A Pilot Study of a Trauma Training for Healthcare Workers Serving Refugees in Greece: Perceptions of Feasibility of Task-Shifting Trauma Informed Care

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Abstract

Few studies to date have investigated trauma training programs for healthcare workers who serve refugees. The purpose of this pilot study was to investigate the feasibility of a Train-the Trainer (TTT) seminar designed to bring knowledge of trauma-informed practices and task-shifting to healthcare workers charged to provide trauma informed care (TIC) for refugees in Greece. This study used a mixed-methods design, gathered survey data and qualitative descriptions of the barriers, facilitators, and perceived feasibility of task-shifting trauma screening and TIC interventions in healthcare settings that serve refugees. Thirty-three participants who attended a two-day TTT seminar completed a questionnaire, and 11 participants participated in two focus groups. Descriptive findings showed that healthcare workers reported satisfaction with knowledge gained after the TTT seminar. Qualitative findings indicated three main themes associated with the perceived feasibility of task-shifting TIC: a challenging work context; the relational stance; and broadening the conceptual map related to trauma. The findings suggest a TTT seminar may be a feasible method for knowledge dissemination on trauma and TIC in healthcare workers; however, additional training and supervision in TIC may be an important next-step in task-shifting TIC. Recommendations for supporting healthcare workers and integrating TIC into refugee services are discussed.

Keywords: Train-the-Trainer model; trauma-informed care; refugees; healthcare worker; barriers

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The number of forcibly displaced persons, which includes refugees, internally displaced persons, and asylum seekers, has reached a record of 68.5 million persons worldwide according to the United Nations High Commissioner for Refugees (UNHCR; 2018). A refugee is defined as a person who is unwilling or unable to return to his or her country of origin due to fear of persecution on the basis of race, religion, nationality, political affiliations, or group membership (UNHCR, 2018). Of the 2.68 million refugees that entered Europe by 2016 (UNHCR, 2018), approximately 857,000 refugees and migrants without travel documents have entered Greece since 2015 and approximately 51,000 refugees have remained in Greece (UNHCR, 2018).

Research suggests refugees may experience multiple types of traumatic events in their countries of origin and possibly during displacement (Nickerson et al., 2017). The traumatic events may be prolonged or interpersonal in nature and lead to negative mental health outcomes (Steel et al., 2009). A meta-analytic review of rates of posttraumatic stress disorder (PTSD) and depression in adult refugee populations suggested a prevalence rate of 30.6% for PTSD and 30.8% for depression in adult refugee populations (Steel et al., 2009). Some evidence suggests possible subthreshold PTSD and elevated rates of other anxiety disorders, grief reactions, somatic symptoms, and psychotic symptoms among refugee populations; however, prevalence rates for other trauma-related mental health issues in refugee populations have not been identified (Bogic, Njoku & Priebe, 2015; Dapunt, Kluge & Heinz, 2017; Nickerson et al., 2014).

Given the high rates of posttraumatic stress reactions among refugees, it is essential to consider a trauma-informed approach to prevention and intervention targeting refugee populations residing in Greece. However, a major challenge is the lack of providers who

have received training in trauma informed care (TIC) and the low number of mental health specialists compared to the current numbers of refugees who may need mental healthcare (Nickerson et al., 2017).

Although research on mental health services in refugee populations is in its infancy, existing studies suggest that a gap exists between the numbers of refugees in need of treatment for mental health disorders and those who actually receive screening and mental healthcare (Laban, Gernaat, Komproe, & De Jong, 2007; Shannon, O'Doughety, & Mehta, 2012). Both individual and system level barriers have been identified with respect to mental health services utilization (Wylie et al., 2018). Individual barriers for refugees include lack of knowledge about the health system, cost, demographics, social structure, beliefs about the causes and treatment of mental disorders, and language skills (Nickerson et al., 2017). System level barriers include time constraints, the austerity ridden context in Greece, as well as limited experience and training of healthcare workers in TIC (Murray, Davidson, & Schweitser, 2010; Sundvall, Tidemalm, Tilteman, Runeson & Bäärnhielm, 2015).

Trauma-informed care is the incorporation of knowledge about trauma in the provision of mental health services (SAMHSA, 2014). Trauma-informed care interventions include components specific to targeting trauma exposure and related symptomatology (SAMHSA, 2014). Programs incorporating TIC generally include: the victim's need to be respected, informed, connected, and hopeful regarding treatment; a focus on the interrelation between trauma and other presenting issues; and collaborative and empowering work with the victim and others (SAMHSA, 2014). The inclusion of collaborative relationships with the public sector service system and practitioners working with traumatized clients as well as attention to cultural issues in relation to trauma symptoms and services are essential components of TIC (Ardino, 2014). Trauma-informed care may help address the mental health needs of refugees, however, trained healthcare staff who can implement trauma-

informed screenings and interventions are scarce in many countries (Nickerson et al., 2017), including Greece (Hémono et al., 2018). Moreover, most healthcare staff working in refugee centers in Greece are graduates from undergraduate psychology departments without specialized training in trauma (Hémono et al., 2018).

Task shifting, which is defined as the redistribution or transfer of tasks from specialists to individuals with abbreviated training (World Health Organization (WHO), 2008 has been found to demonstrate some success with respect to meeting mental healthcare needs in resource poor settings (Bolton et al., 2014; Neuner et al., 2008). Specifically, tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications (Bolton et al., 2014). Task shifting has been used by non-specialist healthcare workers who provided interventions for PTSD in adult refugees in Uganda by applying Narrative Exposure Therapy (Neuner et al., 2008). Only one study to date has reported on the in-depth experiences of non-specialist health workers who were trained to provide the task-shifted intervention for PTSD (van de Water, Rossouw, Yadin, & Seedat, 2017). The qualitative study nested within a randomized controlled trial (RCT) where two psychotherapeutic interventions, supportive counseling and prolonged exposure therapy, were provided by nurses in school settings, suggested providing trauma treatment by non-specialists within the community was well received despite several identified impediments. To our knowledge, no study to date has investigated the perspectives of healthcare workers who have received trauma training and are charged with implementing TIC interventions with refugee populations.

Several methods have been utilized to educate and train healthcare workers, including face-to-face training (O'Hara, Gorman, & Wright, 1996), web-based training (Baker, Kamke, O'Hara, & Stuart, 2009; Wisner, Logsdon, & Shnahan, 2008), and professional consultation (Gordon, Cardone, Kim, Gordons, & Silver, 2006; Yonkers et al., 2009), however, each of

these methods has limitations. For example, although face-to-face training and web-based training may be conducted on a large scale, they often do not include the guidance necessary to increase knowledge and skill development (Segre, Brock, O'Hara, Gorman, & Engeldinger, 2011). Professional consultation has been found to be an effective form of training; however, it is often costly (Segre et al., 2011). Train-the-Trainer approaches appear to be an effective form of knowledge dissemination for healthcare workers in the area of perinatal depression in the U.K. (Elliott, Ashton, Gerrard, & Cox, 2003) and with health and social service professionals with limited to no background in mental health in the U.S. (Segre et al., 2011). A review of the literature suggests no study to date has investigated a TTT approach to trauma-training for healthcare workers working with refugees, despite the growing number of studies focused on implementing trauma-informed systems of care in service systems (e.g., Conners-Burrow et al., 2013; Hanson & Lang, 2016).

Due to the scarcity of psychiatrists and psychologists in Greece with trauma-specific training, a TTT seminar focused on introducing TIC and task shifting mental health interventions to healthcare workers who work with refugees may be an important first step to a critical mental healthcare worker shortage. Healthcare workers in Greece are situated to implement trauma screening, assessment, and interventions; however, lack of training in TIC often leaves them unprepared to engage in these roles (Segre et al., 2011). No study to date has investigated the potential feasibility of a TTT seminar as a method to enhance knowledge in TIC and perceptions of task-shifting among healthcare workers in Greece. The current study used a mixed-methods design and aimed to gather preliminary survey data and qualitative descriptions of healthcare workers' perceptions of the feasibility of TTT seminar and the barriers, facilitators, and perceived feasibility of task-shifting trauma screening on the implementation of TIC interventions in settings that serve refugees.

Methods

Study Design

The present pilot investigation utilized a two-phase explanatory sequential design (Creswell & Zhang, 2009) where quantitative methods were first used to identify sample characteristics, previous training, satisfaction with the training, and workshop outcomes (N = 33). In the second phase, data was collected using two focus groups with a total of 11 participants (n = 11) to further explore the feasibility of task-shifting TIC, focusing on training, professional, and personal development perspectives of the healthcare workers. This approach allows for the qualitative inquiry to further investigate experiences and perceptions of the healthcare worker population reported in the quantitative analysis to explore at a deeper level the study aims (Banyard & Williams, 2007; Creswell & Zhang, 2009).

Train-the-Trainers: Seminar Description

Initially, four large non-governmental organizations (NGOs) in Athens working with refugees were contacted and informed of the training seminar. All four stated that they were interested in participating and eventually two were able to participate. The authors consulted one-to-one with the NGO representatives to tailor the TTT seminar to the needs of the healthcare workers. The NGO representatives stated the population of healthcare workers who would attend the TTT seminar would need basic information on trauma, how to recognize trauma, and how to respond to trauma. Therefore, the TTT seminar assessed in the current study was designed by the study authors to achieve the following goals: (1) increase the level of knowledge with respect to trauma exposure and the potential mental health impact of trauma on refugees; (2) introduce TIC; (3) introduce trauma screening and two trauma specific interventions to healthcare workers. Since no TIC curricula had previously been developed for healthcare workers working with refugee populations in Greece, the authors utilized specialized knowledge of trauma and a thorough review of the literature to

create a new curriculum tailored to the needs of healthcare workers in Greece. The training process included four phases: 1) the presentation of didactic information; 2) the presentation of the techniques; 3) the use of vignettes to enhance diagnostic skills; and 4) the practical application- experiential component.

Our experts provided attendees with training materials which were created specifically for the TTT seminar. The curriculum was taught over a 2-day, 6-hour per day training. Both days of TTT training focused on transferring knowledge of specialized TIC into therapeutic work the healthcare workers may engage in with refugees. Day one of the TTT program focused on information about traumatic stress, common mental health issues associated with traumatic stress exposure in refugees, the concept of TIC, screening and assessment for mental issues in refugee populations, and a narrative intervention which focused on human dignity which has been used effectively with refugee populations in Greece (Jacobs, 2018). Day two of the TTT seminar focused on a review of TIC and an introduction to Narrative Exposure Therapy (NET; Neuner et al., 2008), an evidence-based trauma intervention that has been effectively applied to decrease traumatic stress symptoms in refugee populations (Neuner et al., 2008).

Participants and Procedure

After receiving approval from the California State University Long Beach Institutional Review Board (IRB) and Hellenic American University IRB, Greece, the TTT seminar was provided to 72 attendees on the premises of the latter. Individuals who attended the TTT seminar were invited to participate in the study, which included completion of a questionnaire and focus group interviews. Interested participants were given an informed consent form to sign before completing the questionnaire. After the TTT seminar attendees were invited to participate in the focus groups. Participants received no incentive for participation in either part of the study.

Data Collection

Of the 72 individuals who attended the TTT seminar, 45.8% (N = 33) consented to participate in the quantitative portion of the study. Some attendees of the TTT seminar left the premises before the end of the seminar and were not given the opportunity to complete the questionnaire. Twenty of the attendees expressed interest in participating in the second part of this study (the qualitative focus groups) and were contacted by telephone by one of the authors (EF). Nine attendees subsequently either withdrew their participation in the qualitative portion of the study for personal reasons or because they could not fit the focus group in their schedule. Eventually, eleven healthcare workers from the two NGO's who attended the TTT seminar (15.3% of 72) completed two 90-minute, audio-recorded, semi-structured focus groups, and comprised the qualitative sample for this study. Audiotapes were transcribed, reviewed, and checked for accuracy by three of the authors (EF, ST, RS).

Quantitative Measure

As part of the quantitative data collection, all participants were asked to complete a short questionnaire developed by the research team at the end of day two of the training seminar. The questionnaire assessed demographic information including: professional discipline (psychology, social work, nursing, medical doctor, other); age; gender (male, female); educational level (M.D./Ph.D., Master's Degree, Baccalaureate Degree, Other College Degree, Some College, High School Degree, Other); ethnicity (White, Black, Hispanic, Asian, Other); previous training in traumatic stress (yes/no), previous training in evidence-based mental health treatment (yes/no); overall satisfaction with the TTT seminar (very satisfied, satisfied, neutral, dissatisfied, very dissatisfied). Participants were also asked to rate (from strongly agree to strongly disagree) the following questions: 1) the training helped build my capacity to respond to the needs of refugee populations; 2) the training increased my knowledge of traumatic stress; 3) the training increased my understanding

about the key issues related to working with refugees who have experienced traumatic stress; 4) the training increased my knowledge of the link between trauma exposure and mental health outcomes; 5) the training improved my skills to respond to traumatic stress; 6) the training described screenings that I can use in my work; and 7) the training described interventions that I can use in my work.

Focus Groups

Two focus groups were conducted in Greek with a sub-sample recruited from the TTT seminar participants (n = 11) to understand barriers, facilitators, and perceptions regarding task-shifting TIC. Semistructured interview questions were developed by the research team. Each focus group lasted for 90 minutes and no follow-up interviews were conducted.

Data Analysis

Sociodemographic characteristics and perceived usefulness of the TTT seminar were calculated using frequencies and means. Each focus group interview was audio-recorded and subsequently transcribed verbatim. Using a methodology of "Coding Consensus, Co-occurrence, and Comparison" outlined by Willms et al. (1992) and rooted in grounded theory (*i.e.*, theory derived from data and then illustrated by characteristic examples of data; Glaser and Strauss, 1967) interview transcripts were analyzed. All data were read and reviewed by the authors at the various stages on analysis. The goal was to develop a broad understanding of content as it relates to the project's aim to delineate healthcare workers' perceptions of the barriers and facilitators of task-shifting TIC with refugees, focusing on the TTT content. Material in interviews was coded to condense the data into analyzable units. Segments of text were assigned codes on the basis of emergent themes (known as open coding) or a priori themes (from the interview guide; Corbin and Strauss, 2008). Lists of codes developed by each investigator were then matched and integrated into a single codebook. Members of the research team coded all of the interviews using the codebook to establish consensus

reliability. When disagreement arose, the research team attempted to identify the source of the discrepancy, and coded sections were reviewed again until consensus was reached. Analysis of the interviews was completed to identify categories, subcategories, and relationships between codes and categories across the interviews and constant comparison was used to further condense the categories into broader themes (Braun & Clarke, 2006).

Results

Demographic Characteristics of Sample

Characteristics of the sample are summarized in Table 1. The majority of the sample of healthcare workers were female (*n* = 26; 78.1%), and self-identified with the discipline of psychology (*n* =18; 56.3%). The average age of the healthcare workers was 32.0 years (*SD* = 9.2). The sample of healthcare workers included 42.4% (*n* = 14) with a master's degree, 42.4% (*n* = 14) with a college degree, and 15.2% (*n* = 5) with some college or less. Approximately 24.2% of the sample (*n* = 8) reported some previous training specifically on trauma, while 48.5% of the sample (*n* = 16) reported minimal training in evidence-based treatments in general. The average caseload of known individuals with a trauma was 5.4 cases (*SD* = 9.5).

Table 1.

Demographic Characteristics of Sample

Demographic	Total Sample (*N* =33) n (%)
Professional Discipline	
Psychology	18(56.3)
Social Work	5(15.6)
Other	9(28.1)
Average age (mean, standard deviation)	32.0(9.2)
Gender (male)	7(21.9)
Educational level	68.70
Masters degree	14(42.4)

College degree	14(42.4)
Some college or less	5(15.2)
Race	55.13
White	30(90.9)
Other	3(9.1)
Previous training in traumatic stress (yes)	8(24.2)
Previous training in evidence based treatments (yes)	16(48.5)
Caseload of known individuals with a trauma (mean, standard deviation)	5.4(9.5)

Perceived Usefulness of Train-the-Trainers Seminar

The majority of the sample reported being satisfied or very satisfied overall with the TTT seminar and felt the training built capacity to respond to refugee populations (*n* = 30; 90.9%). The sample reported increased knowledge of traumatic stress (*n* = 29, 87.9%). With respect to the ability of a TTT seminar to facilitate task-shifting, a majority of the sample reported improved skills to respond to traumatic stress (*n* = 26; 78.8%). In addition, a majority of the sample perceived the TTT seminar described TIC screenings (*n* = 30; 90.9%) and interventions (*n* = 29; 87.9%) that can be used in their work. The results derived from the questionnaire are presented in Table 2.

Table 2.

Perceived Usefulness of Train-the-Trainers Training

Questions	Total Sample (*N* =33) *n* (%) of agree or strongly agree responses
Overall satisfaction with Train-the-Trainers workshop (satisfied or very satisfied)	30(90.9)
The training built capacity to respond to the needs of refugee populations	30(90.9)
The training increased knowledge of traumatic stress	29(87.9)
The training increased understanding about key issues related to refugees who have experienced traumatic stress	28(84.8)

The training increased knowledge of the link between trauma exposure and mental health outcomes	29(87.9)
The training improved skills to respond to traumatic stress	26(78.8)
The training described screenings that can be used in work	30(90.9)
The training described interventions that can be used in work	29(87.9)

Focus Groups, Qualitative Results

After completing questionnaires and reviewing results, two focus groups were conducted (see Table 3). Three distinct themes relevant to the study aims emerged from participants' narratives that contributed to the understanding of their experiences with the TTT seminar and their perceptions of the feasibility of healthcare workers ability to task-shift TIC: (1) challenging work context: a Sisyphean context; (2) the relational stance between healthcare worker and refugees; and (3) broadening the conceptual map related to trauma (Table 4).

Table 3.

Demographic Characteristics of Sample of Focus Groups

Pseudonym	Age	Gender	Education	Years or months working with refugees
Paul	33	M	BSc Psychology	6 years
Mary	31	F	BSc Psychology	2 years
Fay	40	F	BSc Sociology	2 years
Ava	40	F	MD Child Psychiatry	10 years
Emily	26	F	BSc Psychology	2 ½ years
Emma	28	F	BSc Anthropology	2 years
John	37	M	PhD Psychology	5 years

Ashley	31	F	BSc Psychology MSc Psychology Clinical	2 years
Olivia	35	F	MSc Social Policy	5 years
Abby	27	F	BSc Psychology and MSc Forensic Psychology	9 months
Peter	33	M	BSc Psychology MSc Child Psychology and systemic therapist	4 years

Table 4.

Summary of Themes - Focus Groups Analysis

Themes	Sub-themes
Challenging work context: A Sisyphean context	1. Unfavorable refugee status 2. Overwhelmed healthcare workers 3. Context challenges
The relational stance between healthcare worker and refugees	1. Mediated therapeutic communication and difficulties with interpretation 2. Cultural differences between the healthcare workers and refugees 3. Frustrations with relationship building
Broadening the conceptual map related to trauma	1. Cognitive representations of trauma 2. Timing of discussing trauma narratives 3. Additional training to address trauma stories through interventions

Challenging work context: A Sisyphean context. Experiences with barriers and challenges to possibly task-shifting TIC were discussed during the focus groups such that

they parallel the participants' work and the refugees lives to a Sisyphean undertaking. Sisyphus in the ancient Greek myth was condemned to roll a massive stone up a hill only for it to roll back down when reaching the top. This metaphor depicts the perception of the futility the participants felt as a result of the great efforts they make in order to meet the refugees' needs and the challenges and frustrations they encounter in evaluating the outcomes of their efforts. Moreover, it underscores how participants experienced the fluid contexts where they worked, specifically the constant movement in the refugee holding centers and the numerous pressing needs of the refugees (i.e. legal, housing).

They explained how refugees viewed Greece as a transit country on their way to settlement in other European countries where they imagined they would have more social welfare benefits and job opportunities. The healthcare workers stated that refugees confronted and continue to confront, Sisyphean tasks that included: carrying the burdens of war, poverty, and persecution in their homeland; trauma, loss, and great adversities before, during, and after their journeys; futility of living in camps; and the disappointment of having their asylum applications rejected and facing deportation. Moreover, participants reported many of the refugees were accustomed to seeking help for health problems and not psychological issues. This complicated the healthcare workers' perceived abilities in task-shifting TIC efficiently and effectively as two participants describe below:

> They (refugees) are certainly in transition but I mean even geographically if we put it, many think they will be leaving, that some other resettlement situation awaits them which might not be the case. That is, there may not be a resettlement. Regardless of what they have lived up to now, they have such an expectation (Ashley).
>
> They [refugees] do not know about psychologists and are not literate about mental health issues. Maybe it is a matter of culture, that is why their requests are mainly

about medical concerns even if there is nothing (physically) wrong with them. Doctors say that as well but something else is hiding behind this (Emily).

The healthcare workers described an overwhelming burden of responsibility when they were called to satisfy the diverse and complicated needs (e.g., safety, legal, medical, status etc.) of the refugees. They felt as if they were positioned in the front line of a battle given that attending to traumatic distress is a new field of knowledge that they could only learn by applying knowledge of TIC to specific cases. They felt overwhelmed with the caseloads and daily demands of their work, and they tended to distance themselves in order to deal with the 'impossibilities' of giving of themselves tirelessly. Two participants describe this below:

I believe we need more ways so that we do not carry that much of responsibility, maybe it is my personal mistake, something I am doing wrong but…I always feel as if I am not doing enough, that something is always going on, something will come up, cases are not concluded. I mean, I wake up at 5 am and I am thinking of the cases (Emma).

We are the first that entered [this field of work] and because of that I think we are the ones that clear the path now. So, we are being smacked in the face. When you clear the path, the rubble falls on us, we are there (Fay).

Participants reported that refugees forced to stay in the camps or other supported accommodation without the foreseeable ability to resettle in other European countries was a source of great duress and fatalism. In this context, the participants feared that the TIC techniques would be rendered ineffectual as there is insufficient time and space for them to engage in therapeutic work with the refugees, who are not grounded or settled literally and emotionally. One respondent, Paul, stated, "but really there is no solid ground [for refugees],

and we are called, each one of us from their own perspective to function as that [solid ground], great burden!"

The relational stance between healthcare worker and refugees. Experiences with respect to the perceived feasibility of task-shifting TIC were primarily discussed by participants in the context of the relationship between the healthcare worker and the refugees who were their clients. When the refugees spoke the same language with the healthcare workers the contact was perceived to be direct, and the development of the therapeutic relationship was perceived to be facilitated. Most of the time, though, interpreters and cultural "mediators" were necessary in communicating with the refugees. The "mediators", who spoke the same language as the refugees, often established their own relationships with the refugees which at times overshadowed the relationship with healthcare workers. Participants suggested that interpreters and mediators needed to be trained on the TIC techniques as well so that they were adequately involved in the therapy process. The participants discussed barriers of translation and interpretation as well as the difficulties raised by the fact that they did not work with the same interpreters consistently, as Emily mentions below.

> I believe it is the biggest obstacle in our work […] because this is not multicultural mediation in reality. Many times, interpretation happens, no, rather translation is taking place, not even interpretation and many times the message we want to transfer is not received as we send it (Emily).

Healthcare workers contemplated on how emotionally involved they should be and the boundaries they should establish with refugees. They discussed the need to learn the new and culturally different ideas and understandings that the refugees narrate. They brought up their need for time to process the trauma narratives that the refugees presented in order to be fully present and provide a positive therapeutic environment for the refugees. Despite the cultural differences they discerned, the participants discussed being in close emotional

contact with the refugees as human beings, which may serve as a facilitator to implementation of TIC.

> Yes, somehow to connect emotionally because the story elicits many emotions in you for sure. The narrative, the contact with all this provokes many things for you. So, I am not sure but like that, usually, we meet on the deeper human level for sure (Paul).

Despite their efforts and commitment to their work, participants experienced disappointments and frustrations when the refugees did not respond to their efforts to build relationships or when they did not have desirable results. They described a vicious cycle of mutually intense feelings, where healthcare workers experienced futility in their efforts to respond to the refugees' requests, especially when they were about practical and direct needs such as moving on to other countries. Healthcare workers perceived the refugees may not engage in TIC with them considering the many stressors they are dealing with, annulling their efforts and idealizing the circumstances in other European countries. Mary states that "...at that moment it just came to my mind that we are talking about people who have lost their moorings and place. And so, my thought was how a tree can continue to grow without its own soil?" and Ashley adds:

> For me, it is not so much the stories of these people, it is my story; that I am asked to do things which I cannot. I really want to help them. I really want to find a job for them, a home, a wife to marry and raise his children. But I cannot. And we experience our own frustrations; our job per se, in whichever team you intervene, has many frustrations (Ashley).

Broadening the conceptual map related to trauma. The healthcare workers highlighted the differences in their perceptions and beliefs about trauma and task-shifting TIC following the TTT seminar. Initially, they understood trauma as due to war and disasters

whilst they had to incorporate “biographical trauma”, i.e. trauma induced by life experiences (e.g., abuse, family violence) in their conceptualizations. They also had a new understanding of the traumas experienced during the refugee’s journey to Greece or while living in the camps. The healthcare workers emphasized the fact that what they deemed to be trauma prior to the TTT seminar might not be interpreted as such by the refugees as shown below.

> Something else new was the understanding of trauma beyond what we define so far as trauma which entails social events, wars, riots, civil wars, natural disasters etc. And we saw that biographical experiences and traumatic events can be the targets of interventions of a trauma focused therapy (Ashley).

The healthcare workers contemplated the timing in discussing the trauma, whether they should implement TIC when it is recent (“when the wound is open”) or whether they should wait until the refugees were “back on their feet”. They acknowledged learning that discussing the trauma narrative alleviates the potential negative appraisal of the trauma and provides opportunities to use culturally appropriate methods to process it. They reflected on their learnings from the TTT seminar and on the fact that they engaged in non-threatening demonstrations of implementation of two TIC techniques. They expressed a strong desire to inspire hope and empower the refugees. In this context they discussed how the intervention of the tree-of-life they learned in the TTT seminar could help them instill hope in the refugees.

> I believe it is more feasible to apply the tree-of-life exercise. It does not require any particular training for the interpreter, some guidelines can be provided so that they are also informed what the exercise is about; there are many empowering elements for the clients and the therapist that can be directly applied [through this technique] (Peter).

They emphasized how this is new area of practice, thus they feel that there is not adequate training and support to implement TIC. The need for further and continuous training and supervision was also underscored in both phases of the TTT seminar evaluation.

Discussion and Limitations

The current pilot study used multiple methods to investigate the feasibility of a TTT seminar designed to bring knowledge of trauma-informed practices and task-shifting to healthcare workers charged to provide trauma informed care (TIC) for refugees in Greece. Quantitative results revealed that healthcare workers reported satisfaction with the type of knowledge gained with respect to TIC as a result of the TTT training. Our finding is consistent with other studies that found a TTT approach as an effective form of knowledge dissemination in healthcare workers (Elliott et al., 2003; Segre et al., 2011). The current study also adds to the literature describing the perspectives of healthcare workers with respect to the feasibility of task-shifting TIC with refugees. Qualitative data revealed themes related to a challenging work context, the relational stance, and broadening the conceptual map related to trauma were associated with perceived feasibility of task-shifting TIC. The combination of qualitative and quantitative findings may add to the understanding of important factors related to the feasibility of task-shifting TIC in Greece.

Consistent with past research, healthcare workers perceived difficulties with respect to implementing TIC when safety and stabilization issues were imminent and length of stay in Greece was unknown (Nickerson et al., 2017). Our data suggested that healthcare workers were concerned about the possible transitory stay of refugees in Greece, which may impact their ability to complete a TIC intervention. Focus group data highlighted that despite interest in implementing a TIC treatment, feeling overwhelmed, fear of possible negative mental health reactions, and lack of knowledge of how discussing trauma may impact the mental health and well-being of the refugee are important considerations for healthcare workers when contemplating starting a TIC treatment. The barriers to implementing TIC are consistent with the broad trauma literature describing reasons why clinicians may be concerned about implementing trauma-focused treatments (Aarons & Palinkas, 2007;

Glasgow, Lichenstein & Marcus, 2003; Schoenwald & Hoagwood, 2001). Past research evaluating the outcomes of trauma-focused treatments have generally disconfirmed concerns about using these treatments (Cook, Schnurr, & Foa, 2004; Foa, Zoellner, Feeny, Hembree & Alvarez-Conrad, 2002).

Language and communication issues were also highlighted as a challenge to providing TIC to refugees (Hémono et al., 2018; Kousoulis, Ioakeim-Ioannidou, & Economopoulos, 2016). The role of interpreters was discussed as a possible faciliator or barrier to treatment depending on whether or not direct and accurate interpretation of the healthcare worker was occurring. Healthcare workers acknowledged that interpreters may facilitate treatment by serving as important cultural mediators when doing TIC. Future research is necessary to further understand the role of interpreters in the implementation of TIC.

Similar to past studies, participants described the significant mental health needs as well as different types of trauma exposure in the refugees they worked with (Hémono et al., 2018). Participants emphasized how their conceptualization of trauma differed with the refugees' perception of a traumatic experience. Perhaps, in accordance with literature suggesting that cultural competency and cultural awareness are necessary components of appropriate screening and interventions in trauma-exposed populations, cultural conceptualizations of trauma should be considered in TIC implementation practices (Ardino, 2014).

Another important theme was a need for ongoing training and supervision for healthcare workers charged with implementing TIC. Only a few studies to date have identified the need for additional psychosocial training for healthcare workers who work with refugees in Greece (Hassan et al., 2016; Hémono et al., 2018). In Greece, healthcare workers working with refugees may have varied educational experiences, and the level of

mental health literacy with respect to trauma treatment may vary (Hémono et al., 2018). Future research is necessary to understand the amount of training and support necessary for healthcare workers to not only ensure successful delivery of TIC but also to build their confidence and competence.

As this was a preliminary pilot study, it had several limitations. This study focused on the perspective of healthcare workers, and it did not include the perspectives of the refugees with respect to their mental health needs and mental health access and engagement issues. Knowledge was assessed by a self-report instrument developed by the authors, which limits conclusions about perceived effectiveness of the TTT seminar. The current study was exploratory in nature, and a pre-post design was not used to understand amount of knowledge gained as a result of the TTT seminar. The high level of satisfaction with the TTT seminar found in this study may have been due to a skewed sample considering many trainees did not participate in the research. Also, although participants reported that they were satisfied with the TTT seminar, the study did not assess whether participants actually applied any new knowledge. Participants were from NGOs and may not represent the broader population of healthcare workers in Greece, which limits the generalizability of the results. Individuals in this study were seeking training in TIC, which may influence the satisfaction found in this study. In the qualitative portion of this study, both collection and interpretation of the data were susceptible to subjective bias and preconceived ideas by the investigators.

Conclusions

This study adds to the emerging body of literature describing trauma training for individuals working with refugees. Our findings provide preliminary support for TIC knowledge dissemination to healthcare workers using a TTT seminar. As the results of this study imply, it is important to develop training which enhances healthcare workers' knowledge on TIC, perceived competence, motivation and satisfaction, and understanding

and compassion towards refugees (Mechili et al., 2018). We recommend that healthcare staff working with refugees may benefit from ongoing seminars in TIC, from basic trauma seminars to more advanced seminars focusing on trauma-specific intervention techniques (Dierkhising & Kerig, 2017). Ideally, it would be helpful to have healthcare staff who speak the same language as the refugees, as this poses an additional barrier to implementing TIC. As many of the participants in the current study reported feeling overwhelmed and unsure of how to respond to trauma stories, we suggest incorporating access to support for staff on an ongoing basis either in-person or by technology-assisted support. Since the implementation of NET would require ongoing support for staff, it may be helpful to train some healthcare workers or mental health specialists who have fewer competing responsibilities in NET. Future studies that include follow-up interviews are necessary to further understand the potential of healthcare workers to effectively task-shift TIC interventions for refugees residing in Greece.

Disclosure of Interest None of the authors had any financial or personal relationship with the companies whose employees served as research participants.

Ethical Standards and Informed Consent All procedures followed were in accordance with the ethical standards of California State University Long Beach Institutional Review Board (IRB) and Hellenic American University IRB, Greece and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

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