you but please send us your family members, your neighbours, your friends or anyone else you might know or think already that person needs help. So they have these group meetings and then kind of mobilize via this group and then additionally when you are in the community you always find some mobilizers somebody who knows everyone.

This recruitment and spreading awareness about stigmatization and trauma goes hand in hand in these community sensitizations.

> Sometimes they bring those people where they say this person is crazy or this person a troublemaker or completely isolated nobody likes talking to that person. And it is of course stigmatizing but at the same time from our experience, is it is often those people who need help because of course they are not crazy but they have a reason for their seemingly crazy behaviour. And of course being isolated is a classical PTSD case. [...] Having PTSD symptoms seeming like as if you were ignorant or arrogant but you were isolating yourself because you're so scared about what happened to you.

When looking at the treatment options for the clients, the traditional way of dealing with mental health issues is to go through different traditional rituals, which can be expensive. This supervisor pointed out how they are careful not to conduct treatment at the same time as a client is going through rituals. The supervisor pointed out that they don't know how effective these rituals are against for example PTSD, but pointed out that sometimes they play an important role in dealing with the stigmatization. That supervisor recalled some clients describing their experiences with these rituals.

> [The treatment] helped me individually with my symptoms like the rituals couldn't do anything about that but the rituals were a very important social factor because it's a social thing and the whole clan or the village attends. It's not a one on one thing with the traditional leader and it helped me socially you know I felt again accepted. You know you have the PTSD but then you have also the stigma and these other issues, which we cannot deal with. We cannot make the stigma go away.

One supervisor emphasized how widespread the suffering from PTSD is in Northern Uganda and how it is preventing the individual, the community and the country from moving on and being able to develop more efficiently. When a person is suffering from PTSD, it can be very difficult to make use of other types of interventions, such as material aid.

> Also the country cannot develop if you think about how many people might be traumatized. So it's kind of a vicious circle and you have to break it[...] our experience is that you can't do anything about your daily problems if you keep on being kind of trapped in the past. You know if you want to do something but then you are reminded and you think again about the killing or whatever it was.

One supervisor pointed out that by providing trauma treatment can be a way of freeing up resources within the people suffering from PTSD, so that they can live their lives the way they want. If the treatment frees up resources within the person, but without any possibilities of using those resources to improve ones' life, that can leave the clients in a difficult situation. Just as both the clients and the therapists pointed out, it is important to consider what situation you leave the client in. One supervisor reasoned that having access to both therapy as well as other interventions would be ideal.

> The combination would be good you know if they would get some kind of seeds or whatever the livelihood is then they could combine it with trauma treatment because for those who have severe symptoms it will be too difficult to profit actually from that help. And you would want them to profit as much as possible, but of course it still it doesn't it can help them to get capacity to take care of their own problems

By working with both community sensitization and individual therapy, it is possible to work with both the individual's capacities as well as addressing the stigma in the community. When this can be combined with other interventions, aimed at for example material needs or livelihood interventions, this can result in a more effective way of both providing interventions that meet the needs of the clients and filling the holes in the system left by the lack of resources. Whether it is possible to provide such services in a country where the governmental support is severely limited is beyond the scope of this thesis, however in the next section, the strategies used the supervisors use to navigate this landscape will be analysed.

Navigating the aid industry. Despite both supervisors mainly emphasizing the flaws of the aid industry, they also pointed out possibilities and strategies that can be useful when working in this setting in comparison to a governmental setting. Many of the difficulties brought up by both the supervisors are, in one way or another, regarding the donors' implementation of funding and the organization's strategies to access this funding. One large

difference between receiving funding from the government and receiving funding from donors, is that the donors often work within shorter time spans.

> Of course it's difficult, donors give out money sometimes for one year and then like we have projects where we train somebody and then you know we follow up later and like how is it going and then yeah I know that project ended[...] It was a one-year project and within that project people received training were employed, but then it ended and that's it. Of course you still have the capacity within those people and maybe they move on to another job where maybe they could use those skills so it's not completely lost but in terms of that project it's sometimes frustrating that might be one or two years only and then that's it.

One supervisor described how even when working with the UN, the maximum limit for a project is ten years. This supervisor also described how, when applying for funding it is often declined on the basis that the issue regards a post-conflict zone where the war ended in 2006.

> That is not really like it's not in terms of what is needed in that country and I mean ten years in post-conflict is nothing. If you look at Europe or Germany or you know some of the work only started in the seventies and eighties and some is only starting now. Like there was some research about some things that happened in second world war where only started 50 years later like oh that also happened you know. So ten years is nothing.

Despite this, not all requirements or demands from the donors are seen as negative. One supervisor described how the community sensitizations began as a request from a donor.

> Sometimes the donor makes that we do individual therapy and then the donor says "oh but what about the community, couldn't you sensitize the community more?". Of course we could you know it's fine and then we're doing of course we developed something which I thought was really useful for the people to understand and also the feedback from the client was very some of them they said there's a lot of stigmatization so we thought it's a good idea to have like community sensitization training which we are now also doing in the villages

Working with donors can also be a way of getting in contact with other organizations and collaborating with them.

> At the moment one of our donors [name of an organization], they also provide, they also give money to other organizations in northern Uganda and one of them is [name of an organization][...] So [that organization] is into this economical support they had no psychologists they had no clue about that but we met them and it was really nice that they kind of immediately got the concept of basically it's not that easy but the basic concept is that if somebody has a PTSD and has so to say a severe mental health disorder they are often not able to benefit from the economical support.

One supervisor described different trends in the aid-industry and that much of the funding goes to the organizations that use the correct jargon in their applications and how organizations adapt their services and descriptions to that. The supervisors gave examples such as using the words "culturally sensitive" and "holistic", or how local rituals for a time were a focus for the donors.

> It's like a big hype in the NGO world, like this thing where cultural appropriate or culturally sensitive is the right word, that word is like everywhere. But it's such a non-meaning term when someone says oh, we're culturally sensitive, it's like yeah but what does it mean? You know, you could have organizations that say we're culturally sensitive so we're providing maybe - I don't know, I'm exaggerating - but maybe we're providing support only to the men because the women has a different status in this society and that's how their culture is, and we're respecting that and so we only do this with men. Then it's like ok, this might be culturally sensitive but it's still a culture can also be discriminating, and then you're supporting that discrimination.

One way of adapting to the changing requirements of the donors, as one supervisor pointed out, can be to adapt those words within the boundaries of what you know your organization is capable of providing. That way you don't have to change too drastically in order to get funding. The funding from donors may be moving quickly, but then it is important to move within the competences of your organization when applying for those funds. In doing so it is crucial to know the limits of what you can provide, which is the focus of the next section.

Limitations of what we can offer. As we have seen, the supervisors described it as being common for organizations in the aid industry to try and provide several different services at the same time, as well as moving between different target groups. This could stem from those organizations both wanting to help more people as well as trying to get as much funding as possible.

Any organization will change over time, depending on both internal and external factors, and the enormous external needs as well as the necessity to have funding for the service you are providing can be a factor that will force an organization to make really sudden changes as we have seen. In order to know the limits of how much you can change as an organization, one of the supervisors named the IASC *Intervention pyramid for mental health and psychosocial support*, which is described in the Introduction.

The supervisor argued that for organizations providing basic services further down in the pyramid, it is possible to move around between different target groups. If you are working within a more specialized field, such as trauma therapy, you need to know where you are specialized and expand your services slowly, within the range of competences of your organization.

> It's basically like the pyramid of needs and at the base you have most people so most people in conflict area need water security hygiene those things and then you have maybe social support in terms of maybe forming youth groups and then which they can basically do by themselves and then the next level you have more specialized help where you maybe need to if you are offering maybe for the nodding syndrome the children they also need water and hygiene and security so maybe if you work in that field it's actually not that bad to go from one to another because that is basically the same everywhere. But we work in the specialized in the top and that one of course can not just shift since it's specialized you can not just shift to another group and say it's the same yeah. So maybe that's also important if you are an organization that works with drilling bore holes that basically doesn't matter if you do that for LRA survivors or nodding syndrome survivors they both need that as well as maybe mental health support. [...]my observation is that I sometimes feel like some organizations don't know where [in the pyramid] they are and I think all of these are important and I think you have to know where you are.

The supervisors described how issues where therapy can't always help such as with alcoholism, gender-based violence and poverty are enormous problems in the communities they work in. That makes it important to know if there are other organizations that can be of service if the clients have needs outside of what you can provide. This enables the possibility to write referrals or collaborate in other ways.

However, when the clients are desperate for any kind of help they can get, this puts a large responsibility on the service provider - in this case the supervisors and the therapists - to select people that are in need of the service they are actually providing. The supervisor here plays in integral role both during the training and the supervision to ensure that the selected clients can benefit from the treatment they are receiving.

> What I believe is important to distinguish what is counselling and when a client comes for counselling and when he is coming for material support and livelihood psychosocial services. [...] Now at this point because this is the situation, you see the skill which is very relevant the skill should be at that point how to select the person who is there for what you have to offer[...] "remember you will be as poor the start of the session at the end of the session you will be as poor as when you started you will get no material support no medical service, no this no this no this the change will be internal." [...]Learning this straightforwardness is one of the skill that a training should provide and in many being this straight forward like here being straight forward at the point to look rejective it sounds so impolite but it's a crucial condition then you will be able to see clients that you can help

Setting clear boundaries for what you can provide is also a way of minimizing the risk of the therapists' feelings of inadequacy, as well as remaining honest towards the clients.

> So this distinction to me is very crucial. And as well for the service provider not to feel inadequate because for people who wants to do counselling but the client is looking for other type of service they feel I'm a bad counsellor and this include a clear distinction for what can help and what can not help how to set goals for a therapy. If the goal is to change someone outside, the conditions above the ends of a counselling. Learn to say you cannot. Learn to set boundaries as well, boundaries are as well on the request of the client.

In being aware of the limitations in what you can offer, the organization can make sure that the clients they are providing these services to are actually in need of them. Additionally,

in being aware of the limitations in your organization, it is possible to both minimize the distress of the therapists and expand at a rate that ensures working within the zone of their competences.

To summarize, the supervisors have a complex role that include the planning and execution of training the therapists as well as supervising them. They also recruit therapists and are responsible for training and supporting them so that they can provide a well-functioning therapy to the clients that need it. They are required to plan so that the therapists have a feasible workload and prohibit them experiencing distress, at the same time as providing their services to as many clients as possible. Furthermore, they need to work with donors and make sure that there is adequate funding, as well as collaborating with other organizations to try and cover the holes that are lacking governmental support system. It is a large and complex responsibility and as they point out it is also highly dependant on factors above them, such as the donors and the politicians.

This large responsibility and the lack of local psychologists to delegate responsibility to, could be important factors in what we interpret as them describing themselves as indispensable.

From here, we will look at the common themes between the clients, therapists and the supervisors in order to look at whether there are any commonalities between the experiences of the different groups.

General themes

Building trusting relationships. In one way or another, participants from all three groups discuss how establishing trusting relationships has been an integral role in their experiences of lay therapy.

The clients describe an initial suspicion towards both the therapists and the method, and how that suspicion combined with an initial increase in their symptoms made it difficult to trust the therapist. Through regular contact with the therapist and after seeing a reduction in symptoms, the clients describe how they could start trusting both the method as well as the therapist and the commitment to uphold confidentiality. One client also mentioned how home visits and sharing a meal together with the therapist, combined with having contact information to their supervisor made it possible to trust the therapist.

The therapists express how it requires both empathy and patience as well as ample reassurance in order to help the clients overcome their suspicion.

Some therapists also describe an initial insecurity regarding what they could say during supervision and what repercussions it could have if they would say or do the wrong thing. Several therapists stress that this was their experience in the beginning of their careers and one of them emphasized how, the trusting relationship towards the supervisor which exists today has been the most important factor as to why it has been possible to work as a therapist for as long as they have.

The perspective from one supervisor is that most lay therapists are not accustomed with the concept of supervision and that it can take some time and effort getting used to it. The same supervisor also describes how their role is a combination of supervision and management, which makes it harder for the therapists to be totally honest at all times towards the supervisor. In order to address that, this supervisor stressed the value of promoting a climate where the therapists also support each other.

Endless needs, few resources. One of the most distinct themes that appeared throughout the data-set, was how all the participants request in one way or another more resources in order for more therapy to be provided. The clients request having the opportunity to have more contact with the organization and for more people in their communities to receive treatment. The therapists describe how the needs for treatment in the communities are immense at the same time as they request more colleagues. These requests are received by the supervisors, who has to try and find resources or convince someone higher up in the hierarchy to do so. This relies on the dependence of an aid industry, which both supervisors describe as flawed in many ways. By following these requests, we can see that throughout the chain of interviews, everyone is dependent on someone higher up in the hierarchy in order to provide the services needed by the clients. In other words, all participants describe how they believe that the treatment they are in contact with is needed, and that more people needs access to it. However, since political decision-making and organization of the aid industry, the government and global resource allocation is outside the scope of this paper, we will not go any further up in this hierarchy.

Collaborate more with other organizations. Related to the previous theme, participants from all three groups request further collaboration with other organizations. This is suggested as a way of meeting the needs outside the reach of trauma therapy.

The degree of which collaboration and integration with other service providers can be made possible is of course highly dependant on whether there are other organizations to collaborate with. One supervisor described how, when the UN were active in the area there used to be integrative meetings for all NGOs in order to promote collaboration as well as

ensure that every organization could be reached by the latest news together with providing other supportive services for the active NGOs. However, this supervisor describes how the UN withdrew from the area very sudden, resulting in all those services disappearing. One of the supervisors described both successful and unsuccessful attempts at working together with other organizations and points at high staff-turnover as well as short project life-spans as factors that hinders such collaboration.

Discussion and summary

Summary of the results and conclusion

The following section is discussing the research questions in their respective order.

How do clients, therapists and supervisors experience lay therapy as trauma treatment?

Clients. Both clients express experiencing difficulties in the beginning of the contact, when not being certain of whether they could trust the therapists or be certain of their motives. They do however describe that home visits as well as regular contacts and seeing the results of the treatment made it possible to build a trusting relationship towards their respective therapists. This goes in line with the results of Naved et al. (2009) where the clients also express experiencing privacy concerns in the beginning of the treatment.

The clients describe positive experiences of the results and how they are in a better place today compared to when they started their treatment. One of the clients describes how self-disclosure by the therapist as well as being able to ask the therapist questions as being important for the treatment.

They do also request more follow-up, for the organization to check how they are doing, as well as more treatment for others in their communities. One of the clients requested the training of local counsellors in the community and one requested that the organization could provide their contact details to other organizations who could provide other kinds of services. The clients emphasized that more trauma treatment combined with other interventions could help putting the conflict behind them and making society a better place.

Therapists. The therapists that participated in this study describe how difficulties with establishing an honest relationship with their clients can be both understandable as well as frustrating and demanding. They emphasize that this part of the job requires a lot of patience, empathy and reassurance from the therapist. Similar experiences have been described in

Musyimi et al. (2017) where the participants requested more explicit ways of identifying themselves as well as measures to create awareness among the general public.

Such measures were described by the participants of this study where they refer to it as community sensitisation. The therapists describe it as a way of establishing a trusting relationship as well as to prevent stigmatization, address ongoing conflicts and recruiting clients in the communities. By doing that as well as providing trauma treatment, the therapists describe how that gives them motivation and hope in developing the communities to be more fair, trusting and to be able to leave the civil war behind.

Most of therapists describe how sharing a background both in terms of being from the same area as the clients, as well as having direct or indirect experiences of the past conflict has given them motivation to keep working as therapists. Some of them also describe how they have sometimes disclosed parts about their past in order to provide hope or motivation in suicidal clients. Several therapists describe how they find motivation in either wanting to find out what happened in the war or from already knowing the suffering of the people involved and therefore wanting to help them. One of the most prevalent statements regarding the motivation of the therapists comes from being able to give something back to the people they consider their own. Some of the therapists describe both finding motivation and understanding of the clients in their own past experiences and this could potentially be explained by Adversity-Activated Development as described in the introduction (Papadopoulos, 2007).

The therapists also describe how seeing the results of the treatment they provide is highly rewarding and a motivating factor and most of them express being proud of their work and what they can provide.

As much as this can motivate the therapists, they also describe that the vast amount of people suffering from PTSD, as well as other types of suffering in the communities, can be overwhelming. They emphasize that in order to be able to meet the need of trauma treatment in the communities there would need to be an exceptional increase in the amount of available therapy. They also describe it as being difficult to not be able to provide all the services that the clients need. Several therapists express how difficult it is to be leave the clients still needing other services or ways to make a living, and request further collaboration with other NGOs who could provide such services. A similar request was made by one of the clients and it goes in line with the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007) as well as the results of a previous study conducted by Woods-Jaeger et al. (2016). In that study the participants, who were lay therapists in Tanzania and

Kenya, also pointed out the importance of lay therapy projects collaborating with other organizations to address unmet socioeconomic needs.

Some of the therapists describe how they feel that if they had more knowledge or competence, then perhaps they could be of more help to their clients, especially the ones that are more difficult.

Most of the therapists describe the training as being demanding, in terms of learning many things in a short time; difficult, in terms of having a hard time grasping the psychological concepts in the beginning, as well as rewarding and productive. Most therapists describe the practical aspects of the training as being the most important part in their learning experience, when they received and provided therapy together with their colleagues. This was both in terms of learning therapeutic skills as well gaining a better understanding of themselves and of what the clients are going through. Some therapists point out that it helped them to grasp the concepts of the training when receiving practical experiences of the work.

Most therapists seem to have experienced difficulties in the beginning of their careers and point out how an ongoing learning is important - both in terms of the treatment methods and in terms of self-care. Many of the therapists point out that they would carry the pain of the clients with them when they first started working and some of them describe having nightmares caused by the stories they heard from their clients.

In order to handle both the difficult emotions as well as the technical aspects of their job, most therapists emphasize the importance of the organization of the workplace. They point out how important their fellow therapists have been both for learning and emotional support, and how the supervisor and supervision has been essential for them to do their job. One therapist even describes how the relationship to the supervisor has been the most important thing in order to be able to keep working for a long period of time.

Supervisors. The role of the supervisor in a lay therapy setting can be quite complex compared to working within a classic psychotherapy context. The participating supervisors describe how their work involves: planning and conducting the training of the therapists, conducting supervision, recruiting therapists as well as performing tasks of regarding administration and management. One supervisor emphasize how this can add up to a quite heavy workload. Both supervisors suggest that the combination of having a wide range of tasks, high demand for their services as well as the lack people who could take over their job, can put them in a position where they are almost indispensable.

Both supervisors emphasize how experience and knowledge amongst the therapists as well as the therapists providing emotional support for one another can ease the workload for the supervisors.

Both supervisors normally work in a setting where they can provide regular supervision and ongoing training. When describing their experiences of training and supervising external groups, they express frustration regarding not always being given the circumstances to provide regular supervision or refresher training, and how short-term projects often terminate making the training they provided redundant.

Both supervisors describe how it can both difficult and frustrating to work in a setting where the needs are so great, while the governmental instances providing either psychological treatment or social support are almost non-existent. Working in this context made it necessary to work with lay therapists, since there were no educated psychotherapists available.

Being aware of the limitations of the services you can provide is something that both supervisors stress as of being of great importance. For the supervisors these boundaries can go two ways. Both towards the clients who request material or social interventions, as well as towards donors who may be providing funds for services that the organization may or may not be able to provide. They stress that being aware of these limitations can be a way of ensuring that the clients who receive their services are the ones in the greatest need of it, at the same time as it can be a way minimizing feelings of inadequacy experienced by the therapists.

What is experienced as the limitations and potentials of lay therapy?

Limitations. Both clients requested further contact from the organization as well as other NGOs in order to meet the needs of them and their communities. Since this lay therapy setup is not strongly integrated with a health care system or other support system it means that they have limited possibilities for providing the clients with such contacts or help with other social or material needs. In a therapy setting integrated with for example a governmental health care system or an integrated network of NGOs, those possibilities would potentially be bigger. This is of course highly dependant on the availability of such support systems as well as resources for those systems to work as previously mentioned.

Many of the therapists describe difficulties coping with the stories told by their clients and even having nightmares about them. This could be examples of vicarious traumatization (McCann & Pearlmann, 1990). In a similar manner Goode-Cross(2011) describe that similarities between the therapist and the client could increase over-identification. If lay

therapists, especially when working with trauma, runs a considerable risk of vicarious traumatization, that begs the question weather supervision could be of even greater importance in a lay therapy setting compared to a regular psychotherapy setting. This is in line with the descriptions from the therapists regarding how supervision and support from their colleagues has been important in order to manage difficult emotions related to their work.

Some therapists describe experiencing a lack of competence or perspectives in some aspects of their work. In regards to this as well as when addressing emotional distress, the therapists describe how supervision and support from their colleagues as being important. The therapists also stress the importance of practical experiences during the training as well as recurrent training sessions in order to facilitate their learning experience. One supervisor stresses the importance of hiring someone with experience when starting out in to give the new therapists a way of model learning.

As described in the theme "*The supervisor has a complex role*" working within a lay therapy setting can impose more responsibility as well as a higher workload on the supervisor.

When discussing what would have been different if working with psychotherapists, one of the supervisors describe how they would be able to provide then could have provided a wider range of treatments, supervised more organizations as well as been able to introduce a system for training people to become lay therapists. This supervisor considered that these are tasks are considered more or less outside the range of what a lay therapist should be expected to do. by that supervisor.

Potentials. As illustrated in the theme "*Lay therapy as a necessity"*, it is possible by the use of lay therapy interventions to be able to provide therapy, even when there is a lack of psychologists or psychotherapists. In that sense, lay therapy could be a way of addressing the treatment gap. This has previously been pointed out by several sources and guidelines (Musyimi, 2017; Tol et al., 2014; Wright & Chiwandira, 2016). One supervisor illustrates that this potential could be taken even further through "training of trainers" whereby it could be possible to train many more lay therapists. Such setup would however require more psychotherapists in order to train them to be supervisors and trainers.

In the themes "S*haring a background with the clients", "Connecting when the trust is low"* and "*At first I was afraid: building trust"* there are implications that some degree of shared cultural or personal background between the client and the therapist could facilitate a greater understanding and trust in the relationship. This is in line with is in line with the conclusions by Hultqvist and Berg (2015). In these themes the therapists also illustrate how

they can find motivation in aspects of their past being shared with their clients. Some therapists and one client also expressed how self-disclosure from the therapist had been helpful in some instances. This description of self-disclosure seems to be in line with the results of a study by Hill et al. (2018) where they found that instances of therapist self-disclosure were associated with improved therapy relationships as well as overall helpfulness and improved mental health functioning. It could also be understood from the perspective of Adversity Activated Development, as described by Papadopoulos (2007), which could be a way of explaining why a shared background or self-disclosure is described as helpful by some of the participants. These personal factors along with empathy and patience, as mentioned by the participants, could be what Padmanathan and De Silva (2013) refer to when they describe "personal characteristics" as being of importance for both clients and colleagues in their results.

Since some instances of lay therapy will not require the use of a translator to the same extent as when using foreign psychotherapists, this opens up for a possibility of using those resources for direct treatment instead of interpretation. Some of the therapists also describe getting their first experiences of treatment when working as translators which can be a way of getting insights and practical experiences of the job before the initial training.

When discussing the potentials of lay therapy in the section "*Background*", the possibility it of having a decentralizing and empowering effect was pointed out. As seen in the results, several participants expressed the need for such a process to go further. This could for example include training local and more permanent counsellors in the communities, rather than only training counsellors who travel to different communities for a limited period of time.

What is experienced as important in the implementation, planning and context, and what should be avoided?

This question is answered by first comparing the results to the review by Padmanathan and De Silva (2013) which describes important factors to take into consideration before, during and after the implementation of a lay therapy intervention. Several of these factors may be measured in a more satisfactory and accurate manner by quantitative measures and in this section they are discussed in a qualitative manner.

Satisfaction with services - Are the clients satisfied with the treatment? During the interviews with the clients they express how they are both grateful and feel better than when they started the treatment. They describe being more capable of being in social situations as

well as putting their pasts behind them and being more capable of living a satisfactory everyday life. The client main issues regarding the satisfaction of the treatment were regarding how one client requested that the treatment could have been done in a shorter period of time and one requested more follow-up after the end of the treatment.

Satisfaction of need - Did the treatment satisfy the needs of the clients? Since the treatment of PTSD is a specialized treatment on the fourth layer of the IASC (2007) pyramid of interventions, the treatment in itself is not intended to satisfy the broader needs of the clients but only the needs and symptoms related to PTSD. The measurement of for example symptom reduction is outside the scope of this thesis. For more qualified conclusions regarding this, see for example Ertl et al. (2011), Neuner et al. (2008) Van Ginneken et al. (2013) or Wright & Chiwandira (2016).

As mentioned above, the statements from the clients regarding the treatment are mostly of a positive nature. Both clients do however request further contact with the organization in a terms of the organization contacting the clients to see how they are doing.

Even though the clients express a general satisfaction with the treatment that was provided, they both express having more needs outside of what therapy could help them with and request a collaboration with other NGOs who could provide such services. They also request a training of local counsellors in the community as well as for the organization to provide more treatment for others in the community.

Acceptability to service users - In what ways, if any, did the clients express experiencing distress in connection to the treatment? Both clients describe how they were experiencing difficulties in the beginning of the treatment. Both in terms of trusting the therapists and in terms of the symptoms getting worse before getting better. In order to trust the therapists, they describe how home visits were of importance as well as noticing results of the treatment. The therapists also stress the importance of repeated psychoeducation and reassurance of confidentiality as well being empathetic and client towards the clients.

In a study by Wright and Chiwandira (2016) they conclude that the lay therapists that participated in that study was able to give an explanatory model of the interventions that the local population deemed credible. This study has not examined the explanatory models used by the therapists, but it is possible that this could be a factor in explaining how the reassurance and repeated psychoeducation, as described as helpful by the therapists and the clients, could be effective. One example of such explanation is found in the title of this thesis taken from a quote in the section *"Working with the whole community"*.

Acceptability to health care providers and stakeholders - In what ways, if any, did the therapists express experiencing distress in connections to these roles? Many of the therapists describe how hearing the stories of the clients could be overwhelming in the beginning of their careers. Some of the them describe having nightmares about the clients' stories and there is a possibility that they experienced some degree of vicarious traumatization.

The therapists describe how learning psychological self-care and having support from the fellow therapist as well as the supervisor was important in order to manage, both this, as well as other types of work-related distress. Those factors are also supported by Pearlman & Mac Ian (1995) as being important in managing vicarious traumatization amongst trauma therapists.

Another factor related to the acceptability to health care providers and stakeholder is what Padmanathan and De Silva (2013) refer to as "Acceptance by the workforce and other health care professionals". This refers to whether team members or other colleagues viewed them as competent. They describe how regular interaction with their superiors, as well as the superiors receiving feedback from the clients, as potential factors to improve this. In the setup of this clinic, the therapists seem to have limited interactions with other professionals but very close contact both to their supervisor as well as the other therapists. Many of the therapists describe how this has been an important factor both when it comes to learning and in order to minimize the distress experienced in relation to their professional roles. Since the organization where the therapists are active is dominated by lay therapists, that may be a factor contributing to their acceptance by the workforce. This could therefore be a more pressing issue in settings where the lay therapy is more integrated with other types of treatment and professionals such as when being a part of the public health care system.

As mentioned by the supervisors and requested by both the therapists and the clients, further collaboration with other organizations to minimize distress experienced by both therapists and clients.

This approach is in line with a previous study by Woods-Jaeger et al. (2016) where the participants, lay therapists in Tanzania and Kenya, also pointed out the importance of lay therapy projects collaborating with other organizations to address unmet socioeconomic needs. Further collaboration with other service providers is promoted by the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007).

> Activities and programming should be integrated as far as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with

> people with a specific diagnosis, such as PTSD, can create a highly fragmented care system. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma (p.11).

Self-perceived competence - Did the therapists express experiencing themselves as being competent? In the sections *I'm proud of what we do* and *Learning is ongoing: growing with the work*, we can see how many of therapists' express confidence regarding their competence and abilities in the role as therapist. Both therapists and supervisors stress the importance of regular refresher training or other ongoing training as well as regular supervision as being of great importance in this regard.

One factor Padmanathan and De Silva (2013) identified as important for strengthening this is for the organization to get positive feedback from the clients regarding the lay therapy contacts, which seems to be a prominent factor for the interviewed therapists in terms of both self-perceived competence and pride in their work.

As one supervisor points out, if you are treating clients who are in need of something other than therapy, the lack of results can cause the therapists to feel incompetent or demoralized. Therefore this supervisor stresses the importance of teaching lay therapists the diagnostics and selection of clients as well as clearly communicating the boundaries of what will be provided in the treatment. This can be a way of ensuring that the therapists work with clients who can benefit the treatment which can in turn reduce feelings of incompetence and increase the satisfaction of needs amongst the clients.

Adequate and sustainable training and supervision. Most of the therapists describe feeling like they were able to do a good job when they first started out their career. Many of them also point out how it was easier to grasp the concepts and the ideas behind the treatment after getting practical experience. Both the therapists and the supervisors emphasize the need for ongoing training as well as supervision. The therapists' experiences of practical experiences making the psychological concepts easier to grasp shows us one way in which this setup could be helpful. In the clinic where the therapists work they initially receive supervision twice a week, which is later reduced to one day a week upon them gaining more experience. Many of the therapists describe how their need for supervision was greater in the beginning of their careers.

In many regards, the two supervisors who participated in the study shared experiences that were quite similar to one another. However, regarding their views of what the training of lay therapists should contain, their views differed quite a bit. One supervisor promoted a broad training covering several perspectives in order to give more flexibility. This supervisor also emphasized the importance of promoting curiosity in themselves and the clients when conducting training. The other supervisor promoted a narrower training focusing on a manualized treatment method in order to give a deeper knowledge regarding that treatment. This supervisor also emphasized the importance of ongoing training to turn the lay therapists into specialists in their field. It is possible that a broader training would require more time. Since none of the therapists that participated in this study went through this type of training it is not possible draw any conclusions regarding that in this context.

Feasible workload. Some of the therapists describe how the great need for trauma treatment in the communities has made them consider taking on more clients. They describe not doing that in respect of their own mental health.

The supervisors describe it as being common, when doing external trainings, that there are not enough hours assigned to conducting therapy or that there are not enough staff to manage the received clients. The supervisors describe frustration regarding this and about how some lay therapy service providers don't provide sufficient training, supervision or clear descriptions of what interventions they are providing. These shortcomings are also described in a review by Van Ginneken et al. (2013) where the authors request a more extensive typology regarding lay therapy and its implementation in order to address these issues.

One of the supervisors describe how the workload can be overwhelming and also points out that as the team of therapists have become more experienced, they have been able to help out with some of the supervisors' task and hence eased the workload. This supervisor does however emphasize the need for another member of staff.

In connection to the sub-theme "*Supervision is crucial for both learning and emotional support"*, some of the therapists described feeling the need to be perfect and fearful of revealing mistakes in situations where an imbalance in power was present. This points towards the importance of, when possible, separating the roles of supervisor and management. Keeping these roles separate could be a way of promoting a more honest relationship between the supervisor and the therapist as well as easing the workload of the supervisor. If so, that could potentially help promoting a learning environment where mistakes are seen as essential for learning. This view of learning from ones' mistakes is already described by some of the

therapists, however many point out that it took time to establish the confidence to talk openly about their mistakes in front of the supervisor.

Career progression and staff-turnover. When the supervisors describe how experience and knowledge amongst the therapists can ease the workload for the supervisor, one of them also explain how that can be a career progress for the therapists when they become "senior counsellors" and get more responsibilities and some different tasks. This could potentially be developed further and one supervisor expresses hope of training supervisors or trainers in the future, but points out that this may be too difficult for lay-personnel. Career incentives is something that Padmanathan and De Silva describe as being important in order to keep a low staff-turnover. Another important factor as emphasized by one of the therapists is for the therapists and the supervisors have a good relationship and for the supervisor to be understanding and supportive towards the therapists.

Methodological limitations

Most participants have in some way been connected to one treatment centre. This limits the generalizability of the results.

Many of therapists describe having difficulties in the beginning of their careers. Most of them have several years of work experience which may have led them to understate these difficulties since they are now behind them**.**

The authors recruited one of the supervisors, by contacting researchers that had published articles on lay therapy. Through this supervisor, the other interviewees were also contacted. It could be that lay therapy organizations closely connected to research tend to be more ambitiously, scientifically and/or optimistically driven. This could result in better results and/or more positive attitudes among what our interviewees reported, than what would have been the case if an average participant in a lay therapy project would have been interviewed.

Furhermore, the therapist was recruited in the following way. The authors visited a meeting at the clinic, where they presented themselves and asked for participants for the study. Everyone interested was interviewed. There is a risk that the most positive and/or confident therapists wanted to be interviewed, which might have led to a similar bias in the material as mentioned above. In a similar way the therapists chose what clients they found suitable for the study which might be the clients where they had good results.

More generally, the fact that a qualitative method was used gives strengths such as a deep and nuanced understanding of participants' experiences. However, it also means weakness such as limitations in generalization and reliability, partly due to a small number of interviewees and possible biases due to sampling, such as mentioned above. To lessen these risk, there was a focus on contrasting material in the analysis, which was also emphasized in results and noted in headings.

Ethical discussion. Hugman et al. (2011) argues for taking the ethical perspective further than what is demanded in standard ethical requirements concerning vulnerable groups. They write that the standard approach is usually primarily based on the principle of "do no harm", and argue that this is not enough when working with vulnerable groups. Instead they suggest that cooperation and participatory designs of studies is needed to cater to the needs of these groups.

At the same time, Hugman et al. (2011) also point out potential obstacles to a cooperative and participatory approach such as limited time and resources, as well as the process of planning scientific projects itself, which can make it harder to include participants as active subjects shaping the research in every step.

These aspects have been an area of difficulty in this project, where there has been a limited amount of time and money which made it necessary to plan the main parts of the study before arriving in Uganda. It has been an active intention to include the participants as active subjects in all ways possible. This has included discussing and shaping or reshaping the research after the needs and questions of our participants. As an example, this has been done through the partly open and intentionally broad interview guide, where among other things the participants themselves were asked what they considered important to tell other people involved in lay therapy projects, and what questions they think should be asked. Also, an open discussion about the purpose of the research and reconnecting the results and the complete study to the participants by sending it to them, is considered to be important parts of moving from a potentially objectifying view of participants as information sources to a more reciprocal or equal relationship.

It is important to be clear about exactly how the information will be used and to have any risks explained clearly and sometimes repeatedly. As Hugman et al. (2011) write, it is important to see informed consent "as a process rather than an event in that participants may need to be reminded of the relationship at many stages" (page 1278).

One of the points they make is that when leaving out participants from all other stages of the research process apart from the gathering of information itself, it may risk to commodify the information from the participants and make the relationship between participant and researcher even more unequal. Hugman et al. (2011) also point out the risk that when participants are not active participants and co-researchers, they may be viewed simply as sources of information, which can be seen as objectifying rather than empowering and may also complicate communication, informed consent and leave participants disappointed. They use the example of refugee participants that have talked with researchers in the belief that this may improve their situation directly, only to be disappointed when nothing changes or their stories are even so exposed that this puts them in danger.

Hence, when working with vulnerable groups, the standard use of informed consent, such as the use of written consent as a one-time disclaimer, may not be sufficient. Due to a skewed power balance (coming from differences such as researcher-participant, differences in socio-economic background, a history of colonial oppression as well as many other factors) it is necessary to modify this conduct to a more ongoing process and discussion throughout the research.

In one of the interviews with the clients, found in the theme "*What happens now?",* the client asked the authors a question regarding whether the organization could provide them with other services in the future. This made the authors question whether the participant had fully understood the content of the informed consent. The informed consent had been repeated in spoken terms and read to the participant by the translator, however there still seemed to have been a misunderstanding. When asking the question, the client had also said that "you are students and you are here to conduct research and this question you may not be the appropriate people to answer" which suggests that the client may have been aware this was outside of what the interview and the authors could be of service with.

After the interview, this client was showed who to address regarding questions about the future and the treatment and we sincerely hope that satisfactory answers were given to them.

This repetition of the informed consent could be related to how the therapists emphasized the importance of patience and repeated psychoeducation as well as their experience of often having to repeat that material support is not included in the treatment. This is found in the themes "*Connecting when the trust is low: building alliances"* and "*Endless needs: we can't do enough".* One of the therapists attribute the need for those repeated clarifications regarding the boundaries of the treatment as an expression of

desperation and poverty from the side of the clients. It is possible that this is what the authors got to experience when trying to provide informed consent.

The influence of the authors. Since many of the preconceptions of the authors were well matched with the results, there is a possibility that they to some extent influenced the results. This could, amongst other ways, occur through the phrasing of questions and the interpretation of answers, which leads to a biased data-set and analysis to better fit with the ideas of the authors.

Despite this, there were results that did not appear in the noted preconceptions (for example how the therapists were working with the whole community) as well as previous assumptions that were not confirmed by the material (such as distress due to the fact that the traumatic events may be close to the therapists' experiences).

It is difficult to conclude whether, or in what way, the preconceptions did influence the results. However, since the preconceptions and attitudes may have directed the questions and analysis, the chances of finding results conforming with the preconceptions may have increased. This could mean that this thesis presents a more positive picture overall compared to the findings that other authors would have rendered.

When conducting the interviews with the clients, a translator was utilised. During these interviews the authors experienced some difficulties of being able to have a free-flowing conversation with the interviewee, since the translator often spoke longer with the interviewee and translated what they had said in third person, occasionally as a summary. This could have made it more difficult to capture the direct experiences of the clients and may have affected the credibility of the results.

After some of the interviews, as well as when analysing the data, the authors raised questions regarding whether the participants felt safe and secure enough to be open and honest during the interviews. This issue became more explicit in statements from three of the therapists, which are presented in the sub-theme *Supervision is crucial for both learning and emotional support*.

In these quotes the therapists expressed how they previously attempted to present themselves without flaws in the presence of in their supervisors. In relation to this the therapists pointed out factors such as that the supervisor had been a Westerner, that there was a difference in academic background and that they were uncertain of what repercussions it could have if the supervisor found out about their mistakes. One of the therapists connects the

ethnic background of the supervisor to how they used to experience describing their therapy process during supervision.

> Your supervisor is next to you and the supervisor is a mzungu like you [...] you have now declared that you are now something bad and are now panicking about doing it correctly [...] you kind of, did I ask the right question, did I leave out something then you [...] yes, you want to be perfect and perfect yourself.

With this in mind, differences in power seem to play an important role in how confident some of the therapists feel about showing sides of themselves that are still in the learning process.

One important aspect of the previous quote is how the therapist pointed out that the authors also are mzungus. From this follows the important question of whether the experiences described above could somehow affect the credibility of some of the interviews. Since the data-set does not contain many negative statements regarding the participants experiences some degree of influence from the researchers skewing the statements in a positive manner seems plausible.

Before the interviews the therapists had been reassured, both orally and through the written informed consent, that an agreement had been made with their employer saying that their answers and participation in the study would not have any repercussions regarding their employment or position at work.

This does however not take away the power-difference of the researchers being white, European, university students. In regards to the therapists most of them were both older and more experienced than the researchers which are factors that could be evening out the power-balance.

This discussion becomes more relevant in regards to the results of the clients, where the power-balance is even more skewed. The power-dynamics in the interview setting can be related to how previous studies have found that a shared structural position in society has an importance for therapy outcome, the alliance, as well as on how much information is shared by the client in therapy (Goode-Cross, 2011; Hultqvist & Berg, 2015).

In addition to the influence of power in the interview situation, it is possible that the authors at some points felt a reluctance to ask deeply about experiencing difficulties, for example due to concern that questions may risk to sound accusative. This is not enough to dismiss the statements from the participants, yet it is important to consider that some of the more negative experiences may have been left out during the interviews.

Recommendations for future research

The authors propose two main categories of potential future research.

Firstly, as seen in the results and discussion above, the participants described several aspects of the therapeutic work that may be seen as unconventional by the authors in regards to their backgrounds and Western conventions within psychotherapy.

These include: the regular opportunities for a second chance to accept treatment, which is offered in cases where it has been difficult for the client to open up during the first treatment; therapists and clients visiting each others homes and eating together; the extensive amount of time for the therapists to discuss their practice with colleagues and supervisors; the focus on the clients' communities; and the utilisation of shared backgrounds in general, and experiences of adversities in particular.

The fact that these aspects are generally (but not exclusively) described as positive by the participants, indicates the need for future research to investigate how and if other psychotherapy organisations may benefit from imitating or adapting some of these aspects. Some may be directly translatable to a professional therapeutic setting, such as the focus on communities at large or an unsuccessful treatment resulting in a second chance. Other aspects may be difficult to accommodate directly, but raise questions that may indicate areas for future research, such as the role of shared background between client and therapist.

Secondly, there are the aspects of difficulties, dilemmas and uncertainties concerning lay therapy as trauma treatment. These indicate need for future research more specific to this field. One example is the question of a narrower or broader lay therapy training as described in the theme "*Training: deep and focused or broad and spontaneous".* Does a broader training enable the therapists to use and integrate several different concepts more freely? If so, is that beneficial for the clients?

Since the treatment provided by the lay therapists in this study is specialized in regards to trauma treatment and their training is aimed at specific diagnosis, it would be useful to further examine the differences of competencies necessary in a more general treatment setup where a wider array of clients is treated. Perhaps a broader training could be more useful in such arrangement?

In the *IASC Guidelines for Psychosocial Support in Emergency Settings* (2007) it is recommended that as much as possible of psychosocial interventions take place in an integrated manner in order to avoid fragmentation within the health care system. In order for lay therapy interventions to be as acceptable and feasible as possible, this might indicate the

need of integration with other societal institutions and support systems such as the primary health care system or economic or material support from other NGOs when possible. This is something which was raised by participants from all three groups in the study. The setup, consequences and potential synergies of such an integration is an area suggested for future research. In the previous studies examining the integration of lay therapy within a public health care system, such as Musyimi et al. (2017) it is done with the focus on short trainings (2 days in this case) and basic interventions such as referrals to primary care. It would be of further interest to examine an integrated setup when a longer training and supervision has been provided and possibly specialized treatments.

Final remarks

It may be questioned to what extent the implications of this study are limited to a lay therapy context only. Cooperation at the workplace in terms of support and learning is not a new idea. However, the amount of time and flexibility when co-workers and supervisors are available for support and exchange of ideas or experiences in this material, was something that the authors found notable and surprising in comparison to the authors' own experiences in a Western clinical education. For the therapists, this occur in the hours of unscheduled time traveling together every week, going to and from the villages where they meet clients. This also occur as more or less "on demand" access to supervision on top of the regular, weekly supervision. Such procedures might be factors contributing to the seemingly supportive environment as well as what the participants described as good results.

The extensive access to support may be of particular importance in relation to lay therapy as trauma treatment. However, the question may also be, how and if a model to try and accommodate for some aspects of this lay therapy setup would improve a more traditional psychotherapy setting. In light of the referenced literature indicating that lay therapy may yield even better results than traditional psychotherapy in some cases (Gwozdziewycz & Mehl-Madrona, 2013), it is not only interesting to ask what can be learnt about optimal circumstances for this kind of psychotherapy, but also for psychotherapy in general.

Parallel to this are the indications from the theme *Working with the whole community*. This theme, indicating the successfulness on an individual level of working with the community (the client meeting less stigmatization), as well as working with the individual on a community level, presents alternative images to a more individual-focused view in psychotherapy. This emphasizes an alternative focus on what is considered and valued as therapy outcomes: improvements on not just an individual level, but also on a community

level. Again, a therapeutic practice focusing on other levels than the individual is not new. However, the extent to which the focus is on the community level in the settings studied here may shed new light on the degree of individualism that occur in many psychotherapy contexts.

As has been described in both previous studies and indicated by the participants, it could be that similarities in social position or background between counsellor and client helps to build trust, empathy and motivation in the therapeutic relationship (Hultqvist & Berg, 2015). If so, a degree of reconsideration regarding what competences are valued in a therapist, could be of importance. Such implications also call for an examination regarding what can be done in order to take factors regarding structural or personal experiences into consideration by the profession.

Bibliography

Atwoli, L., Stein, D. J., Koenen, K. C., & McLaughlin, K. A. (2015). Epidemiology of posttraumatic stress disorder: prevalence, correlates and consequences. *Current opinion in psychiatry*, *28*(4), 307.

Balaji, M., Chatterjee, S., Koschorke, M., Rangaswamy, T., Chavan, A., Dabholkar, H., et al. (2012). The development of a lay health worker delivered collaborative community based intervention for people with schizophrenia in India. BMC Health Services Research, 12, 42.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology*, *3*(2), 77-101. doi:10.1191/1478088706qp063oa

Crompton, R. (2012). Klass och yrkesstruktur. *Fronesis,* 40-41, 33-49. ISSN: 1404-2614

Canadian Women's Foundation (CWF). (2011). *Report on Violence Against Women, Mental Health and Substance Use*.

Ertl, V., Pfeiffer, A., Schauer, E., Elbert, T., & Neuner, F. (2011). Community-Implemented Trauma Therapy for Former Child Soldiers in Northern Uganda. *JAMA*, *306*(5). http://dx.doi.org/10.1001/jama.2011.1060

Goode-Cross, D. (2011). Same difference: Black therapists' experience of same-race therapeutic dyads. *Professional Psychology: Research And Practice*, 42(5), 368-374. http://dx.doi.org/10.1037/a0025520

Gusic, S. (2017). "I feel like I do not exist" - Adolescent Dissociative Experiences and the Importance of Trauma Type, Attachment, and Migration Background Lund

Gwozdziewycz, N., & Mehl-Madrona, L. (2013). Meta-analysis of the use of narrative exposure therapy for the effects of trauma among refugee populations. *The Permanente Journal*, *17*(1), 70.

Healy, M., & Perry, C. (2000). Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qualitative Market Research: An International Journal*, *3*(3), 118-126. doi: 10.1108/13522750010333861

Hill, C., Knox, S., & Pinto-Coelho, K. (2018). Therapist self-disclosure and immediacy: A qualitative meta-analysis. *Psychotherapy*, *55*(4), 445-460. doi: 10.1037/pst0000182

Hugman, R., Pittaway, E., & Bartolomei, L. (2011). When 'do no harm'is not enough: The ethics of research with refugees and other vulnerable groups. *British Journal of Social Work*, *41*(7), 1271-1287.

Hultqvist, A., & Berg, S. (2015). Upplevelser av psykoterapi hos patienter med arbetarklassbakgrund.

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. (2007). Geneva.

Jordans, M. J., Keen, A. S., Pradhan, H., & Tol, W. A. (2007). Psychosocial counselling in Nepal: perspectives of counsellors and beneficiaries. International Journal for the Advancement of Counselling, 29, 57e68.

Marmot, M. (2007). *Statussyndromet*. Enskede: TPB.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal Of Consulting And Clinical Psychology,* 68(3), 438-450. doi:10.1037/0022-006X.68.3.438

Mann, M. (1950). Primer on alcoholism; how people drink, how to recognize alcoholics, and what to do about them.

McCann, L.I. & Pearlman, L. A. (1990), Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *J. Traum. Stress*, 3: 131–149. doi:10.1002/jts.2490030110

Mendenhall, E., Isaiah, G., Nelson, B., Musau, A., Koon, A., & Smith, L. et al. (2016). Nurses' perceptions of mental healthcare in primary-care settings in Kenya. *Global Public Health*, 1-14. http://dx.doi.org/10.1080/17441692.2016.1207196

Mugisha, J., Muyinda, H., Wandiembe, P., & Kinyanda, E. (2015). Prevalence and factors associated with posttraumatic stress disorder seven years after the conflict in three districts in northern Uganda (The Wayo-Nero Study). *BMC Psychiatry*, 15

Naved, R. T., Rimi, N. A., Jahan, S., & Lindmark, G. (2009). Paramedic-conducted mental health counselling for abused women in rural Bangladesh: an evaluation from the perspective of participants. *Journal of health, population, and nutrition*, *27*(4), 477.

Neuner, F., Onyut, P., Ertl, V., Odenwald, M., Schauer, E. and Elbert, T. (2008). Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 76(4), pp.686-694.

Padmanathan, P., & De Silva, M. J. (2013). The acceptability and feasibility of task-sharing for mental healthcare in low and middle income countries: a systematic review. *Social science & medicine*, *97*, 82-86.

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

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research And Practice*, *26*(6), 558-565. doi:10.1037/0735-7028.26.6.558

Pereira, B., Andrew, G., Pednekar, S., Kirkwood, B. R., & Patel, V. (2011). The integration of the treatment for common mental disorders in primary care: experiences of health care providers in the MANAS trial in Goa, India. International Journal of Mental Health Systems, 5.

Skau, G., & Ganuza Jonsson, L. (2007). Mellan makt och hjälp. Stockholm: Liber.

Storr, W. (2014). Kony's child soldiers: 'When you kill for the first time, you change'. Retrieved from https://www.telegraph.co.uk/news/worldnews/africaandindianocean/uganda/10621792/Konys-child-soldiers-When-you-kill-for-the-first-time-you-change.html

Tol, W. A., Barbui, C., Bisson, J., Cohen, J., Hijazi, Z., Jones, L., ... & Silove, D. (2014). World health organization guidelines for management of acute stress, PTSD, and bereavement: Key challenges on the road ahead. *PLoS Medicine*, *11*(12), e1001769.

UNHCR. United Nations High Commissioner for Human Rights (2011). *"The Dust Has Not Yet Settled" Victims' Views on The Right to Remedy and Reparation. A Report from the Greater North of Uganda.* Kampala. Uganda Human Rights Commission.

UNHCR. United Nations High Commissioner for Human Rights (2013). *Report on the activities of the office of the United Nations High Commissioner for Human Rights and the Human Rights Situation in Uganda.*

Van Ginneken, N., Tharyan, P., Lewin, S., Rao, G. N., Meera, S. M., Pian, J., ... & Patel, V. (2013). Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low-and middle-income countries. *The Cochrane Library*.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. http://doi.org/10.1002/wps.20238

Willig, C. (2014). *Introducing qualitative research in psychology*. Maidenhead: Open University Press.

World Health Organization, US President Emergency Plan For AIDS Relief, & Joint United Nations Programme on AIDS. (2007). Task shifting: Global recommendations and guidelines.

Woods-Jaeger, B., Kava, C., Akiba, C., Lucid, L., & Dorsey, S. (2017). The art and skill of delivering culturally responsive trauma-focused cognitive behavioral therapy in Tanzania and Kenya. *Psychological Trauma: Theory, Research, Practice, And Policy*, *9*(2), 230-238. http://dx.doi.org/10.1037/tra0000170

Wright, J., & Chiwandira, C. (2016). Building capacity for community mental health care in rural Malawi: Findings from a district-wide task-sharing intervention with village-based health workers. *International Journal Of Social Psychiatry*, 62(6), 589-596. http://dx.doi.org/10.1177/0020764016657112

APPENDIX A. Interview guide

Lay therapists

Introduction

This interview will probably take approximately 30-90 minutes and will focus on your experiences as a lay therapist. We will be recording this interview and that is in order to help us remember what we have been discussing. What you say will be treated with confidentiality throughout the work and it will not be possible to connect your answers back to you. The recording will be locked in, coded with only available to us. The answers that all therapists give in these interviews will be presented anonymously and in group as a master thesis at the psychology programme at Lund University, Sweden.

We have spoken to your supervisor who does guarantee that no answers in this interview will have any consequences for your employment. Also, we will not tell your supervisor, boss, or anyone else what you specifically has said. It is important that you don't have to answer any of the questions if you don't want to and you can cancel the interview at any time without having to give any explanation. When the study is completed it can be either posted or e-mailed to you if you wish.

How does this feel? Do you have any questions for us before we start the interview? If you have any questions during or after the interview you are welcome to ask them at any time.

First we have a few short background questions:

- How do you define lay-therapy? What does it mean to you?

Your background

- What is your background? (cultural and geographical)
- How did you get interested in becoming a lay therapist?
    - Why did you choose to work with this?
    - How did you get in contact with the clinic?
    - Do you yourself have any history of mental health issues?
    - Have you ever attended any psychological treatment?

- What experiences in your personal background do you find important/relevant/matters to you in your work as a lay therapist? How?
    - Is your background in terms of [the civil war] relevant to your therapeutic work and relationships in any way, and if so, how?
    - Do you have any experience of coming from the same region or area as your patient(s), and that it has affected your therapeutic relation and alliance with the patient in any way? How, in that case? Negatively and/or positively?
    - Have you ever experienced any hardship separating between the roles as a professional and private person?
    - If you have a background within a conflict, how would/do you react to receiving patients that also has a background in this conflict? Who has been on the same side, or the other side of that conflict?
    - What is your background in relation to your patients?
        - Are you from the same area?
        - Do you share any history or community with them, or do you have the therapeutic relationship only?

Education

- Can you tell us about your education to become a therapist, at [-] outpatient clinic? And if you have any previous education? What use, if any, do you have of your education in your work as a therapist?
    - What do you wish you knew when you started out as a therapist?
    - Was there anything you thought was missing within your education?
    - Have you ever felt that the patients problems have been outside your competence, knowledge or therapeutic tools? If yes, what help or educational addition do you think would have been needed in order to prevent this? How did you handle the situation?
    - What part of your education do you consider the most beneficial?

Working as a therapist

- Do you remember what you thought/felt when beginning to work as a therapist? Please tell.

- How is it to work as a therapist here?
    - Approximately how many patients do you meet per week?
    - Is that a good amount of work for you?
    - Is this your only work/source of income or do you have any additional work/profession/source of income?

- How is your relationship with the others at the clinic?
    - With the other therapists?
    - With the supervisors?

- How does it affect yourself and your work when patients' experiences are close to your own experiences? And when it is very far from what you have been through? How do you handle it?
    - How often do you feel like you have personal experiences of the issues they are facing?

- How has working as a lay therapist affected you?

- Have you been treated differently by your community since you became a lay therapist, if so how? How have your family and friends reacted?

The organization

- In what ways, if any, have you been getting support from the clinic, the colleagues and the supervisors?
    - Is it important, and if so, in what way?
    - Is there anything that you would like more support with?

- What supervision have you received? What has been the setup, frequency and duration of your sessions?
    - In what ways, if any, has supervision been important or helpful to your therapeutic work?
    - What parts of your supervision do you think could be improved and how could that be done?

- What do you think is important think about, when working with lay therapy? What should be avoided? Do you have any recommendations?
    - Have you been keeping a journal while working as a therapist? If yes, what guidelines have you followed?
    - How do you handle confidentiality in your work as a lay therapist? How do the patients seem to feel about this issue? How do you feel about it?
- Are there any opportunities to meet and talk to other therapists? If so, how has that been?
- Do you see yourself working as a lay therapist in the future?
    - In what way?
    - Are there any career developments or other incentives?

Other questions

- What, if any, advantages do you see in lay therapy compared to other forms of therapy?
- What, if any, negative aspects do you see in lay therapy compared to other forms of therapy?
- What potentials, possible areas of applications, and limitations do you see in lay therapy?
- What experiences do you have from working with lay therapy, that you think could be useful for existing or future task sharing or lay therapy projects? What do you think is important when setting up a lay therapy initiative/project?
- What questions do you think we should have asked you, that we haven't asked you yet?

Patients

Introduction

This interview will take approximately 30-90 minutes and will focus on your experiences of lay therapy from the perspective of a patient. The focus will be your experiences of the therapy itself, and not the reasons you started going to therapy or your personal life. This is because we don't want this interview to bring out any potential painful memories and feelings. But if it would, you are welcome to talk to your therapist, who has previously agreed to this.

We will be recording this interview and that is in order to help us remember what we have been discussing. What you say will be treated with confidentiality throughout the work and it will not be possible to connect your answers to you.The recording will be locked in, coded with a number only available to us. The results will be presented as a master thesis at the psychology programme at Lund University, Sweden.

As we said before, we have spoken to your therapist who has said that you are welcome to bring up any feeling or questions that this interview might raise with him/her.

The answers you give will be presented together with other patients answers, therefore your therapist or anyone else will not be able to know what answers came from you. It is important that you don't have to answer any of the questions if you don't want to and you can cancel the interview at any time without having to give any explanation. Cancelling the interview will not have any negative consequences for you. When the study is completed it can be either posted or e-mailed to you if you wish.

How does this feel? Do you have any questions for us before we start the interview? If you have any questions during or after the interview you are welcome to ask them at any time.

First we have a few short background questions:

Background

- Do you have any previous experiences of therapy?

Going to therapy

- How many sessions have you attended up until this day and how many are you planning to attend?
- How does it work with payment for the therapy?
- How was it to get in contact with the practice? How did you get in contact with the clinic?
    - What were your hopes and fears regarding what therapy was going to be like?
- Do you remember when you first started this therapy? What was your thoughts and feelings about it?
    - In what way is it different today?
- How has it been to go to therapy?

Relationship with the therapist

- How is your relationship with the therapist? How has it changed since the therapy started?
    - *Do you feel safe in terms of what you tell your therapist will not be told to other people? /*What are your about thoughts regarding confidentiality in this setting?
    - When you tell your therapist about your life, how do you think your therapist receives it?

- Do you know if you share any similar experiences as your therapist? In what way? How do you know? How has this affected your view of the therapist?/how you feel about the therapy?
    - If you have a background within a conflict, how would you react to receiving therapy from a person /that also has a background in this conflict/ from the other group of that conflict?
    - In what way do you think that(would) affect you relationship with the therapist?

Satisfaction of needs

- How helpful has the therapy been? In what ways? Is there anything that could be improved?
- Do you remember any specific part of the therapy that was especially helpful? In what way? Do you remember anything as being harmful?
- Have you thought about any other needs you experience that you think this clinic could be of service with?

If the person has previously gone through therapy:

- What, if any, advantages/disadvantages do you see with this form of therapy compared to the therapy you have previously attended?

Supervisors

Introduction

This interview will approximately take approximately 30-90 minutes and will focus on your experiences as a supervisor in a lay therapy context. We will be recording this interview and that is in order to help us remember what we have been discussing. What you say will be treated with confidentiality throughout the work and it will not be possible to connect your answers to you. For the sake of confidentiality and to reduce the risk of being able to trace your answers to you, we will also interview supervisors from other lay therapy settings.The recording will be locked in, only available to us. It is important that you don't have to answer any of the questions if you don't want to and you can cancel the interview at any time without having to give any explanation. When the study is completed it can be either posted or e-mailed to you if you wish.

How does this feel? Do you have any questions for us before we start the interview? If you have any questions during or after the interview you are welcome to ask them at any time.

Background

- How came you started to work with lay therapy?
    - What was your thoughts and feelings about it? In what way is it different today?
    - What hopes and fears did you have?
        - How do you feel about them today?
    - What is your strongest memory of working with lay therapy? Please tell us.

Organizational issues

- Can you tell us about your clinic? How does it work? How many people work there? What professions and roles do they have?
- In what ways, if any, do you think the organization has to be different when it comes to lay therapy compared with other forms of therapy?
    - What is important concerning the organizational context, supervision and so on?
    - What purposes does supervision need to fill? How, if in any way, does the supervision with lay therapists differ from supervision with other therapists?
        - How do you structure your supervision in terms of setup, frequency… ?
    - Do you feel like you can give the therapists the support they need in their role?
        - How?
        - Is it lacking anything?
        - What is important?
    - Have you ever worked with group therapy within this setting?
    - How has it been working under confidentiality within this setting?

- Tell us about your relationship with the therapists
- How do you conduct the training of the therapists?
- How long do the therapists usually stay and work here?
    - Are there any incentives in terms of career options or other things to make them want to stay longer?
- How do you get the resources to run this clinic?
    - How do you distribute this within your organization?

    - Has there ever been times with financial struggles?
        - How did you manage this?

- Is there anything you wish you knew regarding the setup of clinic, administrative work, sharing of workload or other practical aspects you wish you knew before you started working as a supervisor?

Demarcations and limitations

- What limitations do you see in regards to lay therapy?/What limitations do you see to the format of lay therapy?

- How does your screening process work and what is important to consider in this process?
    - Therapists
        - How can you know who will be a good lay therapist?
        - What characterizes a good Lay Therapist?
    - Patients:
        - What limitations have you set up in your screening process for potential patients in terms of complexity and severity in the patients mental health?
        - What happens when it shows during the course of therapy that a patient has to complex problematics for the therapist to handle, if that happens?

Challenges and things learned

- What has been the most important thing you've learnt from this experience?
    - How does that affect your work today?
- What ethical considerations have been the most pressing during your work with lay therapy?
- What do you wish you knew when you started working as a supervisor within a lay-therapy setting?
    - What has been the biggest challenge? How did you deal with that?
    - What challenges were most prominent when you started this work?
    - Are there any new challenges that has arisen along the way?

Potentials and future of lay therapy

- What advantages (and disadvantages) do you see in lay therapy? What makes it work well? Not so well?
- What potential developments within lay therapy are you hoping for?
    - Do you have any concerns?

Other questions

- What experiences do you have from working with lay therapy, that you think could be useful for existing or future task sharing or lay therapy projects? What do you think is important when setting up a lay therapy initiative/project?
- What questions do you think we should have asked you, that we haven't asked you yet?

APPENDIX B - Information about the study for the patients.

LUND
UNIVERSITY
Department of Psychology

From patient to therapist – a master thesis about therapy as trauma treatment

Information to research participants

We are Mattias and Jenny, and we are studying psychology at Lund University, Sweden. As one of the final parts in our education, we will do a study about trauma therapy. As part of this, we would like to interview you about your experiences of this form of therapy.

This information sheet contains information regarding how the study is conducted.

By participating in this research you can help others by contributing with more knowledge about this therapy. This can be helpful to people who suffer from trauma and need treatment.

Since you are a patient at [---] clinic we are asking if you would be interested in participating in an interview regarding your experiences of your treatment so far. It is completely voluntary if you want to participate and you are free to discontinue the interview at any time without any explanation and without any negative consequences for you.

Participation in this study means you will be sharing your experiences regarding your treatment in an interview which will take approximately 30-90 minutes. The interview can be terminated by you at any time without explanation and without any negative consequences for you. You will not have to answer any questions you don't want to answer. You will be anonymous in the study, and what you say will be treated confidentially.

In the interviews, we will avoid talking about any difficult experiences you have been through. We will focus on the treatment, how it has (or has not) been helpful and the relationship with your therapist. This is because the interview is not supposed to wake any difficult or painful memories that you might have. If it does, you can talk to your therapist about it who has previously agreed to this.

If you want to read the final thesis we can send it to you, either by e-mail or via regular mail.

Compensation
5000 Ush

Who is responsible:
Lund university
The department of Psychology
Lars-Gunnar Lundh, professor in clinical psychology
lars-gunnar.lundh@psy.lu.se
+46 46 222 36 47

APPENDIX C - Information about the study for the therapists.

LUND
UNIVERSITY
Department of Psychology

From patient to therapist – a master thesis about lay therapy as trauma treatment

Information for research participants

Hi! We are Mattias and Jenny, and we study psychology at Lund University. As one of the final parts in our education, we will do a study about lay therapy. As part of this, we would like to interview you about your experiences of this.

By lay therapy, we mean therapy that is conducted by a person who has a shorter, specific education to do a certain therapy, such as the one that you are working with.

Lay therapy seems like a promising method for trauma treatment for many people, according to the research that has been done. But there has not been so much research done to understand why it can be a good method, or what is actually needed for lay therapy to be helpful as a trauma treatment.

Therefore, we want to interview patients, therapists and supervisors involved in lay therapy as trauma treatment, to understand more about why it can be a good method and what is important to think about when working with this method.

By participating in the research you can help others by contributing with more knowledge about this method. This might be helpful to people who suffer from traumas and need treatment for this.

Since you are a therapist at the [---] clinic, we are asking if you would be interested in participating in an interview regarding your experiences of your work so far. It is completely voluntary if you want to participate and you are free to discontinue the interview at any time without any explanation. This information sheet contains information regarding how the study is made/conducted.

Participation in this study means you will be taking part of an interview which will approximately take between 30-90 minutes and by sharing your experiences regarding your work. The interview can be terminated by you at any time without explanation. You will not have to answer any questions you don't want to answer. You will be anonymous in the study, and what you say will be treated confidentially.

If you want to read the final thesis we will send it to you, either by e-mail or by posting it.

Compensation
10 000 Shilling in compensation for your time and transport

Do you want to participate?
Contact us at:
Mattias: 0795316969
Jenny: 0795301842
or via email at:
mattiasnorlinder@gmail.com
or talk to us during the supervision on Thursday 15/3

Who is responsible:
Lunds university
The department of Psychology
Lars-Gunnar Lundh, senior professor in clinical psychology
lars-gunnar.lundh@psy.lu.se
+46 46 222 36 47

APPENDIX D - Information about the study for the supervisors.

LUND
UNIVERSITY
Department of Psychology

From patient to therapist – a master thesis about lay therapy as trauma treatment

Information to research participants

We are Mattias and Jenny, and we are studying psychology at Lund University, Sweden. As one of the final parts in our education, we will do a study about lay therapy. As part of this, we would like to interview you about your experiences of this form of therapy.

This information sheet contains information regarding how the study is conducted.

By lay therapy, we mean therapy that is conducted by a person who has a shorter, specific education in a certain therapy, such as the one that you are working with.

Lay therapy has shown promising results as a method for trauma treatment for many, according to previous research. However there has not been much research done to understand what is important or needed for lay therapy to be helpful as a trauma treatment.

Therefore, we will interview patients, therapists and supervisors involved in lay therapy as trauma treatment, to understand more about why it can be a good method and what is important to think about when working with this method.

By participating in this research you can help others by contributing with more knowledge about this method. This might be helpful to people who suffer from trauma and need treatment for this.

Since you are a supervisor, we are asking if you would be interested in participating in an interview regarding your experiences of lay therapy and the management of such processes. It is completely voluntary if you want to participate and you are free to discontinue the interview at any time without any explanation and without any negative consequences for you. This information sheet contains information regarding how the study is made.

Participation in this study means you will be taking part of an interview which will take approximately 30-90 minutes. The interview can be terminated by you at any time without explanation and without any negative consequenses for you. You will not have to answer any questions you don't want to answer. You will be anonymous in the study, and what you say will be treated confidentially.

If you want to read the final thesis we can send it to you, either by e-mail or via regular mail.

Who is responsible:
Lunds university
The department of Psychology
Lars-Gunnar Lundh, senior professor in clinical psychology
lars-gunnar.lundh@psy.lu.se
+46 46 222 36 47

APPENDIX E - Informed consent: patients

LUND
UNIVERSITY
Department of Psychology

From patient to therapist – a master thesis about trauma treatment

Information for research participants

Who are we?
We are two psychology students, called Jenny and Mattias from Lund University in Sweden. We are in Uganda to interview people about trauma therapy for our master thesis and we will be in here for approximately three months.

Background and aim
Lay therapy has shown promising results as a method for trauma treatment for many, according to previous research. By lay therapy, we mean therapy that is conducted by a person who has a shorter, specific education to do a certain therapy, such as the one that you are attending. However there has not been much research done to understand what is important or needed for lay therapy to be helpful as a trauma treatment. Therefore, we are interviewing patients, therapists and supervisors involved in lay therapy as trauma treatment, to understand more about how this method works and what is important to think about when working with this method. By participating in the research you help by contributing with more knowledge about this method. This might be helpful to others who suffer from trauma or other people working with this method.

Inquiry about participation
As a patient at [-] outpatient clinic we are asking if you would be interested in participating in an interview regarding your experiences of your treatment so far. It is completely voluntary if you want to participate and you are free to discontinue the interview at any time without any explanation and without any negative consequences for you. This information sheet contains information regarding how the study is made.

How is the study conducted?
This study aims to investigate different experiences of lay-therapy from different perspectives, and we will therefore be interviewing people with different positions and experiences of this treatment. This is in order to help develop lay therapy further with respect for the experiences of previous participants and others involved.

Participation in this study means you will be taking part of an interview about your experiences regarding your therapy. This will take approximately 30-90 minutes. If you wish this interview can be terminated by you at any time without explanation or negative consequences for you. You will not have to answer any questions you don't want to answer.

What are the risks?
In the interviews, we will not delve into difficult experiences you have been through. We will focus on the treatment, and how it has (or has not) been helpful, and the relationship with your therapist. This is because the interview is not supposed to wake up any difficult or painful memories that you might have. If it does, you can talk with your therapist about it.

Handling of data and confidentiality
The data gathered during the interview will be marked with a code, and not connected with your name. We will record the interviews to make it easier for us to remember what was said. The recordings and written versions of the interviews will be stored safely within a locker only accessible to the researchers, and our supervisor. All the information from the interviews will be handled with confidentiality. In the thesis information from several participants will be presented together and anonymously as a master thesis in psychology at Lund University, Sweden. Sometimes there will be short quotations from the interviews. Quotations or other information that can be used to know who you are will not be published. Your identity will not be published. The recordings and other data collected from the interviews will be stored and treated so that no unauthorized persons can take part of them.

How do I get information about the results of the study?
If you want to read the final thesis we can end it to you, either by e-mail or via regular mail.

Contact information:
Who is responsible:
Lund university
The department of Psychology
Lars-Gunnar Lundh, professor in clinical psychology
lars-gunnar.lundh@psy.lu.se
+46 46 222 36 47

Psychology students:
Mattias Norlinder
muh12mn2@student.lu.se

Jenny Pein
psy13jpe@student.lu.se

I have understood the information, and want to be part of the study

Date:

_____
Signature

_____
Printed name

APPENDIX F - Informed consent: therapists

LUND
UNIVERSITY
Department of Psychology

From patient to therapist – a master thesis about lay therapy as trauma treatment

Information for research participants

Who are we?
We are two psychology students, called Jenny and Mattias from Lund University in Sweden. We are in Uganda to interview people about lay therapy for our master thesis and we will be in here for approximately three months.

Background and aim
Lay therapy has shown promising results as a method for trauma treatment for many, according to previous research. By lay therapy, we mean therapy that is conducted by a person who has a shorter, specific education to do a certain therapy, such as the one that you are working with. However there has not been much research done to understand what is important or needed for lay therapy to be helpful as a trauma treatment. Therefore, we are interviewing patients, therapists and supervisors involved in lay therapy as trauma treatment, to understand more about how this method works and what is important to think about when working with this method. By participating in the research you help by contributing with more knowledge about this method. This might be helpful to others who suffer from trauma or other people working with this method.

Inquiry about participation
As a therapist at the [-] outpatient clinic, we are asking if you would be interested in participating in an interview regarding your experiences of your work so far. It is completely voluntary if you want to participate and you are free to discontinue the interview at any time without any explanation and without any negative consequences for you. This information sheet contains information regarding how the study is conducted.

How is the study conducted?
This study aims to investigate different experiences of lay-therapy from different perspectives, and we will therefore be interviewing people with different positions and experiences of this treatment. This is in order to help develop lay therapy further with respect for the experiences of previous participants and others involved.

Participation in this study means you will be taking part of an interview about your experiences regarding your work. This will take approximately 30-90 minutes. If you wish this interview can be terminated by you at any time without explanation or negative consequences for you. You will not have to answer any questions you don't want to answer.

What are the risks?
In the interview, we will talk about the therapies you are conducting at [-] clinic. The focus of the interview will be on matters such as your experiences of conducting therapy, the training, the supervision and your relationships with your clients. If the interview would wake up any painful emotions, you can discuss this either during supervision or with us, if that is preferred. To avoid any risks of jeopardizing your employment if you would discuss negative aspects of your experience, we have spoken to your supervisor to ensure that any answers in this interview will not have any consequences for your current employment. For more information about how we treat the data and minimize the risk of identification, see "handling of data and confidentiality" below.

Handling of data and confidentiality
The data gathered during the interview will be marked with a code, and not connected with your name. We will record the interviews to make it easier for us to remember what was said. The recordings and written versions of the interviews will be stored safely within a locker only accessible to the researchers, and our supervisor in Sweden. All the information from the interviews will be handled with confidentiality. In the thesis information from several participants will be presented together and anonymously as a master thesis in psychology at Lund University, Sweden. Sometimes there will be short quotations from the interviews. Quotations or other information that can be used to know who you are will not be published. Your identity will not be published. The recordings and other data collected from the interviews will be stored and treated so that no unauthorized persons can take part of them.

How do I get information about the results of the study?
If you want to read the final thesis we will send it to you, either by e-mail or via regular mail.

Contact information:
Who is responsible:
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lars-gunnar.lundh@psy.lu.se
+46 46 222 36 47
The department of Psychology
Lunds university

Psychology students:
Mattias Norlinder
muh12mn2@student.lu.se
Jenny Pein
psy13jpe@student.lu.se

I have understood the information, and want to be part of the study

Date:

_____
Signature

_____
Printed name

APPENDIX G - Informed consent: supervisors

LUND
UNIVERSITY
Department of Psychology

From patient to therapist – a master thesis about lay therapy as trauma treatment

Information for research participants

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Background and aim
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Inquiry about participation
As a supervisor, we are asking if you would be interested in participating in an interview regarding your experiences of lay therapy and the management of such processes. It is completely voluntary if you want to participate and you are free to discontinue the interview at any time without any explanation and without any negative consequences for you. This information sheet contains information regarding how the study is made/conducted.

How is the study conducted?
This study aims to investigate different experiences of lay-therapy from different perspectives, and we will therefore be interviewing people with different positions and experiences of this treatment. This is in order to help develop lay therapy further with respect for the experiences of previous participants and others involved.

Participation in this study means you will be taking part of an interview about your experiences regarding your work. This will take approximately 30-90 minutes. If you wish this

interview can be terminated by you at any time without explanation or negative consequences for you. You will not have to answer any questions you don't want to answer.

What are the risks?
The interview will focus on your experiences of being a supervisor working with lay-therapy and any other parts of the job you deem relevant for other lay-therapy projects. Since the amount of supervisors that could potentially participate in the study is lower than the number of therapists and patients, supervisors from other treatment centers will be interviewed in order to minimize the risk of identification.

Handling of data and confidentiality
The data gathered during the interview will not be connected with your name. We will record the interviews to make it easier for us to remember what was said. The recordings and written versions of the interviews will be stored safely within a locker only accessible to the researchers, and our supervisor in Sweden. All the information from the interviews will be handled with confidentiality. In the thesis information from several participants will be presented together and anonymously as a master thesis in psychology at Lund University, Sweden. Sometimes there will be short quotations from the interviews. Quotations or other information that can be used to know who you are will not be published. Your identity will not be published. The recordings and other data collected from the interviews will be stored and treated so that no unauthorized persons can take part of them.

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Psychology students:
Mattias Norlinder
muh12mn2@student.lu.se
Jenny Pein
psy13jpe@student.lu.se

I have understood the information, and want to be part of the study

Date:

_____
Signature

_____
Printed name