PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Qualitative accounts from Syrian mental health professionals: shared realities in the context of conflict and forced displacement
AUTHORS	Hamid, Aseel; Scior, Katrina; Williams, Amanda

VERSION 1 – REVIEW

REVIEWER	Dr Aala El-khani University of Manchester, UK
REVIEW RETURNED	17-Sep-2019

GENERAL COMMENTS	Dr Aala El-Khani This is an excellent article on an important topic which will no doubt add great value to the literature of the professional issues and ethical duty to protect health workers in conflict settings-specifically those of Syrian MPHs but all health care workers in general in this context. It adds a snap shot into the experiences of 16 Syrian MPHs whom have also experienced trauma and challenges that mirror those of their clients. The layout of the introduction is particularly strong with well referenced logical openings and up to date references-this guides well to the framing of the aims of this study. The method section is also well developed and logical though I suggest a little more information on the recruitment process (very minor addition) as I have set out in my comments below. The result section is particularly interesting for me and the level of detail and the structure of the themes and co-themes is a strength of this paper. The examples given and quotes chosen, allow the reader a real insight into the experiences of those interviewed. The discussion is well linked to the introduction and does well to sit the results of the paper within the framework of other research in this field-drawing on parallels. I have listed some very minor recommendations-the majority of which are text specific and a few others that require an additional sentence clarifying or defining a term further. I wish the authors well and congratulate them on this important research. 1- Add full stop to bullet point-page 3, line 18

	2-Page 3, line 38. This last line, 1-should say 'to our knowledge no literature exists …' Do you mean 'the majority of published literature sheds light on the impact of medical personnel, though to our knowledge no literature exists…'? 3-Page 3. Opening sentence of last paragraph too long. Break into two sentences 4-Page 6-line 16. It is not clear for which city, Istanbul or Gaziantep, the description of 97 km north of Allepo is suited. 5-Page 6, line 35- last sentence of paragraph-clarify the impact on whom of conducting therapy on Syrian MHP's ? -the client or MHP, please make sentence clearer 6-Page 6-line 42-purposive sampling is stated as recruitment strategy- can you provide a sentence or two with more details-how were they recruited, from where? Word of mouth, poster? 7-Page 6, line 45 'Working', not 'work 8-Page 7 line 42 . only one interview was independently decoded? Or more-why was one chosen? 9-Can you check all spelling of MHPs for grammatically accuracy-currently sometimes spelt as MHP's sometimes MHPs and other MHPs' 10-Page 17 line 37-47, can you link and say how these two studies parallel with yours? 11-Page 18 line 10, Provide a definition of what using countertransference therapy positively means 12-Page 18, line 37-Spell out EMDR and TF-CBT 13-Page 21, line 50 spell out UN 14-Space before bracket of reference, page 3, line 37

REVIEWER	Andres Barkil-Oteo American University of Beirut Beirut, Lebanon
REVIEW RETURNED	05-Oct-2019

GENERAL COMMENTS	The study by Hamid et al. uses qualitative accounts from Syrian mental health professionals to explore the impact of their work in the provision of mental health services to Syrian refugees in Turkey. The issues of shared realities, self-disclosure, and the impact of providing mental health treatment in this context were explored. The work done by this team is valuable as it provides many insights into the difficulties of the work done by these professionals and their way of dealing with it. In particular, how the professionals in this sample navigate the issues of self-disclosure (identifying city of origin to connect with the client, sharing anecdotes if they belong to the same socio-economic status). Also, the impact of therapy provided given the shared realities, and the ways to cope

	that includes the importance of peer support, social support, supervision, and external therapy. Two issues I would like to point out: 1-The term “forcibly displaced” is used throughout the manuscript. It’s technically correct as forcibly displaced encompasses internally displaced (people inside Syria), and refugees (people who crossed an international border). I agree with this use as not everyone in this sample (providers and patients) could be technically refugees. However, it may create confusion among readers. I wonder if there should be a note explaining the rationale behind using this term. 2-The authors attempt to relate this study to the EMDR training provided by Trauma Aid UK. Two examples: -Page 6, line 3: “to understand how their training is translated within a Syrian culture and displacement context, while seeking better understanding of the potential harmful emotional impact given their own background and settings.” It’s not clear to the reader whether this study aims to evaluate the training, or it is part of a bigger project to evaluate the training. The same statement repeated in line page6 line28, but with a focus on the objectives of this study (without the training effectiveness part). -Page 20, line 42: “This snapshot of Syrian MHPs suggestions [suggests?] a helpful model of training Syrians with a mental health background to provide therapy to Syrians within the community as a way to promotes understanding and empathy while reducing cultural and language barriers.” There is a weak link between the findings and the training program. Especially that the training curriculum is not explained in the manuscript for the reader to understand (number and type of sessions, duration, themes, etc.) I appreciate that there are some overlapping themes, but authors need to be cautious as the benefits experienced by therapists could have come from different sources, including the training. I suggest to the authors either to make the connection more explicit and to explain the different components of the training or to minimize the link to the program and the benefits of said program on the therapists. This seems to be a good research question for a different project, especially that the clinicians were never asked explicitly about the program per se.

REVIEWER	Felicity Brown War Child Holland, The Netherlands
REVIEW RETURNED	16-Jan-2020

GENERAL COMMENTS	**Review of: Qualitative accounts from Syrian mental health professionals: shared realities in the context of conflict and forced displacement** This is an interesting study on a very important and relevant topic- the experience of mental health professionals with shared refugee/trauma backgrounds. It has great implications for the field of mental health and psychosocial support service provision in humanitarian settings. I feel that the manuscript could be suitable for publication, but requires significant revisions. I’ve listed some specific feedback below.

Abstract-

- The analytical method needs to be explained in the abstract.
- The results are presented in terms of frequency of experiences, rather than themes, and do not provide much depth of findings. It's important not to present qualitative results as quantitative findings.

Background-

- Overall, I recommend that the background section be re-written for clarity of several key points, and flow.
- Line 37- it is unclear what these violations are, if separate to attacks on health facilities.
- Page 2, line 8- why are there low supervision rates in such a situation?
- The research aims outlined at the end of the introduction, are quite broad: exploring the context of the shared reality of the Syrian MHP-client dyad, exploring what allows Syrian MHPs to continue in their work as a healer, exploring what coping consists of in this context, understanding how their training is translated within a Syrian culture and displacement context, and seek better understanding of potential harmful emotional impacts. These aims are quite leading, and unclear. They are also different to the aims presented in the methods: *The study aimed to investigate the impact of the shared culture and experiences of forcibly displaced Syrian MHPs and their Syrian clients, the incidence and impact of MHPs' disclosure of shared experiences and the impact of providing therapy on Syrian MHPs.*
- I recommend presenting the aims in a more concise, consistent, and clear way.
- Furthermore, for incidence-related questions, I would argue that qualitative research is not the best research method.

Methods

- Line 45- don't need to repeat that Turkey is host to the largest number of Syrians
- In terms of ethics and consent, it is important to specify what participants were told about confidentiality of data. This is particularly important since participants are health professionals, and are being asked to describe professional experiences and challenges. Were they told under which circumstances (if any) the interviewer might disclose information relating to their professional capability, in the instance of safety concerns?
- How were MHP's identified and recruited? It is mentioned as a limitation that they are largely recruited through the INGO
- MHPs in such settings can have varied backgrounds, trainings, and job roles. It is necessary to specify their

	characteristics further in the methods section, rather than waiting until results section. • More information on the topics asked about in the interview guides would be helpful to provide a clear sense of the interview context from which the data is arising. • Line 35- it would be clearer to list transcription/translation process before coding process. **Results** • The sections on barriers and facilitators is unclear, and seems to be related to barriers and facilitators to providing mental health services in such settings? Since this was not one of the research questions, this section feels a bit out of place. I recommend situating it more clearly, and making it more concise. • The thematic map of the themes is clear and is a strength of the paper. • When reporting the results, it's important not to try to draw quantitative conclusions from qualitative data. I would also prefer to see more linking between the findings, and more explanation of the findings. At times, the description of the findings within the theme is very brief, with several quotes then presented in a list format. I would prefer to see the findings elaborated more and linked together. **Discussion-** • The discussion links the current findings to past research very well. I feel that it could be reviewed to ensure that it flows effectively throughout, and is as concise as possible. • The end of the discussion could more powerfully focus the findings and situate it within the larger context. As it stands, the concluding paragraphs make more general statements about the broader MH field in humanitarian settings, rather than directly link the findings of this study. Best practice in MHPSS service provision includes training and supervising local mental health professionals to deliver services, in order to promote contextually relevant services, and ensure sustainability. This study explored several benefits and challenges in the therapeutic process. It highlights that there are several positive experiences of the shared traumatic reality between MHP and client, but also that considerations around MHP support are needed. • One quote from a MHP suggests that disclosing that the therapist and client were both from similar settings was helpful in building trust. It therefore seems important to consider the potential harm that would exist if Syrian MHPs are from different backgrounds to their Syrian clients. This is one aspect where the shared refugee status can be incredibly helpful, but also has the potential to be detrimental to trust. • Page 20, line 35- why is the MH provision likely to differ significantly in other settings of displaced Syrian refugees, such as Lebanon or Jordan? More clarification of this statement is needed.

	• Page 20, Line 42- the current findings do not directly suggest that any model of training is helpful, nor that any method of service delivery is sustainable. • An important limitation to elaborate more on is that if MHPs are largely recruited through their employer, there may be reluctance to disclose challenges they are facing (as the authors highlight), but also they may be reluctant to openly discuss the use of personal disclosure or boundary violations, or other work related experiences.

REVIEWER	Lloy Wylie Western University, Canada
REVIEW RETURNED	03-Feb-2020

GENERAL COMMENTS	p5 line 6 - should read "and often relates TO MHP's" p5 line 13 - should read "LEAD to burnout" p6 line 45 - should read "worldwide, WHO work with Syrian" p8 line 40 - "number of barrierS" (add S) p17 line 45 - use of co-occur twice - may want to say "showed the positive changes co-occur alongside" p20 line 35 - should read "likely to differ FROM other contexts" p20 - line 47 PROMOTE understanding (remove S from promotes) Comment for the discussion section: It would be good to reflect on how these Syrian MHP could be a resource for other MHP who work with Syrians (Could they educate other health care providers, so they are not the only ones able to provide appropriate care for Syrian refugees)?. One issue that is not addressed could be the challenges of being both care provider and interpreter in team-care settings. Did this come up at all in the study?

VERSION 1 – AUTHOR RESPONSE

Reviewers' requests

We now present the reviewers' comments, in order of reviewer, again numbered in the order that they were made.

Reviewer 1

We would like to thank Aala El-khani for her comments on our manuscript. Below we present her comments and our responses in turn:

1) **Add full stop to bullet point-page 3, line 18**
   Full stops have now been added to all bullet points.
2) **Page 3, line 38. This last line, 1-should say 'to our knowledge no literature exists …' Do you mean 'the majority of published literature sheds light on the impact of medical personnel, though to our knowledge no literature exists…'?**
   Yes, this has been changed as suggested.
3) **Page 3. Opening sentence of last paragraph too long. Break into two sentences**
   This has been amended.

4) **Page 6-line 16. It is not clear for which city, Istanbul or Gaziantep, the description of 97 km north of Allepo is suited.**
   This has been clarified:
   > *Istanbul and Gaziantep, the latter being a city 97km north of Aleppo, Syria…*
5) **Page 6, line 35- last sentence of paragraph-clarify the impact on whom of conducting therapy on Syrian MHP's ? -the client or MHP, please make sentence clearer**
   This has been made clearer:
   > *The study aimed to investigate the impact of the shared culture and experiences of forced displacement on Syrian MHPs*
6) **Page 6-line 42-purposive sampling is stated as recruitment strategy- can you provide a sentence or two with more details-how were they recruited, from where? Word of mouth, poster?**
   This information has been added:
   > *Participants were recruited through Trauma Aid UK's mailing list and word of mouth.*
7) **Page 6, line 45 'Working', not 'work**
   This has now been amended.
8) **Page 7 line 42 . only one interview was independently decoded? Or more-why was one chosen?**
   Given the interpretive nature of qualitative research methodologies, there are no 7tandardized methods to ensure rigour across qualitative studies [see 1]. We decided it was good practice to check reliability of coding. One interview transcript was chosen at random to be independently coded by a peer researcher (this has now been made clearer in the manuscript. As far as we are aware, there is no guideline on size of the sample of transcript to independently code and as such, decisions are often guided by feasibility and practicality. Given that this work was conducted as part of the first author's doctorate, there was a limited timeframe and limited resources to conduct more than one transcript.
9) **Can you check all spelling of MHPs for grammatically accuracy-currently sometimes spelt as MHP's sometimes MHPs and other MHPs'**
   MHP's in the thematic map has been changed from MHPs experience to MHPs' experience.
10) **Page 17 line 37-47, can you link and say how these two studies parallel with yours?**
    This has now been added, see below:
    > *These mirror this study's findings, where fulfilment and distress emerged as parallel themes relating to the overarching theme of the personal impact of therapy. There is a need to shed more light and understanding on the coexistence and interaction of the positive and negative impacts, particularly where there is a shared reality. The concept of a shared resilience in a traumatic reality goes some way in understanding this, yet this concept has not been addressed sufficiently [15].*
11) **Page 18 line 10, Provide a definition of what using countertransference therapy positively means**
12) **Page 18, line 37-Spell out EMDR and TF-CBT**
    EMDR has now been spelled out where it first appears and TF-CBT has been spelled out as trauma focussed cognitive behavioural therapy given that it only appears once.
13) **Page 21, line 50 spell out UN**
    This has now been spelled out as the United Nations.
14) **Space before bracket of reference, page 3, line 37**
    This has now been amended as suggested.

Reviewer 2

We would like to thank Andres Barkil-Oteo for his helpful comments. We present our responses to his comments:

1) **The term "forcibly displaced" is used throughout the manuscript. It's technically correct as forcibly displaced encompasses internally displaced (people inside Syria), and refugees (people who crossed an international border). I agree with this use as not everyone in this sample (providers and patients) could be technically refugees. However, it may create confusion among readers. I wonder if there should be a note explaining the rationale behind using this term.**
   Thank you for bringing this to our attention. We have added a sentence to explain our use of this term after its first appearance in the introduction:
   > *The term 'forcibly displaced' is used throughout this paper to capture those who are seeking asylum as well as refugees.*
2) **The authors attempt to relate this study to the EMDR training provided by Trauma Aid UK. Two examples:**
   a. **Page 6, line 3: "to understand how their training is translated within a Syrian culture and displacement context, while seeking better understanding of the potential harmful emotional impact given their own background and settings."**
   b. **The same statement repeated in line page6 line28, but with a focus on the objectives of this study (without the training effectiveness part). It's not clear to the reader whether this study aims to evaluate the training, or it is part of a bigger project to evaluate the training**

   Page 20, line 42: "This snapshot of Syrian MHPs suggestions [suggests a helpful model of training Syrians with a mental health background to provide therapy to Syrians within the community as a way to promotes understanding and empathy while reducing cultural and language barriers."
   There is a weak link between the findings and the training program. Especially that the training curriculum is not explained in the manuscript for the reader to understand (number and type of sessions, duration, themes, etc.) I appreciate that there are some overlapping themes, but authors need to be cautious as the benefits experienced by therapists could have come from different sources, including the training.
   I suggest to the authors either to make the connection more explicit and to explain the different components of the training or to minimize the link to the program and the benefits of said program on the therapists. This seems to be a good research question for a different project, especially that the clinicians were never asked explicitly about the program per se.
   We thank the reviewer for this insightful comment. While this research was done in collaboration with Trauma Aid UK, it was by no means intended to be an evaluation of the training programme. Instead, Trauma Aid UK simply gave us access to community members who were trained in an evidence-based therapy (according to UN and WHO guidelines). The first author, the interviewer of all participants, was explicit in minimising this link and letting participants know that this research is being conducted separately to any activities that Trauma Aid UK would be conducting. As such, we will minimise this link between the training programme to avoid inadvertently misleading readers into thinking that we refer specifically to EMDR training as a helpful model and linking it to the themes. We outline the multiple steps we took below to minimise this link:
   > *Trauma Aid UK, an INGO who provide specialist trauma training for Syrian health professionals in Turkey facilitated the recruitment of participants in this study.*
   > *This research aims to generate knowledge carved directly from Syrian MHPs trained to provide different evidence-based therapies through communicating with them in their native Arabic language to understand how their experience of providing therapy within a Syrian culture and displacement context. It also seeks to better understand the potential harmful emotional impact given their own background and setting.*

The findings from this snapshot of Syrian MHPs may suggest that training local Syrians with a mental health background to provide therapy to Syrians within the community is a helpful way to promote understanding and empathy while reducing cultural and language barriers, as suggested by best practice in mental health and psychosocial support service provision guidelines [6-8].

Reviewer 3

Next we thank Felicity Brown for her in-depth review and suggestions. Please see our responses outlined below.

1) **Abstract**
    a. **The analytical method needs to be explained in the abstract.**
    We are unsure what the reviewer refers to here as we have included that we will use thematic analysis. We have rephrased the sentence to make this clearer:
    A qualitative study using thematic analysis of in-depth semi-structured interviews to explore shared realities, self-disclosure and the impact of providing therapy.
    b. **The results are presented in terms of frequency of experiences, rather than themes, and do not provide much depth of findings. It's important not to present qualitative results as quantitative findings.**
    We thank the reviewer for this comment. While the analytic approach was not intended to be based on frequencies, we wanted to include them as an additional feature to avoid giving the impression that all or even most participants adhered to all (sub-)themes and therefore to give readers a more accurate representation. Our thematic approach was conducted in line with all six steps suggested by Braun and Clarke [2]. Given that this was the first study to explore this topic, the questions were broad and did not attempt to go into great detail into particular aspects, rather, they touched on all the relevant themes. We have removed references to specific frequencies in the abstract and throughout the text.
2) **Background-**
Overall, I recommend that the background section be re-written for clarity of several key points, and flow.
    a. **Line 37- it is unclear what these violations are, if separate to attacks on health facilities.**
    This line has now been made clearer:
    …ongoing systematic violations of international humanitarian law, including the use of missiles, sniper and chemical attacks on hospitals and ambulances and the torture of health care workers [4,5].
    b. **Page 2, line 8- why are there low supervision rates in such a situation?**
    We have included an explanation for this:
    …with reduced opportunities for supervision given the lack of qualified supervisors relative to demand…
    c. **The research aims outlined at the end of the introduction, are quite broad: exploring the context of the shared reality of the Syrian MHP-client dyad, exploring what allows Syrian MHPs to continue in their work as a healer, exploring what coping consists of in this context, understanding how their training is translated within a Syrian culture and displacement context, and seek better understanding of potential harmful emotional impacts. These aims are quite leading, and unclear. They are also different to the aims presented in the methods: *The study aimed to investigate the impact of the shared culture and experiences of forcibly displaced Syrian MHPs and their Syrian clients, the incidence and impact of MHPs' disclosure of shared experiences and the***

impact of providing therapy on Syrian MHPs. **I recommend presenting the aims in a more concise, consistent, and clear way.**

We thank the reviewer for bringing this to our attention. We have rephrased the aims outlined in the end of the introduction. They are broad by nature given that to our knowledge there are no other studies investigating shared reality of Syrian MHP and client. However, we have presented the aims more concisely as outlined below, briefly in the background section and then more specifically in the methods section.

In the background section: *This research aims to generate knowledge carved directly from Syrian MHPs trained to provide different evidence-based therapies through communicating with them in their native Arabic language to explore their experience of providing therapy within a shared Syrian culture and displacement context.*

In the methods section: *The study aimed to (1) investigate the nature and influence of the shared culture and experiences of forced displacement within the Syrian MHP-client dyad (2) explore the nature and impact of MHPs' disclosure of shared experiences and (3) examine the impact of providing therapy on MHPs and the associated means of coping*

Furthermore, for incidence-related questions, I would argue that qualitative research is not the best research method.

To avoid misunderstandings that we investigating frequency of disclosure or any other concept within this research, we have rephrased the sentence where this occurs:

…., the nature and impact of MHPs' disclosure of shared experiences and the impact of providing therapy on Syrian MHPs…

Methods

1) **Line 45- don't need to repeat that Turkey is host to the largest number of Syrians**
   This line has been removed.
2) **In terms of ethics and consent, it is important to specify what participants were told about confidentiality of data. This is particularly important since participants are health professionals, and are being asked to describe professional experiences and challenges. Were they told under which circumstances (if any) the interviewer might disclose information relating to their professional capability, in the instance of safety concerns?**
   We did not include circumstances of disclosure within the confidentiality agreement and this was not required by our institution's ethics committee. Given that our participants were not classed as vulnerable and were all practising professionals we did not deem this as necessary, especially as it may have changed the power dynamics at interview therefore potentially affecting the richness of data. Of course, in the event of safety concerns (there were none) we would have taken the necessary actions. In the information sheet and consent form, participants were aware of the nature of the questions they would be asked and that all the information given was treated as confidential and kept in accordance with the UK Data Protection Act (1998). They were aware that the information would be stored securely and encrypted, and that all information would be anonymised. This was reiterated during interview stage. This has been included in the methods section:
   Participants were aware that all information they provided would be encrypted and stored securely and that all information would be anonymised.
3) **How were MHP's identified and recruited? It is mentioned as a limitation that they are largely recruited through the INGO**
   The method of recruitment has now been indicated as through the mailing list of the INGO and word of mouth.

4) **MHPs in such settings can have varied backgrounds, trainings, and job roles. It is necessary to specify their characteristics further in the methods section, rather than waiting until results section.**
This has now been amended, and the sample characteristics have been included in the 'Participants' section within the methods.
5) **More information on the topics asked about in the interview guides would be helpful to provide a clear sense of the interview context from which the data is arising.**
As per the reviewer's suggestion, we have included some questions that were on the interview within the text describing the nature of the interview schedule:

> *…a beginning (such as 'In what way do you experience similarities between you and your clients?'), in which the setting was described, a middle which contains a series of obstacles and attempted solutions (e.g. 'Do you talk with your clients about your own experiences?') and an ending or resolution (for example 'What resources do you draw on that help with the challenging aspects of doing therapy?')*

6) **Line 35- it would be clearer to list transcription/translation process before coding process.**
This sentence has now been amended to the following:

> *A thematic analysis was conducted by AH using an inductive approach following the six steps recommended by Braun and Clarke [32] using NVivo 11 software. AH and two bilingual British Syrian health professionals transcribed the interview from Arabic audio to English script and each script was read and reread and systematically coded, giving full and equal attention to each item*

Results

1) **The sections on barriers and facilitators is unclear, and seems to be related to barriers and facilitators to providing mental health services in such settings? Since this was not one of the research questions, this section feels a bit out of place. I recommend situating it more clearly, and making it more concise.**
We have amended this section and provided an explanation of it so that it no longer feels out of place but remains as it is important given that most people do not have a sense of the context that Syrian MHPs are working in in Turkey. First of all, we have removed information about the sample and placed in the methods section as suggested. Second, we have included an introductory sentence to describe this section:

> *Prior to presenting the main themes emerging from the interviews, the context in which the Syrian MHPs described working is presented here*.

We have also specified that here we are talking about barriers and facilitators to mental health care provision, for example:

> *Syrian MHPs spoke of a number of facilitators to mental health provision.*

2) **The thematic map of the themes is clear and is a strength of the paper.**
We thank the reviewer for her comment.
3) **When reporting the results, it's important not to try to draw quantitative conclusions from qualitative data. I would also prefer to see more linking etween the findings, and more explanation of the findings. At times, the description of the findings within the theme is very brief, with several quotes then presented in a list format. I would prefer to see the findings elaborated more and linked together.**
We thank the reviewer for her comment. As mentioned above, our analytic approach was not intended to be based on frequencies, and all steps taken were based on Braun & Clarke's [2] analytical approach. We decided to include quantities while reporting themes as an additional feature, to give readers a sense of the endorsement of each theme. To avoid any potential misunderstanding from readers, we have removed specific quantities when reporting the results in text. We agree that the descriptions within themes are rather

brief, this was formatted for the purposes of this journal. We have however included a few elaborations and linked themes together, examples are below:

> *Syrian MHPs lived through war and were forcibly displaced themselves and directly and indirectly experienced traumatic events. This enabled them to empathise with clients' experience. All referred to this as an asset creating better understanding and trust within therapy.*
>
> *As well as having shared experiences, Syrian MHPs shared the language and culture of their clients. MHPs commented on how their nuanced understanding of Syrian dialects allows them to link a clients' dialect to their cultural, religious, political and social contexts.*
>
> *MHPs also mentioned feeling shocked by the traumatic experiences that their clients endured. This shock often came with MHPs empathising and bearing witness to the reality that individuals experienced such atrocities, rather than seeing them ass abstract events spoken about or reported in media outlets.*

Discussion-

1) **The discussion links the current findings to past research very well. I feel that it could be reviewed to ensure that it flows effectively throughout, and is as concise as possible.**

   We thank the reviewer for their comment. We have reviewed the discussion and ensured that it is concise and flows. We have removed reference to specific quantities of participants when linking to the findings. As well as the revisions we have made on the basis of the reviewer's comments below, we have included a section to more explicitly link current findings to past research:

   > *These mirror this study's findings, where fulfilment and distress emerged as parallel themes relating to the overarching theme of the personal impact of therapy. There is a need to shed more light and understanding on the coexistence and interaction of the positive and negative impacts, particularly where there is a shared reality. The concept of a shared resilience in a traumatic reality goes some way in understanding this, yet this concept has not been addressed sufficiently [15].*

2) **The end of the discussion could more powerfully focus the findings and situate it within the larger context. As it stands, the concluding paragraphs make more general statements about the broader MH field in humanitarian settings, rather than directly link the findings of this study. Best practice in MHPSS service provision includes training and supervising local mental health professionals to deliver services, in order to promote contextually relevant services, and ensure sustainability. This study explored several benefits and challenges in the therapeutic process. It highlights that there are several positive experiences of the shared traumatic reality between MHP and client, but also that considerations around MHP support are needed. One quote from a MHP suggests that disclosing that the therapist and client were both from similar settings was helpful in building trust. It therefore seems important to consider the potential harm that would exist if Syrian MHPs are from different backgrounds to their Syrian clients. This is one aspect where the shared refugee status can be incredibly helpful, but also has the potential to be detrimental to trust.**

   We thank the reviewer for her insights. On the point of Syrian MHPs coming from different backgrounds to their clients, we agree that this would be detrimental to trust particularly if these differences are based on their views and experiences towards parties to the conflict. Given that within this context, access to mental health services is based on recommendations and word of mouth rather than as part of a statutory service, Syrian clients would actively choose Syrian MHPs with similar views towards parties to the conflict and indeed all respondents in this study

were forcibly displaced and so there were no Syrian MHPs who were pro-government. We believe that as our research focusses on similarities, this would be a very interesting question for future research, perhaps one that could only be explored if research were to be carried within Syria.

We believe we have linked our findings to the larger context through the UN's sustainable goals. We now additionally linked this more specifically to the larger context of the best practice in MHPSS service provision as suggested by the reviewer and as mentioned in our introduction,

> *The findings from this snapshot of Syrian MHPs may suggest that training local Syrians with a mental health background to provide therapy to Syrians within the community is a helpful way to promote understanding and empathy while reducing cultural and language barriers, as suggested by best practice in mental health and psychosocial support service provision guidelines [6-8].*

While have already linked a number of findings in the last two paragraphs including emotional vulnerability of Syrian MHPs and the need for supervision, peer support and self-care, we have additionally included a suggestion based on our findings linking this to the larger context of the international Syrian refugee crisis:

> *Given the international refugee crisis as a result of the Syrian conflict, Syrian MHPs are very well placed to support and advise other MHPs who work with Syrians. It would be worthwhile for Syrian MHPs to provide seminars, lectures, workshops and consultations on the provision of culturally appropriate and sensitive support for Syrians*

3) **Page 20, line 35- why is the MH provision likely to differ significantly in other settings of displaced Syrian refugees, such as Lebanon or Jordan? More clarification of this statement is needed.**

This point has now been made clearer, it reads:

> *It would be worthwhile to extend this research to other contexts where Syrians are forcibly displaced, such as in Jordan, Lebanon, Germany and within Syria. Mental health provision is likely to differ in each of these contexts given the differences in the numbers of forcibly displaced Syrians, the majority language and culture of the country, the socio-political context and the available resources; further research could shed light on this.*

4) **Page 20, Line 42- the current findings do not directly suggest that any model of training is helpful, nor that any method of service delivery is sustainable.**

We agree that the findings do not directly suggest this, however given that all Syrian MHPs expressed fulfilment regardless of the negative emotional impact, that their shared culture and language as a tool and strength in therapy, we believe that our findings support the notion of training Syrian MHPs to provide therapy to fellow Syrians and that this would in time be sustainable as Syrian MHPs gain enough experience to become supervisors themselves (rather than bringing in Turkish/ international healthcare professionals and interpreters and so on). We have amended this sentence to suggest a less direct link**.**

> *…The findings from this snapshot of Syrian MHPs may suggest that training local Syrians with a mental health background to provide therapy to Syrians within the community is a helpful way to promote understanding and empathy while reducing cultural and language barriers.*

5) **An important limitation to elaborate more on is that if MHPs are largely recruited through their employer, there may be reluctance to disclose challenges they are facing (as the authors highlight), but also they may be reluctant to openly discuss the use of personal disclosure or boundary violations, or other work related experiences**.

We have now included the following sentence within the limitations section:

Although a number of participants did discuss the challenges they faced, boundary violations and personal disclosure, this may have created more of a reluctance in openly discussing such topics.

Reviewer 4

Finally, we thank Lloy Wylie for her comments. Our responses are presented below. See file attached (bmjopen-2019-034291_Proof_hi.pdf)

1) **p5 line 6 - should read "and often relates TO MHP's"**
   This has been changed as suggested.
2) **p5 line 13 - should read "LEAD to burnout"**
   This has been changed as suggested.
3) **p6 line 45 - should read "worldwide, WHO work with Syrian"**
   This sentence has been removed due to repetitiveness as per Reviewer 3's suggestion.
4) **p8 line 40 - "number of barrierS" (add S)**
   This has been added.
5) **p17 line 45 - use of co-occur twice - may want to say "showed the positive changes co-occur alongside"**
   This has been changed to "…showed the positive changes co-occurred alongside…"
6) **p20 line 35 - should read "likely to differ FROM other contexts"**
   This has been amended.
7) **p20 - line 47 PROMOTE understanding (remove S from promotes)**
   This has been amended.
8) **It would be good to reflect on how these Syrian MHP could be a resource for other MHP who work with Syrians (Could they educate other health care providers, so they are not the only ones able to provide appropriate care for Syrian refugees)?.**
   We thank the reviewer for her insightful comment. We have included this now as an implication, as we believe that Syrian MHPs could be a vital resource given that they have both a heath professional background and in-depth knowledge and experience of the cultural and political contexts from which forcibly displaced Syrians come. We have included this in the manuscript:

   Given the international refugee crisis as a result of the Syrian conflict, Syrian MHPs are very well placed to support and advise other MHPs who work with Syrians. It would be worthwhile for Syrian MHPs to provide seminars, lectures, workshops and consultations on the provision of culturally appropriate and sensitive support for Syrians.

9) **One issue that is not addressed could be the challenges of being both care provider and interpreter in team-care settings. Did this come up at all in the study?**
   We thank the reviewer for raising this important point. Sadly this did not come up in the study due to the fact that, in this particular context, there was no direct liaison with Turkish healthcare providers. In all of these cases, Syrians would be providing healthcare separately (usually within an NGO or INGO).

References

[1] Belotto MJ. Data analysis methods for qualitative research: Managing the challenges of coding, interrater reliability, and thematic analysis. The Qualitative Report. 2018 Nov 1;23(11):2622-33.

[2] Braun V Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77-101.

VERSION 2 – REVIEW

REVIEWER	Andres Barkil-Oteo American University of Beirut Beirut, Lebanon
REVIEW RETURNED	02-Mar-2020

GENERAL COMMENTS	None, authors addressed all concerns

REVIEWER	Felicity Brown War Child Holland, The Netherlands
REVIEW RETURNED	03-Mar-2020

GENERAL COMMENTS	**The revised manuscript is significantly stronger and clearer. It presents an interesting study, with important implications.** **I have responded to each of the responses below. I have just a few minor additional adjustments to suggest.** **1) Abstract** **a. The analytical method needs to be explained in the abstract.** We are unsure what the reviewer refers to here as we have included that we will use thematic analysis. We have rephrased the sentence to make this clearer: A qualitative study using thematic analysis of in-depth semi-structured interviews to explore shared realities, self-disclosure and the impact of providing therapy. **My apologies that the comment was not clear, however I was referring to the need to outline how analysis was conducted (since this can vary in qualitative analysis). However, I'm satisfied with the revised Design section as I feel this provides sufficient explanation.** **b. The results are presented in terms of frequency of experiences, rather than** **themes, and do not provide much depth of findings. It's important not to present**

	qualitative results as quantitative findings. We thank the reviewer for this comment. While the analytic approach was not intended to be based on frequencies, we wanted to include them as an additional feature to avoid giving the impression that all or even most participants adhered to all (sub-)themes and therefore to give readers a more accurate representation. Our thematic approach was conducted in line with all six steps suggested by Braun and Clarke [2]. Given that this was the first study to explore this topic, the questions were broad and did not attempt to go into great detail into particular aspects, rather, they touched on all the relevant themes. We have removed references to specific frequencies in the abstract and throughout the text. **This has strengthened the reporting of results.** **2) Background-** **Overall, I recommend that the background section be re-written for clarity of several key points, and flow.** **a. Line 37- it is unclear what these violations are, if separate to attacks on health** **facilities.** This line has now been made clearer: …ongoing systematic violations of international humanitarian law, including the use of missiles, sniper and chemical attacks on hospitals and ambulances and the torture of health care workers [4,5]. **This is clearer now.** **b. Page 2, line 8- why are there low supervision rates in such a situation?** We have included an explanation for this:

	…with reduced opportunities for supervision given the lack of qualified supervisors relative to demand… **This is clearer now. However in this paragraph (2nd paragraph, line 35) there is reference to 'specialist services', but then reference to training community workers. Is this referring to training non-specialist individuals to provide psychological support? The references are for mhGAP materials, which are geared towards training non-specialists to deliver MHPSS. In this case, I would include specific reference to 'task-shifting' approaches, and an explicit explanation of what this means- i.e. increasing availability of providers, by training non-specialists to deliver psychological interventions, with supervision and training from specialists. This then makes your point about lack of supervision clearer.** **But if this is the case, then there is a need to change the word "specialist", as these services are, by definition, not specialist services. "targeted" may be a better word.** **However, there is also a need to consider how this fits with the current study, since the participants in this study are specialists (psychologists and psychiatrists). So perhaps this paragraph needs reworking.** **c. The research aims outlined at the end of the introduction, are quite broad:** **exploring the context of the shared reality of the Syrian MHP-client dyad,** **exploring what allows Syrian MHPs to continue in their work as a healer, exploring** **what coping consists of in this context, understanding how their training is** **translated within a Syrian culture and displacement context, and seek better** **understanding of potential harmful emotional impacts. These aims are quite** **leading, and unclear. They are also different to the aims presented in the methods:**

	The study aimed to investigate the impact of the shared culture and experiences of **forcibly displaced Syrian MHPs and their Syrian clients, the incidence and impact of** **MHPs' disclosure of shared experiences and the impact of providing therapy on** **Syrian MHPs. I recommend presenting the aims in a more concise, consistent, and** **clear way.** We thank the reviewer for bringing this to our attention. We have rephrased the aims outlined in the end of the introduction. They are broad by nature given that to our knowledge there are no other studies investigating shared reality of Syrian MHP and client. However, we have presented the aims more concisely as outlined below, briefly in the background section and then more specifically in the methods section. In the background section: This research aims to generate knowledge carved directly from Syrian MHPs trained to provide different evidence-based therapies through communicating with them in their native Arabic language to explore their experience of providing therapy within a shared Syrian culture and displacement context. In the methods section: The study aimed to (1) investigate the nature and influence of the shared culture and experiences of forced displacement within the Syrian MHP-client dyad (2) explore the nature and impact of MHPs' disclosure of shared experiences and (3) examine the impact of providing therapy on MHPs and the associated means of coping **This is clearer now.**

	I recommend rephrasing the aim in the introduction, for clarity, to: "This research aims to generate knowledge carved directly from Syrian MHPs ~~trained to provide different evidence-based therapies through communicating with them in their native Arabic language to explore their~~ experiences of providing therapy within a shared Syrian culture and displacement context. **I recommend, for accuracy, rephrasing the third aim in the methods to:** **(3) examine the perceived impact of providing therapy on MHPs and the associated means of coping.** **Furthermore, for incidence-related questions, I would argue that qualitative** **research is not the best research method.** To avoid misunderstandings that we investigating frequency of disclosure or any other concept within this research, we have rephrased the sentence where this occurs: …., the nature and impact of MHPs' disclosure of shared experiences and the impact of providing therapy on Syrian MHPs… **This is clearer now.** **Methods** **1) Line 45- don't need to repeat that Turkey is host to the largest number of Syrians** This line has been removed. **2) In terms of ethics and consent, it is important to specify what participants were told about confidentiality of data. This**

	is particularly important since participants are health professionals, and are being asked to describe professional experiences and challenges. Were they told under which circumstances (if any) the interviewer might disclose information relating to their professional capability, in the instance of safety concerns? We did not include circumstances of disclosure within the confidentiality agreement and this was not required by our institution's ethics committee. Given that our participants were not classed as vulnerable and were all practising professionals we did not deem this as necessary, especially as it may have changed the power dynamics at interview therefore potentially affecting the richness of data. Of course, in the event of safety concerns (there were none) we would have taken the necessary actions. In the information sheet and consent form, participants were aware of the nature of the questions they would be asked and that all the information given was treated as confidential and kept in accordance with the UK Data Protection Act (1998). They were aware that the information would be stored securely and encrypted, and that all information would be anonymised. This was reiterated during interview stage. This has been included in the methods section: Participants were aware that all information they provided would be encrypted and stored securely and that all information would be anonymised. **It is a good addition about data confidentiality.** **However, I think that this issue is important to expand upon for 2 reasons.** **Firstly, I feel it's important to consider reporting expectations and duty of care, of the implementing organization. For example, if it appeared that a particular MHP was not providing sound services, would this have been disclosed to the employer? If this was not discussed prior to the research, then it's OK to omit from the paper.** **Secondly, were participants told about confidentiality of their responses, in a broader sense than safe data storage. E.g. That their responses would not be discussed with their employer, and that when results are presented, their identity will be concealed? If not, this may have significant influence on responses provided. I recommend that a comment on this is added to the manuscript**

	3) How were MHP's identified and recruited? It is mentioned as a limitation that they are largely recruited through the INGO The method of recruitment has now been indicated as through the mailing list of the INGO and word of mouth. **This is clearer now.** **4) MHPs in such settings can have varied backgrounds, trainings, and job roles. It is** **necessary to specify their characteristics further in the methods section, rather than waiting until results section.** This has now been amended, and the sample characteristics have been included in the 'Participants' section within the methods. **This is clearer, however there is repetition between the first and last sentences of this paragraph now. I recommend replacing the first sentence, with the last sentence:** **"The participants consisted of 16 forcibly displaced Syrian MHPs residing in** **Turkey aged between 24 and 54 years (M = 35, SD = 8.3), 8 males and 8 females, 12 psychologists and 4 psychiatrists."** **5) More information on the topics asked about in the interview guides would be helpful to provide a clear sense of the interview context from which the data is arising.** As per the reviewer's suggestion, we have included some questions that were on the interview within the text describing the nature of the interview schedule: …a beginning (such as 'In what way do you experience similarities between you and your clients?'), in which the setting was described, a middle which contains a series of obstacles and attempted solutions (e.g. 'Do you talk with your clients

	about your own experiences?') and an ending or resolution (for example 'What resources do you draw on that help with the challenging aspects of doing therapy?') **This is clearer now.** **6) Line 35- it would be clearer to list transcription/translation process before coding process.** This sentence has now been amended to the following: A thematic analysis was conducted by AH using an inductive approach following the six steps recommended by Braun and Clarke [32] using NVivo 11 software. AH and two bilingual British Syrian health professionals transcribed the interview from Arabic audio to English script and each script was read and reread and systematically coded, giving full and equal attention to each item **This is clearer now.** **Results** **1) The sections on barriers and facilitators is unclear, and seems to be related to barriers and facilitators to providing mental health services in such settings? Since this was not one of the research questions, this section feels a bit out of place. I recommend situating it more clearly, and making it more concise.** We have amended this section and provided an explanation of it so that it no longer feels out of place but remains as it is important

	given that most people do not have a sense of the context that Syrian MHPs are working in in Turkey. First of all, we have removed information about the sample and placed in the methods section as suggested. Second, we have included an introductory sentence to describe this section: Prior to presenting the main themes emerging from the interviews, the context in which the Syrian MHPs described working is presented here. We have also specified that here we are talking about barriers and facilitators to mental health care provision, for example: Syrian MHPs spoke of a number of facilitators to mental health provision. **This helps situate this paragraph.** **2) The thematic map of the themes is clear and is a strength of the paper.** We thank the reviewer for her comment. **3) When reporting the results, it's important not to try to draw quantitative conclusions from qualitative data. I would also prefer to see more linking between the findings, and more explanation of the findings. At times, the description of the findings within the theme is very brief, with several quotes then presented in a list format. I would prefer to see the findings elaborated more and linked together.** We thank the reviewer for her comment. As mentioned above, our analytic approach was not intended to be based on frequencies, and all steps taken were based on Braun & Clarke's [2] analytical approach. We decided to include quantities while reporting themes as an additional feature, to give readers a sense of the endorsement of each theme. To avoid any potential misunderstanding from readers, we have removed specific quantities when reporting the results in text. We agree that the descriptions within themes are rather brief, this was formatted for the purposes of this journal. We have however included a few elaborations and linked themes together, examples are below: Syrian MHPs lived through war and were forcibly displaced themselves and directly and indirectly experienced traumatic events. This enabled them to

	empathise with clients' experience. All referred to this as an asset creating better understanding and trust within therapy. As well as having shared experiences, Syrian MHPs shared the language and culture of their clients. MHPs commented on how their nuanced understanding of Syrian dialects allows them to link a clients' dialect to their cultural, religious, political and social contexts. MHPs also mentioned feeling shocked by the traumatic experiences that their clients endured. This shock often came with MHPs empathising and bearing witness to the reality that individuals experienced such atrocities, rather than seeing them ass abstract events spoken about or reported in media outlets. **This is stronger now.** **Discussion-** **1) The discussion links the current findings to past research very well. I feel that it could be reviewed to ensure that it flows effectively throughout, and is as concise as possible.** We thank the reviewer for their comment. We have reviewed the discussion and ensured that it is concise and flows. We have removed reference to specific quantities of participants when linking to the findings. As well as the revisions we have made on the basis of the reviewer's comments below, we have included a section to more explicitly link current findings to past research: These mirror this study's findings, where fulfilment and distress emerged as parallel themes relating to the overarching theme of the personal impact of therapy. There is a need to shed more light and understanding on the coexistence and interaction of the positive and negative impacts, particularly where there is a shared reality. The concept of a shared resilience in a traumatic reality goes some way in understanding this, yet this concept has not been addressed sufficiently [15].

	The discussion is significantly stronger and clearer now. **2) The end of the discussion could more powerfully focus the findings and situate it within the larger context. As it stands, the concluding paragraphs make more general statements about the broader MH field in humanitarian settings, rather than directly link the findings of this study. Best practice in MHPSS service provision includes training and supervising local mental health professionals to deliver services, in order to promote contextually relevant services, and ensure sustainability. This study explored several benefits and challenges in the therapeutic process. It highlights that there are several positive experiences of the shared traumatic reality between MHP and client, but also that considerations around MHP support are needed. One quote from a MHP suggests that** **disclosing that the therapist and client were both from similar settings was helpful in building trust. It therefore seems important to consider the potential harm that would exist if Syrian MHPs are from different backgrounds to their Syrian clients. This is one aspect where the shared refugee status can be incredibly helpful, but also has the potential to be detrimental to trust.** We thank the reviewer for her insights. On the point of Syrian MHPs coming from different backgrounds to their clients, we agree that this would be detrimental to trust particularly if these differences are based on their views and experiences towards parties to the conflict. Given that within this context, access to mental health services is based on recommendations and word of mouth rather than as part of a statutory service, Syrian clients would actively choose Syrian MHPs with similar views towards parties to the conflict and indeed all respondents in this study were forcibly displaced and so there were no Syrian MHPs who were pro-government. We believe that as our research focusses on similarities, this would be a very interesting question for future research, perhaps one that could only be explored if research were to be carried within Syria. We believe we have linked our findings to the larger context through the UN's sustainable goals. We now additionally linked this more specifically to the larger context of the best practice in MHPSS service provision as suggested by the reviewer and as mentioned in our introduction, The findings from this snapshot of Syrian MHPs may suggest that training local

	Syrians with a mental health background to provide therapy to Syrians within the community is a helpful way to promote understanding and empathy while reducing cultural and language barriers, as suggested by best practice in mental health and psychosocial support service provision guidelines [6-8]. While have already linked a number of findings in the last two paragraphs including emotional vulnerability of Syrian MHPs and the need for supervision, peer support and selfcare, we have additionally included a suggestion based on our findings linking this to the larger context of the international Syrian refugee crisis: Given the international refugee crisis as a result of the Syrian conflict, Syrian MHPs are very well placed to support and advise other MHPs who work with Syrians. It would be worthwhile for Syrian MHPs to provide seminars, lectures, workshops and consultations on the provision of culturally appropriate and sensitive support for Syrians **The discussion is significantly stronger and clearer now** **3) Page 20, line 35- why is the MH provision likely to differ significantly in other settings of displaced Syrian refugees, such as Lebanon or Jordan? More clarification of this statement is needed.** This point has now been made clearer, it reads: It would be worthwhile to extend this research to other contexts where Syrians are forcibly displaced, such as in Jordan, Lebanon, Germany and within Syria. Mental health provision is likely to differ in each of these contexts given the differences in the numbers of forcibly displaced Syrians, the majority language and culture of the country, the socio-political context and the available resources; further research could shed light on this. **This is stronger now.**

	4) Page 20, Line 42- the current findings do not directly suggest that any model of training is helpful, nor that any method of service delivery is sustainable. We agree that the findings do not directly suggest this, however given that all Syrian MHPs expressed fulfilment regardless of the negative emotional impact, that their shared culture and language as a tool and strength in therapy, we believe that our findings support the notion of training Syrian MHPs to provide therapy to fellow Syrians and that this would in time be sustainable as Syrian MHPs gain enough experience to become supervisors themselves (rather than bringing in Turkish/ international healthcare professionals and interpreters and so on). We have amended this sentence to suggest a less direct link. …The findings from this snapshot of Syrian MHPs may suggest that training local Syrians with a mental health background to provide therapy to Syrians within the community is a helpful way to promote understanding and empathy while reducing cultural and language barriers. **This captures the nuance of the findings much more clearly now.** **5) An important limitation to elaborate more on is that if MHPs are largely recruited through their employer, there may be reluctance to disclose challenges they are facing (as the authors highlight), but also they may be reluctant to openly discuss the use of personal disclosure or boundary violations, or other work related experiences.** We have now included the following sentence within the limitations section: Although a number of participants did discuss the challenges they faced, boundary violations and personal disclosure, this may have created more of a reluctance in openly discussing such topics. **This is stronger now.** **On page 25, line 56, I would also edit the opening sentence of the paragraph to read:**

	"Syrian MHPs in this study reported using self-disclosure cautiously while maintaining professional boundaries"

REVIEWER	Lloy Wylie Western University, Canada
REVIEW RETURNED	02-Apr-2020

GENERAL COMMENTS	The authors have done a thorough job addressing all of the comments of the reviewers, and have produced a higher quality piece. I recommend publication of this new version.

VERSION 2 – AUTHOR RESPONSE

Reviewer requests

We thank Felicity Brown for her comments and insightful approach. We outline the steps we took below to address any outstanding issues.

1) **Background**
   a) **In Page 2, line 35 there is reference to 'specialist services', but then reference to training community workers. Is this referring to training non-specialist individuals to provide psychological support? The references are for mhGAP materials, which are geared towards training non-specialists to deliver MHPSS. In this case, I would include specific reference to 'task-shifting' approaches, and an explicit explanation of what this means- i.e. increasing availability of providers, by training non-specialists to deliver psychological interventions, with supervision and training from specialists. This then makes your point about lack of supervision clearer. But if this is the case, then there is a need to change the word "specialist", as these services are, by definition, not specialist services. "targeted" may be a better word. However, there is also a need to consider how this fits with the current study, since the participants in this study are specialists (psychologists and psychiatrists). So perhaps this paragraph needs reworking.**
   Thank you alerting us to this. The mhGAP and IASC materials are used here because they refer to the recommendation of referring clients for evidence-based trauma therapies (EMDR and TF-CBT) where trained and supervised therapists are available. We realise this sentence is confusing due to the use of "local community workers" which has become widely known in the literature to refer to non-specialists. We have therefore omitted this phrase and restructured to the following:
   …where specialist support is required, guidelines recommend referring clients for evidence-based trauma therapies such as eye movement desensitisation and reprocessing (EMDR) and trauma-focussed cognitive behavioural therapy where trained and supervised therapists are available [6-8].
   This now fits with the rest of the paragraph referring to the provision of training and supervision in evidence-based therapy to expatriate Syrians. It also fits with our study given that although all are psychologists and psychiatrists (all trained in Syria), none had any specialised training in EMDR and TF-CBT, due to the nature of the education and training system in Syria.
   b) **I recommend rephrasing the aim in the introduction, for clarity, to: "This research aims to generate knowledge carved directly from Syrian MHPs ~~trained to provide different evidence-based therapies through communicating with them in their~~**

~~native Arabic language to explore their~~ experiences of providing therapy within a shared Syrian culture and displacement context.

This has now been incorporated as suggested.

c) **I recommend, for accuracy, rephrasing the third aim in the methods to: (3) examine the <u>perceived</u> impact of providing therapy on MHPs and the associated means of coping.**

This has now been amended as suggested.

2) **Methods**

a) **It is a good addition about data confidentiality. However, I think that this issue is important to expand upon for 2 reasons. Firstly, I feel it's important to consider reporting expectations and duty of care, of the implementing organization. For example, if it appeared that a particular MHP was not providing sound services, would this have been disclosed to the employer? If this was not discussed prior to the research, then it's OK to omit from the paper. Secondly, were participants told about confidentiality of their responses, in a broader sense than safe data storage. E.g. That their responses would not be discussed with their employer, and that when results are presented, their identity will be concealed? If not, this may have significant influence on responses provided. I recommend that a comment on this is added to the manuscript.**

Thank you for your insightful comment. The point about the potential appearance of an MHP not providing sound services was not discussed prior to the research. The participants were told that their responses would not be discussed with their employer as I made it clear that I had no affiliation with their employer and that this research would not be linked in any way with their practice with them. We have made this clear at the outset of this paragraph and have included the following:

Participants were aware prior to interview that participation was entirely voluntary, that the interviewer was not affiliated with Trauma Aid UK, and that all information provided would be encrypted, stored securely and anonymised through the use of identification codes throughout analysis and dissemination.

b) **There is repetition between the first and last sentences of this paragraph now. I recommend replacing the first sentence, with the last sentence:**
"The participants consisted of 16 forcibly displaced Syrian MHPs residing in Turkey aged between 24 and 54 years (M = 35, SD = 8.3), 8 males and 8 females, 12 psychologists and 4 psychiatrists."

This first sentence has now been replaced with the last as suggested to avoid repetition.

3) **Discussion**

a) **On page 25, line 56, I would also edit the opening sentence of the paragraph to read:**
"Syrian MHPs in this study <u>reported using</u> self-disclosure cautiously while maintaining professional boundaries"

This has been amended as suggested.

VERSION 3 – REVIEW

REVIEWER	Felicity Brown War Child Holland, The Netherlands
REVIEW RETURNED	27-Apr-2020

GENERAL COMMENTS	The authors have responded to all comments, and in my opinion the manuscript is now suitable for publication. It is an important piece of qualitative work on an important topic.