AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THERAPISTS’ PERSPECTIVES OF PREDISPOSING FACTORS OF POST TRAUMATIC STRESS DISORDER

A thesis submitted to the University of Manchester for the degree of Professional Doctorate in Counselling in the Faculty of Humanities

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ABSTRACT

An Interpretative Phenomenological Analysis of Therapists’ perspectives of Predisposing factors of Post Traumatic Stress Disorder

Background: The aim of this study was to explore the experience and sense making of therapists working with clients who present with a PTSD diagnosis. The study engaged with therapists experience and understanding of predisposing factors to PTSD and how they incorporate this understanding into the therapy process. Further to this the experience of the therapists understanding of the influence of predisposing factors on the expression of PTSD was explored.

Literature Review: A literature review is presented identifying core research relating to PTSD, predisposing factors to the development of PTSD and the treatments used when working with PTSD as a presenting issue.

Methodology: To address the aims of the study 9 therapist participants were interviewed. Semi-structured, one to one, in-depth interviews were utilised to elicit participant’s experience of the issues outlined within the aims. Interpretative Phenomenological Analysis (IPA) was used to identify re-current themes across the interviews and analyse the data, which emerged.

Findings: The main findings present thirteen sub-ordinate themes that reflect the essence of the participant’s experience of the phenomenon under investigation. These were based around eight Super-ordinate (master) themes of Previous history, Therapy relationship, Psychoeducation and Normalisation, Identity, Culture, Attachment, Presenting Therapy Themes, and Support Systems.

Discussion and Conclusion: The study identified the participant’s experience of predisposing factors on the expression of PTSD. There was consensus from the participant’s in relation to the significant impact of client’s previous life experience on their expression of PTSD. The participants further identified that the client’s previous life experience influenced their formulation and treatment of PTSD. Significant issues that were described by all of the participants regardless of their theoretical or therapeutic perspective were (1) the central importance of the therapeutic relationship, (without a strong, trusting and safe relationship the participants would not engage the therapy work), (2) the importance of in-depth history taking (identification of previous life experience and its impact on the current response to the trauma), (3) the impact of previous trauma(s), and (4) the impact of support systems, environment and identity. These issues are discussed alongside the existing literature around this topic. Additionally, suggestions for future directions of research and recommendations for practice are presented.

Key words: Post Traumatic Stress Disorder (PTSD); Predisposing Factors; Interpretative Phenomenological Analysis (IPA); Therapists viewpoint
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DEDICATION

To my father who witnessed the start of this journey but sadly not its completion, thank you for your consistent love, support and unreserved belief in me. To my mother for her love and lifelong support. My wife Maxine who has always offered me love, support and huge encouragement, thank you for all you are and give to me. To my son who makes me proud every day, I am overjoyed you are in my life.
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CHAPTER 1
INTRODUCTION

1.1 Introduction

One of the defining factors in the development of Post Traumatic Stress Disorder (PTSD) is the individuals’ experiential process. More specifically the degree of importance that perception held over the manner in which the traumatic event is experienced by the individual (Ozer, Best, Lipsey & Weiss 2003). This study addresses the impact of predisposing factors on the development and expression of PTSD. The aim of this study is to explore the experiences of therapists working with clients who present with a PTSD diagnosis. It addresses the experience of therapists and not directly with client’s experiences of PTSD. This decision was made in an attempt to understand the therapists’ wider experience of PTSD presentation rather than the singular expression of PTSD experienced by the individual client. This chapter provides a brief summary of the key relevant issues regarding PTSD, reflecting upon its history, the suggested predisposing factors to PTSD and the associated psychological treatments. In particular, relevant definitions of terms used throughout the thesis are outlined and the two main diagnostic criteria for PTSD introduced. Finally, this chapter provides a brief reflective statement outlining my personal rationale for undertaking the work and my connection to the topic as a counselling psychologist, the research questions which are utilised to harness this study and an overview of the thesis structure.

1.2 Background

1.2.1 Historical perspectives

PTSD is a relatively recent term, one that has emerged from current contexts. There is a wide-ranging historical evidence base of experiences that are now identified as PTSD; these have emerged within both military and non-military contexts.

From a historical military perspective evidence of a post traumatic response are reflected in the references to terms such as the Spanish use of *estar roto* (to be broken), and a condition named ‘soldiers’ heart’ during the American Civil War. In 1871 Jacob Da Costa published a
A paper describing several hundred cases of ‘soldiers’ heart’ in which the men suffered from palpitations, heart pain, and digestive and respiratory problems. The condition became known as Da Costa’s syndrome (Shephard, 2002).

Following the construction of the railways and the process of litigation that resulted from the disasters, which had occurred, an interest in what is now termed trauma developed. Matus (2010) identified an example of a traumatic response suffered by the author Charles Dickens. In 1865, while travelling to by train he was involved in a derailment in which many people were killed. Dickens described his experience of over-whelming terror. He also described specific symptoms of traumatic response when travelling on trains after the event where he would grip his seat and appeared to be in a trance. He subsequently wrote ‘I am not quite right within, but believe it to be an effect of the railway shaking’ (2010: 410).

Shorter, (2005) discussed the emergence of the term ‘railway spine’ and how its causes were widely debated. Two main causes were described one being proposed by English surgeon Erichson, who believed there to be an organic cause. The French neurologist Charcot proposed the other, when he described it as a form of hysteria. Two evolving terms that emerged were ‘Erichsen’s disease’, relating to ‘nervous shock’, and ‘local hysteria’, relating to ‘traumatic neurosis’ and ‘fright neurosis’.

One of the most recognizable terms to emerge that has been identified, as a key contributor to current understanding of concept of trauma was ‘shell shock’. At the start of the first world war there was evidence that 7 to 10 per cent of all officers and 3 to 4 per cent of all men involved in trench warfare were experiencing mental breakdowns (Shephard, 2002). This required new ways of integrating breakdown into medical thinking. It was at this point that psychologist Charles Meyer presented his conceptually groundbreaking definition of the term ‘shell shock’. Meyer proposed that psychological damage resulted from organic brain lesions caused by the new heavy and noisy artillery. Psychiatric treatments for the condition were developed and included both physical, Faradisation, by Lewis Yealland and psychodynamic by William Rivers, (Stone, 1985).

From a socio-political perspective there was great pressure on the government at this time. The term ‘shell shock’ was officially discredited in the Report of the War Office Committee of Enquiry into ‘Shell Shock’ (1922). The numbers of ex-service patients detained in mental
hospitals had increased from 2,506 in 1919 to 6,435 in 1922, and a huge increase in war pensions were crippling the government. It was with this backdrop broader terms such as ‘neurosis’ or ‘war neurosis’ for war-related psychological effects were introduced, as these served to limit pension costs by acknowledging additional causative factors such as individual character and prior pathology (Barham, 2004).

By the Second World War the military emphasis was firmly on both training and screening. There was an emphasis on the positivist position of contemporary psychology, and drawing specifically from industrial psychology, personality and intelligence tests formed the majority of the screening process (Shephard, 2002).

Northfield Hospital in Birmingham, requisitioned by the military in 1942 was the base for a large number of those with psychiatric problems as a result of their war experiences. Within this setting analytic military psychiatrists including Bion, Foulkes and Main were developing the concept of the group as a powerful therapeutic environment. Treatment developed focused on the level of the community rather than the individual. This process reflected the concept that, just as in war where the individual was part of a unit, so within the hospital they were part of a community and would be exposed to group influence, facilitated by the psychiatrists (Shephard, 2002). These group experiments, now famously termed the Northfield Experiments, also had a much broader and powerful impact on psychiatric thinking, becoming the foundations for the development of therapeutic communities.

It is useful to look at developments in the USA as the term PTSD was created largely as a result of the significant impact of two major conflicts. The Second World War and the Vietnam War. The shift in political and public perception in response to these conflicts was influential in this process. Established in 1930 the Veterans Administration (VA) was created to look after the needs of US military veterans. The VA increased its role and functions substantially following World War Two when American ground forces alone suffered 504,000 psychological casualties (Shephard, 2002). This expansion was supported by the public, as the veterans were perceived as valued defenders of the world. The veterans returning from the Vietnam War were not received as heroes due to press coverage of events seen by the public as atrocities carried out by US service personnel. As a result the veterans were less welcome and received less help. Campaigning by advocate group,
Vietnam Veterans Against the War, was supported by New York psychiatrist Chaim Shatan who went on to publish a highly influential article in the New York Times on Post-Vietnam Syndrome that resulted in the establishment of outreach clinics.

It was at this time of developments within psychiatric and psychological fields, that wider psychiatric classificatory systems were being fundamentally revised from a predominantly psycho dynamically influenced framework to a descriptive system which grouped symptom clusters regardless of causation and theory. In 1980 the Diagnostic and Statistical Manual of Mental Disorders, DSM-III was published replacing the DSM-II (1968) terminology for experiences of trauma which were represented as ‘adjustment reaction to adult life’. The new classification, appearing in DSM-III was the term ‘post traumatic stress disorder’. A key factor, which distinguished this diagnosis from other classifications, was that it recognized the sole criteria as ‘external factors’.

In 1985 there followed the establishment of the International Society for Traumatic Stress Studies and publication of the Journal of Traumatic Stress, and in 1986 there followed military recognition of the term ‘PTSD. This heralded the expansion of research in the field of trauma and PTSD addressing a wide range of issues and translating these findings into therapeutic practice, Douglas and Parnell, (in press).

Current theories of posttraumatic stress emphasize neuropsychological explanations, in particular different forms of information processing and their translation into memories. There is the suggestion that we process and remember traumatic events via different pathways in the brain. The speed of a traumatic event, it is proposed, means that it bypasses cognitive memory processes and is processed by an emotional brain pathway involving the evolutionary primitive limbic system and the amygdala. The subsequent ability to process this memory in context may then be cognitively unavailable to the individual, resulting in their repeatedly reliving the emotional and sensory content of the event (Brewin, Dalgleish, & Joseph, 1996; Ehlers & Clark, 2000).

This brief historical overview reflects on how individuals have tried to understand traumatic experiences. As this section has demonstrated PTSD is a recent construct and remains much debated (Brewin, 2003). It is a diagnostic term, which more broadly evidences the power of psychiatric diagnosis to impact on and change social, legal and political cultures, including
that of psychotherapy.

This chapter now moves on to examine some of the current issues in working therapeutically with people who have experienced trauma.

1.2.2 Definitions

- **Post-traumatic Stress Disorder**

In the NICE (2005) guidelines under section 1 for guidance, Post-traumatic Stress Disorder (PTSD) is described as follows:

“PTSD develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD does not therefore develop following those upsetting situations that are described as ‘traumatic’ in everyday language, for example, divorce, loss of job, or failing an exam. PTSD is a disorder that can affect people of all ages. Around 25–30% of people experiencing a traumatic event may go on to develop PTSD”, (NICE, 2005:6).

The two main manualised diagnostic classification systems used by therapists when working with PTSD and trauma related issues are ICD-10 (WHO, 1982) and DSM-IV-TR (APA, 2000), a summary of the classification for PTSD from each manual is provided below.

- **ICD-10**

The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) (World Health Organization, 1992) identifies the coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases. Under mental and behavioural disorders in section F43.1 Posttraumatic Stress Disorder is listed and outlined as follows:

PTSD arises as a delayed response to a stressful event or situation of an exceptionally threatening or catastrophic nature that would be likely to cause distress in almost anyone.
Predisposing factors, such as personality traits or previous history of neurotic illness, may lower the threshold for the development of the disorder.

Typical features include episodes of repeated reliving of the trauma in intrusive memories (‘flashbacks’), dreams or nightmares alongside a sense of ‘emotional numbness’. Detachment from others, unresponsiveness to surroundings, anhedonia and avoidance of trauma related stimuli.

There is a state of autonomic hyper-arousal with hyper-vigilance, enhanced startle reaction and insomnia. Anxiety and depression can occur and sometimes suicidal ideation. The onset follows the trauma with a latency period from a few weeks to a few months. Sometimes the condition may follow a chronic course over many years.

**ICD-10 PTSD Diagnostic Guidelines**

This disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. A “probable” diagnosis might still be possible if the delay between the event and the onset was longer than 6 months, provided that the clinical manifestations are typical and no alternative identification of the disorder (e.g. as an anxiety or obsessive-compulsive disorder or depressive episode) is plausible. In addition to evidence of trauma, there must be a repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams. Conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are often present but are not essential for the diagnosis. The autonomic disturbances, mood disorder, and behavioural abnormalities all contribute to the diagnosis but are not of prime importance.

The late chronic sequelae of devastating stress, i.e. those manifest decades after the stressful experience, should be classified under F62.0.

Within this research I will be referring to DSM-IV-TR (APA, 2000) as the main diagnostic criteria as this was the classification reference document used by and referred to by all of the participants at the time they undertook the research. Since the interviews, data collection process and analysis were completed DSM-5 has been published and a brief statement of changes made to the criteria for PTSD will be offered.
• DSM-IV-TR

In 2000, the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR). Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning.

**Criterion A: stressor**
The person has been exposed to a traumatic event in which both of the following have been present:
1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person’s response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behaviour.

**Criterion B: intrusive recollection**
The traumatic event is persistently re-experienced in at least one of the following ways:
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific re-enactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
Criterion C: avoidant/numbing
Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal
Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:
1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criterion E: duration
Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2000).

The DSM-IV-TR and ICD-10 criteria for diagnosis of PTSD have clear similarities but there are some separation points. Both sets of diagnostic criteria for PTSD include a history of exposure to a traumatic event and symptoms from each of three symptom clusters. The symptom clusters include intrusive recollections, avoidant symptoms, and hyper-arousal symptoms. Both also include a criterion concerning duration of symptoms. The ICD-10 does not specify a functioning criterion, however it is specified in DSM-IV-TR under (Criterion F), (U.S. Department of Veterans Affairs, 2013).
The latest version of the DSM is identified as DSM-5 (APA, 2013). This version introduced some changes to the definition and recommendations for PTSD. A new chapter was included on ‘trauma and stress or related disorders’. This is a movement away from the classification in DSM-IV-TR (2000) of PTSD as an anxiety disorder. The definition of what constitutes a traumatic event is more clearly defined and sexual assault and recurring exposure are specifically included. Some elements have been deleted relating to the language describing the individual’s response to the trauma event. This version holds a focus on the behavioural symptoms that accompany PTSD and proposes four distinct diagnostic clusters (as opposed to the three within DSM-IV-TR) these are: re-experiencing, avoidance, negative cognitions and mood, and arousal. The trigger for PTSD is considered to be exposure to actual or threatened death, serious injury or sexual violation (Grohol, 2013).

1.2.3 Predisposing factors to PTSD

A substantial range of research identified factors that seemed to suggest a level of prediction of the development potential of a PTSD diagnosis following a traumatic incident(s). Research had focused on the primacy of the trauma as the etiologic agent, rather than individual vulnerability factors (Halligan & Yahuda, 2000). Epidemiological research carried out by Breslau et al (1998) found the rate of exposure to trauma far outweighed the prevalence of PTSD, this suggested that the majority of individuals do not go on to develop PTSD following a trauma. Several important risk factors, which may constitute predisposing factors in the development of PTSD, have been identified. These include; environmental risk factors, stressor severity, history of prior trauma exposure, prior exposure to chronic stress (particularly if it is at a young age) (Davidson et al, 1991). King et al (1996) identified social factors to be influential in the expression of trauma response. They found that a history of family instability was associated with increased prevalence of PTSD. Good social support was found to be associated with lower levels of PTSD symptoms. Breslau et al (1998) identified a range of demographic risk factors for the development of PTSD. These were that a consistent finding was that the prevalence of PTSD was almost twice as high in women than it was in men this reflects the finding that being female is a risk factor for other psychiatric disorders. Lower levels of education and income were also identified as risk factors for developing PTSD. Halligan and Yahuda
(2000) identified a range of risk factors to the development of PTSD they were categorised under the following criteria; environmental risk factors, demographic risk factors, prior psychiatric disorders and personality dimensions, dissociation, cognitive risk factors, biological risk factors, and familial or genetic risk factors (2000:1-3).

The risk and predisposing factors briefly identified here are discussed in more detail within the literature review chapter following this chapter.

1.2.4 Treatments
Trauma and specifically its post trauma consequence, as described in PTSD, emphasizes blocks or difficulties in the individual’s capacity to process memories and/or their experiencing of the trauma. A key treatment focus is to facilitate trauma processing. The National Institute for Health and Clinical Excellence (NICE) published its guideline for the management of PTSD in adults and children in primary and secondary care within the National Health Service directories in the UK in March 2005. This was the statement offered in response to the request for ‘appropriate treatment’ for PTSD: -

“Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis. All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [TF-CBT] or eye movement desensitisation and reprocessing [EMDR]). These treatments should normally be provided on an individual outpatient basis”, (NICE, 2005:4).

The two NICE recommended psychological treatments for PTSD are EMDR and Trauma focused CBT and will be briefly outlined in the following section.

• EMDR
American Psychologist Francine Shapiro developed EMDR in 1987. EMDR is based on the Adaptive Information Processing (AIP) model which proposes that most psychological disturbance has its foundations within distressing past events that have not been appropriately processed (Shapiro, 2001). A summary of the theoretical basis of Shapiro’s Adaptive Information Processing (AIP) model is presented below: -
With severe trauma, an imbalance occurs in the nervous system, causing a block with the unprocessed associated disturbing information encoded neurologically. Eye Movements (EM) or other bilateral stimulation facilitates adaptive reprocessing on both a neurological and consequent ‘mental change’ level. With each set of EM’s, the disturbing information moves at an accelerating rate along the neurophysiological pathways. EMDR treatment progresses through memory networks or ‘channels’, which are accessed through targets or ‘nodes’. The precise mechanism by which the AIP model produces these changes is unclear. Shapiro suggests possibilities such as – dual attention focusing, the effects of neuronal bursts, and de-conditioning caused by a relaxation response (Shapiro, 2001).

Alternatives to this explanation have been proposed by other researchers who have proposed; ‘reverse learning’ (Hassard, 1996), ‘an orienting response’ (Armstrong & Vaughan, 1996), ‘working memory approach’ (Nicosia, 1994), ‘resynchronisation of hemispheric activity’ (Bergman, 1995), ‘conditioning and emotional interference’ (Dyck, 1993).

EMDR is driven by bilateral brain stimulation, which results from a client tracking the therapist’s fingers from side to side (or by sound moving from ear to ear or by tapping the hands left and right), which stimulates brain activity. Simultaneously, the client reactivates an image, with its accompanying sensory experiences, of a traumatic event, along with the associated distorted negative self-beliefs. The process generates emotions, which are often felt as body sensations. With the bilateral stimulation, the client is instructed to uncritically follow his/her thoughts and associations, which often leads to the retrieval of old memories and rapid insights, accompanied by a systemic letting go of the traumatic event and the symptoms associated with it.

After an EMDR experience, the person can then believe that the crisis is in the past, or for example; they were not responsible, they are safe now, and they can go on with their lives. This results in a person finally letting go and engaging in recovery and healing. The EMDR Protocol has 8 Phases these are: - 1. The History taking & treatment-planning phase. 2. The Preparation phase. 3. The Assessment phase: 4. The Desensitisation phase. 5. The Installation phase. 6. The body scan phase. 7. The closure phase. 8. The Re-evaluation of treatment phase.
The second NICE recommended psychological treatment was Trauma Focused Cognitive Behaviour Therapy TF-CBT.

- **TF-CBT**

Monson and Friedman (2006) identified that Cognitive Behaviour Therapy for trauma encompasses a broad range of therapies, which are characterized by a shared emphasis on observable outcomes, symptom amelioration, time-limited and goal-oriented intervention and an expectation that clients will assume an active role in recovery (2006:1). A central factor in the cognitive therapies related to trauma is the adherence to evidence based practice. There are a number of well-researched cognitive behavioural therapies used within trauma work; Prolonged Exposure Therapy (PE), Foa, Rothbaum, Riggs and Murdock (1991); Dialectical Behaviour Therapy (DBT), Becker and Zayfert (2001); Acceptance and Commitment Therapy (ACT), Hayes et al (1999); and Cognitive Therapy (CT) for PTSD, Beck (1976), Ehlers and Clark (2000), Ehlers et al. (2003) and Tarrier et al. (1999). I will briefly address one of the treatment processes, which come under the banner of TF-CBT. Cognitive therapy for PTSD developed by Ehlers and Clark (2000).

Ehlers and Clark (2000) identified a key dilemma at the heart of therapeutic work with clients who present with a PTSD diagnosis that is that anxiety holds a focus on ‘future’ threat. PTSD holds a focus on memory for a past event. A key issue to overcome in the therapy process is that individuals are processing and or remembering the trauma and or its sequelae in a way, which poses a current threat to self. A significant implication to therapy is that within this approach the aim of therapy is to process the trauma so it is seen as a time limited, past event which does not necessarily have global implications for the client’s future.

This is a treatment model developed for people who become ‘stuck’ in their recovery, which holds a focus on identifying and reversing maintaining factors. As discussed, current threat arises as a consequence of excessively negative appraisals of the event and or its sequelae. This is as a result of a number of factors; the fact that the trauma happened, the clients’ behaviour and response in the event, the initial PTSD symptoms, the perceived response of others – (these are often highly idiosyncratic and may reflect shattering or confirmation of previous beliefs). Current threat arises as a consequence of the nature of
trauma memory and unintentional triggering of memory fragments by a wide range of low level cues along with Poor intentional recall which influences the client’s appraisals. The client’s ability to recall the trauma within PTSD is often inhibited; this is commonly due to parts of memory being disjointed and lacking updating, confusion about the order of events that took place and important details potentially missing from the memory. Ehlers and Clark (2000) identified the mismatch in memory processes from ordinary function to function expressed within a PTSD response. They identified that ordinary autobiographical memory is characterised by; an awareness of remembering; emotion being less strong; details of the memory have context; the memories are rarely spontaneous and if they are spontaneous there is usually a closer specific match of triggers. This differs when experiencing PTSD symptoms where autobiographical memories are characterised by involuntary re-experiencing of events and memories; a limited awareness of remembering (feels more like ‘nowness’); experiencing of the original emotions (physiology/behaviour); details without a context as a result of memory not updated and memories and intrusive thoughts easily and involuntary initiated from a wide range of triggers, including sensory similarity, and partial match triggers. This represents the treatment strategies employed by Ehlers and Clark (2000), to address the physical presentation and neurological aspects of PTSD expression.

A key treatment strategy within this approach is to reduce the client’s symptomology and their ability to control intrusive thoughts and imagery. The process of reliving is fundamental to this process and is a central feature of the cognitive therapy approach to PTSD. The treatment component of reliving has three main goals these are: - Goal 1: to reduce re-experiencing by elaboration of trauma memory and discrimination of triggers by use of imaginal reliving, narrative, stimulus discrimination. Goal 2: To modify excessive negative appraisals by engaging directly with appraisals of the trauma and identifying ‘hotspots’, the use of cognitive therapy strategies to integrate new appraisals into the reliving process, engaging with appraisals of sequelae by use of behavioural experiments. Goal 3: To drop the maintaining behaviours and develop cognitive strategies that enhance the client’s capacity to integrate, understand and update the trauma memories.

Reflecting on other treatments for PTSD Foa et al, (1999) identified a number of effective therapies and concluded that “three psychotherapy techniques; exposure therapy, cognitive therapy, and anxiety management; were considered to be the most useful in the treatment of PTSD” Foa, Davidson, et al (1999:15); others offered alternative perspectives; Horowitz
(1998) described psychodynamic approaches; for a conditioning approach, see Kilpatrick et al. (1985); for schema-based approaches, Janoff-Bulman (1985); for bodywork approaches, Rothschild (2000); and behavioural approaches, Fairbank and Brown (1987).

I have briefly outlined the process of cognitive therapy for the treatment of PTSD (Ehlers and Clark, 2000) and EMDR (Shapiro, 2001), to illustrate some of the challenges faced by trauma therapists who work with clients presenting with a PTSD diagnosis and who utilise these approaches in that work. A fuller overview of specific literature relating to these and other approaches can be found within the literature review chapter.

1.2.5 Reflexive statement

I was aware of my knowledge, background and experience of trauma work and how this had a potential to create a bias within the research process. This section of the research is offered in an attempt to be transparent in relation to the influences and beliefs I carried into this research process. Reflexivity has been seen as an acceptable, although in some quarters contested, process of social science research. It has been described as an attempt by the researcher to acknowledge how their experiences and contexts inform the process and outcome of the research (Etherington, 2004). A focus on my humanist ontological perspective, as described by McLeod (2011), draws upon my belief that meaning is co-constructed in relationships and a purposeful activity between people (2011:47). This formed the basis of the development of this research study and the methods I utilised to engage with the issues that emerged. There follows an overview of my experience and the contexts in which I have, and do exist, in an attempt to clarify my positioning as the researcher within this study.

My professional and personal interest in researching PTSD and potential predisposing factors was founded upon my profession experience of working with clients who presented with trauma related issues. I have been a therapist for 20 years, initially trained as a person-centred counsellor and moving to train and work from a more integrative therapeutic perspective, I went on to train as a counselling psychologist 10 years ago. Throughout my professional career I have worked with clients who presented to therapy with a wide range of issues, which impacted on their lives. Significantly I began work as a therapist within a
highly intensive professional environment. This was a bereavement service, which provided support and therapy for bereaved and terminally ill clients. My therapy work was with terminally ill clients and their families. This was my first experience of working with trauma and the often highly charged emotional environment that existed within the therapy process. I had become aware of markedly differing responses to the life limiting diagnosis and how individuals, clients and family, engaged with the traumatic news of impending death. On reflection this was the time that my journey to gain a better understanding of human resource, resilience and predisposition began and my relationship with trauma, which still remains important to this day.

Over the years I have worked in a range of therapeutic environments. These included, primary and secondary care services within the NHS, occupational health department NHS, voluntary sector therapy services, staff and student counselling service within an educational setting, severe and enduring secondary care service within clinical psychology departments in the NHS and more recently in private practice. Within these environments I have offered a range of assessment and therapy services to individuals experiencing a broad range of psychological issues. Although I have had regular contact with trauma issues within my work, for the past 14 years I have had more direct engagement with trauma related issues and clients who had been diagnosed with PTSD. This began within my work in a clinical psychology department, which held a focus on severe and enduring mental health issues.

I was part of a small team of therapists who were the main referral point for severe and enduring anxiety related issues. I undertook a range of focused training and developed a strong interest in trauma and specifically PTSD work. The nature and intensity of the work and the often emotionally charged therapy process held a strong connection for me. Over time this work has become the central focus of my therapeutic practice. For the past 5 years my therapeutic work has been exclusively within a private practice setting. I work as a chartered counselling psychologist offering supervision to both qualified and trainee counsellors, CBT therapists and psychologists, along with therapy to clients who present with a range of psychological issues. The majority of the therapy work I undertake has a trauma focus with PTSD being the most consistent presenting issue. It is important to note that my work comes through self-referral and more commonly referral from external agencies such as health insurance companies and medico-legal organisations. This is
important to identify as it places a specific social and political context on the work I undertake.

The wider context of my professional experience is that of my role as a University lecturer. For the past 20 years I have also been a lecturer initially in the further education sector and for the past 10 years within higher education settings. My role has, and continues to be, to train therapy practitioners to gain formal qualification as practitioners. There is a strong link between my therapeutic practice and my training role as they are both firmly based within, and hold a focus on, a practice context. This was influential when considering my research interest prior to starting this study; I was immediately drawn to exploring the phenomenon of how some individuals seem predisposed to respond to events in what is experienced as highly functionally debilitating ways. My specific interest in trauma and PTSD positioned this focus on developing a deeper understanding of the potential impact of predisposing factors on the expression of PTSD. The seeds of this interest lay in a number of experiences I had encountered within my practice and the work I did with my clients.

There were a number of influential factors that impacted upon my decision to carry out this research project. Over time my ‘low-level’ awareness of consistencies across diverse client presentations had caused me some uncertainty as to the possibility of a wider ‘connectivity’ that may exist between them? This I had dismissed as more in line with the ‘trauma’ consistency in the presentations. There was also the impact of teaching trainees therapeutic theory and skills and the research process required to do this, which shaped my understanding of the potential influence of a range of factors that exist within trauma presentations. When reflecting on the central motivation for this research project I was consistently drawn to a significant event that shaped my thinking in relation to the impact of predisposing factors on the development of PTSD, this event took place within my therapeutic practice. While completing a review of client work for a medico-legal organisation I did contract work for, I came across some similarities in background details of what were very diverse clients. The convergence related to a number of previous personal history variables. Notably clients had reported an insecure attachment profile along with previous trauma exposure, often in childhood. Although this finding was generated by a small-scale personal practice review it encouraged me to widen my research to include my notes for a bigger sample of my PTSD clients. This resulted in confirming the initial finding as characteristic of my wider client’s experience along with the discovery of other potential
factors that may have had relevance. The finding suggested the potential for a wider significance of these factors and began the process of an attempt to discover if my experience was an anomaly or one that other therapists may have experienced? This key event generated the process of my engagement with subject specific research and led to the development of this research study.

The issue of bias within research was a key consideration and as such identifying my preferred and predominant working approach within trauma therapy was important to contextualise my positioning within the research. This predominant working approach is Trauma focused CBT, specifically cognitive therapy for PTSD, Ehlers and Clark (2000). Although trained in the use of EMDR, and I use this approach within my work, by far the predominant approach I utilise is TF-CBT. This had the potential for me to bias my response to participants as a result of my theoretical and experiential positioning. I was very mindful of my experience and how this had the potential to bias the research, however, reflecting openly on my process and constructing an environment where it was possible to hear the lived experience of others had the potential for me to meet the participant where they were rather than where I would want them to be? Willig (2001) identified the researcher’s impossible task of remaining objective in the process of carrying out the research. Willig (2001:15) proposed that those engaging in the research need to be open and flexible enough to facilitate the emergence of new, and unanticipated, categories of meanings and experience. I have endeavoured to engage within this research from a reflexive stance. And attempted to follow what McLeod (2011) described as: ‘the capacity of the researcher to turn back on his or her experience, and then use this material to inform the process and outcomes of the inquiry’ (2011:48).

1.3 Rationale and Research questions
The aim of this study is to explore the experiences of therapists working with clients who present with a PTSD diagnosis. It attempts to engage with the therapist’s experience of therapeutic assessment and therapy with those clients. As previously identified the decision to explore therapist’s experiences and not client’s experiences was an attempt to understand the therapist’s wider experience of PTSD presentation rather than the singular expression of PTSD experienced by the individual client. An awareness of influences on the therapist’s
decision-making process and what forms the rationale for treatment development is also explored within this study.

From personal and practical experience of working directly in the field of trauma for a number of years I became aware of specific recurring themes and issues that clients presented within the therapy process. Research evidence points to the potential influential impact of predisposing factors on the development of PTSD. Little research has held a focus on the experience of therapists working with clients with PTSD and how they make treatment decisions. This study attempts to gain a greater insight into the experience of therapists understanding of predisposing factors to PTSD and how or if they incorporate this understanding into a therapy process? From an engagement with therapists experience there is also the potential to explore the question of the potential influence of predisposing factors on the expression of PTSD. Specifically the study holds a focus on the following research questions:

1. Do trauma therapists believe there to be predisposing factors, which influence the expression of PTSD?
2. How do trauma therapists believe clients’ previous life experiences influence their formulation and treatment protocols for PTSD?

Overview of the thesis

Within the main body of the thesis I will provide an overview of the core literature associated with PTSD and the predisposing factors to its development along with reflection on the treatments offered. I then move on to provide an outline of the methodology utilised in this study. Here I introduce the epistemological basis for the design adopted and the data collection and analysis strategies. This then leads on to a chapter presenting and discussing the findings from the study. These are presented thematically and alongside relevant related literature. Finally, I provide a concluding summary in which I initially reflect upon how the research questions have been answered based upon the experiences of those involved. The strengths and weaknesses of the study are also presented prior to discussing my own reflections upon completing the thesis.
CHAPTER 2
LITERATURE REVIEW

2.1 Introduction
The literature on Post-traumatic Stress Disorder (PTSD) is substantial and has a diverse focus. The intention of this literature review is to initially focus on Posttraumatic Stress Disorder and its core classification; DSM-IV-TR; ICD-10. This will be followed by a review of the literature around PTSD, Predisposing factors and the Treatment of PTSD.

It is beyond the scope of this chapter to detail all the literature related to PTSD rather it is intended to review key research, which holds a focus on PTSD and a range of predisposing issues. A focus will be held on the version of the Diagnostic Statistical Manual (DSM) in use, and referred to by participants, while the data collection process for this research was on going and interviews were undertaken this was DSM-IV-TR (APA, 2000).

The research reviewed was identified from a range of sources including databases such as: Pubmed, Psychinfo, Ebscohost, Cochrane Collaboration, CINHAL, MEDLINE, PsycINFO, NCPTSD. Some of the key words used to search for literature were Post-traumatic stress disorder, Attachment, Predisposition, Therapeutic Interventions, models of learning, Psychosocial, psychopharmacology, EMDR, and TF-CBT. Furthermore the references from papers that were found were utilised to facilitate the identification of additional relevant journal articles.

2.2 PTSD – A Historic Perspective
In 1952 the American Psychiatric Association published its first diagnostic and statistical manual (DSM - I) which contained a diagnostic category known as ‘Transient Situational Personality Disorders’ which included the category Gross Stress Reaction (GSR). The description of GSR reflects the influence of Freud’s thinking about Traumatic Neurosis (Freud, 1928). The inclusion of GSR into the category of Transient Situational Personality Disorders reflected the view that such conditions were expected to be acute reactions to unusual stress that would be
resolved quickly. If the reactions were prolonged or persistent an alternative diagnosis was to be considered. These alternatives included psychosis, neurosis or character disorders. The category of GSR in DSM-I (1952) had features, which parallel the later DSM-III (1980) criteria for PTSD, Wilson (1994). This was the recognition that in ‘conditions of great or unusual stress a normal person may manifest stress related behaviours in response to intolerable stress’ (Wilson, 1994:689).

In 1968 the American Psychiatric Association (APA) re-classified GSR into a category called ‘Adjustment reaction of adult life’ within DSM-II (1968). This contained three examples of ‘adjustment reaction to adult life’ 1, an unwanted pregnancy accompanied by depression and hostility; 2, a frightened soldier in combat; 3, a prisoner facing execution in a death penalty case (Wilson, 1994:690). The brief and simplistic nature of these categories seemed to inadequately address the complex nature of trauma presentation and responses.

The first separate diagnostic criteria for PTSD appeared in the DSM-III (1980). The category of PTSD was placed within the Anxiety Disorders section. This was possibly to reflect that anxiety; emotional distress and physical disequilibrium were among the primary affective reactions associated with trauma exposure (Wilson, 1994). The criteria for a PTSD diagnosis required the individual to present with at least four symptoms from three clusters of symptoms – (12 symptoms in total). Wilson (1994) identified the link between DSM-III (1980) criteria for PTSD and the observations of Freud (1917), ‘the impact of trauma is systematic and influences emotional expressiveness; cognitive process; motivation and goal striving; interpersonal and object relations; physiological functioning and ego-states’ (Wilson, 1994:691).

The identification of a separate classification for PTSD within DSM-III (1980) was a considerable shift from the minimal criteria offered in DSM-II (1968). Kinzie and Goetz (1996) identified that the publication of criteria for PTSD within DSM-III was the ‘accumulated experience of over 100 years finally becoming recognised’ (Kinzie & Goetz, 1996:173).

The PTSD criteria outlined dynamics such as the dissociative process within post-traumatic attempts at coping and processing trauma. Janet (1907) had developed the
concept of dissociation however; the process and its connection to trauma was still in
the process of being clarified at the time of the development of the criteria for PTSD
within DSM-III (Spiegel, 1991; Steinberg, 1994). A further consideration stated
within the diagnostic criteria was that of ‘the existence of a recognisable stressor that
would evoke significant symptoms of distress in almost everyone’ (DSM-III, 1980).

Lifton (1988) extended this concept when proposing that to a large extent PTSD could
be thought of as the normal human reaction to abnormally stressful life events.
Researchers have also proposed that personal variables or environmental factors
influence the patterns of PTSD expression (Wilson, 1989).

The importance of PTSD as a separate diagnostic category created some controversy
specifically within the medico-legal environment this resulted in stimulating research
into the clarification of differential diagnosis and understanding co-morbid conditions
(Davidson & Foa, 1993; Wilson & Raphael, 1993). An associated impact of the
separate criteria for PTSD enabled it to be used as precedent in legal proceedings for
compensation, pensions and legal defence in criminal cases.

A revision to the DSM-III was completed in 1987 and published as DSM-III-R. This
included revisions to the criteria for PTSD. The revisions were based around key
findings from research and clinical work with trauma presentations. The diagnostic
symptom criteria were extended to 17 and to meet the clinical diagnosis the individual
had to meet 6 symptoms from the 3 clusters. In addition the duration of disturbance
had to be at least one month. If the duration of the reactions were less than one month
this would be regarded as a normal pattern of stress response and would not be
regarded as pathological in nature. The changes within DSM-III-R PTSD diagnostic
criteria offered an attempt at clarifying language, meaning and specificity of reactions
to trauma (Wilson, 1994:693).

In 1994 DSM-IV was produced, this represented a further development in the
classification and diagnostic criteria for trauma related presentations. A key inclusion
in this edition was the new disorder of ‘Acute Stress Disorder’. This included a
number of dissociative symptoms along with re-experiencing, avoidance and marked
anxiety. There was empirical support for this syndrome offered by Davis, Bauer, Severino, Spiegel and Widinger (1993).

When DSM-IV was under development the APA commissioned a field trial for PTSD to investigate the impact of several proposed changes in the PTSD diagnosis. It was also tasked with exploring the psychopathology of chronic developmental trauma. This was labelled as Disorders of Extreme Stress Not otherwise Specified, (DESNOS). The findings of the DSM-IV field trial supported the existence of a complex adaptation to chronic interpersonal violence, in both children and adults (Van der Kolk, Roth, Pelcovitz, Sunday & Spinazola, 2005).

DESNOS was listed in DSM-IV however; not as a freestanding diagnosis, but under ‘Associated and Descriptive Features’ of PTSD (APA, 1994; 425). Van der Kolk and Courtois (2005) identified the impact of not including DESNOS as a distinct diagnosis within DSM-IV. They noted that subsequent treatment outcome research has focused almost exclusively on PTSD symptomology, as identified in DSM-IV. ‘Post-traumatic problems not captured in PTSD criteria have generally been referred to as co-morbid conditions, issues secondary to the core post-traumatic psychopathology’ (Van der Kolk & Courtois, 2005:386).

Spinazola, Blaustein and Van der Kolk (2005) carried out a review of treatment outcome studies, which indicated that for a substantial proportion of traumatised patients PTSD symptoms did not capture all of their difficulties. The review identified that the typical subject who is screened out of PTSD studies due to multiple co-morbid conditions may well be the typical patient seen in mental health care settings, (Spinazola, Blaustein & Van der Kolk, 2005). This was a significant finding and represented the lived experience of some of the participants within this study.

Ford, Courtois, Steele, Van der Hart and Nijenhuis (2005) proposed that by diagnosing traumatised patients, with complicated clinical presentations, with a diagnosis of PTSD, clinicians might run the risk of applying treatments that may be irrelevant to them but possibly be harmful to their clients. Van der Kolk and Courtois (2005) proposed that ‘a new diagnostic process is required to provide a clear delineation of the enduring developmental effects of trauma, such as complex
PTSD/DESNOS or Developmental Trauma Disorder’ (Van der Kolk & Courtois, 2005:386). They went on to propose that additional research was needed to ‘identify the effect of specific developmental, contextual and genetic factors on the eventual phenomenology of the post-traumatic adaptation’ (Van der Kolk & Courtois, 2005:387).

Published in 2000 was DSM-IV-TR. This was a text revision of DSM-IV and as such did not differ greatly from the original DSM-IV (1994). The diagnostic criteria for PTSD within the revised edition followed the structure and format of that set out in DSM-IV. Although some text adjustments were made there was no deviation from the core meaning and perspective offered in the initial PTSD diagnostic criteria with all six criterions remaining presented in the same format and wording. It is important to note that DSM-IV-TR was the edition that all the participants within this study followed at the time of the research interviews and as such is the edition I will refer to and hold a focus on throughout the study.

The latest incarnation of the DSM was published in May 2013 and is identified as DSM 5. PTSD is included as a new chapter on Trauma and Stress or Related Disorders. This is a change from DSM-IV, which identified PTSD as an Anxiety Disorder. The definition of what constitutes a traumatic event is more clearly outlined in this edition and sexual assault and recurring exposure are specifically included. There have been some elements deleted from the criterion related to the language describing the individual’s response to the event, these were; intense fear and helplessness or horror as these were proven to have no utility in predicting the onset of PTSD (APA, 2013). DSM 5 holds a focus on the behavioural symptoms that accompany PTSD and proposes four distinct diagnostic clusters as opposed to the three in DSM-IV-TR. These are; re-experiencing, avoidance, negative cognitions and mood, and arousal (Grohol, 2013).

2.3 PTSD

There has been a great deal of debate around the development and structure of the PTSD criteria within DSM-IV. Spitzer, First and Wakefield (2007) identified a need for a tightening of the definition of trauma in PTSD placing a heavier emphasis on
direct experience. They go on to identify the non-specificity of PTSD syndrome, and identify: that criterion A is essentially opposed to other anxiety and mood disorders, and emphasis on re-experiencing symptoms, to eliminate somatic symptoms that overlap with other disorders and that criterion C and D should be integrated into one cluster (Spitzer, First & Wakefield, 2007).

The wider debate around PTSD criteria addressed the subject of conceptual bracket creeping (McNally, 2007). Kinzie and Goetz (1996) reviewed historical clinical reports that preceded the development of the criteria for posttraumatic stress disorder (PTSD) and influenced the formation of PTSD in DSM-IV. They identified that the understanding of PTSD had been complicated by questions of nomenclature, etiology, and compensation. With the publication of the updated version (DSM-5, May 2013) of the Diagnostic Statistical Manual of Mental Disorders (DSM), the debate continues with projections as to what adaptations should be made to the process of diagnosis in response to the changes presented within the new diagnostic criteria.

(Ozer, Best, Lipsey & Weiss 2003) identified that the client’s experiential process has significant impact on the development of PTSD. Specifically the degree of importance that perception held over the manner in which a traumatic event is experienced. A key element within criterion A for PTSD diagnosis is that of the requirement that the individual has experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (APA, 2000). This places perception at the heart of a diagnosis of PTSD and engages a wide range of research some of which addresses the implication of hallucinatory or delusional responses. Morrison, Frame and Larkin (2003) extend this when they proposed that psychotic disturbance could be viewed as traumatic events as they often result in re-experiencing processes.

An issue that Rosen (2004) identified is the impact of the inclusion of the term ‘perceived’ into Criterion A of the diagnosis structure as widening the criteria too much and potentially increasing the legal compensation aspect of holding a PTSD diagnosis. An extension to this concern with criterion A is held by Weathers and Keane (2007) who question the measurability of trauma and how it should be defined. McNally (2004) echo’s this concern when questioning if PTSD as a recognised
disorder has a political or medically significant status? The wider political, legal and social context of the diagnosis has resonance for treatment and the way in which trauma therapists engage with clients and the wider community.

An extension of the client’s experience of a PTSD diagnosis is that of the theoretical perspectives offered to address PTSD within a treatment process post diagnosis. The theories are wide-ranging and seemed to share some common baseline assumptions as to the focus of the therapy process. This is that trauma and specifically PTSD emphasised blocks or difficulties in the individual’s capacity to process memories and / or the experiencing of the traumatic event(s). A key focus is to facilitate the processing of the traumatic event(s). A range of approaches have been formulated to address this aim of therapy for Trauma, the psychodynamic approach (Horowitz, 1998), conditioning approach (Kilpatrick et al.1985), Schema Based approaches (Janoff-Bulman, 1992), bodywork approaches (Rothschild, 2000), behavioural approaches (Fairbank & Brown, 1987) and cognitive approaches (Ehlers & Clark, 2000).

A key area of research addressed outcomes of treatment. Ai, Evans-Campbell, Santangelo and Cascio (2006) identified the importance of the personality of the individual to the outcome of treatment. Self-reliance was also identified as a key factor related to outcome of therapy, (Wakeman, 2003). The issues of self-esteem, self-determination, as sense of purpose in life, personal growth and a continuity of self were also identified as key factors in treatment outcome (Secker, Hill, Villenaue & Parkeman, 2003).

The impact of culture, values and beliefs have also been identified as impacting on the ability of the individual to engage in treatment, with culture being recognised as impacting the individual’s experience of suffering and healing (Kirmayer, 2007). De Jong (2004) identified that it was not understood how culture influenced the recall or the measurement of traumatic experiences. In a study by Spoont, Sayer and Nelson (2005) negative and positive correlations were identified when beliefs and treatments were contradicted and complimented. This outcome is of potential significance to understanding the practices of the participants within this study.
Having identified the specific aspects of PTSD from a historical perspective and the implications for diagnosis and therapeutic intervention. At this point the focus of the review will move to address research which investigates processes and dynamics that could be seen as predictors or predisposing factors to the development of PTSD or Acute Stress Response ASR.

2.4 Predisposition – predictors of PTSD development

A substantial range of research identified factors that seemed to suggest a level of prediction of the development potential of a PTSD diagnosis following a traumatic incident(s). Ozer, Best, Lipsey, and Weiss (2003) identified: peri-traumatic dissociation, perceived support post-trauma, peri-traumatic emotions, perceived life threat peri-trauma, family history of psychopathology, prior trauma and prior adjustment to be key factors impacting on the potential for an individual to progress to a diagnosis of PTSD following a traumatic incident(s). Brewin, Andrews, and Valentine (2000) further identified: Life stress, Poor social support, adverse childhood events, Trauma severity, Childhood abuse, Female gender and family psychiatric history as significant predisposing factors to the development of PTSD following a traumatic event(s).

A key study by Twaite and Rodriguez-Srednicki (2004) identified a link between childhood trauma and an increased potential for a PTSD diagnosis following a traumatic incident in adult life, they also identified dissociation as an influential factor. Neufeld-Bailey, Moran and Pederson (2007) also identified the associations between unresolved attachment and abuse history and trauma related symptomatology. They extended empirical support for the association between dissociative processes and unresolved attachment.

Faure et al (2007) identified early life adversity as a predisposing factor in the development of psychopathology in later life, specifically depression and anxiety disorders. They went on to state that a prior history of stressors might also be a vulnerability factor for developing PTSD in response to trauma. A study by Dieperink, Leskela, Thuras and Engdahl (2001) addressed attachment styles and PTSD and found that those with secure attachment styles scored significantly lower
on measures of PTSD than did those with insecure attachment styles, and that attachment style was a stronger predictor of PTSD symptom intensity than was trauma severity. From a wider perspective Consedine and Magai (2003) also pointed to the importance of attachment profile and emotion response. They proposed that attachment security was associated with less guilt, contempt and shame and that fearful avoidance was associated with greater disgust, fear and anxiety.

Hoge, Austin and Pollack (2007:141) identified a number of risk factors for PTSD these included pre-trauma, peri-trauma, and post-trauma variables: Pre-trauma variables exist before the trauma occurs. Examples include lower educational level (Kessler et al., 1999); lower intelligence (Orr et al., 1998); neuro-developmental delays, such as delayed onset of walking and speech, as well as learning disabilities (Orr et al., 1998); previous history of mental disorders (Kessler et al., 1999); and female gender (Brewin et al., 2000).

Relevant peri-traumatic variables include the magnitude of the stressor (Carlier et al., 1997) and immediate reactions to the stressor, such as fear of threats to one’s safety (Basoglu et al., 2005) or dissociation (Marmar et al., 1994). Pertinent posttraumatic variables include perceived social support (King et al., 1998; Koenen et al., 2003), subsequent life stress (Green and Berlin, 1987), and ongoing threat to safety (Basoglu et al., 2005).

In a key research article in 1991 Emery and Emery et al, explored the conceptualization of predisposition to Post-Traumatic Stress Disorders (PTSD). They summarized the concept of predisposition within three models; 1, predisposition due to pre-existing psychopathology, 2, predisposition due to pre-existing traits or characteristics considered normal, and 3, predisposition due to Pre-existing experience of specified stressors in family of origin. Their study focused on the third model and involved the exploration of major stressors found in the families of origin of 40 veterans, 20 who later developed PTSD and 20 who did not develop PTSD, with key demographic and military service variables balanced across groups. Findings suggested PTSD veterans had greater childhood stress related to parental alcoholism and unemployment than did non-PTSD counterparts. Further, the data suggested two major sets of childhood perceptions separated the two groups of veterans: 1, parental
alcoholism / unemployment in the perception of PTSD participants, and 2, parental strictness / delegation of responsibility in the perception of non-PTSD participants.

Young and Erickson (1988) researched the impact that culture had on the traumatised individual. They proposed that Culture affects and determines how individual members cope with experiences encountered during the life cycle. The research was set in the late eighties at a time of transition in the American culture. The authors identified their belief that the American culture was experiencing a historical transition, which affected cultural standards, archetypes, and institutions such as marriage and families. The authors proposed that there was an increase in psychic numbing, alienation, isolation, and difficulties with intimacy for the general population during the time of writing their research. They contended that for victims of traumatic events the cultural stress overlapped their post-traumatic experience since many trauma victims also experienced these phenomena. The authors concluded the research by suggesting: “that researchers and clinicians must look not only at the characteristics of the individual and the characteristics of the event when attempting to assess the impact of a traumatic event, but must look also at the social and cultural context in which the experience and the healing process occur” (Young & Erickson, 1988:441). This finding is significant as culture and social support were master themes identified by the participants of this study.

Lauterbach and Vrana in 2001 researched the relationship among personality variables, exposure to traumatic events, and severity of posttraumatic stress symptoms. They noted that in examining predictors of posttraumatic stress, researchers had focused on trauma intensity and devoted less attention to other variables. Their study examined how personality and demographic variables are related to the likelihood of experiencing a trauma, and to the severity of posttraumatic symptoms. They found that elevations in antisocial and borderline traits were significant predictors of re-traumatization. Personality variables and trauma intensity were significant predictors of PTSD severity. A further finding was that of neuroticism interacting with trauma intensity to predict Posttraumatic Stress Disorder (PTSD) severity. Among persons low in neuroticism, there was a modest trauma intensity PTSD relationship, whereas among persons high in neuroticism there was a strong relationship (Lauterbach & Vrana, 2001:29).
Another perspective researched as a possible predictive element in susceptibility to PTSD was that of trait anger (Meffert et al, 2008). Studies of Vietnam War veterans provided some of the first, large-scale empirical support for the association between PTSD and anger (McFall, Wright, Donovan, & Raskind, 1999). A meta-analysis carried out by Orth and Wieland, (2006), combining anger and hostility studies of military and civilian populations found strong associations between anger/hostility and trauma in both groups, with a larger effect in samples with military war experience than in populations with other types of traumas. In that study, anger and hostility were described as distinct constructs, with anger identified as an emotion with cognitive, physiological, motivational and behavioural components, and hostility referring to an attitude with a predisposition to dislike and mistrust of others, and to interpret others’ behaviour as egoistic and hurtful (Orth & Wieland, 2006).

Meffert et al (2008) tested two hypotheses on a participant group of 180 police recruits, these were: 1, Greater trait anger during training will predict greater PTSD symptoms at one year; 2, greater PTSD symptoms at one year will predict greater state anger at one year. Both hypotheses were confirmed, suggesting that trait anger is a risk factor for PTSD symptoms (Meffert et al, 2008:410).

Schnurr, Lunney and Sengupta (2004) studied the risk factors for the development versus the maintenance of post traumatic stress disorder. The study was conducted with 482 participants who were Vietnam veterans. Continuation ratio logistic regression was used to compare the predictive power of risk factors for the development versus maintenance of full or partial PTSD. The authors identified that the development of PTSD was related to pre-military, military, and post-military factors. The maintenance of PTSD was related primarily to military and post-military factors. Multivariate analyses identified different models for development and maintenance. The authors concluded that development of PTSD was related to factors that occur before, during, and after a traumatic event, whereas failure to recover is related primarily to factors that occur during and after the event (Schnurr, Lunney & Sengupta, 2004:93).
Irish and Ostrowski et al (2008) looked at the role trauma history characteristics played in the development of subsequent PTSD symptoms. In their study they examined the relationship between trauma history characteristics - number and type of traumas, age at first trauma, and subjective responses to prior traumas, and the development of posttraumatic stress disorder (PTSD) symptoms following a motor vehicle accident. They sampled 188 adults who had been involved in a motor accident. The participants provided information about their previous trauma history and were evaluated for PTSD symptoms at 6 weeks and 1 year following the motor accident. The researchers identified that after controlling for demographics and depression, prior history characteristics accounted for a small but significant amount of variance in PTSD symptoms. The results indicated that distress from prior trauma and the number of types of prior traumas was the most meaningful trauma history predictors (Irish & Ostrowski et al, 2008:382).

A meta-analysis was undertaken by Cox, Kenardy and Hendrikz, (2007). This was to explore the risk factors that place a child at risk of psychopathology following accidental trauma. The results indicated that the majority of effect sizes, although significant, were inconsistent across the studies, yielding little conclusive evidence. However, pre-trauma psychopathology and threat to life were strong and consistent predictors. The authors proposed that: “Information gathered from such meta-analyses could be used in the identification of at-risk children and the development of screening tools. However, further widespread and comprehensive reviews of the potential risk factors and their relationships to psychopathology needed to be investigated (Cox, Kenardy & Hendrikz, 2007:108).

Predisposition to the development of PTSD has a wide research base and it is at this point that an exploration of physiological and attachment issues will be addressed. An understanding of key physiological factors, which may underpin psychological presentations within trauma therapy work, was seen as an appropriate focus within this literature review.

In a theoretical paper in 1999 Hamner, Lorberbaum and George identified the role of the anterior cingulate cortex in PTSD. They concluded that the anterior cingulate region might serve as a vital executive function in conditioned learning, bonding and
attachment. They proposed that disruption of this function might facilitate many symptoms of PTSD due to enhanced fear conditioning. They also suggested that this dysfunction could also be implicated in syndromes often co-morbid with PTSD, including depression and psychosis (Hamner, Lorberbaum & George, 1999).

Bryant et al (2008) looked at enhanced amygdala and medial prefrontal activation during non-conscious processing of fear in PTSD. Biological models of PTSD suggested that individuals would display heightened amygdala but decreased prefrontal activity during the processing of fear stimuli. In their study Bryant et al identified that PTSD participants displayed increased amygdala and medial prefrontal cortex (mPFC) activity during non-conscious processing of fearful images. They concluded by stating: “these data extend existing models by suggesting that the impaired medial prefrontal cortex activation in PTSD may be limited to conscious fear processing” (Bryant et al, 2008:517).

Pitman (2001) in a study addressing hippocampus volume and PTSD concluded that there was a possibility that smaller hippocampi predispose individuals to develop PTSD when exposed to trauma. A source of evidence for this possibility was provided by a study that Gilbertson et al, carried out in 2002 in which two groups of monozygotic twins were compared. The authors found that although the individuals with PTSD had smaller hippocampi than the trauma exposed group who did not have PTSD, there were no differences in hippocampal volume between members of each twin pair. They concluded: “…suggesting that such differences were not due to the traumatic experience itself, but instead might reflect a pre-morbid risk factor for the development of PTSD in response to trauma exposure” (Gilbertson et al, 2002:1244). This would seem to further support the proposition of a physical component to predisposition to the development of PTSD. This review moved on to explore the link between physiological components and social, experiential and attachment variables in the potential for predisposition to PTSD.

Perry et al (1996) addressed the implications of childhood trauma and the neurobiology of adaptation and the development of the brain. They noted the impact of trauma on the emotional, behavioural, cognitive, social and physical functioning of the child. They linked the impact of developmental experiences to the organizational
and functional status of the mature brain. In their conclusions Perry et al (1996) stated: “there are various adaptive mental and physical responses to trauma, including physiological hyper-arousal and dissociation. Because the developing brain organizes and internalizes new information in a use-dependent fashion, the more a child is in a state of hyper-arousal or dissociation, the more likely they are to have neuro-psychiatric symptoms following trauma. The acute adaptive states, when they persist, can become maladaptive traits” (Perry et al, 1996:283).

Perry et al’s work points to the potential for a predisposition to develop trauma responses in later life from specific experience and brain adaptation in childhood. The implications to the work of psychological trauma therapists would seem self evident and have a potential to be influential in understanding the lived experiences of the participants within this study. Perry et al’s work was extended by Schore who is an influential researcher in the field of neurophysiology and attachment.

Schore produced a series of research articles addressing brain development, attachment, childhood trauma and relational trauma and their impact on predisposition to PTSD. The effects of a secure attachment relationship on right brain development, affect regulation and infant mental health was explored by Schore in 2001. The findings from this study identified that attachment relationships directly shape the maturation of the infant’s right brain stress coping systems that act at levels beneath awareness. He goes on to state: “in line with Bowlby’s description of a ‘control system’ that regulates attachment behaviour, the right hemisphere is dominant for inhibitory control” (Schore, 2001a: 44). In 2001 Schore further researched the effects of early relational trauma on right brain development. He was addressing the fundamental problem of what constituted normal and abnormal development. His research concluded that: “….these findings suggest direct connections between traumatic attachment, inefficient right brain regulatory functions, and both maladaptive infant and adult mental health” (Schore, 2001b:201). In a further study where he addressed the physical and emotional implications of traumatic attachment and PTSD Schore (2002) proposed some conclusions: “…Early abuse negatively impacts the developmental trajectory of the right brain dominant for attachment, affect regulation, and stress modulation, thereby setting a template for the coping deficits of both mind and body that characterise PTSD symptomatology…” (Schore,
This research would seem to indicate that an understanding of the attachment profile of the prospective client would be beneficial to trauma therapists when developing treatment strategies.

In 2003 Fosha researched the practical process of working with emotion and relatedness in trauma with disorganized attachment. She identified three key elements: 1, the right brain and sub-cortical structures like the hippocampus and amygdale are centrally involved in emotion processing, 2, the pre-frontal cortex plays a major role in affect regulation and secure attachment, 3, trauma and emotional neglect (which leads to disorganized attachment) compromise the structure and function of right hemisphere, sub-cortical structures and the pre-frontal orbital cortex. She went on to state “it appears that therapeutic interventions that involve emotion, the body, somatosensory activation and bi-lateral information processing mechanisms are effective in functionally reversing the effects of trauma” (Fosha, 2003:222). This research would seem to lend support to the treatment approaches which focus on these physiological mechanisms such as bodywork approaches, TF-CBT and EMDR.

In 2006 Declercq and Willemsen researched distress and PTSD in high-risk professionals from a perspective of adult attachment style and the dimensions of anxiety and avoidance. The results indicated that fearful – avoidant and preoccupied - attached individuals reported more stress than secure - attached and insecure - attached individuals of the dismissive type. The results support the assumption of the ‘buffering’ effect of attachment style on distress and PTSD.

Another perspective that had a resonance with attachment processes was that of support. In 2007 Lauterbach, Koch and Porter examined the relationship between childhood support and later development of PTSD. Three sources of social support were identified; maternal; paternal and peer, and the development of PTSD. The results identified that individuals with a history of PTSD reported that they received less maternal, paternal and peer support as children than those without PTSD. A separate finding was that individuals that developed PTSD after the age of 17 years old reported lower levels of early childhood support from a paternal source (Lauterbach, Koch & Porter, 2007:857). The impact of early life experiences, specifically parental support in childhood, seems to hold a predisposing influence on
the development of PTSD and offers further evidence of the need for a comprehensive history taking process within trauma therapy work.

The importance of attachment was identified by Shapiro and Levendorsky (1999) when they described their view that attachment may act as a key resiliency factor for children who are exposed to distressing experiences. They proposed that a secure attachment could act as a buffer to mitigate the impact of overwhelming stressors, and to support recovery and healing.

In a border research focus on attachment Cloitre, Stovall-McClough and Zorbas in 2008 researched attachment organization, emotion regulation, and expectations of support in a clinical sample of women with childhood abuse histories. This arose from the desire to construct an empirical study to address the notion of an association between compromised attachment and clinical disorders as although this process had been documented few empirical studies had been undertaken. The study evaluated the potential roles of emotion regulation and social support expectations in linking adult attachment classification and psychiatric impairment in 109 women with a history of childhood abuse and a range of diagnosed psychiatric disorders. Results indicated that insecure attachment was associated with psychiatric impairment through the pathways of poor emotion regulation capacities and diminished expectations of support. The authors suggest; “the importance of attachment theory in understanding the myriad psychiatric outcomes associated with childhood maltreatment and in particular, the focal roles that emotion regulation and interpersonal expectations may play” (Cloitre, Stovall-McClough & Zorbas, 2008:282).

Another element explored when looking at individual difference and the debate around predisposition to PTSD development is that of resilience. This has been addressed in a number of studies and the outcomes of these offer some contribution to the debate.

Yehuda and Flory (2007) researched the process of differentiating biological correlates of risk, PTSD, and resilience following trauma exposure. They proposed that risk and resilience factors possibly explained the individual differences in the response to adversity. They identified that little was known about how such factors
were related. They conclude by proposing that it is necessary to distinguish between resistance to PTSD and recovery from the condition. In the study they demonstrated that different aspects of resilience were associated with different neurobiological alterations (Yehuda & Flory, 2007).

Hoge, Austin and Pollack carried out a theoretical review in 2007 addressing the issue of resilience. The review identified research evidence and conceptual considerations for post traumatic stress disorder in relation to the concept of resilience. The research was carried out from a backdrop of a growing recognition and occurrence of traumatic exposure in the general population, which had given increased motivation to understand the concept of resilience. The authors considered resilience to be more than an alternative to a risk factor. They proposed that resilience encompassed psychological and biological characteristics, intrinsic to an individual, that might be modifiable and that confer protection against the development of psychopathology in the face of stress. The outcome of the study reflected on the many psychosocial variables, including positive or action oriented coping styles, internal locus of control, cognitive abilities, and social support as being key components of resilience. They proposed several biological variables as being promising lines for future research into resilience (Hoge, Austin & Pollack, 2007:148).

Another potential predictor of the development of PTSD has been proposed by Michael, Halligan, Clark and Ehlers (2007) that of rumination. In their research they identified that recent studies had proposed that rumination was a powerful predictor of persistent PTSD. They noted that the mechanisms by which rumination maintains PTSD symptoms were not understood. In an attempt to clarify this position the study was undertaken. They identified that certain elements of rumination such as compulsion to continue ruminating, occurrence of unproductive thoughts, and ‘why and what’ questioning along with negative emotions before and after rumination, were significantly associated with PTSD. The authors identified that these characteristics could explain significantly more variance in PTSD severity than just the presence of rumination. This they suggested indicated that not all ways of ruminative thinking are equally maladaptive (Michael, Halligan, Clark & Ehlers, 2007:307).
The studies identified seem to provide evidence to support the contention that early trauma experience has a negative impact on the physical structure and functioning of the childhood developing brain. As such the trauma experience changes the functional capacity of the brain to deal with affect regulation and stress modulation. This implies the potential for a predisposition to susceptibility to the development of PTSD. The impact of attachment experiences seems to have influence over the potential for developing PTSD at some point following a traumatic experience. The experiences in early development have been proposed as defining elements in individuals potential for a predisposed response to PTSD symptoms following a trauma. Researchers have identified the physiological structures in the brain responsible for processing a range of psychological mechanisms related to trauma and PTSD. The issues addressed represent some of the key research focused on predisposing factors to the development of PTSD; now the review will address some of the research, which holds a focus on the treatment of PTSD.

2.5 PTSD – Treatment
The National Institute for Health and Clinical Excellence (NICE) published its guideline for the management of PTSD in adults and children in primary and secondary care within the National Health Service (NHS) directories in the UK in March 2005. This was in response to the growing demand for determining efficient and effective treatments for PTSD from the many techniques and interventions that had been developed to address the psychological consequences of traumatic stress. The guideline was intended to inform and guide clinical practice across the UK. The details of the guidelines are presented below.

2.5.1 NICE Guidelines (2005)
Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. The recommendation of the guidelines was:

- **Initial response to trauma**
  For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as
debriefing) that focus on the traumatic incident, should not be routine practice when delivering services.

Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by people with post-traumatic stress disorder (PTSD), should be considered. A follow-up contact should be arranged within one month. For those who have symptoms, which are present within three months of the trauma psychological treatment is recommended.

- **Trauma-focused psychological treatment**

Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis.

All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]). These treatments should normally be provided on an individual outpatient basis (NICE, 2005:4).

Dorahy (2006) identified a range of issues related to the methodology of the development and construction of the guidelines. He discussed the implication of inclusion and exclusion criteria for studies eligible for review. He also addressed issues of validity and the impact on research focus to design and support even more effective treatments. This last point was particularly relevant as a considerable number of individuals with a PTSD diagnosis fail to respond to the most empirically grounded treatments available (Andrews et al, 2002; Tarrier, Sommerfield, Pilgrim & Humphreys, 1999).

The recommendations for the psychological treatment of PTSD from the NICE guidelines were based on ‘an independent, systematic, rigorous and sophisticated multi-stage process for identifying, reviewing and appraising evidence for the effective treatment of PTSD’ (Dorahy, 2006:314). The guideline required more than
just randomized control design for inclusion in review it also required ‘at least 70% of participants needed to have a diagnosis of PTSD’ NICE (2005:35). In addition the intervention had to be greater than a single session and be commenced no less than three months following the trauma. The recommendations from this analysis were that all individuals with PTSD should receive either Trauma Focused CBT or Eye Movement Desensitisation and Reprocessing (EMDR). Drug treatments were also recommended in specific circumstances, these were for sleep disturbance or if the individual is unable to begin psychological treatment. It was also recommended that these procedures should be offered regardless of the length of time since the trauma and 8-12 sessions should be devoted to the treatment of single incident trauma. It further stated that more than 12 sessions could be required for multiple trauma and co-morbid difficulties (Dorahy, 2006:315).

**WHO Guidelines (2013)**

International guidelines relating to the treatment of PTSD were developed by the World Health Organization in 2013. These are the most up to date guidelines for the treatment of PTSD and reflect a comprehensive review of the research. The guidelines state, ‘Trauma-focused CBT and EMDR are the only psychotherapies recommended for children, adolescents and adults with PTSD’. The guidelines identify specific separation points between TF-CBT and EMDR when they state, ‘Like CBT with a trauma focus, EMDR therapy aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework.’ WHO, (2013: 1).

An extension of the international perspective on trauma has been offered by the International Society for Traumatic Stress Studies. The society produced a range of guidelines related to trauma. One such guideline addresses the treatment of PTSD and comorbid disorders. The revised edition of this guideline emerged from a systematic review of the literature and was produced by Foa et al, (2010). The guideline identified 9 summary points these were; (1) Addressing comorbid conditions in treatment is recommended. (2) There are various ways to address comorbidity, but integrated treatment is generally the most highly recommended; research is needed to address whether it actually outperforms other approaches. (3) Single-diagnosis
treatments (the majority of PTSD treatments thus far) may have impact on comorbid conditions even if not originally designed for them. (4) Patients with PTSD and comorbid conditions can benefit from psychosocial treatments, as well as from pharmacotherapy. (5) Most studies thus far are uncontrolled pilot studies; only four Level A studies were found (for SS, CBT for MVA survivors, sertraline, and risperidone); only SS meets the criteria for efficacy. (6) Axis II comorbid conditions have been especially underaddressed. (7) Almost all studies address CBT-based models rather than other theoretical orientations. (8) Only one model was suggested to have negative outcomes (behavioral treatment of OCD). (9) More research is needed on those disorders and other, commonly occurring disorders not named, especially studies with strong methodology (Level A), Foa et al (2010: 612-613).

The International Society for Traumatic Stress Studies also produced Expert Consensus Guidelines on the treatment of complex PTSD, CTTF (2012). These guidelines identified a key recommendation: ‘The use of a Phase-based treatment approach for adults with complex PTSD has excellent consensus as well as two Level A (randomized controlled) studies supporting its use. Evidence supports the benefit of this treatment approach in enhancing outcomes related to PTSD symptoms, and equally importantly, in resolving other key aspects of this disorder, including persistent and pervasive emotion regulation problems, disturbances in relational capacities, alterations in attention and consciousness (e.g. dissociation), adversely affected belief systems, and somatic distress or disorganization. In addition the guidelines recognize and highlight the importance of flexible, patient-tailored treatments where interventions are matched to prominent symptoms’, CTTF (2012: 12).

2.5.2 EMDR

Francine Shapiro the creator of EMDR offers this description of EMDR:

“Eye Movement Desensitization and Reprocessing (EMDR) is an integrative psychotherapy that synthesizes aspects of the major schools of psychology. Clinicians are coached to attend to the multidimensional indicators of change, as identified by the various approaches. In addition, they are taught to apply EMDR according to
certain principles expressed in the Adaptive Information Processing (AIP) model, which addresses (a) the past experiences that have set the foundation for pathology and their manifestations (e.g., nightmares, physical sensation), (b) the present circumstances that trigger and/or exacerbate the condition, and (c) the creation and incorporation of templates for appropriate future action. This protocol is integrated within an eight-phase treatment approach” (Shapiro, 2002:1454).

It is important to place EMDR in its therapeutic context by reviewing the research that has informed the NICE (2005) guidelines and current practice. Shapiro and Forrest (1997) research addressed the evolution, development and structure of EMDR from the perspective of Shapiro, who initially discovered, and went on to develop this psychotherapeutic approach. It also described the Adaptive Information Processing (AIP) model that the approach holds as a core element of practice.

Van Etten and Taylor (1998) carried out a meta-analysis of EMDR and determined that EMDR and behaviour therapy were more effective than psycho pharmaceuticals as a treatment protocol, in addition, EMDR was found to be more efficient than behaviour therapy, with results obtained in one-third of the time. Davidson and Parker (2001) also carried out a meta-analysis and found that EMDR was equivalent to exposure therapy and other cognitive behavioural treatments but there was no evidence found for the utility of eye movements. In 2013 Lee and Cuijpers carried out a meta-analysis, which identified a significant effect for the eye movement component within EMDR for processing distressing memories, something that previous meta-analyses had not identified. Schubert, Lee and Drummond, (2011), also identified that the eye movement component in EMDR was beneficial and; ‘coupled with distinct psychophysiological changes that may aid in processing negative memories,’ (2011: 1). Power et al (2002) carried out a controlled comparison of EMDR versus exposure therapy and cognitive restructuring versus waiting list in the treatment of post-traumatic stress disorder, which resulted in both EMDR and CBT producing significant reduction in PTSD and behaviour problems. EMDR was found to be significantly more efficient, using approximately half the number of sessions to achieve results. Supporting this finding Lee, Taylor and Drummond, (2006) identified that; ‘the active processes during EMDR and that of traditional exposure are different…a distancing process that occurs during EMDR treatment was associated
with more improvement than when participants relived the trauma experiences.’ (2001: 105).

Van der Kolk et al (2007) carried out a randomised clinical trial of brief EMDR, fluoxetine and pill placebo in the treatment of PTSD. The study supported the efficacy of brief EMDR treatment to produce substantial and sustained reduction of PTSD and depression in most sufferers of adult-onset trauma. It did suggest a role for SSRI’s as a reliable first line intervention to achieve moderate symptom relief for adult victims of childhood onset trauma. Upon termination of therapy, the EMDR group continued to improve while the fluoxetine participants again became symptomatic. They proposed that future research should assess the impact of lengthier intervention, combination treatments, and treatment sequencing on the resolution of PTSD in adults with childhood onset trauma (Van der Kolk et al, 2007:1).

Bisson, Ehlers and Matthews (2007) carried out a systematic review and meta-analysis addressing the question ‘what are the effects of different psychological treatments in people with post traumatic stress disorder’? The study sampled randomised control studies (RCT’s) of psychological treatments of adults with PTSD that met the following criteria: PTSD was the main target treatment: participants had PTSD symptoms for at least 3 months: at least 70% had a diagnosis of PTSD: PTSD measured using recognised scale: report at least pre- and post- treatment measures: and at least 50% follow up. The main outcomes of the review were that trauma focused cognitive behaviour therapy (TF-CBT) and EMDR both improved PTSD symptoms and reduced the number of people with PTSD diagnosis compared with waiting list/usual care. A small number of RCT’s investigating stress management, group CBT or other psychological therapies compared with waiting list/usual care did not consistently find significant differences between the groups. Based on direct comparison studies the reviewers found that there was unlikely to be a clinically important difference between TF-CBT and EMDR. Comparison between stress management and other therapies suggested that stress management could be more effective for PTSD symptoms (Bisson, Ehlers & Matthews, 2007).

Bisson and Andrew (2007) carried out a systematic review of RCTs reporting on a range of interventions for PTSD. These included TF-CBT, EMDR, exposure therapy,
stress management, supportive therapy, non-directive counselling, psychodynamic therapy, hypnotherapy, and group CBT. The main outcomes of the review were that there was evidence individual TF-CBT, EMDR, stress management and group TF-CBT were effective in the treatment of PTSD. Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There was some evidence that individual TF-CBT and EMDR are superior to stress management in the treatment of PTSD between 2 and 5 months following treatment, and also that TF-CBT and EMDR and stress management were more effective than other therapies. There was insufficient evidence to determine whether psychological treatment was harmful (Bisson & Andrew, 2007).

EMDR has consistently been supported within a range of RCT reviews and recommended as a treatment of choice by NICE, some of these studies, which address its therapeutic mechanism, construction and application are discussed here.

Welch and Beere (2002) addressed the issues of training and dissemination (Acierno, Hersen, Van Hasselt, Tremont, & Meuser, 1994; DeBell & Jones, 1997), treatment efficacy, similarity/differences relative to other PTSD treatments and the absence of a theoretical explanation for EMDR’s outcomes. They summarised their findings as follows: -

“Though the evidence is mixed, EMDR is probably an efficacious treatment for civilian PTSD and possibly an efficacious treatment for military PTSD. The authors propose that EMDR’s treatment effect results from bilateral activation of the right and left cerebral hemispheres during exposure to the traumatic imagery, affects, and cognitions. In addition, the ‘reconnection’ of the hemispheres, the increase in left hemisphere activation, and the resultant reduction in emotional arousal is facilitated by engaging conscious attention via the EMDR procedures, as well as disrupting avoidant and constricted attention” (Welch & Beere, 2002:173).

In 2002 Shapiro offered an overview of the developmental progress of EMDR from its inception and reviewed the historical context and empirical research of EMDR. She concluded that: -
“EMDR is a complex psychotherapeutic approach that integrates aspects of a variety of theoretical orientations. Evidence from PTSD controlled research indicates that it is capable of rapid clinical results that can both complement and expand outcomes achieved by other treatments. The large base of supportive empirical PTSD studies indicates that research can now fruitfully be directed at identifying the appropriate weighting of EMDR’s various components with respect to this clinical population. Evaluation of a wide range of parameters can identify possible differential effects of various components on the change processes in PTSD, and determine whether reported client and clinician preferences for dual stimulation over other non-task conditions apply to non-PTSD populations as well” (Shapiro, 2002:14).

In addressing the wider application of EMDR, Korn and Leeds (2002) offered a review of the complexity of adaptation and symptomatology in adult survivors of childhood neglect and abuse. They looked at participants who met the criteria for the proposed diagnosis of Complex Posttraumatic Stress Disorder (Complex PTSD), also known as DESNOS. They proposed a specific EMDR protocol, Resource Development and Installation (RDI), as an effective intervention in the initial stabilization phase of treatment with Complex PTSD/DESNOS. They concluded that RDI can be effective in reducing distress and associated behaviours in Complex PTSD patients while increasing self capacities and readiness for middle phase, trauma-focused work with the EMDR - PTSD protocol (Korn & Leeds, 2002).

Further support for key findings from a range of reviews was offered by Forbes et al (2007). They carried out a comprehensive review in Australia to compare the outcomes of reviews from the UK and USA. The intention was to develop a series of practice recommendations and develop a set of guidelines while addressing a series of clinical questions.

Key recommendations indicated the use of trauma-focused psychological therapy specifically TF-CBT or EMDR in addition to in-vivo exposure, as the most effective treatment for Acute Stress Response (ASD) and PTSD. Where medication was required for the treatment of PTSD in adults, they recommended that selective serotonin re-uptake inhibitor (SSRI); antidepressants should be the first choice. They went on to state that medication should not be used in preference to trauma-focused
psychological therapy. It was concluded that in the immediate aftermath of trauma, practitioners should adopt a position of watchful waiting and provide psychological first aid. In conclusion to the review Forbes et al (2007) state:

“The clinical practice guidelines outlined in the present paper not only provide Australia with its own NHMRC endorsed guideline for the treatment of ASD and PTSD in adults, but add to the existing literature through the review of an additional 23 studies across psychological and pharmacological treatment for PTSD and preventative interventions for adults exposed to trauma. In addition, these guidelines integrate different foci of research questions and recommendations addressed across the range of international guidelines, and as such, assist in moving the field further forward. While findings from the current review largely mirror comparable documents from other countries (notably the NICE recommendations), key differences between the Australian and overseas contexts highlight the need for local clinical practice guidelines” (Forbes et al, 2007:647).

2.5.3 TF-CBT

Since its introduction into the DSM-III (1980) numerous randomised controlled studies have evaluated a range of treatments for PTSD, most involving some form of cognitive–behavioural therapy (CBT). A meta-analysis of randomized treatment studies for PTSD carried out by Bradley, Greene, Russ, Dutra and Westen (2005) identified 26 studies producing 44 treatment conditions, of which 37 were classified as some form of CBT including EMDR, and 23 control conditions – waiting list or active controls such as supportive counselling and relaxation. The evidence was compelling that CBT was helpful in the treatment of PTSD relative to waiting list and active control conditions. Effective CBT programs included Cognitive Therapy, Stress Inoculation Training (SIT), EMDR, Exposure Therapy, and Prolonged Exposure Therapy (PE), sometimes implemented individually and other times in combination (e.g., PE & SIT).

The quantity and quality of data on the efficacy of CBT prompted the Expert Consensus Guidelines on the Treatment of PTSD led (Foa, Davidson, et al., 1999) to conclude that “three psychotherapy techniques; exposure therapy, cognitive therapy,
and anxiety management are considered to be the most useful in the treatment of PTSD” (Foa, Davidson, et al, 1999:15). Similarly, the CBT chapter from the ISTSS Practice Guidelines (Rothbaum, Meadows, Resick & Foy, 2000), stated: “….strongly recommend the use of some form of exposure therapy in the treatments of PTSD. . .” (Rothbaum, Meadows, Resick & Foy, 2000:323).

In 2008 Ehlers & Clark carried out a review of psychological treatment for PTSD, specifically addressing the approaches that focus on the individual’s memory for the traumatic event and its meaning. The review focused on the available evidence for these treatments. It then illustrated the process of developing effective psychological treatments by discussing how a combination of phenomenological, experimental and treatment development studies, and theoretical considerations was used to develop a Trauma-Focused Cognitive Behavioural Treatment (TF-CBT), Cognitive Therapy (CT) for PTSD. They identified from four randomised controlled trials and two dissemination studies that cognitive therapy (CT) for PTSD is acceptable and effective. This supported their development of an enhanced treatment program, which builds on their initial model (Ehlers & Clark, 2000) of PTSD, which specified two core cognitive abnormalities in PTSD.

First, people with chronic PTSD show idiosyncratic personal meanings (appraisals) of the trauma and/or its sequelae that lead to a sense of serious current threat. Second, the nature of the trauma memory explains the occurrence of re-experiencing symptoms. It further proposed that the idiosyncratic appraisals motivate a series of dysfunctional behaviours (such as safety-seeking behaviours) and cognitive strategies (such as thought suppression and rumination) that are intended to reduce the sense of current threat, but maintain the problem by preventing change in the appraisals and trauma memory, and/or lead to increases in symptoms. They proposed that CT addresses the cognitive abnormalities and maintaining behaviours in an individualised, but focused, way (Ehlers & Clark, 2000:11).

Cloitre (2009) identified the impact of the combination of both exposure and cognitive therapies on the treatment of PTSD. The treatments work to disrupt the complex, fear conditioned response by altering the meanings and cognitions associated to the initial trauma event. It was found by Cloitre (2009) that the use of
the combination of cognitive restructuring and exposure therapy to treat PTSD was found to be more successful than the use of exposure therapy alone.

Zoellner, Fitzgibbons and Foa (2001) identified several cognitive behavioural treatments that were successful in treating PTSD and related symptoms. And discussed the finding that prolonged exposure therapy had some advantage over other approaches. They focused on three psychological factors in an attempt to explain natural recovery and treatment efficacy. The three factors which they identified to be involved in the successful processing of a traumatic event were; 1, emotional engagement with the trauma memory, 2, organization and articulation of the trauma narrative, 3, modification of basic core beliefs about the world and about self.

2.5.4 Alternative Approaches to the Treatment of PTSD

Having addressed the primary and recommended treatment approaches to PTSD, it is at this point a reflection on alternative approaches to working with PTSD is considered.

A meta-analysis carried out by Sherman in 1998 looked at the effects of psychotherapeutic treatments for PTSD. The meta-analysis synthesized the results from controlled, clinical trials of psychotherapeutic treatments for posttraumatic stress disorder (PTSD). Psychotherapeutic modalities included behavioural, cognitive, and psychodynamic treatments, within group and individual settings, Participants in the studies included combat veterans from the Vietnam and Lebanon Wars, crime-related victims, and severe bereavement sufferers. The outcome of the analysis identified the impact of psychotherapy on PTSD and psychiatric symptomatology as significant. Sherman further stated that for target symptoms of PTSD and general psychological symptoms (intrusion, avoidance, hyper-arousal, anxiety, and depression), effect sizes were significant. He proposed that the results suggested substantial promise for improving psychological health and decreasing related symptoms for those suffering from PTSD when employing psychotherapeutic treatment protocols (Sherman, 1998:423).
In 2006 Krisanaprakornkit, Sriraj, Piyavhatkul and Laopaiboon carried out a small-scale review to address the issue of the impact of Meditation therapy for anxiety disorders. The review was initiated from a background of a desire to identify alternative treatment approaches to working with a wide range of anxiety disorders including PTSD. The authors noted that anxiety disorder is a state of pathological anxiety which is characterized by autonomy - spontaneous occurring or minimal trigger by stimuli, tension and autonomic nervous system over activity, intensity - in which the severity exceeds the individual’s capacity to cope with the level of intensity, duration - which is usually persistent or chronic, and behaviour - in which coping ability is impaired, with disabling behaviour as a consequence. The inclusion criteria for the review identified all relevant randomised controlled trials comparing meditation therapy alone or in combination with conventional treatment - consisting of drugs or other psychological treatment, or to another type of meditation or to conventional treatment alone or no intervention / waiting list control.

The authors concluded that the small number of included studies and lack of high quality trials in the review did not permit firm conclusions to be drawn. In one moderate quality trial, the use of meditation therapy in anxiety disorder was associated with some reduction of anxiety symptoms in general, which was comparable to another form of relaxation therapy. They went on to state that motivation and adherence to practice under supervision of a qualified therapist were essential ingredients.

They further reflect on the lack of evidence to demonstrate the effectiveness of meditation therapy over drug therapy, standard care or other psychotherapy. They proposed that it was important to delineate between meditation that is a part of religious/spiritual practice and meditation for psychiatric treatment. They illustrated the lack of conclusive evidence when identifying one randomised controlled trial of small sample size and of moderate study quality suggesting that Kundalini Yoga was no more effective than Relaxation/Mindfulness meditation. They finally proposed a need for more large well-designed clinical trials. And suggested that comparisons of meditation therapy with other psychotherapy would be of particular interest. They also noted the resource implications of this approach when they stated: “patients attending for meditation therapy could develop a self regulatory strategy to cope with
anxiety in the long term; this may help preserve medical care resources” (Krisanaprakornkit, Sriraj, Piyavhatkul, & Laopaiboon, 2006:11).

A further pilot study was carried out in 2007 by Waelde et al, addressed the utility of meditation for mental health workers following Hurricane Katrina. The study examined the effects of a manualised meditation intervention called ‘inner resources’, for post traumatic stress disorder, depression and anxiety symptoms among mental health workers in New Orleans. All subjects participated in a 4-hour workshop followed by an 8 week home study programme. The results indicated that participants’ PTSD and anxiety symptoms significantly decreased over the 8 weeks of the intervention. The results were significantly correlated with the total number of minutes of daily meditation practice. The authors proposed that the findings suggest, “meditation may be a feasible, acceptable and effective post disaster intervention” (Waelde et al, 2008:499).

Thompson and Waltz researched an alternative perspective in 2008 when they looked at the impact on post traumatic symptom severity following the implementation of a self-compassion process. They explored the concept of Neff’s (2003) notion of self-compassion which emphasizes kindness towards one’s self, a feeling of connectedness with others, and mindful awareness of distressing experiences. This is based in the belief that exposure to trauma and subsequent post traumatic stress symptoms may be associated with self criticism and avoidance of internal experiences. In the study Thompson and Waltz examine the relationship between self-compassion and post traumatic symptoms. The outcome of the study identified that participant’s avoidance symptoms significantly correlated with self-compassion, but re-experiencing and hyper-arousal did not. The results suggested that individuals high in self-compassion could engage in less avoidance strategies following trauma exposure, allowing for a natural exposure process (Thompson & Waltz, 2008).

The experiences of individuals who were treated using Compassion-Focused Therapy (CFT), for trauma were researched by Lawrence and Lee (2013). They identified that participants experienced an aversive and threatening emotional response to self-compassion and found the process of becoming self-compassionate extremely difficult. The participants described the therapeutic relationship and the experience of
feeling understood as being vital in enabling them to shift their beliefs about being deserving of self-compassion. An increased sense of hopefulness for the future was also experienced by the participants (2013:11). Lawrence and Lee (2013) identified the challenges within the approach, but that it could enable people to experience the benefits known to result from a more compassionate relationship with the self (2013:11).

Another area of treatment strategy offered in response to PTSD presentation is that of psycho education. Wessely et al (2008) carried out research into the impact of psycho education in the prevention of post traumatic psychological distress. They identified that Psycho education was increasingly used following trauma. The term covers the provision of information about the nature of stress, posttraumatic and other symptoms, and what to do about them. The provision of psycho education can also occur before possible exposure to stressful situations or, after exposure. The intention of both is to mitigate the effects of exposure to extreme situations. Educational information can be offered in a number of ways and can also form part of what has been termed psychological first aid.

The findings from the review highlighted that there was inadequate evidence for presuming that providing psycho education will assist trauma survivors. They went on to state that they were not rejecting the possibility that psycho education may serve an important function. They proposed that previous psycho education attempts might not have been optimally successful, as they may not have integrated knowledge about factors that enhance resilience. And speculated that by providing trauma survivors with lists of possible symptoms ran the risk of implanting expectations of pathology and dysfunction. They further identified that “for many years, psycho education was conceptualized in this simplistic manner, and it is therefore hardly surprising that it resulted in modest, or even harmful, results. However, psycho education can comprise constructive information that proactively encourages an expectation of resilience and, if necessary, help-seeking” (Wessely et al, 2008:296).

Pratt et al (2005) evaluated the use of psycho education for PTSD and concluded that; ‘although psycho education alone is unlikely to produce meaningful clinical change in functional outcome…providing information about common responses to trauma and
frequently observed patterns of symptomology can help to normalize post-traumatic reactions’ (2005:126). They concluded by identifying that psycho education was found to instill hope and motivation for individuals to seek treatment for their trauma related symptoms.

Another approach that has been investigated in the treatment of PTSD is that of future-oriented writing therapy. This was researched by Nixon and Kling (2009), who investigated if the intervention could reduce PTSD severity and associated symptoms such as depression and unhelpful trauma-related beliefs. They found that expressive writing with a focus on achieving future goals and personal change may have some utility in reducing post traumatic stress. They found that the majority of participants did reliably move from PTSD severity categories in a positive direction, from severe to mild, severe to moderate and moderate to mild. They also identified the need for more comprehensive research to be undertaken (2009:10).

I will conclude this section of the literature review with a quote from Bessel Van der Kolk who identified the core aim of therapy for PTSD;

“The goal of treatment for PTSD is to help people live in the present, without feeling or behaving according to irrelevant demands belonging to the past. Psychologically this means that traumatic experiences need to be located in time and place and distinguished from current reality”. (Van der Kolk, 1994:262)

2.6 Summary

It was beyond the scope of this chapter to detail all the literature related to PTSD. Rather this review has attempted to offer a focused overview of key issues relating to PTSD, treatment processes, predisposition / predictors of the development of PTSD from a physiological and psychological perspective.
CHAPTER THREE

METHODOLOGY CHAPTER

3.1 Introduction
Within this chapter I begin by briefly reintroducing the rationale for this study and the associated research questions that are posed. Following this I then outline the qualitative methodology and methods that have been used within this study. This design was selected to facilitate the subjectivity and uniqueness of the narratives involved and elicit a deeper understanding of the individual’s experience (May, 2001). The study focused upon the experiences of practitioners within therapy interactions with clients presenting with a PTSD diagnosis. The practitioner’s experience of working with this client group and specifically their experience of the impact of predisposing factors on the client’s expression of PTSD holds the central focus of the study. A methodology was required to facilitate an understanding of the highly subjective and personal thoughts, beliefs and experiences of the practitioners. An approach that had the potential to capture the practitioner’s interpersonal thought processes and meaning making when engaged in a therapy approach and developing and maintaining a working relationship with client’s presenting with PTSD. The purpose of this chapter is to describe my positioning in relation to the methodology and methods I utilised within the research. It describes the rationale for the chosen methodology and the research design inclusive of participant recruitment and procedures. Collection and analysis of data is discussed along with ethical considerations and issues of reliability and validity.

3.2 Research Questions
Research evidence points to the potential influential impact of predisposing factors on the development of PTSD. Little research has held a focus on the experience of therapists working with clients with PTSD and how they make therapy decisions. This study attempts to gain a greater insight into the experience of therapists experience and understanding of predisposing factors to PTSD and how or if they incorporate this experience and understanding into a therapy process? From an engagement with therapists experience there is also the potential to explore the question of the potential influence of predisposing factors on the expression of PTSD. Specifically the study holds a focus on the therapists understanding and experience of the following research questions:
1. Do trauma therapists believe there to be predisposing factors, which influence the expression of PTSD?

1. How do trauma therapists believe clients’ previous life experiences influence their formulation and treatment protocols for PTSD

The rationale and research questions formed the basis of the study and to a large extent shaped the development of the research methodology used within the research. The inclusion criteria set for participants in the study constructed specific parameters that positioned the use of qualitative research methodology.

3.3 Epistemology

This research takes its epistemological inspiration from phenomenology and specifically the role of interpretation in accessing and making sense of the phenomena of the life world, (Tomkins and Eatough, 2013). Giorgi (1989) described four core characteristics that exist across all variations of psychological phenomenological approaches. These were identified as 1, that the research is rigorously ‘descriptive’, 2, that it uses the phenomenological ‘reductions’, 3, it explores the ‘intentional’ relationship between persons and situations, and finally 4, it discloses the ‘essences’ or structures of meaning immanent in human experiences through the use of imaginative variation (Finlay, 2009a: 7). These characteristics were significant as they informed the choice of a phenomenological theoretical position for this study. The emphasis on exploring the intentional relationship between people and situations and a focus on understanding the essence of structures of meaning within human experience matched the key aims for this study.

Below I outline some of the key philosophical concepts that underpin this piece of research. I will briefly introduce the concept of phenomenology alongside some of the key proponents of this philosophical stance. Following this I will reflect upon the additional concept of hermeneutics and how it relates to the study in question.

3.3.1 Phenomenology

When considering a methodological approach to explore the lived experience of trauma therapists I was presented with a range of alternatives. Willig (2008) identified the importance of the need for the researcher to be clear about which epistemological and ontological
philosophies that underpin and inform the research to be undertaken. I identified a clear
collection with the ontological position of knowledge being co-constructed within a socio-
cultural context. This position offered an alternative to the ontological notion of a fixed reality,
which is proposed within the positivist paradigm.

A philosophical approach to the study of experience is phenomenology, this approach holds
focus on a diverse variety of emphases, however, there is a shared interest among
phenomenologists in their understanding of what it is like to be ‘human’. Phenomenological
researchers offer a general consensus to the idea that the aim of this approach to research is to
engage with the embodied, experiential meanings and the complex and rich descriptions of the
phenomenon as lived (Finlay, 2009a). Wertz described this philosophy as: ‘Phenomenology is
a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-
world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy
over the known’ (2005:175). Spinelli (2005) identified a core assumption at the heart of
phenomenology, which is that humans are active interpreters as opposed to passive recipients
of the world and react to those interpretations.

Phenomenological research aims to capture lived experience in all its complexity, this tasks the
researcher to capture ‘insider meanings and what the lived experience feels like for the
individual’ (Finley, 2009b: 475). Finley further identified the term ‘lifeworld’ and its use to
describe; ‘the world as directly and subjectively experienced in everyday life, as distinguished
from the objective physical world of the sciences’ (2009b: 475).

• Husserl
German philosopher Edmond Husserl is widely acknowledged as the founder of the
phenomenological movement (Moustakas, 1994). Central to his philosophy is the belief that
experimental scientific research could not be used to study all human phenomena. He held the
belief that this scientific approach was obstructing the understanding of self (Crotty, 1996).
Husserl proposed that phenomenology required the careful examination of human experience.
Phenomenology holds a central focus on developing insights from the perspective of those
involved in the phenomena. This is achieved by the participant, who is the focus of the
research, offering detail of their lived experience of a particular time in their lives (Clark,
2000). Husserl held a focus on the rigorous study of the ‘lived’ experiential world of the
individual within specific times and contexts (Willig, 2008). For Husserl the process of making
sense of experience was central to the human condition he identified the concept of ‘natural attitude’, which reflected the tendency of individuals to engage with the world from a position of preconceived beliefs based on previous experience.

Phenomenology from Husserl’s perspective required a process of deferring the process of ‘natural attitude’ in an attempt to focus on and unpack the lived experience and in doing so adopting a ‘phenomenological attitude’. Central to this process is, as Smith, Flowers and Larkin (2009), put it, ‘a reflexive move, as we turn our gaze from, for example, objects in the world and direct it inward, towards our perception of those objects’ (2009:12). In practical terms phenomenological inquiry requires the individual to focus on what is experienced in their consciousness, Husserl offered the term ‘intentionality’ to describe this process and the interplay between the focus on conscious awareness and the focus of that conscious awareness.

A key contribution offered by Husserl (1970, 1983) was that of his perspective of the need for a self-meditative process, he described as ‘Epochē’, where the individual ‘brackets’ or suspends the wider world to experience the phenomenon in its essence. The process of bracketing has its roots in mathematics and relates to the concept of separating out. This process has often been misunderstood as simply a requirement to acknowledge the subjective bias of the individual. Husserl described a more focused process of ‘reduction’ where each reduction offered a different lens or prism and way of thinking about the phenomenon in focus (Smith, 2009). The task of this reduction for Husserl was to establish what is at the core of the subjective experience of the phenomenon, what is its essence or ‘eidos’ (Smith, 2009). Langdradge (2007) discussed the belief within descriptive phenomenology that the individual should transcend their assumptions and preconceived perspectives in order to achieve the process of Epochē. In achieving this process the belief is that the individual would be able to address the phenomenon in a naïve and open manner.

An aspect of human function that Husserl was particularly interested in was that of consciousness. He was concerned with the nature of consciousness and the underlying factors that enables human consciousness. He described this process as ‘transcendental reduction’, which was an attempt to get to the content of conscious experience; this was achieved by holding a focus on experience and the subjective and essential features of this experience.
It is important to note that Husserl held a focus on the individual’s capacity to apply phenomenological methods to their own personal experience. Husserl’s approach ‘was ‘egological’ and grounded in the self-reflection of the philosopher-inquirer’ (McLeod, 2011:86). This raises the issue of Husserl’s uncertainty of the applicability of his phenomenological methods being suitable for the transfer from philosophy to the social sciences. When considering an approach to adopt to address and understand the lived experience of others I noted Husserl’s main concern with first-person processes, where phenomenological enquiry is undertaken by reflection on own/personal experience (McLeod, 2011).

- **Heidegger**

Finlay (2009) identified three broad methodological approaches relevant to phenomenological enquiry, first-person phenomenology, descriptive phenomenology and Hermeneutic phenomenology (2009b: 477). I was drawn to taking a hermeneutic approach, which proposed the central tenant of interpretive engagement within the research. The approach challenged the concept of ‘bracketing’ proposed by Husserl (1970), and takes the alternate view that researchers are engaged in making interpretations and required to be reflexive; ‘about how their previous experience, knowledge and assumptions might have impacted on the research’ (Finlay, 2009b: 479). Heidegger’s approach reflects the aim of the researcher to interpret and analyse the individuals experience through the lens of the researchers own knowledge and experience. Heidegger’s perspective was that the researcher would require a detailed first-hand knowledge of the subject being researched in order to provide an interpretation (Mapp, 2008:309).

As a student of Husserl, Heidegger had a deep understanding of Husserl’s phenomenological position and offered what was a divergent perspective to it. Heidegger’s approach to Phenomenology proposed a marked move away from what he perceived as Husserl’s focus on the abstract and theoretical. Heidegger held a focus on meaning and interpretation as key considerations at the centre of phenomenological inquiry. This perspective held at its core the importance of the context within which the individual exists and is influenced, by all of the external elements within the world (Finley, 2009). Heidegger described the state of human existence as ‘Dasein’ literally ‘there-being’, which reflected his belief that we exist in a ‘pre-existing world of people and objects, language and culture’ (Smith, Flowers & Larkin, 2009:17). This was a specific divergence from Husserl’s positioning in relation to
phenomenology; Heidegger proposed the perspective that it was impossible to suspend our preconceptions. Another point of separation between Husserl and Heidegger was that of focus of concern. Husserl was concerned with individual psychological processes, issues such as perception and consciousness. Heidegger held a focus on ‘the ontological question of existence itself, and with the practical activities and relationships we are caught up in, and through which the world appears to us, and is made meaningful’ (Smith, Flowers & Larkin, 2009:16-17).

Heidegger’s perspective of human being’s is that we are embedded within a world in which we have at the centre of our functioning the process of meaning making and interpretation. As such our existence in this world is always perspectival, temporal and in ‘relation-to’ other things. For Heidegger the basis of phenomenological enquiry in psychology is the interpretation of individuals meaning making processes. Heidegger conceptualised interpretation as a fundamental aspect of human functioning and described this in terms of the concept of ‘fore-conception’ (Heidegger, 1962/1927). When discussing this process he described how the individual brought their fore-conception (beliefs, experiences and assumptions) to any encounter they experienced and as such would contextualise this encounter within a framework of their prior experience. This process of fore-conception (extended to fore-structure) has the potential to create a barrier to the interpretation of the focus of the interpretation. Heidegger (1962/1927) described this concept in the following terms; ‘our first, last, and constant task is never to allow our….fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out the fore-structures in terms of the things themselves’ (1962/1927:195). Heidegger’s perspective in relation to phenomenology was situated firmly within an interpretive and meaning making process this aligned him to the hermeneutic philosophical position. The next section will look at this theoretical position, which holds a focus on the process of interpretation.

3.3.2 Hermeneutics
Hermeneutics offers a theoretical framework for interpretative understanding and meaning; it holds a specific focus on context and original purpose (Patton, 2002). German philosopher Frederich Schleiermacher developed hermeneutic philosophy. It was developed in an attempt to offer structured underpinning interpretation of texts (Smith, Flowers & Larkin, 2009). Central to the purpose of interpreting the text was developing and understanding of what the author wanted to communicate, to understand intended meanings and to situate the documents in
historical and cultural context (Palmer, 1969). Hermeneutics challenged the assertion that ‘an interpretation can ever be absolutely correct or true. It must remain only and always an interpretation’ (Patton, 2002:114).

Kneller (1984) proposed four principles of hermeneutic inquiry, which were not only linked to the interpretation of text, but had the potential to be extended beyond this format. The principles were; 1, Understanding a human act or product, and hence all learning, as like interpreting a text. 2, All interpretation occurs within a tradition. 3, Interpretation involves opening myself to a text (or its analogue) and questioning it. 4, I must interpret a text in the light of my situation, (Kneller, 1984:68). The origins of hermeneutics within the interpretation of written texts, the process of narrative analysis expands the concept of text to be inclusive of interview transcripts and a range of personal recorded narrative texts. Patton (2002) identifies that ‘narrative studies are also influenced by phenomenology’s emphasis on understanding lived experience and perceptions of experience’ (2002:115).

A concept central to hermeneutic theory is that of the hermeneutic circle. This process is focused on the dynamic relationship between the ‘part’ and the ‘whole’. Smith, Flowers and Larkin (2009) describe this process as; ‘To understand any given part, you look to the whole; to understand the whole, you look to the parts’ (2009:28). This circular process places an emphasis on non-linear thinking, which fits well with the analytical perspective of interpretation and represents a practical expression when considering the process of analysing a text such as an interview transcript. For example when looking at a particular word it requires the wider context of the sentence within which it is embedded to be understood. Extending this example the readers understanding will be influenced by their reading history, (exposure to previous reading), and as a result of exposure to the new text will change and impact on the readers textual history.

The concept of ‘double hermeneutic’ or dual interpretation process, was described by social theorist Anthony Giddens. It represents the process by which access to the participants experience depends on, and is complicated by the researchers own conceptions. Smith and Osborne (2003) described this process as: ‘the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world’ (2003:51). From an interpretive perspective the challenge for the researcher is to engage with the subjective world of the participant and take an ‘insider’ perspective. This attempt at a
shared viewpoint requires a two stage interpretive process (a double hermeneutic), within the analytic process (Smith, 2004). The Heideggerian perspective resonates with this process in that the researcher is trying to identify their understandings of a phenomenon while acknowledging an awareness of their fore-conceptions, which may not come to light until they have begun the interview or the analysis, as the phenomenon begins to emerge (Smith, Flowers & Larkin, 2009).

A qualitative research approach, which holds a focus on the detailed exploration of the lived experience and seeks to enable that experience to be expressed in its own terms, is Interpretative Phenomenological Analysis (IPA) (Smith, 2004). As this study sort to understand the lived experience of therapists working with PTSD and specifically the impact of predisposing factors on the expression of PTSD, a methodology was required which facilitated this aim. IPA was adopted as the data collection and analysis method for this research. An overview of key theoretical assumptions and positioning IPA are now presented.

3.3.3 Interpretative Phenomenological Analysis (IPA)

The choice of appropriate methodology requires a high level of reflexivity from the researcher. There is a range of qualitative methods available to the researcher. A strong contender for this research was that of grounded theory, Glaser and Strauss (1967). This has been one of the main qualitative methods used for analysis in counselling research. Grounded theory is constructed to offer a theoretical level account of the phenomenon under investigation. It utilises an inductive approach with the goal of arriving at an interpretation of the phenomenon, which represents its core hermeneutic approach. A core difficulty I experienced when making a choice of an appropriate methodology for this research was the desire not to generate a theoretical level account of the trauma therapists understanding of predisposition to PTSD, rather to capture aspects of the lived experience of the participants. Smith et al (2009) identified a key aspect of the process of IPA that attracted me to this approach when they identified; ‘Clearly there is considerable overlap between IPA and what Grounded theory can do, and as both have a broadly inductivist approach to inquiry. On the whole, however, an IPA study is likely to offer a more detailed and nuanced analysis of the lived experience of a small number of participants with an emphasis on the convergence and divergence between participants’, (2009: 202). This focus and difference was central to my decision in choosing IPA as my data analysis method.
The nature of therapeutic experience, from the perspective of a therapist, is based within a dynamic process, which is central to that therapeutic relationship. This dynamic process offered some key challenges when trying to identify a method to assess it objectively, a phenomenological approach seemed well suited to this specific challenge (Rake & Paley, 2009). The flexibility of IPA and its central focus on the meaning ascribed to the lived experience was considered to be the most appropriate methodology to understand the participant’s experiential world within this study.

Jonathan Smith developed and introduced IPA in his seminal paper of 1996 as an alternative and complimentary methodological approach to the more established methodologies used within the field of psychology (Smith, Harrè & Van Langenhove, 1995). Larkin, Watts and Clifton (2006) note the flexibility in terms of methods employed within IPA. Eatough and Smith (2006) also described the flexible nature of IPA when they stated; ‘IPA is not a prescriptive approach rather, it provides a set of flexible guidelines which can be adapted by individual researchers in response to their research aims’ (2006: 120).

Biggerstaff and Thompson, (2008) described the underpinnings of Interpretative Phenomenological Analysis (IPA) when they stated; ‘IPA’s theoretical underpinnings stem from the phenomenology that originated with Husserl’s attempts to construct a philosophical science of consciousness, with hermeneutics (the theory of interpretation) and with symbolic interactionism, which posits that the meanings an individual ascribes to events are of central concern but are only accessible through an interpretative process’ (2008:215). A focus on rich descriptions of lived experience and meanings (Smith, 2007) was central to the decision of using IPA as the choice of a phenomenological method for the study. Finlay identified the specific nature of interpretive phenomenology and the work of hermeneutic philosophers when she stated; ‘Heidegger, Gadamer and Ricoeur, who argue for our embeddedness in the world of language and social relationships, and inescapable historicity of all understanding’ (2009a: 11). As discussed earlier Heidegger (1962), discussed a core function of interpretation as a process of being in the world for the individual when he stated; ‘The meaning of phenomenological description as a method lies in interpretation’ (1962:37).

IPA’s theoretical underpinnings originate from a phenomenological enquiry, which has at its core an interpretative process and based within an idiographic commitment, situating participants in their particular contexts and exploring their personal perspectives (Smith,
Flowers & Larkin, 2009). IPA differs from other methods in that it assumes an epistemological stance where through careful and explicit interpretative methodology it enables access to the participant’s inner world (Biggerstaff & Thompson, 2008:215). One of the characteristics of IPA is that it requires a highly intensive and detailed analysis of accounts produced by a relatively small number of participants. The verbatim accounts are gathered in a number of ways, the most common being semi-structured interviews although a range of other methods are available such as diaries and focus groups. The analysis focuses on patterns of meaning, which are represented in thematic form. Larkin, Watts and Clifton, (2006) identify two key aims for the IPA researcher utilising this approach. The initial aim is to try and understand their participants’ world and to describe it as clearly as possible from a ‘what it is like’ perspective. The second aim is to develop an overtly interpretative analysis. This analysis has to position the initial description within the wider social, cultural and potentially theoretical context, (2006:104). Smith and Osborne (2003) describe the aims of this ‘second order’ account as providing a critical conceptual reflection on the participants’ sense making processes. They go on to describe the intention of IPA as ‘concerned with understanding the person-in-context, and exploring persons’ relatedness to, or involvement in, the world’ (2003:110). When discussing the way in which conclusions are drawn from research engaged from this perspective Smith and Osborne (2003) comment; ‘our conclusions do not find any inner experience, then; they simply acknowledge that the only way to find the subject is as a person-in-context’ (2003:110).

The IPA methodology is founded upon a Heideggerian combination of phenomenological and hermeneutic insights. This combination follows a requirement for the researcher to get as close to the personal experience of the participant (phenomenological), while also becoming an interpretative process (hermeneutic), for both the participant and the researcher (Smith, Flowers & Larkin, 2009). In the sections below I outline how this approach is adopted within this particular study.

3.4 Participants and Sampling

Below I briefly outline the sampling protocols involved in the study. This involves reflecting upon the sample size within this study and the inclusion criteria. Following this I then provide an overview of the participants who took part. In keeping with IPA designs, brief biographical overviews of these people are included.
3.4.1 Sampling
A central aim within IPA is to explore how individuals make sense of their personal and social world (Smith & Osborne, 2008). The sampling procedure used within the study was purposive. This required participants to be identified who are able to offer a purposeful and informed perspective on the area or phenomenon under investigation within the research (Creswell, 2009). The aim was to build a homogeneous sample, which does not ‘represent’ the population who are the focus of the research, rather, has an ability to accurately reflect on the core research focus (Willig, 2008). The issue of homogeneity of sample was a particular challenge within the study as I had elected to include practitioners with a range of theoretical orientations in an attempt to more fully understand the practice of trauma focused therapists, as the therapists who work in this area do not all work from the same theoretical orientation. There is an implication that the sample could be seen as more in line with heterogeneity than homogeneity. Dallos and Vetere identify my aims within my sampling strategy when they propose that the aim is to ‘capture both the uniqueness of meanings relating to [the] phenomenon as well as commonalities’ (2005: 41).

My desire to hear the voice of trauma therapists was the key driver in this inclusion decision. A mediating factor in this choice was that although the practitioners held a range of core theoretical orientations the practice of trauma therapy, specifically the treatment of PTSD, seemed to centre on a relatively small range of therapy interventions. This is as a result of the National Institute of Clinical and Health Excellence (NICE, 2005) identification of three approved treatments for PTSD. These are Trauma Focused Cognitive Behaviour Therapy (TF-CBT), Eye Movement Desensitisation and Reprocessing (EMDR) and Psychopharmacology. The power of NICE approved treatments has had the effect of these identified treatments becoming the only ones to be accepted by the health care providers, insurance companies and the legal profession, who are the biggest contractors of treatment for PTSD in the UK.

3.4.2 Sample Size
This study aimed to interview between 8 to 10 participants. Ultimately 9 participants were interviewed. Smith and Osborne (2008) identified the difficulty in answering the question of appropriate sample size within IPA. They point to the trend of working with small sample sizes, 4 to 6 participants, in an attempt to stay committed to detailed interpretive accounts, and an in depth reflection on participants perceptions and understanding (Smith & Osborne,
Smith, Flowers and Larkin (2009), identified the process where a larger sample is used within the research, they identified that measuring ‘recurrence’ across cases to be an important factor. The key to this is for the researcher to determine what would be seen as an appropriate level of recurrence? They proposed that recurrence in at least a third, or half of the participant interviews would be appropriate. This was considered to be a way of enhancing the validity of the findings of a larger participant study (2009:107). The level of recurrence set for this research was 50% of participant’s; this is represented in table 1 within the Discussion of Findings chapter.

3.4.3 Inclusion Criteria

Some of the key elements within the process of selecting participants for inclusion in an in-depth interview process are the iterative process at the core of the approach and how purposeful sampling seeks to maximise the depth and richness of the data (Kuzel, 1999). To this end I identified specific criteria for inclusion in the study. The participant population were drawn from experienced practitioners from a range of theoretical backgrounds.

Practitioners were identified as therapists belonging to the group of ‘core mental health professionals’. These include psychiatrists, clinical psychologists, counselling psychologists, community psychiatric nurses (CPN), UKCP accredited psychotherapists, BACP accredited counsellors, and CBT therapists. Other qualified therapists were also able to meet the entry criteria through their on-going work within the area of psychological trauma.

A key entry requirement was that the practitioner had direct experience of working therapeutically with adult clients who have experienced psychological trauma and present with a PTSD diagnosis. A summary of the participant’s background details is offered in Table 1.
Table 1: Table outlining the research participant background information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Profession</th>
<th>Clinical Experience</th>
<th>PTSD Experience</th>
<th>Therapy Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>Clinical Psychologist</td>
<td>10+ Years</td>
<td>5 Years</td>
<td>Integrative/ CBT</td>
</tr>
<tr>
<td>2</td>
<td>Male</td>
<td>Counsellor</td>
<td>30 Years</td>
<td>12 Years</td>
<td>Integrative/ Relational</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>Psychotherapist</td>
<td>14 Years</td>
<td>14 Years</td>
<td>Integrative/ EMDR</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>Psychotherapist</td>
<td>27 Years</td>
<td>10 Years</td>
<td>Integrative</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>CBT/EMDR Therapist</td>
<td>10 Years</td>
<td>7 Years</td>
<td>CBT/EMDR</td>
</tr>
<tr>
<td>6</td>
<td>Male</td>
<td>GP/EMDR Therapist</td>
<td>2 Years</td>
<td>2 Years</td>
<td>Bio/Psycho/ Social/EMDR</td>
</tr>
<tr>
<td>7</td>
<td>Female</td>
<td>Psychotherapist</td>
<td>8 Years</td>
<td>3 Years</td>
<td>EMDR/ Body Psychotherapy</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>CBT Therapist</td>
<td>18 Years</td>
<td>11 Years</td>
<td>CBT</td>
</tr>
<tr>
<td>9</td>
<td>Male</td>
<td>Priest/CBT Therapist</td>
<td>16 Years</td>
<td>16 Years</td>
<td>CBT</td>
</tr>
</tbody>
</table>

- **Biographical details of participants**

The participants that met the inclusion criteria, had accepted the conditions and parameters of the study and opted in through the process of informed consent illustrated by means of signature of the consent form were invited to attend a semi-structured interview. Smith, Flowers and Larkin (2009) identified the utility of outlining the biographical profiles of the participants in an attempt to clarify the contextual relevance they offer to the issues under investigation. Below I outline brief biographical details of the participants, provided by them prior to the interview process, (see appendix 6 for Participant biographical details document), of this study, holding in focus the principles of confidentiality and anonymity.
Participant 1 – is a male Chartered Clinical Psychologist who worked in the South of England, with a background of over ten years of therapeutic experience in a range of settings. He originally worked as a counsellor before undertaking his training as a Clinical Psychologist. He is a highly experienced Psychologist with five years experience of working directly with PTSD and related trauma presentations. He described his therapeutic approach as integrative and draws upon a range of theoretical positions and described using Trauma-focused CBT within his trauma work. He described his qualification for and experience of diagnosing PTSD within his work. When interviewed he worked full time in a military setting mostly in a one to one modality and also with group work experience.

Participant 2 – is a male Counsellor who worked in Wales, with an extensive therapeutic background with over thirty years of practice experience within a range of settings. The settings for his practice are the voluntary sector and a range of NHS environments, working within a one to one modality. He has a broad range of experience of working with diverse therapeutic presentations and for the past 12 years has worked with PTSD and trauma issues. He described his therapeutic approach as integrative and relational. He did not work from an identified PTSD NICE recommended treatment perspective.

Participant 3 – is a female Psychotherapist/EMDR Consultant who worked in the North of England, she had an extensive therapeutic experience base with fourteen years of practice experience. She worked within Private Practice and described working predominately with trauma and anxiety based issues in both one to one and group modalities. She had fourteen years of experience of working with PTSD and trauma related presenting issues. She described her therapeutic approach as integrative and EMDR focused. She worked from an EMDR (NICE) recommended therapeutic treatment perspective.

Participant 4 – is a female Psychotherapist who worked in the North of England, she had a comprehensive therapeutic practice history with twenty-seven years of therapy work in a range of settings. She worked within a specialist voluntary sector environment and had a background of working from a wide client base working with young people and adults who present with trauma issues. For the past ten years she has worked with PTSD and trauma related presenting
issues in a one to one modality. She described her therapeutic approach as integrative and did not use the NICE recommended treatment protocols in her work with trauma clients.

Participant 5 – is a male Psychotherapist who worked in the North of England, he had a substantial therapeutic practice background with ten years experience of working within a range of settings. He worked initially within a specialist NHS setting and was currently working in a Private medical setting with a range of clients and presenting issues. He had worked with PTSD and trauma issues for seven years in a one to one modality. He described his therapeutic approach as CBT and EMDR and worked from both of these NICE recommended therapeutic interventions for PTSD.

Participant 6 – is a male General Practitioner with therapeutic training who worked in Wales, he was a relatively newly qualified therapeutic practitioner who had extensive experience as a medical practitioner. He had experienced working, from a medical perspective, with a wide range of trauma presentations. He had two years of therapeutic experience working with PTSD and trauma related issues. He worked within an NHS setting and specialist medical setting and worked within a one to one modality with his clients. He described his therapeutic approach was Bio/Psycho/Social model and was trained and worked from the NICE recommended EMDR approach with his trauma clients.

Participant 7 – is a female Psychotherapist who worked in the North of England, with considerable experience of working with a range of client presenting issues and a range of client groups. She had eight years of therapeutic experience and had been working with PTSD and trauma presentations for three years. She worked in a Private Practice setting and described referrals from NHS, Private Medical companies, medico-legal services and self-referrals. She described her therapeutic approach as Body Focused Psychotherapy and EMDR. She described working from a one to one modality and used the NICE recommended EMDR approach within her work with PTSD and trauma work.

Participant 8 – is a female CBT Psychotherapist who worked in the North of England, who had extensive experience of working as a therapist with a wide range of clients and presenting issues. She had been a therapist for eighteen years, initially as a counsellor and then retraining as a CBT Psychotherapist. For the past eleven years she had worked with PTSD and trauma
presentations in a range of settings. She had a background of working in the NHS and was currently working in Private Practice with clients referred from Private Health Care Companies, medico-legal services and self-referrals. She described her therapeutic approach as CBT and used the NICE recommended Trauma Focused CBT in her work with PTSD and trauma clients.

Participant 9 – is a male Priest who is a trained CBT Therapist and worked in the North of England, he had extensive experience of working therapeutically with a range of clients and clinical presentations in both a one to one and group modalities. He has had sixteen years experience of working therapeutically within a wide range of settings. He has also worked with clients presenting with a PTSD diagnosis and related trauma issues for the past sixteen years. He described his therapeutic approach as CBT and described using the NICE recommended treatment of Trauma – Focused CBT with his PTSD and trauma clients.

3.5 Method of Data Collection

3.5.1 Recruitment

Participants were recruited by placing a notice in the BACP journal ‘Therapy Today’, which included an entry on the website (see appendix 2). The notice was also placed within the BPS journal ‘The Psychologist’ this was in the ‘community notice board’ section along with the website. The notice and information sheets were also circulated to organisations and therapists who were identified as working with trauma. Clarification of the purpose of the study was offered along with inclusion criteria and a description of the requirement of a recorded one-hour semi-structured interview and my contact details as the researcher along with details of my research supervisor.

The actual respondents were drawn not from the journal or internet notices but from participants who had seen or been told of the study as a result of the notice and information sheets circulated to organisations and therapists. All of the participants within the study came from either accessing the information sheets sent directly to their therapeutic practice placements or from word of mouth conversations with other practitioners. This may reflect the relatively small number of trauma therapists, and the networks within which they function or the manner in which the information was circulated? This ‘continuity’ of recruitment may be
significant in the wider discussion of the findings from the study or be more representative of
the nature of trauma therapist networks? The participants were not drawn from a singular
geographical area and this may also be a significant factor when considering the self-reported
discreet grouping of trauma therapists within specialist therapy services and private practice.
The decision to accept all prospective participants who met the inclusion criteria as they
responded had the impact of creating this participant profile. The participants came from a
variety of geographical areas within the north and south of England and mid and north Wales.

Participants who responded with an expression of interest were contacted by telephone or email
and following discussion and explanation of the research project were sent a participant
information sheet (see appendix 3). Along with dual copies of the research consent form (see
appendix 4 & 5). Once the potential participant had accepted the criteria for engagement within
the study they signed the two copies of the consent form and one copy was retained by the
participant and other one returned to me in the SAE I had provided. Once the signed consent
form had been received I contacted the participant by the participants chosen method (e-mail,
Skype or telephone) and they were offered either a face to face or an agreed alternative method
of semi – structured interview, which was then arranged. Interviews were carried out at a venue
and in a method agreed by both participant and myself. It should be noted that all of the
interviews were face to face and in person, none of the participants opted for telephone or
Skype interview methods. I travelled to 4 participant’s locations to carry out the interviews and
5 participants opted for interviews at Manchester University campus.

Following each interview a verbatim transcript was constructed, noting all pauses, speech
dynamics and interactive processes. Transcripts were sent to the participants for confirmation
of content and feedback. In all cases this was done, with agreement, by e-mail with a set time
frame for return. Statements made within the transcript that had the potential to identify client
work or breach confidentiality were removed by the participant, or on request from the
participant, by myself. This process resulted in 5 transcripts being revised by participants with
the other 4 participants electing to not change any text within the transcript of their interview.
Following this process the transcripts were then available for the next stage of analysis.

I had made the decision to suspend the analysis process at this point and continue to carry out
other interviews. This was in an attempt to hear the voice of each participant, as individual
perspectives, and to not be overly influenced by in-depth analysis of previous participant
interviews. There was recognition that carrying out each interview, however, would impact me, in-depth analysis had the potential to overly influence my interaction with the next participant to be interviewed. Once all of the interviews had been completed and transcribed the process of in-depth analysis was carried out. This was a slight deviation from the central strategy of analysis proposed by Smith and Osborne (2008). There is acceptance that there is considerable room for manoeuvre in the process of IPA and Smith, Flowers and Larkin (2009) describe there being ‘no clear right or wrong way of conducting this sort of analysis and we encourage IPA researchers to be innovative in the ways that they approach it’ (2009:80).

3.5.2 Interview Process

Reflecting on the impact and utility of interviewing Seidman (1998) identifies; ‘[interviewing]…provides access to the context of people’s behaviour and thereby provides a way for researchers to understand the meaning of that behaviour. A basic assumption in in-depth interviewing research is that the meaning people make of their experience affects the way they carry out that experience’ (1998:4).

The epistemological origins of interviewing is described by Rubin and Rubin (1995) when they stated; ‘qualitative interviewing is a way of finding out what others feel and think about their worlds. Through qualitative interviews you can understand experiences and reconstruct events in which you did not participate’ (1995:1). The interview process is concerned with ‘searching for meanings and essences through first-person accounts during informal one to one interviews’ (Mapp, 2008:308).

An aspect of the choice of a semi-structured interview process for the study was in response to the aims of the interview format as described by DiCicco-Bloom and Crabtree (2006), ‘the in-depth interview is meant to be a personal and intimate encounter in which open, direct, verbal questions are used to elicit detailed narratives and stories’ (2006:317). This perspective held a resonance to my aims of engaging with the narratives of therapists who work in the field of trauma and specifically with PTSD.

Key areas that characterise a semi-structured interview are: a focus on rapport building, the order of the questions is less important, the interviewer has more freedom to hold a focus on relevant areas developed by the interviewee and the interview is flexible enough to follow the
interviewees interests and concerns (Smith & Osborne, 2008: 58). Kvale and Brinkman (2009), discussed the concept of narrative interviews and how the process of the development of the participant’s narrative within a response to an initial question, along side the use of body language, and clarifying questions by the researcher, engages the researcher as co-creator of the story (2009: 153).

DiCicco-Bloom and Crabtree (2006) also identified the importance of rapport within the process of interviewing when they stated, ‘…it is necessary for the interviewer to rapidly develop a positive relationship during in-depth interviews. The process of establishing rapport is an essential component of the interview…’ (2006:316).

The interviews were arranged in a variety of settings. The majority of interviews were conducted in confidential and private rooms within the University of Manchester. Other interviews were conducted at venues agreed with participants conforming to standards of safety and confidentiality and ensuring security of privacy. All interviews were face to face and no participant opted for a telephone or Skype interview. These options were available, particularly for those who were geographically situated away from the Manchester area.

The interviews ranged from fifty-two minutes to a maximum duration of one hour and fourteen minutes. They followed a pre constructed semi structured question format. The interview schedule was constructed around 11 questions, (see appendix 7), in the structured element of the interview. The questions were constructed around the directional flow of the research questions and influenced by the literature around PTSD.

There was a concerted effort to offer and maintain an unbiased and open approach, which had the potential to enable the participant to discuss and explore areas of core significance to them. All participants were asked the same questions in the same order in an attempt to offer as much consistency as possible; however, this was determined by the interviewee’s responses and choice of direction. Additional prompts or clarifying questions were also added where required. There is no requirement for the questions to be asked in the same order as long as the core questions are discussed, the order is of less importance. It is recognised that this process will be guided by the schedule rather than dictated by it (Smith & Osborne, 2008). Eatough and Smith (2008) identified the aim of flexibility and a reduction of a prescriptive format which offers a
capacity to be responsive and a clear focus on holding closely to the participant’s perspective within the interview process.

### 3.6 Data Analysis

As indicated earlier in this chapter, the choice of Interpretative Phenomenological Analysis (IPA: Smith, Flowers & Larkin, 2009) was made with an aim to explore how individuals make sense of their personal and social world, by studying what particular experiences, events or states mean to the participant (Smith & Osborne, 2008). The key aim of this approach is to reproduce the unique view of the participant, as far as possible, utilising a semi-structured interview format (Carruthers, 1990). Willig (2008: 56) identified a key aspect of IPA when she stated: ‘the method accepts the impossibility of gaining direct access to the participant’s life world’. She goes on to identify the dynamic of the interplay between the researcher’s sense of their own world and the interaction between researcher and participant. She describes the outcome of this interaction and concludes, ‘as a result the phenomenological analysis produced by the researcher is always an interpretation of the participant’s experience’ (Willig, 2008: 57).

An issue identified by Conrad (1987) addressed the desire of the researcher to take and ‘insiders view’ of the participant’s world, and the recognition that this cannot be achieved directly or completely. This process is seen to be complicated by the researcher’s own conceptions however; this is required in order for the researcher to make sense of the personal world of the participant through the process of interpretative activity (Smith, Jarman & Osborne, 1999: 218).

IPA attempts to analyse in detail how participants make sense of and perceive events, which they engage in or are happening to them (Smith & Osborne, 2008: 57). The semi-structured interview offers a well-utilised method of data collection from an IPA perspective. This form of interviewing offers a flexible approach to data collection, which has the potential to respond to researcher/participant movement in dialogue. Interviews were carried out and digitally recorded. From the recording a transcript was constructed.
The transcripts were examined in line (with the adaptation discussed above) with the adapted framework outlined by Smith and Osborne (2008: 65). Each transcript was analysed individually through these stages:

1. **Initial Coding process – (Preliminary Analysis)**
   a) A verbatim transcription of the interview was undertaken and each line is assigned a number.
   b) This stage is focused upon reading and rereading transcripts and developing comprehensive notes. Notes were constructed that were descriptive of general points of interest, associations, connections and early interpretations. Recordings were listened to while reading through transcripts to identify wider issues of pace and delivery and the process repeated several times to get an in-depth feel for the developing themes. With the participant at the centre of the analysis process reflection on my recollections of the interview process and my observations of the structure and content of the session with the participant were recorded.

2. **Initial identification of emergent themes**
   Identification of emergent themes from discrete chunks of the transcript and reflection on the early notes compiled was carried out at this stage. This required mapping the interrelationships,
connections and patterns between exploratory notes and transcripts. Within this process there is movement between the transcript and the notes in an attempt to develop and identify emergent themes. This stage is characterised by a shift in focus from the large amount of information developed, (transcript and associated notes), to reducing the volume of detail while maintaining the depth of reflection and focus. Themes were tested in a cyclical process. Modification and revision is central to this stage of analysis. Biggerstaff and Thompson (2008) discussed this stage of the IPA analysis process when they stated; ‘The more material researchers have, the more rigorous they need to become in the later selection process. The mere frequency of a theme does not necessarily mean it should be selected as super-ordinate to, or more important than, other themes. The richness of the selected text and how the theme might inform other parts of an individual’s account must also be considered’ (2008:218). Smith, Flowers and Larkin (2009) identified a specific aspect of this stage when they stated; ‘This process represents one manifestation of the hermeneutic circle. The original whole of the interview becomes a set of parts as you conduct your analysis, but then these come together in another new whole at the end of the analysis in the write-up’ (2009:91).

3. **Emerging themes chronologically ordered**
   Themes were arranged into a chronologically sequenced listing that is themes were listed in the order in which they came up. The themes were then reorganised and clustered.

4. **Clustering Themes**
   Themes were organised into clusters then the process of making sense of connections between emergent themes was initiated. During this process themes were physically moved around, following being cut up into separate pieces of paper to enable a spatial representation of how themes related to each other. Connective and parallel themes were grouped and those that were opposed were separated. Themes were grouped into clusters relating to shared meanings or connected references. This process was carried out for each transcript and lists of themes, which were identified for each interview, were drawn together into a consolidated list. With nine participants and a considerable amount of data, the process of selection and development of themes was focused on how they informed the wider understanding of the participant’s experience. This process was designed to ensure that the themes truly reflected the original data.
6. **Identification and selection of themes for interpretation**

The method of the selection of themes for interpretation was carried out utilising the processes of abstraction and subsumption (Smith, Flowers & Larkin, 2009). Abstraction is a way of identifying patterns between emergent themes this is enacted by connecting similar themes together and creating a name for the emerging cluster, identified by Smith (2004) as a ‘super-ordinate’ theme. Subsumption is a similar process to abstraction but differs in that it describes the process where an individual emergent theme acquires a super-ordinate theme status, as a result of bringing together other related emergent themes (Smith, Flowers & Larkin, 2009:97).

7. **Creating a table of Super-ordinate & Sub-ordinate themes for each participant**

At this stage there were a number of choices in relation to how the themes were consolidated. Smith, Flowers and Larkin (2009) describe not wanting to be prescriptive in the analytical process and encourage researchers to adapt the approach to fit with the requirements of the research undertaken. This informed my development of an informal table identifying the specific Super-ordinate and related Sub-ordinate themes for each participant these were developed from the transcript initially (see appendix 9, fig 1).

8. **Identification of Patterns across all Participants**

This stage held a focus on the identification of patterns across all participant themes. This again was a physical process where all transcripts and theme tables were compared. The emphasis was on how a theme from one participant helped inform or reflect what other participants were describing. This process resulted in some renaming and restructuring of theme titles to capture this connection while retaining key meaning. Reflection on the individual participant themes and the potential for extrapolation to wider higher order concepts that represent other participants was the key task of this stage of analysis (Rake & Paley, 2009).

9. **Creation of a table of Master and Sub-ordinate themes.**

This stage is characterised by the construction of a representation of the final results of the process described in stage 7. There are two key alternatives in the manner of the representation of this information these are in the form of a table or a graphic representation. A table of themes was not constructed for this study; instead a graphic representation of the Super-ordinate (Master) themes and Sub-themes identified from stage 7 was developed (A diagram of these themes is offered within the findings chapter, Fig 2).
3.6.1 Trustworthiness & Rigour

Tobin and Begley (2004) discussed Johnson’s (1999) perspective on rigour when they stated; ‘the need to incorporate rigour, subjectivity and creativity into the scientific process of qualitative research has fuelled debate over the issues of bias and the process of demonstrating validity’ (2004:390). Lincoln and Guba (2000) discussed the view that positivism is associated with quantitative research that holds a focus on the notion of objectivity. To facilitate this aim it offered an adherence to specific methodological standards and benchmarks. These benchmarks are framed around key considerations of; internal validity, external validity (generalizability), reliability, and objectivity (neutral observer), they adapted and elaborated these benchmarks to, what they termed ‘parallel criteria’. Morrow (2005) described these as; ’criteria that run parallel to validity and reliability criteria stemming from post positivist quantitative methods of rigor’. (2005:251). She goes on to state that; ‘These parallel criteria are intended to very loosely achieve the same purposes as internal validity, external validity, reliability and objectivity in quantitative research’ (2005:251).

There has been no universal acceptance of criteria for judging quality in qualitative research. Rolfe (2006) proposed; ‘any attempt to establish a consensus on quality criteria for qualitative research is unlikely to succeed for the simple reason that there is no unified body of theory, methodology or method that can collectively be described as qualitative research’ (2006:305). Morrow and Smith (2000) identified that the ‘goodness’ of qualitative inquiry is assessed on the basis of the paradigmatic underpinnings of the research and the standards of the discipline, (Morrow, 2005:250). Yardley (2000) proposed four principles that hold a focus on the core qualitative research principle of trustworthiness. These were; 1, Sensitivity to Context, this is represented by a focus on the theoretical, relevant literature, empirical data, socio-cultural setting, participants’ perspectives and ethical issues. 2, Commitment and Rigour, this is represented by a focus on an in-depth engagement with the topic and methodological competence. 3, Transparency and Coherence, this is represented by engagement with the clarity and power of description and or argument, a transparency of methods used and data presentation, and the fit between theory and method along with the presentation of reflexivity. 4, Impact and Importance, this is demonstrated by a focus on enriching understanding, the socio-cultural context, the practical context, implications and impact.
These principles informed the development and construction of this study and the focus on a clear and transparent process that could be easily followed and was replicable. From an IPA perspective, Smith, Flowers and Larkin (2009) identified the concept of independent audit as a way in which the researcher can conceptualise constructing and presenting the research in relation to validity. Reflecting the possibility of an independent auditor being able to check the chain of data collection, analysis and final conclusions drawn, was seen as being a useful concept when considering the depth and detail required when presenting the research, (2009:183). Holding this perspective in mind I constructed the format and structure of this research in an attempt to develop a trustworthy research study.

Stiles (1999) identified a range of general principles of good practice in qualitative research. These were; Coherence, Uncovering (self-evidence), Testimonial validity, catalytic validity, consensus (replication), and reflexive validity. One of the key aspects of good practice within qualitative research is that of the disclosure of the researchers’ fore-structure. This includes a description of the social and cultural context along with a description of the manner and level of exposure and experience of the phenomenon under investigation (Stiles, 1999). Reflexivity of the researcher was described by Yardley (2000) as an important aspect of the third principle of transparency and coherence and was central to this study. Transparency was communicated within the study when I offered, within chapter 1, an extended positioning statement in relation to these issues and reflecting the centrality of my lived experience, which acted as a lens by which I interpreted the data. Offering my world-view enables the reader to assess my capacity to analyse and interpret the data and create their own understanding and conclusions. Elliott, Fischer and Rennie (1999) developed guidelines for the publication of qualitative research studies and identified seven points, the first of which was ‘owning one’s perspective’. The positioning statement was an attempt at addressing this criterion. This transparency was extended along Yardley’s third principle with a clear explanation of the data collection and analysis procedures, which are offered in a detailed documented format. This audit trail reflected an attempt to enable the reader to identify decision points and the manner in which these were addressed.

3.7 Ethical Considerations

A range of ethical codes and research ethics guidelines has informed this study. The initial step in developing an ethically grounded research study was to go through the University ethical approval process for the study. This required application to the University of Manchester Ethics
Committee by means of completion of a structured ethics form, (see appendix 1), presented for formal consideration. This was the second stage of ethical clearance and the process resulted in ethical approval by the committee for the study and followed successful progression through the initial stage of approval at the university research panel.

This research study was constructed around and conforms to the BACP Ethical framework for Good Practice in Counselling and Psychotherapy, and the ethical guidelines for research (BACP, 2010). It also complied with the BPS Code of Ethics and Conduct, and ethical research framework (BPS, 2009). Three key areas for consideration within these codes are awareness of confidentiality, avoidance of harm to participants and procedures for dealing with potential distress caused to participants (McLeod, 2003). I had checked and reflected upon my chosen design and methodology against these codes in an attempt to identify possible ethical implications.

The semi-structured interview format was constructed to minimise the amount of participant personal information recorded. The pre-interview section was developed to maximise the information captured while minimising the potential for identification of the participants. The manner in which participant information was used within the research was a key ethical consideration. When discussing participants a focus was placed on confidentiality as trauma therapists are a relatively small sub group within the wider therapeutic community and the potential for a breech of anonymity was increased. Anonymity was seen by Smith et al, (2009) as the key factor that can be offered by qualitative researchers’, as they believed that it was more difficulty to ensure complete confidentiality due to the nature of access to participants’ narratives. The focus on anonymity was central within my decision making process when constructing the research format and structure. No names were used within the research write up and no pseudonyms were constructed, participants were assigned numbers to allow for tracking within the findings and analysis process. This was identified as a way to maintain and further ensure anonymity. Another key ethical consideration, which embedded an appropriate ethical expression of this research, was participant informed consent. This was expressed by the use of specifically constructed consent documents (see appendix 4&5), which provided focused, documented information of the ethical issues relating to the study. Detailed information about the study and the implications of engaging in the research was offered within the participant information sheet (see appendix 3), which identified the intention and focus of the research and practical and logistical issues relating to the research. This document also
consolidated and offered clarification of the method adopted by the study along with inclusion criteria and a description of the ability of participant’s to withdraw from the study at any point should they wish. The issue of the right to withdraw was a key ethical consideration in the process of client informed consent, and it was clearly stressed that the participant could withdraw at any stage in the research process. Discussion, clarification and further information were available from myself to any prospective participant who required clarification to reach an informed choice of participation in the study. I had built into the research method a process incorporating alternative options, which addressed the issue of participants’ inability to engage in a face-to-face interview in a physical location. The options of telephone, or Skype interviews were made available to those who may prefer them. No participant took up these options and all completed face to face interviews in locations agreed and confirmed as confidential and appropriate for purpose. Within the informed consent process I had made available information about my background and positioning in relation to the research. This was designed to offer a transparent and open environment where discussion and reflection were encouraged. The option for participants’ to review and amend transcripts after the interview was also provided to offer as much autonomy and influence to the participants’ in representing their true meaning within the discussions undertaken in the interview.

All information and data collected was held securely and in an environment that enhanced confidentiality and every effort was engaged to ensure that participant’s were offered anonymity within the construction and presentation of the study. Written information and recordings of interviews were stored in a locked storage cabinet and electronic information was stored on an encrypted electronic storage device. I had responsibility for access and confidential containment of this secured information and the only other person who was able to access this information was my supervisor throughout this process.

3.8 Summary

This chapter has presented a brief reintroduction of the research questions posed within this study and the associated rationale. An outline of the qualitative methodology and methods that have been used within this study has also been presented. Associated data collection and analysis strategies were discussed and related trustworthiness; rigour and ethical considerations were discussed.
CHAPTER FOUR

DISCUSSION OF FINDINGS

4.1 Introduction

The aim of this chapter is to provide a summary of the themes that emerged from the discussions within interviews undertaken with the participants in relation to their experiences of working with clients who present with a PTSD diagnosis.

Eight Master themes and thirteen related Sub-themes were identified. The themes are representative of the iterative process of understanding and interpretation and result from grounding in the data. It is important to note that the thematic analysis does not follow the chronological order of the interviews/transcripts.

There was variation in the contribution of each participant to the master themes; however, participant discussion of key related sub-themes held connection to the overarching master themes. Throughout the analysis process emphasis was offered to convergence of participant accounts and the master themes identified represent the reflective continuity of at least 50 percent of the participant group. Identification of the match between participant and their reflection on specific themes can be viewed in table 2. It is my intention to offer firstly a representative account of the data and then to elaborate an interpretation of that data within a discussion of each theme and sub-theme.

Below is a graphic representation of Master (Super-ordinate) and Sub-themes derived from the analysis of text (fig2).
Master (Super-ordinate) Themes and Sub-Themes (fig 2)

- Previous History:
  - Traumas
  - Predisposing issues
  - View of Self & Life

- Therapy Relationship:
  - Developing Trust
  - Safety in the Relationship
  - Issues Impacting the Relationship

- Psychoeducation Normalisation:
  - Resource Building

- Identity:
  - Perception
  - Beliefs/Assumptions

- Culture:
  - Environment

- Attachment:
  - Secure/Insecure
  - Childhood Experience

- Presenting Therapy Themes:
  - Coping Strategies
  - Emotions/Affect

- Support Systems:
  - Internal/External
Table 2: Table outlining the Key Master Themes Recurring within and across the participant interview transcripts

<table>
<thead>
<tr>
<th>Key Master (Super-ordinate) Themes Recurring within and across Participant Interview Transcripts</th>
<th>Participants</th>
<th>No of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master Themes</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>1, previous History</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>2, Therapy Relationship</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>3, Psycho-Education/Normalising</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>4, Identity</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>5, Culture</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>6, Attachment</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>7, Presenting Therapy Themes</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>8, Support Systems</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

Although the themes were not experienced or presented as a hierarchy the first three Master themes presented were addressed by all participants. The remaining five themes were addressed by a variable range of participants, (not less than 50% of the participants) illustrated in table 2 above. Smith, Flowers and Larkin (2009) proposed that recurrence of themes in at least a third, or half of the participant interviews would be appropriate. This was considered to be a way of enhancing the validity of the findings of a larger (more than 4-6) participant study (2009:107).

Participant quotes are complete and verbatim directly representing the statements made within the interviews; they are presented in italics within the following text. I will be addressing all themes to substantiate and develop my discussion and reflect the central aspect of the embedded nature of these within the findings.
4.2 Master Theme 1: Previous History

Sub-themes:
* Traumas
* Predisposing Issues
* View of Self & Life

A central factor in the understanding and treatment of PTSD and trauma responses was the background and previous experiences of the client. All the participants who identified the following issues reflected upon their understanding of their client’s previous experiences and the meaning made of these. A focus was held on the participants meaning making of these issues.

Participant 3 discussed the general concept of history taking as a core process in working with clients who present with a PTSD diagnosis. She identified her focus of the potential influence of ‘past and present’ and associations between these. Participant 8 who extends this discussion to incorporate the client’s response ‘post’ presenting trauma discusses a similar focus.

P3 “in my history taking, as I’m doing the history I’m explaining a little bit about why I’m asking – explaining that I’m not being nosey, but I’m trying to work out how he’s got to this point in his life... I am looking at associations between the critical incident, the trauma they have been referred for, and prior ones.”

P8 “it’s the usual sort of mental health history. So you’re looking at any traumas that they have experienced other than the actual trauma that they are going through. Their situation – work, family/ home situation, those sorts of things. History of mental health problems, history of physical health problems...plus, of course, the history of what’s happened since the trauma for which they are being treated.”
This theme reflected a standard practice of the participants when engaging in trauma therapy work. Participants identified the sense of expectation of the need to complete an initial review of the history of the client. They discussed the assessment process and the integral process of history taking with a focus on aspects of the client’s current situation and wider family, work and mental health background. Detailed information was sort in respect of the presenting trauma, what happened and what had happened since. These elements formed the basis of treatment planning and development (Ehlers & Clark, 2000).

Pre, peri and post trauma responses were seen by all participants as holding great influence on the development of treatment direction and choice. This reflected the specific nature of trauma, as discussed by the participants, who proposed the requirement of a very ‘tailored’ approach to developing a therapeutic relationship and treatment process with clients presenting with PTSD. The need for, and emphasis on, previous history of the client seemed to hold great sway over the thinking and practice of the participants.

The participants addressed specific aspects of the process of ‘previous history’ and three sub-themes emerged as representative of the participants thinking and experience of working with their clients. The first of these reflected the discussion of the importance of an understanding of the client’s previous trauma history, which was engaged by all of the participants.

4.2.1 Sub-theme (i) Traumas

This sub-theme represented a highly important factor in the participants understanding of a client’s trauma response and experience. All participants talked of the impact of previous traumas on the client and how, when working with clients, they have experienced that work to be enhanced and greatly informed by this knowledge and understanding.
Participant 9 discussed his experience of his clients who had experienced childhood abuse and how, in his working environment (prison setting), that a common childhood trauma was sexual abuse.

\[ P9 \text{ “and very often the clients will present then with some sort of early childhood trauma, which is usually sexual abuse. Sometimes physical abuse.”} \]

Participant 2 reflected upon his experience of working with clients who report having experienced previous traumas, prior to the one that initiated the therapy interaction. He described the narrative process of identifying previous experiences of trauma and the issue of previous traumas often being more intrusive or concerning to the client than the presenting trauma and his experience of this being a common factor.

\[ P2 \text{ “they had obviously been exposed to traumas of various kinds…getting them to write a list of what they consider to have been traumatic in their life, and you know, they may produce five or six items, and then say “Now, which is the one that bothers you most?” and you will be surprised that it’s not the most immediate presenting problem, but it’s something that happened twenty-five years ago. And that, I think, is quite common, when you do that scaling.”} \]

A common reflection by participants was the phenomenon of the current or presenting trauma not being the most powerfully impactful on the client’s life. There was a sense that the presenting trauma was commonly rated as lower level than previous traumas experienced. Cloitre et al (2009:406) identified that ‘complex PTSD often emerged from a sustained relational or interpersonal traumas beginning with early life attachments’. This would seem to offer support to the lived experience of the participants who reported that an understanding of the trajectory of the client’s previous trauma history was of central importance in their decisions when engaging in therapeutic work with the client.

Participant 3 addressed the issue from a different position when she discussed her experience of the process of vulnerability. She identified that this vulnerability
resonated from the client’s previous trauma experiences. She also identified her experience of the nature and intensity of these previous traumas and how they would not need to be the same.

P3 “And if you start thinking in terms of not just big traumas, but small traumas – every single person has got those. So, you know, it could be somebody who was bullied at school and the later trauma – you know, what we would say is the trauma – resonates with that earlier one and makes them that much more vulnerable.”

A potentially impactful aspect of previous trauma was the cumulative effect of lower level traumas, which seem to develop sensitivity to trauma later in life. Participant 3 described her experience of working with clients who had developed what she identified as vulnerability to trauma and how this impacted upon her way of working with them as a result. Neuner et al (2004:1) discussed vulnerability to PTSD from the perspective of the number of traumatic events experienced. They identified a ‘dose effect’ relationship between traumatic exposure and PTSD in the studied population with exposure to high levels of traumatic events. Although the findings from Neuner et al’s study draw evidence from participants who have experienced high levels of traumatic events there seems to be some resonance with the lived experience of the participants of this research. A somewhat surprising finding of this study is that of the comprehensive ‘shared’ experience of all participants in relation to the aspect of ‘previous trauma’ and its influence on the work they do with their clients, particularly as they came from differing theoretical backgrounds.

The issue of vulnerability sits at the heart of thinking in relation to the debate around pre-disposing factors to PTSD. Vulnerability has expression across a range of physical and psychological perspectives and reflection and understanding of these elements, in combination, were seen as central to working with those presenting with PTSD by participant 6. The impact of ‘past’ factors was also seen as an important issue in relation to client perception and meaning making and the subsequent impact that had on the way in which participant 6 experienced his work and relationships with his clients. The bio-psycho-social model that Participant 6 worked from was
linked to the centrality of ‘past’ factors in his ability to work with his clients in the present.

P6 “And when you hear the stories of these people, it’s you know, very hideous backgrounds and lives they have actually had…it makes sense under that model of how a bio-psycho-social complex system – that factors in the past would have an impact.”

Reflection on factors from past experience, specifically emphasis on trauma experiences, were seen by participant 6 and other participants, as an important part of the process of understanding the complex interplay between biological, social and psychological elements relevant to the client’s presentation to therapy for PTSD. The frequency of client reporting of previous trauma history was seen as a consistent experience for the participants of this study. They reported that this had potential implications for the development of a focused assessment and formulation and the decision to employ specific tools and protocols to aid the in depth understanding of the client’s unique expression of trauma response. Participant 7 discussed the frequency of client reporting of previous traumas when she discussed the link between past traumas and a later diagnosis of PTSD. She offered her belief and experience that this is not a ‘coincidence’ and her experience would support her view that there was a link in this process.

P7 “There’s a link between what’s happened to them – the kind of most recent trauma that has happened to them – the thing that has landed them in my office – there tends to be a link between that and something earlier in their lives that is very significant and traumatic – at least one thing anyway. And that seems to be the thing that people tend to come up with. It seems to be more than a coincidence that this happens. That when they’ve been through at least one previous trauma – usually it’s more than that – that’s when people seem to come with a diagnosis of PTSD.”

The experience of participant 7 held a focus on a clear link between previous trauma and presenting trauma. She described her experience of clients who present with one trauma and who have experienced an earlier trauma as more than coincidental and
implied a more causal connection. This sense of linkage between traumas, and by extension a potential predisposing relationship, offers insight to the complex nature of the foundations and expression of PTSD. This perspective of linkage resonated with the findings of Emery et al’s (1991) study, which identified three models of predisposition within PTSD. These were; 1, predisposition due to pre-existing psychopathology, 2, predisposition due to pre-existing traits or characteristics and 3, predisposition due to pre-existing experience of specified stressors in family origin. Pre-existing experience seemed to be the most linked to participant 7’s experience and although she did not express a specific link to stressors in family origin as Emery et al (1999) do, she did express a more general adherence and alignment to their findings.

Another perspective on this aspect of previous trauma is offered by participant 8 who identified what she experienced as the identification of previous traumas holding an ‘amplifying’ impact on the presenting trauma response and ultimately the diagnosis of PTSD. She also reflected other participant’s views that the presenting trauma did not have to be the same level of intensity as the previous traumas. Drawing on her experience she went on to propose an ‘accumulation’ effect being important in understanding the client’s presentation within therapy.

P8 “It was quite noticeably that they seemed to be suffering significantly more than one would expect at all. I wasn’t surprised really when it eventually.... when they eventually told me that they’d suffered childhood abuse. It sort of amplified it maybe...the one that has created the problem has maybe been a very minor thing, but it’s triggered off a PTSD response which is actually to do with an accumulation of the different traumas.”

The level and intensity of symptoms and subsequent ‘affect’ are discussed by participant 8 and her experience of the specific amplifying impact of previous child abuse on the presentation of the current trauma. This ‘accumulation’ effect of previous traumas seemed to suggest a significant variable in the understanding of the presentation of PTSD in the therapy room? Research carried out by Breslau et al (1999:902) would seem to support this view, they identified that research participants who had a history of exposure to previous traumas were at greater risk of PTSD from
an index trauma. They further concluded that previous events involving assaultive violence, single or multiple, in childhood or later on, were associated with a higher risk of PTSD in adulthood. This amplifying/accumulation effect was discussed by a number of the participants of this study and seemed to suggest a fundamental aspect of their lived experience when working with this client group.

Participant 5 offered a different perspective to the issue of previous trauma and its’ potential influence on the clients experience. He identified the potential impact of lower level ‘adversity’ as important in the client’s expression of trauma responses. He spoke of his experience of ‘shattered assumptions’ and how this was an important factor in his client’s experience of their trauma.

P5 “it’s that theory of shattered assumptions sort of thing. That’s very, very clear. So, it’s not always that they have previous traumatic experiences, but they could have previous experiences of adversity that they dealt with very well and that creates a problem for them.”

This perspective opened up a wider range of potential predisposing factors in the development of PTSD. The notion of lower level adverse experiences, which had an impact on the development of a PTSD response, has been discussed in relation to vulnerability, as previously identified. This concept of previous trauma having a vulnerability effect on clients was supported by the findings from a study by Blanchard et al (1996), who identified a wider potential vulnerability variable when they discussed the presence of a prior major depressive episode as significantly predictive of an individual developing PTSD.

Sub-theme (ii) identified predisposing issues in more general terms and broadened the scope of previous traumas to incorporate a range of psychological and social variables as significant in the development of PTSD.

4.2.2 Sub-theme (ii) Predisposing Issues

Participant 7 reflected her uncertainty at the mechanism of why previous trauma would predispose someone to develop PTSD; however, she confirmed her belief and
experience that it did. She speculated as to potential for both previous high levels of anxiety and dissociation as factors, which were influential in this process.

P7 “the previous trauma seems to predispose the person to developing PTSD when something else happens. I don’t quite know what the mechanism of that is, or why that would be, but possibly they’ve had a lot of anxiety since then that they’ve minimised and sometimes I think it’s connected with dissociation.”

Participant 7 saw her client’s past history of anxiety and dissociation as being of central importance in the development and maintenance of PTSD. This reflected a wider belief in trauma therapy work that the incidence of dissociation peri-trauma was of clear importance when engaging in developing a treatment formulation or strategy (Ehlers & Clark, 2000). Therapeutic approaches are ruled in or out on the basis of this significant variable. Participant 7’s uncertainty in relation to the mechanism at the heart of the relationship between previous trauma and current presentation of PTSD seemed to reflect the wider experience of some of the other participants within this study. The recognition of this uncertainty and the reliance on personal experience of working with clients who present in this way seemed to hold some significance for her. This reliance on lived experience of practice and a sense of ‘knowing’ was expressed by a number of participants. Participant 1 extended this sense of knowing when he identified his experience and thoughts about some work he had carried out with a specific client.

He identified the central importance for him of understanding the client’s way of construing the world and the meaning they constructed around this. He discussed his experience of the client’s ability to identify ‘control’ as an important factor in their development of ‘over-accommodation’ as a coping strategy.

P1 “he was able to realise some of the over-accommodation that he had done as a result of this based on his pre-disposed traits with regard to issues of control…but I think a lot of these issues have a strong predisposing...you need to formulate and you need to look at what is driving it, and how a person is now construing their world.”
Participant 1 described his sense of needing to get to a core understanding of the clients way of understanding the world and what drives their thoughts and behaviour. He experienced a clear sense of the existence of predisposing factors in the development of PTSD and reflected on the importance of formulation when developing a treatment process for this work. The predisposition was discussed in terms of client traits and the influence this had on the development of coping strategies, specifically for his client, the process of over accommodation. This demonstrated participant 1’s clear sense of the need to have a deep level of engagement with, and understanding of, the way in which the client understands and constructs their world-view. Elswood et al (2009) identified the importance of self-concept and challenges to this from traumatic experiences. They described the way in which the individual’s core sense of self and the world can be so challenged by the experience of a trauma that they become highly vulnerable to developing PTSD. A further perspective on the central importance of the client’s view of the world and self was offered by Janoff-Bulman (1992) who held a focus on the schema of the individual, proposing that the development of PTSD was the result of the person’s beliefs about their self/world-view, (assumptions), being ‘shattered’ when confronted with the traumatic event that dramatically challenged those beliefs. This theory is challenged on the basis of it not incorporating those who develop PTSD from a background of psychiatric history who held a negative schema in relation to safety before the trauma (Kirkpatrick, Veronen & Best, 1985). It seems there are a range of positions taken to explain this process, however, the participant’s lived experiences refer to the impact and importance of the client’s world and self-view being influential and significant in the therapy processes they undertake with their clients.

Participant 5 spoke of his experience and belief that ‘on going stress’ acts as a predisposing factor that could create a susceptibility to trauma. He proposed that stress enables the client to develop skills in ‘worrying’ and his experience of how this created a maintaining strategy conducive to the trauma expression for some of his clients.

*P5 “on going stress is in itself something that could well make us more susceptible to trauma. Because actually on going stress teaches us to*
worry, so that when a traumatic event happens, we are already skilled in something that could maintain it."

The issue of predisposition to the maintenance of trauma symptoms, as a ‘learned’ element in the client’s life, is addressed by participant 5 who opened the discussion of this more indirect process of personal susceptibility to the development and maintenance of PTSD. He described his belief that this reinforced the need to understand the previous history of the client and suggests the core nature of the therapist’s requirement to develop a comprehensive history of the client’s practical and psychological experiences prior to the trauma. It also suggested that the emphasis of the assessment should have a broader scope than a focus on the specific presenting trauma.

Participant 9 talked of his experience of his client’s life experience as a factor in their expression of their trauma. He spoke of key issues relating to their backgrounds of violence, poor education, very low self-worth and a ‘disproportionate’ number of his clients having experienced someone close to them having died in traumatic circumstances.

P9 “we would look at family history, like social history stuff, get a flavour of what their background is. They often come from broken homes usually. Very poor education. Very low self-worth. Violent – in terms of gang members. I would say a disproportionate number do present and report as having experienced a family member or close friend has been murdered. Usually died in traumatic circumstances.”

Participant 9 described family history, social history and a general understanding of the life background as invaluable in understanding the client and contextualizing the client’s experience. He identified the regularity of specific aspects of client’s presentation and how specific criteria seemed to be repeated in his experience of working with his clients. These issues were; clients coming from broken homes, poor education, low self-worth and having experienced and engaged in violent behaviour. Participant 9 identified what he described as a ‘disproportionate’ number of clients who had experienced a family member or close friend who had been murdered or died.
in traumatic circumstances. His experience was that these issues were of great
importance in the work he undertook with his clients and represented underlying
predisposition to their trauma responses.

This is reflective of other participant’s experience of their clients having specific and
traumatic previous life experiences. Participant 9’s identification of key presenting
issues within his clients is supported in research, which found that poor education
(Kessler et al, 1999) and low self-esteem and personality variables (Lauterbach &
Vrana, 2001), were predictive factors in the development of PTSD. The repeated
incidence of his clients presenting to therapy with a similar history and background
experiences could be related to the forensic setting within which he works, however,
PTSD and trauma related symptoms were reported as common responses throughout
his therapeutic work event though his work was not restricted to this presenting issue.

4.2.3 Sub-theme (iii) View of Self & Life

Another element that resonated with the participant’s experience of working with
clients with a PTSD diagnosis was client’s views of self and life. Participant 3
identified her process of trying to understand the client’s beliefs about self and
previous events that have taken place. She went on to discuss how when working with
her clients she focuses her interest on the client’s thought process and their
mechanisms of coping in differing situations.

P3 “So I would look at previous events. I would look at the beliefs around
them. I would look at how they viewed themselves – so personality – you
know, what kind of person is this? How do they generally cope? Do they
have anything missing in terms of, you know, not being able to keep
relationships – you know, is that an issue.”

This emphasis on the clients view of self and the wider world was discussed by the
majority of the participants as important in understanding how their clients make
sense of the trauma(s) they have experienced. Participants identified that in their
experience at the centre of this issue was the impact of the client’s core beliefs in
relation to their response to the trauma(s). A study by Maes et al (2001) identified
some factors, which, if individuals were exposed to them prior to the trauma, were influential in the development of PTSD. These were; 1, the number of previous traumas, 2, a past history of simple phobias, 3 loss of control, 4, alcohol consumption (and alcohol intoxication – at the point of the trauma). The findings identified the first 3 points as being influential in increased prevalence of PTSD development and point 4 as being a factor that decreased the prevalence of the development of PTSD.

The impact of life events and the manner in which the individual constructed understanding has been shown to have a significant impact on the individual’s capacity to cope with, or be predisposed to develop, PTSD. The emphasis on perception is reflected in the diagnostic criteria for PTSD in DSM-IV-TR (APA, 2000). An understanding of the client’s perception of the traumatic event(s) is influenced by their core beliefs and by extension they’re lived experience and the understanding they create as a result. Exploration of the client’s perception and underpinning beliefs and assumptions provided insight for participant 3 and enhanced her ability to work more effectively with her clients.

Reflecting on the issue of client perception, participant 5 identified client ‘worry and rumination’ as key issues that he had experienced when working with his clients. He also discussed the impact of the trauma on the client’s view of self. He described how he experienced his clients view shifting to an almost ‘polar opposite’ of their pre-trauma view of self.

P5 “their perception of self-change is massively...they can almost view themselves as the polar opposite to what they were and there is a high incidence of rumination, worry.”

The emphasis on shifts in self-concept and change was identified as a clear characteristic of participant 5’s experience of working with clients presenting with PTSD. Other participants described this shift as something they regularly experienced when working with their clients. The dramatic shift in self-concept and the resulting impact of this on the client’s ability to cope with trauma symptoms was also discussed and found to be a significant variable that the participants identified and accommodated within the therapy process. A need to understand and unpack this pre,
peri and post perception of self and wider perceptions in respect of a sense of safety was seen as essential in the experience and view of the participants. The increase in worry and rumination in clients diagnosed with PTSD was seen by the participants as a common presenting issue. This increase in rumination is consistent with the PTSD symptom of hyper-vigilance, APA (2000), which most clients with a PTSD diagnosis would commonly present to therapy with, and as such would suggest both a physical and psychological impact.

Participant 7 and participant 4 spoke of the impact of the client’s ‘world’ view and how this is influential in how the client’s experience the trauma and the post-trauma process. Participant 7 held a focus on the messages and experiences the client had from childhood, and how these were influential in the client’s presenting issues. Participant 4 focused on the importance of the client’s intensity of inflexibility in relation to their worldview.

P7 “I’m kind of listening as well for their beliefs about themselves and about the world and about other people... The messages that they’ve received and their experiences as very young children – they seem to play a real part.”

P4 “There’s a number of things, but the biggest one for me is somebody’s world view. What I find is that most people I see say ‘I can’t believe this happened to me’, ‘I’ve never hurt anyone’. And it’s this view that bad things happen to bad people – ‘I’m a good person, nothing bad will happen to me’. It’s those things that are shaken. So they’re people who have very strong world views, which are fairly inflexible.”

The client’s ‘world’ view is seen as significant and important in developing a way of working with the client to address their trauma responses. The focus on the client’s ‘messages’ from childhood and the subsequent way in which these shape their perception of the wider world and their place within it. This aspect of the client’s perception and lived experience was of significant interest to participant 7 and was seen by other participants as equally important. Participant 4 also discussed the importance of the client’s worldview, and how within therapy she explored the way in
which they rationalized the traumatic experience and how this informed and impacted upon their worldview. She spoke of her experience of the implication of strong and inflexible views held by her clients being more susceptible to being powerfully shaken and as a result deepening the client’s expression of PTSD symptoms. Understanding the client’s wider views of the world, safety and a sense of self were seen as central to developing both an understanding of the client’s resources and directly impacted upon the manner in which she engaged with the formulation of treatment.

4.3 Master Theme 2: Therapy Relationship

Sub-themes:
* Developing Trust
* Safety in the Relationship
* Issues impacting the Relationship

Another major theme that emerged from the study was that of the impact and importance of the therapeutic relationship. All participants spoke of their experience of their relationship with clients and how it impacted on their ability to work effectively with their clients.

Initially the six participants below discuss their feelings and belief in the centrality of the quality and importance of developing a strong therapeutic relationship. Issues that emerged were building rapport, being a witness to the client’s story, facilitating discussion of the trauma, the relationship being more important than techniques, and enabling toleration of overpowering emotions. Participant 8 proposed that the relationship was the most important factor in the work she did with clients.

P1 “so it takes a couple of sessions to work through this, and you are building a rapport with the individual as well.”

P2 “And so, my role is not to help them, my role is not to intervene or make things better. It is just to be a witness to their story and to what has
happened to them. And that sometimes involves me naturally showing that I am affected by what I am hearing.”

P3 “you’ve got to have that therapeutic relationship to stand that, and they’ve got to know why they are doing it... So I couldn’t even find out what the trauma was until we’d build a very, very solid therapeutic relationship.”

P5 “(the relationship)..... But without it I don’t think you’ve got anything, so to speak. It is the core point. You can have all the wonderful techniques in the world, but if you can’t engage with someone...and that relationship has to adapt and change as well.”

P7 “if they can’t really tolerate overwhelming emotions or even kind of high affect really – if they can’t tolerate that, I’ll spend quite a lot of time working with that person to help them to be able to do that.”

P8 “the relationship... I would say that is probably THE most significant factor for me. More important than the actual techniques that we use.”

One of the most consistent statements all of the participants offered within the interview process was that of the importance of developing a strong therapeutic relationship with their clients. The participants in a range of ways discussed this with an emphasis on the centrality of the process of developing this relationship with their clients as quickly as it could be achieved. The participants offered the view that before any therapeutic techniques or interventions could be considered, the nature of working with PTSD required a well-developed and interactive relationship that had the depth and flexibility to incorporate adaptation and change.

Participant 5 identified the need for this flexibility and began to deconstruct his experience and belief that the interplay between relationship and technique should be focused upon. This interplay was researched by Goldfried & Davila (2005) who looked at the role of relationship and technique in therapeutic change. They concluded that both technique and relationship serve to facilitate general principles that are the
keys to the change process, (2005:428). Bordin (1979) had previously identified 3 factors which were central to a therapeutic alliance, these were; 1, the presence of a personal ‘bond’ where client views of a caring/understanding and knowledgeable therapist are required, 2, and agreement of ‘goals’ of therapy, 3, agreement as to how these goals will be realized. This process encourages a therapeutic alliance, which facilitates a context in which specific interventions, or techniques can be incorporated to meet the goals and aims agreed.

The participants in this study defined the order in which for them this process takes place. They clearly identified the need to establish a well-developed therapeutic relationship before any work on the presenting issues related to the trauma could take place. This was seen as a fundamental factor in the work they undertook with their clients and was in response to the participant’s identification of the highly emotive nature of the trauma work they carried out. Participant 8 went further when she defined the therapeutic relationship as ‘the’ most significant factor in working with client’s who present with PTSD and represented her primary focus.

4.3.1 Sub-theme (i) Developing Trust

Participant 2 spoke of his desire to empower the client and reduce their sense of him holding an ‘expert’ role. He also proposed his desire to build trust and to understand what the client needed from therapy.

P2 “Well, specifically in relation to their trauma, what is bringing them to counselling, and I think that is important in terms of building up the professional relationship about building up trust and also beginning to identify what it is that they themselves want to do. I am wanting to empower them rather than them feeling they are coming to me as an expert to fix this.”

Participant 2 unpacked the process he is trying to achieve with his clients, specifically his desire to empower his clients. This identifies one of the challenges faced by those who work therapeutically with those who have experienced a debilitating trauma experience(s). Participants identified that often clients would present with a sense of
loss of power and control and a sense of disconnection from their ability to overcome their issues. The need to re-establish a sense of power and control was seen by the participants as important in making inroads to establishing a renewed sense of self. One of the aspects of working with clients who present with PTSD was described by the participants as the delicate balance that had to be achieved when addressing coping strategies that have been developed to reconcile the mismatch in the client’s sense of self from pre and post trauma.

Participant 4 used a metaphor to describe her way of working with clients and the way she reinforced their effective strategies and supported the development of trust in the therapeutic relationship.

P4 “if I pull away the things that have helped them to survive, the old rickety walls, the house falls down; the person has no framework from which to live. So what I need to do is give them some new skills before I try and pull away the ones they have. You know, it’s a bit like – I need to build a new wall before we can pull the old, crumbling wall away. Otherwise the house just falls down. So a lot of what I do is respect and value of what they are doing right now and then try and build on that. But is quite a slow process, because of these issues of trust.”

Participant 4’s used a metaphor to describe the delicate process of engaging with her clients coping strategies. She also described the way in which she helping them to develop a wider understanding and possibly replacing some less than helpful strategies they used and described a process of developing trust in the therapeutic relationship. She reflected on the pace needed to engage this process and discussed the time needed to fully address this challenging element of the therapy process. The enhancement and development of skills by the client was seen as an important step in achieving the overall aim of therapy for participant 4 without which success would be inhibited. The emphasis on a ‘preparation phase’ for therapy was proposed here where time is taken to establish understanding and skills development to prepare her client to engage with the trauma(s) in a new and effective manner. This was described as having a strong potential to encourage trust in the therapist and the therapeutic environment and relationship.
The environment was the focus for participant 7, she spoke of her experience of her clients needing freedom to fully experience and explore their emotions. This environment was experienced as a space where her clients could begin to develop a sense of trust in her she believed this to be ‘vital’ aspect of the work she did with her clients.

P7 “Well, I think it’s really important to have an environment where the client feels free to experience the traumas to be able to talk about it, and to cry if they need to, or react if they need to do that. So I think the relationship is really important and part of that preparation stage is the relationship and trust…. It’s vital I think. It’s vital.”

A widely discussed aspect of the development of a trusting therapeutic relationship was that of the quality of the therapeutic environment. Participant 7 discussed her sense of the development of a therapeutic environment where clients were free to explore and express their emotions, cognitions and behaviours in an open and safe space. She spoke of this environment as being a ‘preparation’ stage and how this can have a positive impact on the development of trust. She described the formation and development of the relationship as the core aspect of trust as being vital to the success of the therapy process.

Participant 8 reinforced other participant’s views in relation to the importance of the therapeutic relationship and introduced the issue of client motivation.

P8 “there’s got to be the motivation there to face some really distressing stuff. But secondly, it’s about the relationship with the therapist, isn’t it? It’s about the relationship with the therapist that they can share stuff, and talk things through and feel comfortable and trust them, etc.”

Participant 8 discussed the issue of client motivation in relation to her clients facing the challenge of addressing the trauma and engaging fully in a therapy process, she noted the need to confront the trauma was generally at the core of the trauma therapy process. This posed a specific challenge to the participants who were confronted with
clients who had spent the time since the trauma(s) specifically not confronting the trauma or engaging with it in limited ways. Participant 8 saw the need for the client to be safe and trust the person they were working with in the therapy process as fundamental to her engagement with her clients.

4.3.2 Sub-theme (ii) Safety in the Relationship

The participants addressed the issue of the development of safety in the relationship. There was a consensus of the participant’s reflections, which identified that due to the nature of the high levels of anxiety generated by the client’s response to the trauma, the need for a safe environment was essential. Holding attention on a client focus was seen as an important factor in this process.

P4 “And what I find is then the trust develops because I’ve listened to them and believed them. That seems to be the biggest issue in terms of developing a therapeutic relationship. So, the longer that relationship goes on the more, if you like, I can steer things, but initially it’s really important to do exactly what the client wants,”

A focus on the clients wishes and needs in the therapy process was explored by participant 4 when she discussed the process of ‘hearing’ the client and responding to the clients needs. Participant 4 experienced this development of trust as enhancing the sense of safety experienced by the client and ultimately defined a space for the development of a therapeutic process. There was recognition of some of the key challenges faced by participants when working with traumatised clients. A key challenge was a requirement to spend time to engage and develop a therapeutic relationship. This was often difficult to manage as some participants worked in private practices, which were more susceptible to the confines of sub-contracted work for agencies. These contracts were described as often limited to a specified number of sessions for each client contact and as such often made it more challenging to be as responsive to client need as described by participant 4. There were other dilemmas discussed by the participants.
Participant 5 identified a core dilemma at the heart of his work with traumatized clients. He spoke about his experience of the courage clients needed to demonstrate when confronting issues that they believe were ‘harmful’.

P5 “you know, really you’re asking someone to do something that they really believe will be harmful to them. So the amount of sort of courage they need to engage with the therapist to overcome their anxiety disorder is immense.”

The dilemma of inviting a client to face what they believe to be ‘harmful’ issues and experiences is something the majority of the participants discussed within the interviews. Participant 5 puts this into some sense of context when he described how he had experienced his clients seeing the process of therapy as potentially harmful to them. This dilemma is not unique to working with PTSD as a presenting issue but according to the participants does characterize a substantial response of clients who engage in PTSD therapy work. The core dilemma of inviting clients to fully commit to engaging in a therapy process that has the potential to generate genuine fear and anxiety for them requires the generation and maintenance of a strong sense of safety within the therapy relationship. The participants spoke of creating a dialogue in response to the fear and concern presented by the client as a starting point in the process of developing trust and safety.

Both participant 6 and 9 spoke of taking time to establish a safe and trusting relationship that could form the basis of a client’s sense of understanding and control.

P6 “what I’ve found, before doing anything formal, is that simply by providing a safe space, by creating that relationship and that trust and by doing simple things like re-attribution.”

P9 “To go at his pace, to keep reassuring him and to hold him. To make him feel safe. Over and over to be explicit in – ‘you have to do this, if you want to have a peep at it, that’s fine, but as soon as you want to stop we’ll stop’. So once he felt in control.”
Previous discussion has identified the need to establish both a trusting and safe environment to facilitate a strong platform to enable and empower clients to engage in what can be perceived as dangerous or harmful to their wellbeing. The statements from participants 6 and 9 bring together these issues and link them to the connected requirement of their experience for the need to facilitate a sense of control and understanding within the client. Participant 6 saw the process of re-attribution as important in developing that sense of control. He spoke of his task to establish a link. He further discussed the progressive nature of the re-attribution of previous knowledge and understanding and what he described as the simple process of progressive development of safe-space of being more important to establish before engaging in more formal therapy interventions.

This was extended by participant 9 who described his experience of offering an ‘invitation’ to the client and going at the client’s pace with the aim of deferring control of the therapy process to the client. The sense of ‘holding’ was very important to him, as was the process of reassurance. The concept of deferring control in direct terms of pace and speed of the process to the client was experienced by participant 9 as a way of encouraging a sense of control both psychologically and physically to his clients.

4.3.3 Sub-theme (iii) Issues impacting the Relationship

There were a number of issues impacting on the therapeutic relationship identified by the participants. Participant 3 discussed the level of complication in relation to the diagnosis of PTSD and the resultant potential for mis-diagnosis.

P3 “but there will always be people who, they get a mis-diagnosis and, not through any incompetence, simply because it’s a complicated subject...I think all of the symptoms of PTSD have an impact on the therapeutic relationship.”

The complicated nature of PTSD as both a diagnosis and an expression of distress was seen by participant 3 as issues, which she experienced as impacting her ability to work with her clients. The issue of misdiagnosis, (Spinazola et al, 2005), is an area
discussed by a number of participants within the interview process. They spoke of working with clients whom had a diagnosis of PTSD but on closer observation they found that they did not meet the diagnostic criteria for PTSD as described by DSM IV-TR (APA, 2000). They also experienced the opposite presentation where clients did not have a PTSD diagnosis but clearly met the DSM diagnostic criteria. Participant 3 described the impact of all the PTSD symptoms on the therapeutic relationship and opened the discussion of the nature of trauma therapy work and some of the she challenges faced in this work. The symptoms, (Ozer et al, 2003), would often be experienced by her as a barrier to engagement within the therapy relationship.

The experience of intrusive imagery and thoughts was described by participants as being particularly difficult to overcome within the work they undertook with their clients. They reported that their clients as ‘uncontrolled’ and uninvited experienced them. This created a specific challenge for the participants who described client’s avoidance and reluctance to do anything that could trigger these responses. Clients routinely had experienced the intrusive symptoms without knowing what triggered them and for the participants to ask them to knowingly engage with the trauma and risk triggering the intrusive symptoms was often seen by them as very risky. An inherent problem with the client’s experience of uncontrolled triggering of intrusive symptoms is that they experienced their client’s as seeing threat in the most low level interaction within the therapeutic relationship. The participants reported that the client’s hyper-vigilance related to this fear of triggering intrusion was often played out in the therapy process. The participants saw client engagement as being a significant factor in successful outcomes. They reported that the process of helping the client to fully engage in the therapeutic relationship required them to look at employing specific interventions and ways of working.

Participant 2 spoke of their difficulty in establishing a relationship when specific trauma symptoms are present for the client.

P2 “I am seeking to make an empathic connection with them, and I think that takes time, particularly if people are very traumatised or dissociative, because it’s often quite difficult to establish a relationship.”
Participant 2’s use of an empathic connection within the therapeutic relationship was experienced as important along with the use of a relaxed time frame these strategies were used to encourage trust and client engagement. Another symptom of PTSD, which was experienced by the participants, was dissociation. They identified that clients who had experienced dissociation peri and/or post trauma would often generate specific challenges within the therapeutic relationship. This influenced their choice of therapy intervention, excluding those approaches that would not usually be considered the most appropriate therapeutic approach where dissociation was identified within the trauma (Scaer, 2001).

Participant 4 reflected upon the unpredictable nature of trauma. She spoke of how she had been impacted by her respect for ‘human resourcefulness’.

P4  “I just think it literally could happen to anyone and you can’t predict how you are going to behave in that situation, and so, more than anything what I have gained from this is just a massive respect for human resourcefulness really.”

Opening the concept of ‘impact on the therapist’ participant 4 reflected upon how she experienced a heightened awareness of the randomness of trauma and how she had witnessed and had come to believe in the process of human resourcefulness. This statement spoke of her respect for this human quality and brought into focus the wider topic of the impact of doing therapy work with clients who present with trauma(s) and how this impacts the therapist.

Extending the topic of ‘impact on therapist’, participant 5 reflected on how his sense of safety had been impacted in relation to the work he had been engaged in.

P5  “I mean it does impact on you. There’s no two ways about that. So, with the best supervision and everything else, you know, you can have a run of cases that make you re-evaluate your views of safety.”
Participant 5 discussed how working with clients offering him direct evidence, within their trauma stories, of how the lack of safety and control had impacted upon him. He had recognized that this had caused him to re-evaluate his own views on safety. Being a witness to others pain and suffering and hearing stories of graphic scenarios in which these events took place was seen by a range of participants as greatly impactful on their own functioning. The use of support systems including practice supervision was described as a helpful tool in facilitating a balanced perspective, however this did not stop shifts and changes in beliefs of safety and control for some participants. Sanderson (2010) discussed this shift in a sense of safety. How therapists can be compromised in their sense of safety in the presence of the often-explicit material offered by the client and how this can impact the therapist’s wider sense of a lack of safety in the world. This has the potential to overpower the therapist and if unaddressed has the potential to develop into vicarious traumatization (2010:278). Other participants reported being impacted by their trauma work in a variety of ways.

When participant 7 discussed her response to working with clients with PTSD she spoke of the way she felt a connection in her body. How she felt much attuned to the client and speculated as to how this came about.

P7 “I feel, quite a lot, I feel about what the client’s going through, in my own body... I just have a sense of kind of something building and getting stronger and then I know at the moment that that changes, I can feel it before they say anything, I can feel it.... its weird isn’t it? ......., I think that’s part, I don’t know whether it part of being in tune with the client or sitting close to them, or something along those lines.”

Just as there can be a disconnection and a moving away from the client due to the intensity of the presenting material, there can also be a very strong sense of connection generated and felt by the therapist. Participant 7 discussed her sense of attunement felt with clients. She described a direct physical expression in her own body of her client’s process. She did not see this as uncomfortable or worrying but as part of her way of working with traumatised clients. When discussing this aspect of her work with clients she was initially tentative and gauging my response. She moved to an open discussion of her ‘preferred’ working style and how this way of connecting
to her clients was central to her engagement in the therapeutic relationship. It was how she created an environment designed to encourage openness and trust. This process represented for her a way of being closely connected and in-tune with her clients. She discussed how this had a powerful impact on her and often resulted in her becoming very connected to the clients story as well as the person, with some resulting negative and uncomfortable imagery and emotional responses for her.

The forensic environment of the prison created specific challenges for participant 9 in developing and maintaining the therapeutic relationship, and opened the issue of his ability to offer and maintain confidentiality.

P9 “you have the normal boundaries of confidentiality in terms of self harm and harm to others, but the added one in prison is that you must tell them at the beginning – ‘if you say anything that will compromise the security of this prison I will report it’. Because that needs to…so they know, that’s part of the system, that’s the deal.”

The specific challenges faced by participant 9 were outlined in his statement when he spoke about how impactful the environment within which he worked was. He described a requirement to move outside of accepted confidentiality boundaries, which generated some unique challenges to his ability to engage a therapeutic relationship. Boundaries were set as expected at the start of the therapy process with specific caveats in relation to the security of the environment within which the therapy took place and the client lived. This has some parallels with other in-patient/contained environments and as a result had a clear potential to create a barrier to the development of trust and engagement within the therapeutic relationship. There was an issue for him of dual roles and to some degree a compromising requirement to be a monitor of environmental and institutional standards and also offering an open accepting environment for the client to discuss any issue, participant 9 discussed this challenge.

Participants discussed the unique nature of trauma and the way it is expressed and experienced by the client. They discussed how this required modification and adaptation from the therapist within the therapeutic relationship.
Participant 6 discussed the ‘bespoke’ nature of trauma therapy and how he experienced all of his therapeutic relationships as different and unique. His need to offer a flexible approach with the capacity to modify his method and way of working with each client was seen by him as essential. He identified the importance of exploring and understanding the unique set of conditions that were in place for each client in relation to their trauma experience. Other participants who discussed specifically tailored therapy processes developed in response to specific client needs offered their experience of ‘re-inventing’ the process of therapy.

A related area that was identified was that of the ‘systems’ that accompany therapeutic trauma work. A significant number of trauma therapist’s work within the private sector, including three of the participants of this study, and are governed by the requirements of the agencies that commission trauma therapy assessment and treatment. Participant 8 discussed her experience of the tension that can be generated within this system.

Participant 8 offered her belief that even though there are sometimes significant external pressures on her work from outside agencies, she believed fully in the need for an understanding of the ‘wider’ picture of the clients’ history from a trauma perspective and resource and belief perspective. Pressure to complete therapeutic processes within a specified number of sessions can place great challenges on the time available to complete this review of the clients’ past experience and the therapist often holds this tension. This view of a need for a wider understanding of the clients’ life and experiences was central to all of the participants and reflected their process of
developing both an understanding of the individual and also formed the foundation of formulating a treatment process for the work they were to engage with the client.

4.4 Master Theme 3: Psychoeducation/Normalisation

Sub-theme:  
*Resource Building*

The third master theme to emerge from the study was that of Psychoeducation and Normalisation. All of the participants reflected on the importance of these issues in relation to their ability to work effectively with their client’s who presented with a PTSD diagnosis.

The process of normalizing the range of trauma symptoms was described as important in creating the foundation for the trauma therapy to take place. The principle of understanding key reactions and clarifying client’s physical and psychological experiences was central to the participant’s experience of working in this environment.

\[P1\] “We do it in the session first to explore their reactions and kind of make sure it’s safe and normalise some emotions and have some support systems in place, but I don’t want to try and get them to avoid the emotional experience.”

\[P5\] “It’s usually beneficial to normalize it for the client…and spend time explaining why it is their body does this, why their stomach is jumping in knots, how memory systems work, what we are trying to achieve.”

\[P6\] “So the whole thing, I suppose, it’s like an educational process – it’s a two-way process…So I validate them. Then I try and create a safe place for them to say that – as we said earlier – that normalising.”
Participant 1 presented his perspective on the process of normalizing emotional responses, he also identified the importance of support systems for the client in what he described as a difficult process of therapy. He reinforced his experience of the need to fully engage with the clients’ emotional experiences and to work on the clients’ potential to avoid engagement with these issues. This challenge is discussed by all of the participants in relation to ‘disarming’ some of the powerful emotions and physical responses experienced. This process is as Wessley et al (2008) described; ‘Psycho-education following trauma is increasingly used. The term covers the provision of information, in a variety of media, about the nature of stress, posttraumatic and other symptoms, and what to do about them’ (2008:287). The use of psycho-education was described by all of the participants as a central tenant of their approach to therapy with traumatised clients, this was irrespective of the therapeutic approach they employed.

Participant 5 spoke of the need to be specific in relation to both physical and psychologically experienced symptoms of trauma. Deconstructing specifically experienced concrete events and responses for the client was seen as a fundamental aspect of his work in educating and reframing the clients’ understanding of the process of trauma. His rationale behind this was to reduce the direct impact of these symptoms and resulting beliefs with the intended consequence of freeing the client to be empowered enough to engage in the therapy process.

Participant 6 discussed the ‘two-way’ process of psycho-education and normalizing. He experienced the process of ‘validating’ the clients’ experience and clarifying underpinning aspects of their experience in relation to wider principles of trauma as of great importance. He also discussed his ability to develop a ‘safe place’ to engage in normalizing the clients’ experiences and from that a platform to empower the client to engage fully with the trauma.
Participant 8 described her use of media and handouts in enabling the client to understand key aspects of PTSD and its impact on their lives. She had described feedback she had received in relation to some clients’ need for ‘external’ information. This was described to her by some clients as being very reassuring to see something formal from a book or journal as it increased validity for those clients and enabled acceptance of the information. She also reflected on her experience of some of her client’s presenting with a sense of ‘weakness’ and how she attempted to normalize this initial perception by widening the context and implication of the trauma experience.

4.4.1 Sub-theme (i) Resource Building

The participants went on to discuss the way in which they provided Psychoeducation and Normalising to elicit a sense of control, empowerment and resource building for the client’s. The strategies employed by the participant’s had a consistency, however, they also demonstrated some clear variation in delivery.

P5 “it starts right at the psycho-education session really, to begin with. Even at assessment I try to get that person leaving knowing something that they did not know before they came in. Something they can go away and think about, and in those early sessions, where you are really socialising that person to the model, I’m trying to get them to think - ‘well actually I didn’t know...this makes sense to me’.”

Participant 5 offered his strategy of creating an environment where his client would have access to information about PTSD and the wider aspects of symptom expression. He described his desire to ‘socialise’ his client to the model used and for them to develop a deeper level of understanding of the events they were experiencing. He spoke of the emphasis he placed on engaging the client in the process of therapy by starting with the lower level, but essential, process of providing information that challenged their beliefs and understanding. He stated that he designed this to socialize the client not just to the model used but the very process of the interactive nature of therapy and its potential to shift perception.
Participant 2 addressed his process of providing specific inputs designed to reduce his client’s sense of isolation.

P2 “in terms of normalising, what I am trying to describe is that what they have told me they have experienced is normal. It is a normal known reaction to the kinds of life events that they have been describing and it’s very common. Because often they will feel alone, isolated, they are going mad. They don’t imagine for a moment that other people will be experiencing similar kinds of events.”

Here participant 2 extended the purpose of psycho-education within the trauma work that he undertakes. He described addressing his clients’ sense of isolation, loneliness and in some cases their perception of ‘madness’. The use of psycho-education to elicit a normalizing effect within the client is seen as fundamental in the process of engaging with their trauma. Participant 2 offered his process of extending clients’ specific responses to the wider population, and by doing so creating an environment where clients’ can conceptualize their issues in a ‘normal’ framework.

Participant 3 spoke of her sense of the lack of awareness of some trauma therapists in relation to an understanding of trauma. She described her belief in enhancing her client’s ability to feel a greater sense of control.

P3 “And one of the other issues is that I see a lot of people who work with trauma who don’t actually understand trauma and don’t do any psycho education or normalising and that is a massive faux pas for me…During that time as a standard, I will be doing psycho-education and normalising…. And I think with PTSD that’s so important because they usually feel completely out of control, so you’ve got to build some control in.”

Participant 3 saw the shift in her clients’ sense of control as a key function in the use of psycho-education as a process of normalizing the clients’ experience of their response to the trauma. She discussed her experience of other therapists who work
with trauma clients who do not use psycho-education and viewed this as a considerable error in professional judgement. This position is supported by all of the participants of this study who attested to the considerable positive impact of using psycho-education as fundamental to their treatment of PTSD.

Participant 7 also reflected on the theme of enhancing the client’s sense of ‘control’.

*P7* “And it, (Normalising), seems to have a kind of generalising effect to other areas of that person’s life too. It seems that sometimes the way the person thinks about themselves changes as we process the old trauma, and some of their emotions change and they begin to get a greater sense of connection to themselves, a greater sense of well-being, a sense of being stronger and having more control...So you help the client make meaning of it really. They can feel like they have a little bit more understanding and control.”

The issue of enhancing control is further extended by participant 7 who discussed her experience of a strong link with change and particularly the process of movement in her clients’ perception of self and their experience of emotions. The links between the clients’ enhanced sense of control; well being and strength are directly attributed to the psycho-education process and the wider processing of the trauma undertaken in therapy. Understanding the clients’ sense of control and meaning making were experienced by participant 7 as central to the engagement of the trauma therapy she created with her clients.

Participant 4 offered her use of psychoeducation and relaxation as a means of enhancing the client’s sense of control; she also held a focus on their body as a resource in this process.

*P4* “if someone says ‘I’m getting panic attacks and I can’t sleep’ then obviously I do some psycho-education stuff, some relaxation. I’d give them some information, I will make them aware of their body.”
An extension to the more recognized process of psychoeducation was relaxation proposed by participant 4. She saw the focus on the physical body as important in experiencing a sense of control for the client. Participant 4 saw the link between physicality and psychological functioning as important to model within the therapy process. The use of physical relaxation was experienced as a powerful and direct method for the client to express control over their body at a time when commonly they experience the opposite within their trauma response. Participant 4 discussed how she used psychoeducation to discuss the interaction between mind and body and how by following this with developing skills in physical relaxation with the client, this enabled them to regain a sense of power over their body again. Participant 4 held a clear focus on encouraging a ‘re-connection’ with the body that often her clients had lost, or had actively discontinued due to their experience of trauma.

4.5 Master Theme 4: Identity

Sub-themes:
* Perception
* Beliefs/Assumptions

Identity was seen as important in understanding and working with clients with PTSD. The participants identified the trajectory and process of identity development as useful in understanding the client and their expression of trauma symptoms.

\textit{P1 “fit with his sense of who he was and his identity and which had emanated from an earlier time in life when he learned that if you want to get things done you get them done yourself...I guess I draw upon our understanding of broadly how a person’s identity develops, how they respond to stress.”}

\textit{P8 “It’s about their identity, yes.”}
P5 “These aren’t people who I would say are vulnerable in some way. I’m saying there has been a sort of…an attrition in a way, over the years, and problems are not getting resolved.”

The three participant statements addressed their experience of clients’ ‘identity’ being significant in both their expression of trauma symptoms and centrally how this impacts on their perception of self and by extension their ability to cope with the trauma. Participant 1 explored his use of in-depth history taking in an attempt to understand how the client had formed their identity and experienced significant stage points in that process. The importance of understanding the impact of the clients’ perception and construction of personal identity was seen as a significant factor in his ability to work with clients’ who were addressing trauma related issues.

Research has identified a significant connection between alteration in self-concept following trauma and post-traumatic psychological adjustment, Webb and Jobson (2011:103). This connection was also explored in research by Sutherland and Bryant (2006), who identified those participants who were diagnosed with PTSD reported themselves as more strongly defined or identified by their trauma than those participants who did not have PTSD. This finding would suggest a shift in the sense of self-identity of those who developed PTSD, which would offer support to the experiences of the participants of this study. This shift toward a trauma-centred identity for some who develop PTSD is seen as significant by Webb and Jobson (2011), who identified that when trauma was more central to the individuals identity, they would be more likely to suffer from higher levels of PTSD symptoms, this was specifically represented with highly intensive memories (2011:108).

4.5.1 Sub-theme (i) Perception

A core aspect of the theme of Identity was that of perception. Eight of the participants reflected on how the clients perceived both themselves and the shift they experienced in their sense of identity in response to their trauma and how this impacted on their work with their clients.
P1 “But really the world is pretty much the same as it was before the trauma. It is just that he is seeing it differently. So in terms of safety levels, it is not actually any more dangerous than it was before, but it’s just that he has a sense of instability and insecurity if you like, and so that perception is clearly the big issue, one of the big factors here.”

In his statement participant 1 discussed his experience of balancing the clients’ subjective perception and that of the wider perspective that may exist. The focus on the clients’ way of seeing things and how this impacted on their sense of safety, instability and insecurity, was seen as a significant factor in the work he undertook with his clients. Mismatches in the perception of threat and the reality of those potential threats were recognized as impactful on clients’ sense of safety. Participant 1’s therapeutic focus on the clients’ perception driven from their trauma experience was one aspect of this impact of perception. Other participants identified alternative ways in which they worked with clients’ perception and how this can be impacted.

Participant 2 spoke of his experience of working with clients who perceive their trauma in a relational manner to previous events. He identified his experience of blame being a common perception for his clients.

P2 “you begin to see there are certain common themes because in people’s perception they are trying to make some sense of it as a natural process and that is often around “If only”, “Yes I am to blame”, or at some level “It’s my fault” or that connects with previous life experience where something has been their fault or blame has been a key factor in their early relationships.”

Participant 2 discusses common themes in client presentation when he identified perception and specifically ‘sense making’ as fundamental to the clients’ understanding of their experiences. The link between past and present experiences and specifically the clients’ acceptance of fault and blame was explored. The experience of working with clients’ who accepted blame within their trauma experience, and respond from an emotional base of guilt was reported by participant 2 as a common occurrence in his work. Lee, Scragg and Turner (2001), identified the
prevalence of anger, shame and guilt as common presenting issues of those diagnosed with PTSD and how these would impact the individual in their functioning and would be expressed within the therapy relationship.

The clients ‘learned’ experience was seen as important to participant 3. She held a focus on the client’s interpretation of the event as important to the experience of the trauma and how this impacted the wider therapy process.

\[P3 \text{ “Yes. It’s basically how they have learned to be in life will somehow affect them when a potentially traumatic event happens. Because it’s their interpretation of that traumatic event.”} \]

The interpretation of the traumatic event(s) and how that matches, or not, to the clients’ previous life experience, was another common theme when discussing identity with participants. Participants also saw the predisposing impact of previous life experience as very impactful on the clients’ presentation to therapy. Understanding this previous life experience and incorporating the beliefs and behaviours it initiated formed the basis of both therapeutic formulation and treatment intervention for the participants.

4.5.2 Sub-theme (ii) Beliefs/Assumptions

The second sub-theme to emerge from the theme of Identity was that of beliefs and assumptions. Participants described the impact of these elements on both their understanding and experience of working with PTSD.

\[P2 \text{ “So, what I want to do is to establish with the individual what the experience that they are having means to them, what is their understanding of it. What is happening, what sense are they making of it, because to an extent they are either coping or not coping with it.”} \]

The theme of meaning making through beliefs and assumptions generated from specific experiences was described by participant 2 when he spoke of the ‘collaborative’ process in understanding the way in which clients’ make sense of the
trauma and how that impacts on their coping capacity. The link with meaning making and coping was discussed by other participants who proposed a range of issues relevant to this mechanism.

Participant 3 identified ‘shattered assumptions/beliefs’ as key to negatively impacting on a person’s sense of identity.

P3 “The trauma is that they are feeling helpless and that doesn’t sit with their sense of identity. So they can cope with the blood and the guts and all of that, but they cannot cope with that sense of being helpless..........it’s all shattered assumptions isn’t it? You know, shattered beliefs – I believe that I’m strong. If I’m in a critical incident where actually I’m shown in a huge way that I’m not strong, that’s going to completely overturn my sense of identity.”

The link with clients’ previous beliefs and the challenge the trauma offered to those beliefs is discussed by participant 3, she described her experience of the ‘mismatch’ between core beliefs of ‘strength’ tied to identity and the actual perception of weakness experienced within the trauma and how this had a ‘shattering’ effect on the clients’ core sense of identity (and self). For some the power of the physical and psychological impact of the trauma seemed to initiate a fundamental shift in the individual’s experience of expectation due to previous learning verses actual events that take place within and around the trauma. An example of this would be a belief, that the client held prior to the trauma, that they would stand up to a threat and face it head on, overcoming the issue, this is challenged by their actual experience of being fearful and shrinking away from facing the threat within the trauma. Participants described this mismatch as often overpoweringly difficult and can form a break in the clients’ capacity to see self as strong being replaced with the opposite, (forced through experience), belief of weakness. The polar shift that can take place makes it impossible to retain the pre-trauma belief of self and the basis of an identity shift ensues.

Participant 4 talked about her belief structure and how she was impacted by the client’s religious beliefs. She discussed her difficulty with conflicting perceptions of
religion and put forward how she understood her clients ‘sense making’ of their situation.

P4 “the people that I find who seem to get better faster is those that have a religious belief. I have a religious belief and I find it quite awkward because some of them will say ‘well god wanted that to happen to me’ and I sit there thinking ‘I believe in god but I don’t believe god wanted you to be tortured’, you know, it’s that Viktor Frankl and Neitzsche thing and about, you know, ‘if I can find a reason of why, then I can survive anything’.”

Here participant 4 reflected on the issue of religious belief and how she experienced the potential for client and therapist beliefs to be conflicted and how this can impact the therapeutic relationship. She discussed the need of clients’ to have a ‘why’ for what had happened to them, which she proposed would enable them to continue and survive traumatic events. The importance of the client having a ‘reason’ for events, and by extension how individuals respond to those events, is seen by participant 4 as important in overcoming traumatic events and from her experience is fundamental to clients’ having positive outcomes in trauma therapy.

4.6 Master Theme 5: Culture

Sub-theme:
*Environment

The theme of Culture was reflected on by more than half of participants. They described experiences of working with clients who were influenced by cultural issues relating to community, race, gender, class and values. The issue of religious belief and the impact of ‘sense making’ for the client was further discussed and seen as significant for participant 4.

P4 “So there is another layer which is about culture and community and values – both their internal ones, and their external ones within the
community as well...So I find that people who do have a religious belief have a ‘why’, it’s not necessarily their ‘why’, but they truly believe that this is their destiny.”

P7 “some people are just... utterly powerless...and feel completely disempowered and have done, in terms of class, sometimes in terms of race, sometimes gender will make a difference.”

P8 “something about the culture made a difference there, and something about the fact that he worked with all men also had a difference there, and just various factors.”

All three of the participant’s statements reflected upon the impact of culture on clients’ ability and capacity to overcome traumatic events. The impact of cultural issues was described by participants as influential in both understanding how and why clients’ responded in the way they did. Reflection on internal and external values, culture and community by participant 4 extended to her experience of clients’ perception of ‘destiny’ in their experience of trauma from a religious perspective. She described her experience of a powerful ‘external’ figure that drives the clients’ personal experiences and responses to the trauma. This external figure provides a ‘why’ for the client who presents in this way and she believed that this perspective needed to be integrating into the therapy process.

Participant 7 described her experience of clients’ who felt powerless and this was embedded within issues of class, race or gender. She described how she believed that the sense of powerlessness was an important variable that needed to be accommodated by the therapist within the trauma therapy process.

Participant 8 described her experience of culture being influential to her clients’ who worked in an all male environment, which she believed impacted, her clients’ response to their trauma and by extension impacted the work she undertook within the therapy process with them. A study carried out by Hinton and Lewis-Fernández (2011), described substantial cross-cultural variation in the expression of PTSD. They found specific examples of cross-cultural variation these were; ‘the relative salience
of the avoidance/numbing cluster and of somatic symptoms; the importance of distressing dreams…the specific characteristics of the negative expectations as a result of trauma; the impact of the meaning of the trauma on PTSD severity and symptom expression’, (2011:796). The findings from this study suggested the potential for a substantial difference in the way different client cultural backgrounds influenced their response to trauma and expression of PTSD. Jobson and O’Kearney (2006) looked at treatment choices in response to cultural differences in autobiographical memory of trauma. They found that participants from an independent oriented culture (Western) responded to clinical cognitive models of PTSD however, for participants from interdependent oriented culture (Eastern), these approaches were less impactful. This casts some doubt on the universal applicability of the clinical cognitive models of PTSD. This suggests that an understanding of the clients’ cultural background and influences could have an important impact on therapist’s treatment choices of PTSD.

4.6.1 Sub-theme (i) Environment

Participant’s offered discussion of cultural aspects relevant to their interaction with clients and some of the factors that underpinned this theme. A sub-theme that emerged from this theme was that of Environment and its impact on the issue of culture. Participant 1 worked in a military setting and reflected on the diversity of his clients and how their cultural identity and the impact of these issues reflect their expression of their trauma and his experience of the therapy process.

P1 “Cultural factors, you know I may be working with a certain group from a certain nation, you know, across the socio-economic spread and the different ethnic groups in that culture and the difference communities across that country and the gender differences that you can see, and the culture of that individual’s family, and how they have learned to view themselves. How they have learned to view themselves in relation to others and how they see their purpose and direction in life. All that will be shaped uniquely, you know, to that individual and so it starts to shape their reaction to the trauma……….well, I work in a military setting and the cultural aspects of the military are quite important in looking at how
individuals maybe either assimilate, accommodate or over-accommodate their experiences and what they take away from the traumatic experience related to probably schema.”

Participant 1 described his need to hold a focus on the environment, particularly the developmental environment within which his client grew up and the influence this had on their reactions to the presenting trauma. He listed a range of influential factors, which he experienced as creating a unique profile, which acknowledged the impact of cultural factors on the individual’s manner of engaging with the trauma(s) they had experienced. Participant 1 also discussed the environment/setting within which the client worked or lived, and the way they engaged with their experiences within those environments and settings. He described the specific nature of the military setting in which he worked and how it presented a focus on cultural issues, which created particular challenges and opportunities in his work. Beliefs about ‘purpose’ and direction in life were experienced as significant issues in the cultural profile of his military clients.

Participant 8 looked at ‘male cultures’ and the impact these can have on the client’s ability to admit to having a problem.

P8 “I’ve seen an awful lot of lorry drivers and van drivers and a few policemen and men in very male orientated cultures, and find it very difficult to admit that they have an issue, that they have a problem and think that they’re being soft or weak, That’s a common one.”

The impact of a ‘male’ environment and how this impacted on the work of participant 8 was discussed by her in relation to her clients’ need to present an image of themselves which usually followed an ‘I need to be strong’ narrative. Her experience was that the trauma was often experienced as challenging this narrative with specific consequences for the clients she worked with. Her key challenge was encouraging her clients’ to present the actual experienced feelings and emotions not the ones they believed they needed to present. As a female therapist she also experienced some male clients resistance to discussing issues they perceived would present them as ‘weak’ which created a barrier and often had a negative impact on the therapy
relationship she was trying to create with them. The development of trust and acceptance were key requirements in her work and formed a baseline to the therapy work she was attempting to engage with her clients. An understanding of the nature of the culture of her clients’ working environments was essential to facilitate her ability to reach them and develop a trusting relationship where they could allow themselves to face the emotions that in her experience they commonly denied.

Participant 9 discussed the impact of the environment and culture of the prison, and how this impacted on the development of rapport and trust in the relationship with his clients.

*Participant 9*: “I think it is an unusual context the prison. And one of the tools I would put a lot of store by is rapport. Rapport is a massive thing really, because I work on the assumption....and this is past experience not just in this prison, but other prisons, that people in prison are in survival mode – they have to be. It is a traumatic environment and you have to survive in there to get through it. So they are incredibly astute, they suss someone out very quickly. Because they have to – have to know who is genuine, who is going to lead them astray, who is going to harm them and who can be trusted. And I think part of the therapeutic process for me is to keep that trust and rapport alive.”

Participant 9 saw the impact of a forensic setting as very influential. The culture within the prison was specific and impactful in the manner in which his clients presented to therapy and within the contained environment of their living environment. There was a sense that they had to be seen by others in a particular manner and that to not be seen that way carried with it risk. A similar issue of client narrative applied to the working environment of participant 9 as with participant 8 previously discussed. The ‘I have to be strong’ narrative was a common client presentation for participant 9. He spoke of the importance he placed on the development and maintenance of ‘rapport’. He described his experience of his clients being in ‘survival’ mode and being very vigilant and aware of those they came into contact with, as they lived within a traumatic environment. He saw building rapport and trust as very important to enabling the therapeutic process to be developed and
maintained. This contained and gender dominated environment was seen by participant 9 as influential in his choice and method of therapeutic engagement. This positioned culture and environment at the centre of a number of the participant’s decision-making processes when working with clients presenting with PTSD.

4.7 Master Theme 6: Attachment

Sub-themes:
* Secure/Insecure
* Childhood Experiences

It is clear from the findings that the participants’ experience of working with clients’ that presented to therapy with a diagnosis of PTSD were heavily influenced by previous experiences. Attachment was identified as an important theme and influential in shaping the participants clients’ capacity and manner of processing their trauma experience.

4.7.1 Sub-theme (i) Secure/Insecure

The clients’ experience of security or insecurity in their development of relationships was seen to be influential in their capacity to respond to their trauma experience and therapy process. The experience of more than half of the participants was that of the significance of the impact of childhood attachment on clients’ response to trauma. Participant 1 reflected on the issue of attachment.

       PI “He was an individual who had a bit of a difficult childhood – divorced parents, being moved from one to another during that period. A sense of instability, insecure attachments.”

In responding to the interview question 9 requesting reflection on work he had carried out with a PTSD client, participant 1 offered the statement above. Participant 1 saw his experience of his clients’ childhood difficulties and resulting insecure attachment profile as representative of a wider and common presentation profile of his clients.
who came from a military background. The need to have a clear understanding of his clients’ attachment history was seen as an important part of his assessment and formulation process. Participant 3 was also interested in the attachment history of her clients.

Participant 3 addressed the nature of the level of intimacy required to work with the highly emotive issues around the trauma presented by her clients’. She spoke of her experience of her client’s previous difficulty with attachments potentially causing problems in the therapy relationship.

P3 “And then there are the issues of intimacy. Because that’s another one, you know, working with trauma can get very intimate and a lot of people struggle with that, especially people who’ve not had a good history of attachment. So that’s another theme

Participant 3 focused on the level of intimacy needed when working with trauma and how this can be negatively impacted by the clients’ history of attachment. She identified the unique nature of trauma therapy, which required the development and maintenance of high levels of trust and intimacy. She discussed the challenge she often faced in developing a therapeutic relationship with those who have difficult attachment histories and as a result find it difficult and sometimes impossible to trust others.

Central factors that participant 7 believed to be influential in determining both the formulation and the treatment choices she made were the security of relationship and previous traumas.

P7 “if they feel secure or insecure, those kind of things, and generally if they have had a history of a series of lots of traumas or a few traumas or maybe just this one off trauma, and that will have a significance as well. So all of these are significant factors in determining what you... how you make your formulation and then engage with the treatment.”
Participant 7 saw information about the impact, on the client, of previous history, and security of attachment as essential in her formulation and treatment process. Research carried out by Schore (2001) into attachment and neuro-physiology offered insight to the links between right brain hemisphere development and the influence of security of attachment in infancy. Outcomes of the study carried out by Schore indicated that there was a physiological basis to attachment experience and right brain development. Those children who had secure attachments have a more developed right hemisphere, which acts as a stress coping system site, this hemisphere is also dominant for inhibitory control (2001a: 44). In a further study that he carried out in 2002, Schore identified that early abuse negatively impacted the child’s capacity to develop sites in the right hemisphere and as a result he concluded that this ‘set a template’ for coping deficits of both mind and body which characterize PTSD (2002:26). This research underscored the importance of the need for the trauma therapist to understand previous life experience, specifically attachment history.

Research carried out by Benoit et al (2010) addressed emotion regulation strategies as mediators of the association between the level of attachment security and PTSD symptoms following trauma in adulthood. They identified that a higher level of attachment security was associated with fewer PTSD symptoms. The results also identified that substance use and emotion-focused strategies mediated the association between attachment and PTSD symptoms, (2010:101).

4.7.2 Sub-theme (ii) Childhood Experiences

Participant 2 who placed great store in understanding the clients’ childhood experiences also discussed the link with childhood experiences and attachment and how their experience of attachments influenced both their current responses to the trauma and their sense of security within themselves.

P2 “I think that the quality of early relationships and the sense of safety and security that they feel with themselves is a big factor. . . . . . . I think the other factor that people’s personal history which comes in is very much about the quality of relationships in their earlier life and the nature of attachments and what kind of attachments they have had. Sometimes that
will become pretty clear. You know, if someone generally presents as being an insecure kind of person, you might at some point, or I might at some point want to open up that to get a feel for the quality of their early relationships with their primary caregivers and then you get into the whole relationships – secure relationships/insecure relationships/anxious relationships, patterns of unpredictable parental behaviour which lead to the variety of attachment patterns that you can see in terms of ambivalent and avoidant and clinging and so on...........You know, again arising from the quality of relationships or the atmosphere, the dynamics within their home at the time, which they carry into adult life.”

It is important to note that the link between past and present was central to all those participants who identified attachment as a significant variable in working with clients’ who present with PTSD irrespective of their theoretical background or choice of therapeutic approach. A focus on this aspect of the clients’ life would be expected from approaches, which hold childhood experiences at the centre of their theoretical and therapeutic construct. However, this focus on past events and attachment history was also described as of significant importance in the formulation and treatment development process of those participants who worked from a range of theoretical positions including CBT and EMDR. This would seem to support the view that this knowledge and awareness was of wider utility and positions history taking, at an in-depth level with specific focus on attachment, as important in the process of therapeutically engaging with clients presenting with a PTSD diagnosis. The comprehensive statement offered by participant 2 about clients’ previous relationship profile embeds his sense of this issue being fundamental to his way of working, the considerable time and focus he offers to this process indicated the importance he placed on attachment within his therapy work.

Participant 9 discussed themes of abuse and broken relationships in the history of the clients’ he works with.

P9 “as I have mentioned before a theme I think is very common is sexual abuse and physical abuse. They share a theme of broken relationships.”
Participant 9 held a focus on and awareness of the clients’ history of abuse, both sexual and physical, which reflected his sense of the importance of understanding the profile of broken relationships as an indicator of potential issues within the therapy relationship and the clients’ expression of their difficulties. The issue of the impact of broken relationships was identified in research carried out by Cloitre et al (2008), who identified participants with childhood abuse histories and how insecure attachment was associated with psychiatric impairment through the process of poor emotion regulation capacities and diminished expectations of support, (2008:282). Although this study was carried out with female participants the findings resonated with participant 9, who works in an all male forensic environment with clients’ presenting with similar backgrounds and behavioural responses.

4.8 Master Theme 7: Presenting Therapy Themes

Sub-themes:
*Coping Strategies
*Emotions/Affect

This theme identified specific issues and common presenting themes that clients’ offered to the participants. Six of the participants addressed this theme and held a focus on coping strategies employed by clients’ and the impact of emotions and affect on the clients’ presentation and ability to manage their issues. An understanding of how clients coped with their symptoms and responses to the trauma(s) they have experienced was been cited as an important factor in treatment and formulation decision making for participants of this study. The strategies clients employ and the impact these have on their ability to function in everyday life were of great interest and informed clinical decisions and more generally identified how participants could engage with clients’ on a personal level.

A common theme that emerged in the participant interviews was how impactful self-help or individually developed coping strategies were on clients’ functioning. It was common for participants to experience clients’ who presented with avoidance and detachment as a key coping strategies often connected to substance use in an attempt
to alleviate PTSD symptoms. This section looks at some of the issues raised by the participants in response to clients’ use of differing ways of coping.

4.8.1 Sub-theme (i) Coping Strategies

Determining what kind or if the client has coping strategies in place is important to participant 2 as it was experienced as a way of informing his strategy for therapy with the client.

P2 “…What is happening, what sense are they making of it, because to an extent they are either coping or not coping with it.”

An understanding of how an individual is or is not coping with their symptoms was important to participant 2 who held a focus on this process, which informed his capacity to work effectively with his clients. He spoke of the use of this knowledge, which informed his treatment decisions and enabled him to focus on those strategies, which had been identified as unsuccessful to be replaced by more effective strategies, which created an environment and process where his client could feel empowered and begin the process of recovery.

Participant 5 extended this process of movement and altered coping processes when he discussed the concept of ‘adaptation’ and described this as a ‘healing process’. He identified his experience of a potential conflict in this process of ‘worrying’, which can be a counter-productive coping strategy for his client.

P5 “when a trauma happens there is an adaptive process that the person has to go through, like a healing process. But what can happen is people can generate ideas from that, that actually become sort of counter-productive, and the more they try and help themselves by worrying, the more they become blocked…I would say the way in which people try and help themselves when they are upset, can often become the thing that traps them in it.”
Participant 5 discussed counter productive thinking, which can impact negatively on the clients’ capacity to overcome and naturally adapt to the trauma experience. In identifying this ‘circular trap’ of worrying to ‘survive’ which has the effect of keeping his client embedded within a consistent sense of danger, participant 5 captured the common trap that some trauma clients fall into. His experience of clients’ perception and experience of developing short term coping strategies which are effective for an initial and short time but become less and less effective as they continue to use them in the medium and long term. Participant 5 identified the adaptive nature of trauma and how his clients get ‘stuck’ in this adaptive cycle, this was a description that was offered by the majority of the participants who had experienced this as a common issue presented by their clients. The concept and imagery of being ‘trapped’ was addressed in other participant statements, which are explored more fully in sub theme (ii).

4.8.2 Sub-theme (ii) Emotions/Affect

The second sub-theme connected to presenting therapy themes is that of Emotions/Affect. These were reported by the participants to be common expressions of the clients’ experiences when presenting to therapy. The participants identified guilt; trust issues, shame, anger, lack of control, safety, avoidance, depression and negative self-judgment as significant presenting issues.

P1 “the things like guilt and trust, you know probably trusting himself and then this projects onto other people, you know, trust, there was some shame, anger and yes, some depression, mood and associated thoughts........one of the themes that I see is control, that a person’s symptoms are often driven by the sense that they weren’t in control enough at the time of the trauma or that life now is somewhat out of control and then triggers questions around trust with others, and safety and then the future being kind of unpredictable.”

Participant 1 identified a central presenting theme as control and how this had a connective influence on wider expressions of concern to the client. With control at the centre of the client issues internal concern and external projection was experienced as
common for his clients. Arising from his experience of working in a military setting he identified control, planning and a desire for predictability as goals to be achieved by his clients. For his clients’ to experience situations where they feel unable to attain these goals, as a result of a traumatic process, had the potential to generate a major shift in their concept of control and fundamentally shift their ability to trust self and others. Participant 1 identified these issues as common starting points in his work with his clients. In his work setting order, predictability and control were experienced as core processes in military life. He discussed his experience of clients who experienced a suspension of these elements having a very destabilizing effect on their lives, which generated a sense of little or no resource to address their issues.

Participant 1 identified a complex mixture of emotions and specific behavioural responses. This experience is supported by participant 2 who introduced his experience of the client issue of a sense of violation.

P2 “I think the blame can be of themselves or of other persons, and I think obviously anger, sometimes rage, are common themes. But depending on the nature of the trauma, this sense of not having control and violation would be some of the themes.”

An extension to the theme of control (loss) was the process and expression of violation experienced by participant 2 in his work with trauma clients. He had observed both anger and rage as presenting issues and confirmed these as common themes presented by his clients. Self-criticism and projected criticism were also seen as common presenting issues. Participant 2 experienced the need to have someone or something that was responsible for the trauma as significant; this was either internalized (self blame) or projected to others.

The issue of avoidance was seen to be important and a possible response to facing the trauma in the therapy relationship.

P3 “control, fear, hopelessness, shame, trust – what else could there be? Avoidance, because of course, who would want to come and sit and talk about difficult things. You know, nobody is going to want to, are they? “
Another consistent report of core emotions and behaviours presented within therapy was offered by participant 3 who recounted control, fear, hopelessness, shame and trust as presenting issues for her clients. A key coping strategy employed by her clients was that of avoidance and she identified that this strategy can be engaged and experienced within the therapy process. Participant 3 in her reflections within the interview highlights the challenge this can present to the therapy process. Research carried out by Mellman et al (2001), addressed issues of avoidance as a coping strategy. They identified that heightened arousal and the employment of avoidance as a coping style, (with feelings being overwhelmed), were predictive of severity of PTSD. The study was focused on participants who had suffered an initial injury in the traumatic event. Participant 3 did not specify if the clients she had experienced and who presented with avoidance coping strategies were injured in their trauma(s), however, she did recount a common experience of these presentations with a varied range of client trauma backgrounds.

Another element present in the experience of participant 4 was that of the external pressure of ‘getting better’. She described the complexity of the core emotional responses experienced by her clients’.

P4 “there are some common emotions. The stories are completely different, but the emotional reactions are similar, and I suppose you just see how human nature works. How it heals and how it doesn’t heal…I think what they all feel is pressure. They all feel pressure to get better and so some of that guilt and shame is what happened to them, but there’s guilt and shame that they are judging themselves.”

Participant 4 proposed a different direction in the discussion of presenting issues in PTSD therapy. She discussed her experience of common emotions presented and reflected on the emotions of guilt and shame and extended this to incorporate internalized pressure. Participant 4 discussed the identification of clients’ feeling pressure to ‘become well’, and how this impacts on the therapy process. She discussed her belief and experience of a significant proportion of her clients reporting
feeling this pressure and how that presented itself for them as symptoms of guilt and shame within the therapy process.

Participant 6 introduced the physical expression of his clients’ trauma experience. He discussed the diversity of his clients’ and identified the similarity of the physical ‘embodied’ nature of their presentation.

P6 “There is a definite personality that presents.... my feeling is that the presentation.... everyone is unique...everyone is different... but there is something in the way they hold themselves, the way they respond... there is something within them that their symptom cluster and their experience...”

The emphasis on physical embodiment was something participant 6 was particularly focused on in his work with clients. He recognized the unique and diverse experiential experience that his clients offered when presenting to therapy, however, he reflected on the similarity of the manner in which his clients responded and physically presented to therapy. Other participants when reflecting on common presentations discussed this focus on ‘difference versus similarity’. The way in which clients had obviously different stories and experiences were reported as counterbalanced by great similarity in the manner in which clients responded both physically and psychologically within therapy. Participant 6 conceptualised this phenomenon as a ‘definite personality’, which was embodied in the manner in which clients ‘held’ themselves.

When reflecting on her clients’ presenting emotional issues, participant 7 discussed her approach of using the clients’ reflection on their body as a key treatment process. She also expanded the emotional presentation to somatic effects.

P7 “They all, at some point, have re-experienced the pain of the trauma in the therapy room or changed shape in a sense as well. Move their bodies in different ways. Or had.... I always focus clients on the body anyway, this seems to take place in terms of trauma and focus on what they’re feeling and the common thing that it brings up is that the feeling starts in
Support for the bodily expression of trauma was offered by participant 7 who discussed how she worked with and invited her clients to connect with their bodies in a direct manner, which formed a clear base to her therapeutic strategy. She explored her experience of all of her clients using their bodies to express emotion and core experiences of their trauma(s). She described a level of consistency in the patterns of her clients’ bodily responses even though they presented with vastly different traumas. It is a somewhat surprising outcome that there could be so much conformity of response in such a diverse group.

Participant 7 went on to discuss her experience of her clients presenting with a ‘hierarchy’ of emotional presentations.

P7 “Well, they all start off in a state of fear and other things as well. It’s always fear but then sometimes if there’s sadness, usually then, it seems to go from fear to anger quite a lot of the time... So they will go to.... it’s almost like a layer, the next layer of anger, and very often, shame. Not always, but very often, there’s a bit of shame involved. And then sort of the feeling of calmness and relaxation, that sometimes happens. But that seems to be the hierarchy in the sense of things.”

Participant 7 discussed her experience of what she described as a process of ‘layering’. She described a typical expression of emotions, which follow layers beginning with fear, sadness, anger and then to shame. Although she did not attribute this process to all of her clients she did experience this often with her trauma work with clients. When discussing the final layer, which she identified as ‘calmness and relaxation’, she described her motivation to enhance her clients’ capacity to experience this physical and emotional state. It is interesting to note that all of the participants who responded to this theme described their experience of their client’s presentation of key emotional responses of fear, anger, shame, guilt, helplessness and lack of control. All participants who responded to this theme when they described the experience of their clients using, either knowingly or unknowingly, their bodies to
express emotional responses and reactions within the therapy process, also discussed the experience of bodily responses. This physiological representation of a traumatic experience was discussed in research carried out by Van Der Kolk (1994), his research looked at the impact of trauma on the body; he described the centrality of the limbic system in the manner and process of expression of PTSD. His work identified the way in which those with PTSD tended to over-interpret sensory input of past trauma and that most processing of sensory input occurs outside of conscious awareness, (1994:263). This research would seem to support participant 7’s experience of the clients’ physiological expressions of emotion.

4.9 Master Theme 8: Support Systems

Sub-theme:

*Internal/External

The final master theme developed from the participant interviews was focused on the issue of support systems. The participants reflected on the importance of internally and externally generated support processes and how these impact the therapy process for themselves and their clients presenting with trauma related issues, specifically a PTSD diagnosis. More than half of the participants discussed these issues and reflected on their experience of the impact of these issues on their work.

4.9.1 Sub-theme (i) Internal/External

The main discussion of issues related to support systems was expressed within the connective sub-theme of Internal/External (resources). Support systems were seen as crucial for a successful therapeutic outcome by a number of participants. Participant 2 stated that his treatment decisions would be influenced by the factor of ‘client support’ available to them through treatment.

P2 “And one of the factors that I am looking at is, you know, what else is going on in their life. Because – who is there to support them, who is of significance emotionally in their day-to-day living, or not. Because that’s
Participant 2 placed a high level of importance on identifying the amount and quality of support available to his clients before deciding what work would be engaged within therapy. Research carried out by Schumm et al (2006) identified that a secure and comprehensive social support system had a buffering effect on the impact of child and adult interpersonal trauma, (2006:825). Participant 2 reflected his awareness of the importance of support outside of the therapy room and how this would have an impact on the therapy process. A number of research findings confirm that individual’s who had support systems and networks in place were more likely to have positive outcomes to the therapy process. This element is seen as a significant variable in the clients’ capacity to cope with the treatment process particularly while undertaking the more difficult and challenging aspects of trauma therapy such as revisiting/reliving the trauma or directly confronting elements of the trauma. Participant 2 sees the focus on the clients’ access to emotional support as centrally important to his core decision of if he would attempt to engage in the therapy process with the client. The nature of trauma therapy has been experienced by some clients’ as challenging and potentially dangerous. Participant 2 identified that with this background the need for a substantial support system was essential for the positive outcome of therapy for the client.

He went on to expand on his sense of ethical practice and how he recognized the potential problems associated with asking a client to engage in a difficult and potentially isolating experience.

P2 “it’s about safety...it’s about...I don’t want to open something up in the course of a one hour session, or maybe a bit longer, one and a half hours sometimes for particular traumas and then leave the person to go home to an equally unstable situation which could be detrimental to them and their integration...but also with just talking about traumas that it doesn’t stop when the counselling session ends and a lot can happen between sessions and it’s really important that the person doesn’t feel alone and isolated and not able to cope.”
Participant 2 expressed his sense of ethical practice being central to his decisions when asking a client to address very distressing material and then leaving them with these issues open with no external support or ‘holding’ available to them to enable them to cope and contain the material discussed. He discussed his experience of the negative impact on the clients’ integration of the trauma when they faced going back to a social or physical situation that is potentially re-traumatising for the client. The importance and impact of the ‘between’ session time was discussed by a number of participants and participant 2 reflected on his sense of the importance of the client having access to support and the ability to cope with potentially increased emotional content generated from the therapy process. Without this support participant 2 believed that it would be very difficult to engage fully in the therapy process and changes would need to be employed within the therapy design and application.

This external support was also seen as potentially counter productive in certain circumstances and is reflected upon by participant 4. She expanded the theme of isolation and also identified shame and guilt as emotional responses that can arise for her clients’. Support is also discussed and identified as potentially less influential as it was sometimes proposed.

P4 “there’s definitely that sense of isolation and shame. Shame about what happened to them, and shame about not being able to cope, and also I think that those who are in families have a real guilt that they are not getting out of it fast enough, however their partner is.”

The emotions of isolation and shame were seen as common responses for the clients of participant 4. She identified the external pressure that can be felt by her clients’ when they felt hurried and pushed to become ‘well’. Participant 4 identified that this was not always experienced as an explicit process but often internally generated by the client. Her experience of clients’ reporting a sense of guilt and shame was significant and she reflected upon how these emotions were often generated by a desire to reduce the worry and concern of those around them, family, friends and partners. This identified the interplay between internal and external sources of both support and pressure. The focus on the clients’ resources and how these impact their ability to cope with the high pressure of addressing their trauma within the therapeutic...
process is something that all of the participants were focused on when developing
treatment decisions and methods of working with their clients.

Participant 7 went on to reflect on these resources and her client’s access to both
internal and external sources of support. She discussed how her treatment decisions
could be significantly impacted by the level and quality of her clients’ access to
supportive resources.

P7 “How stable they are, whether they’ve got any resources – obviously
they will have resources, but how they are able to access those at that time
and whether I need to work more with them about developing that... So if
they don’t have a supportive social network, for example, or if they don’t
self soothe or aren’t able to deal with massive emotions and overwhelming
emotions, that would kind of influence what I would sort of decide on
doing.

Participant 7 saw the issue of client stability as an important consideration,
specifically in relation to therapeutic decision making for the therapist. Participant 7
discussed her need to identify client resources and if there was a requirement for her
to enhance and develop these prior to engaging in a more direct therapy process. This
may include psychoeducation and normalizing as previously discussed or a focus
‘pre-therapy’ engagement activities where clients anxiety is gently engaged with to
increase their resources and ability to engage in the therapy process. Another
consideration she reflected on was the clients’ internal support systems, which were
also seen as significant in the development of treatment and formulation of the
therapy process. A clients’ internal resources, their capacity to cope with addressing
difficult and upsetting issues and powerful emotions, were a significant consideration
in the order and sequence of treatment. An ability to access both internal and external
sources of support when engaged in the trauma therapy process, which holds a focus
on emotion, is seen by participant 7 as a core requirement. The emphasis on
understanding what resources, and how they are accessed and used, formed a central
consideration in treatment selection and delivery for the participants who responded
to this theme in the study. This information seemed to form a baseline for
participant’s clinical and therapeutic decision-making. This perspective is supported
by research carried out by Shea and Zlotnick (2002), who identified five issues, which were influential in the choice of treatment for PTSD. One of these issues was; ‘the nature of the client’s current physical and social environment’ (2002:871). This would seem to support an understanding of the importance of the wider social context that the client exists within and the impact this may have on their ability to engage in specific therapeutic processes such as the highly emotionally challenging process of trauma therapy.

The findings express the experiences of the participants and the issues and factors that make up their lived experience. The summary section will expand and unpack key elements of the findings.

4.10 Summary

This chapter has presented and discussed the findings constructed within eight Master (ordinate) themes and thirteen related sub-ordinate themes. Within these themes there are a range of key participant reflections on their lived experience in relation to the work they engage in with trauma clients. Their wider understanding and experience of PTSD and the challenges of working with people who present to therapy with this issue is also reflected upon. This section has briefly summarized the key findings and issues, which were reported to have impacted on and shaped the participant’s lived experience.

There was a general consensus among the participants of a specific range of client presenting issues which supported the general view that predisposing factors to PTSD were present for their clients who presented for therapy. This finding followed outcomes from a wide range of research relating to predisposing factors to PTSD. In one such study Brewin, Andrews and Valentine (2000) had identified: life stress, poor social support, adverse childhood events, trauma severity, childhood abuse, female gender and family psychiatric history as significant predisposing factors to the development of PTSD following a traumatic event(s). Some of these key factors were experienced by the participants within their therapy work. Theses were; child abuse, poor social support and adverse childhood events. The participants identified other factors as significant; attachment issues, low educational level, a range of previous
traumas, and previous low-level mental health issues. These issues were experienced
by a significant proportion of the participants and were considered by them as factors,
which they believed predisposed, their clients to developing PTSD. Lower
educational level was identified as a predisposing factor to PTSD in research carried
out by Kessler et al (1999). Attachment issues were also identified as predisposing
factors to the development of PTSD in research carried out by Schore (2001, 2002).
The other factors identified by participants were all cited in research identifying them
as predisposing factors to the development of PTSD.

Issues impacting on the participant’s experience of developing formulations and
treatment strategies within their work with trauma clients were also discussed. A
range of issues were identified by the participants who discussed their experience of
the following issues; client resources, severity of presenting issues, support systems
available to the client, the therapy relationship, development of trust, and issues
connected to beliefs, safety, control and identity. This brief summary of key issues
identified by the participants is explored in more depth in relation to the initial
research questions proposed by this study in the final conclusion chapter.
CHAPTER FIVE

CONCLUSION

5.1 Introduction

In this final chapter I reflect on key findings and their relationship to the initial research questions posed. I discuss strengths and limitations of this study and propose some recommendations for future practice and research. I end this chapter on a personal note with a reflexive statement sharing the impact of engaging in this research process and how it has informed my personal and professional thinking and influenced my future engagement with the issue of trauma and PTSD.

5.2 Reflecting on the Research Questions

The conclusions of this study emerged from the findings where thirteen sub-ordinate and eight super-ordinate themes were identified as significant and representative of the participants lived experience of working with clients who present with PTSD as a presenting issue. This section will focus on linking the initial two research questions to the findings outlined in the discussion of findings chapter. There is no attempt to draw global inferences or present the findings as representative of the wider experience of other trauma therapists but to reflect on the participants personal and subjective lived experience in relation to the issues identified within the core research questions.

The first research question proposed was;

*Do trauma therapists believe there to be predisposing factors, which influence the expression of PTSD?*
The participants individually identified a range of issues that would support the view that predisposing factors do influence the expression of PTSD in the clients they worked with. Predisposing factors identified by Hoge, Austin & Pollack (2007) were pre-trauma, peri-trauma and post-trauma risk factors. This finding echoed outcomes from a wide range of research relating to predisposing factors to PTSD. In one such study Brewin, Andrews, and Valentine (2000) had identified: life stress, poor social support, adverse childhood events, trauma severity, childhood abuse, female gender and family psychiatric history as significant predisposing factors to the development of PTSD following a traumatic event(s). Some of these key factors were experienced by the participants of this study within their therapy work. These were; child abuse, poor social support and adverse childhood events. The participants identified other factors present for their clients these were; attachment issues, low educational level, a range of previous traumas, and previous low-level mental health issues. These issues were experienced by a significant proportion of the participants and were considered by them as factors, which they believed predisposed, their clients to developing PTSD. Lower educational level was identified as a predisposing factor to PTSD in research carried out by Kessler et al (1999).

Attachment issues were also identified as predisposing factors to the development of PTSD in research carried out by Schore (2001,2002). The majority of the participants described the issue of ‘attachment profile’ being significant in the client’s expression of PTSD. The security of the client’s previous and current attachment experience was described by participants as influential in the client’s ability to engage in a trusting relationship with the participants in the challenging environment of trauma therapy work. Schore’s (2001,2002) described a potentially more fundamental implication of childhood difficulties within attachment relationships. He identified that his findings suggested direct connections between traumatic attachment, inefficient right brain regulatory functions and maladaptive infant and adult mental health, (Schore, 2001b: 201). Participants spoke of their experience of working with a high number of clients with PTSD who had insecure attachment profiles and who had experienced specific fractures in close relationships in earlier life. The issue of insecure attachment was addressed in research by Dieperink, et al (2001) who identified those with a secure attachment style scored significantly lower on measures of PTSD than did those with
insecure attachment styles and that attachment style was a stronger predictor of PTSD symptom intensity than the severity of the trauma.

Participant 9 who identified lower educational level as a common presenting issue from his clients represented another example of participant experience of what they perceived to be a predisposing factor in their clients development of PTSD. This was one of the factors identified by Kessler et al (1999) as a significant pre-trauma variable and has been proposed as a predisposing factor in the development of PTSD. Participant 9 perceived his experience of working with individuals who commonly present with this personal expression as significant and impacted on his clients expression of PTSD.

A significant factor that was reflected upon by all of the participants was that of their client’s previous experience of trauma(s). The participants commonly experienced this factor as not the trauma that was the focus of the client’s presentation to therapy. Another experience was that these previous traumas were often described by the client as more intense or impactful at the time than the trauma they were experiencing at the point of presentation to therapy. The frequency and similarity of experience of all of the participants presented this as an unexpected finding within this study. Research has identified exposure to previous trauma as a risk factor for the development of PTSD, particularly if that trauma was experienced at a young age, (Davidson et al, 1991: Twiate & Rodriguez-Srednicki, 2004). The previous trauma experiences of clients were experienced by participants as shaping the beliefs and way in which their clients engaged with the world and perceived self. These were potentially impactful factors on the therapy process and reinforcing of the sense of loss of control many clients reported.

A presenting issue perceived by participants as a predisposing factor to the development of PTSD within their clients was the client’s sense of identity and beliefs about self and the world. The participants saw these interlinked issues as important in understanding the manner in which their clients engaged with the trauma and strategies they employed to cope with the impact of the trauma. Schnurr and Vielhauer (1999) researched the impact of personality variables and identified that adult avoidant, antisocial or neurotic personalities prior to the traumatic event had an
increased risk for the development of PTSD. An understanding of these interlinked presenting issues and client individual identity variables formed a key factor in the participant’s ability to engage and work therapeutically with their clients. At this point I move to the second research question and reflect on the participants experience of their clients impact upon them.

The second research question proposed was;

*How do trauma therapists believe clients’ previous life experiences influence their formulation and treatment protocols for PTSD?*

As discussed there was consensus among the participants of a specific range of client behaviours, beliefs and presenting issues which supported the general view that predisposing factors to PTSD were present for their clients who presented for therapy. The predisposing factors represented for them impactful processes on the individual’s life and were experienced and characterized by participants as significant previous life experiences. The participants discussed their belief that their client’s previous life experience significantly impacted on their therapeutic decision making including formulation and treatment planning. Specific issues impacting on the participant’s experience of developing formulations and treatment strategies within their work with trauma clients were discussed. Participants identified the following issues; client resources, previous experience of trauma, severity of presenting issues, support systems available to the client, the therapy relationship – development of trust, and issues connected to beliefs, safety, control and identity.

The issue of client exposure to previous trauma(s) was seen by all of the participants as the most influential factor impacting on the expression of their client’s trauma response and having a significant impact on discussion of both of the research questions. The significance of their client’s previous trauma history was seen as specifically impacting on their client’s expression of PTSD. This also had a direct impact upon the choice of focus of treatment, specifically on either the current or previous trauma. The participants described commonly having to address previous traumas prior to dealing with the presenting trauma. This had a potentially significant impact on practical and therapeutic decisions made within the therapy process. A
consistent reflection offered by all of the participants was that of their practice of engaging in detailed history taking with clients. This was to establish a range of detailed baseline information with which to create appropriate therapy plans and engagement strategies. All of the participants spoke of their focus on this aspect of their work with trauma and PTSD clients and its importance regardless of theoretical or therapeutic perspective (Ehlers & Clark, 2000; Shapiro, 2001).

The main consideration each participant individually reflected upon as fundamental to the success of the therapy process from their experience was the quality of the therapeutic relationship. This was a somewhat surprising finding given the range of therapeutic approaches utilized by the participants. Rationale offered for this focus on the therapeutic relationship was; development of trust, socialization to the therapeutic approach, creation of safe environment, diminishing of symptoms and preparation for confronting trauma. Bordin (1979) described similar goals for the development of a therapeutic alliance with three key factors at the core of the alliance. These were; the presence of a personal ‘bond’ where client views of a caring/understanding and knowledgeable therapist are required; agreement of ‘goals’ of therapy and finally an agreement as to how these goals will be realized. There has been great discussion in relation to the balance between technique and therapeutic relationship. Researchers have addressed a range of issues in relation to this interplay. Hill (2005) proposed a pan theoretical model to capture the key components of successful therapy interactions. She identified three interrelated and connected variables which should be considered when reflecting on the therapy process, these were; therapists techniques, client involvement and therapeutic relationship (2005:431).

The participants placed such emphasis on the therapeutic relationship that it became the most consistent issue they described within discussions of their experience of working within trauma therapy. Participant 8 described it as ‘the’ most significant factor for her more important than the techniques she used. Participant 5 described not having ‘anything’ without the relationship and its ability to adapt, he placed emphasis on it being central to the change process, more important than technique. These statements were representative of the general level of importance other participants placed upon the therapeutic relationship within their work.
Another issue that participants described as central to the work they did with clients was engaging in the process of psychoeducation and normalizing. This was linked to the desire to develop trust and reframe client’s appraisals, beliefs and experience of their trauma. Participants saw these processes as interlinked and described as the starting point of the therapy relationship. The process of resource building was another aspect of this process and related to the experience of all of the participants. Those participants who described a more relational and non-directive approach to their work also employed the process of psychoeducation. This was discussed as a way to foster client control and rebuilding a sense of trust in self. Common experiences for the participants were clients who presented with a lack of trust in self and their body with sense of greatly reduced control. The process of developing client resources before engaging with the trauma was also described as something participants were concerned with and had experienced as important. Support systems both internally and externally driven were seen as significant in the resource building process and was a determining factor in which direction they would take the therapy process. Participant 2 spoke of his focus on support in the client’s life, as this would be a determining factor in his decision of working with a specified trauma. Schumm et al (2006) identified that a secure and comprehensive social support system had a buffering effect on the impact of child and adult interpersonal trauma (2006:825). The participant’s focus on support systems employed by their clients is supported within research; Shea and Zlotnick (2002) identified five issues, which were influential in the choice of treatment for PTSD. One of these issues was; ‘the nature of the client’s current physical and social environment’ (2002:871). This supports the experience of participants who placed an emphasis on understanding the wider resources available to their clients working with PTSD.

5.3 Implications and Recommendations from the study

Within this section I reflect and summarise the key findings of the study in relation to wider implications and offer some recommendations in response to these findings. There were a range of issues that participants identified within their clients previous life experience which exerted influence over their decision making process in relation to formulation and treatment. The participants also confirmed individually that they
had experienced a range of issues that would support the view that predisposing factors do influence the expression of PTSD in the clients they worked with. The participants identified their experience of clients presenting with predisposing factors to the development of PTSD, these were, child abuse, poor social support and adverse childhood events, attachment issues, low educational level, a range of previous traumas, and previous low-level mental health issues (Twaite & Rodriguez-Srednicki, 2004; Faure et al, 2007; Kessler et al, 1999; Irish et al, 2008; Perry et al, 1996).

Specific issues relating to the clients previous life events impacting on the participant’s experience of developing formulations and treatment strategies were addressed. Participants identified the following issues; client resources, previous experience of trauma, severity of presenting issues, support systems available to the client, the therapy relationship – development of trust, and issues connected to beliefs, safety, control and identity (Kessler et al, 1999; Carlier et al, 1997; Young & Erickson, 1988; Lambert & Barley, 2001).

Significant issues that were described by all of the participants regardless of their theoretical or therapeutic perspective were, 1, the central importance of the therapeutic relationship, (without a strong, trusting and safe relationship the participants would not engage the therapy work), 2, the importance of in-depth history taking, (identification of previous life experience and its impact on the current response to the trauma), 3, the impact of previous trauma(s), 4, the impact of support systems, environment and identity.

A significant implication arising from the findings is the central importance placed on the therapeutic relationship by all of the participants. This positions the therapeutic relationship as a significant factor in the process of trauma therapy work, irrespective of the theoretical position of the participant within this study (Lambert & Barley, 2001). The participants identified a range of theoretical perspectives, EMDR, TF-CBT, relational/humanistic, psycho dynamically oriented, integrative, and body psychotherapist. It is rare to experience such a range of traditions sharing an underpinning factor in their expression of therapeutic process. Participants reported finding it important to their way of working to hold to recognized frameworks of trauma-focused work which was securely underpinned by a strong therapeutic relationship, often going beyond the recognized protocols of the approach adopted in regard to the requirement of depth of relationship. The focus on the therapeutic relationship may be attributed to the unique presentation variables and symptoms
experienced within trauma therapy work. Participants reported the need to address specific presenting issues of fear, anxiety and intrusion (Ozer, et al, 2003), and the requirement to establish a safe and trusting environment prior to the process of addressing the trauma. Horvath (2005) identified the re-emergence of the relationship as a pan theoretical concept capturing the relational dynamics of therapy.

Another implication of the findings from this study is that of the experience and belief of participants in the requirement for a highly detailed history taking process, (Lauterbach et al, 2007). This reflects the experience of participant’s of an understanding of previous life events being central to accurate formulation and treatment development. The impact of some previous life events such as previous trauma experience (Irish et al, 2008), were described as highly relevant to understanding the clients needs within the therapy process. Previous attachment history, adverse childhood experiences, cultural and environmental issues, and support structures are identified through this comprehensive history taking process and was seen by all participants as essential.

**Implications for Practice**

The study identified the participants’ experience of predisposing factors on the expression of PTSD. There was consensus from the participants’ in relation to the significant impact of client’s previous life experience on their expression of PTSD. The participants further identified that the client’s previous life experience influenced their formulation and treatment of PTSD. Significant issues that were described by all of the participants regardless of their theoretical or therapeutic perspective were; the central importance of the therapeutic relationship, (without a strong, trusting and safe relationship the participants would not engage the therapy work); the importance of in-depth history taking (identification of previous life experience and its impact on the current response to the trauma); the impact of previous trauma(s); and the impact of support systems, environment and identity.

These four elements present a specific focus for practice. Although some key therapeutic approaches to trauma work emphasise a focus on history taking, previous life experiences, and a focus on the quality of the therapeutic relationship, not all
approaches emphasise the level of attention on all of the elements identified within this study. The implications for practice seem to centre on the integration of these identified elements within a workable therapeutic delivery. Approaches such as EMDR, Shapiro, (2002), and some TF-CBT therapeutic interventions, Ehlers and Clark, (2000); Zoellner, Fitzgibbons and Foa, (2001), incorporate the vast majority of these identified elements. Other approaches address different combinations of these elements, however, some adaptation of these approaches could facilitate the incorporation of all the elements identified within this study. The obvious difficulty with this option is the potential resistance of practitioners to change their custom and practice related to their training in core approaches and practice techniques.

**Contribution to Knowledge**

Although some of the key findings of this study reflect wider research findings related to predisposing factors in the development of PTSD. Within the findings of this study there are some specific emphases on ‘depth, intensity and focus’ not fully described in that wider research. The voice of the trauma therapists is highlighted within this research and specifically a focus on their practice and therapeutic experience. Reflecting on the scientist practitioner model, Gelso (1993), and its emphasis on integrating research into practice, a key aspect of the development of an original contribution to knowledge was the integration of the findings of this research within my practice. Chwalisz, (2003), identified a parallel process of evidence-based practice, when she stated; ‘A training model based on evidence-based practice may…expand notions of evidence, away from sole reliance on positivist science, and specific attention to practice-based evidence are critical to science-practice integration,’ (2003: 521).

With an emphasis on the integration of the key findings of this study into my practice I identified factors, which reflected my practice and those, which had the potential to extend my practice. The factors that reflected my practice was; an emphasis on the development of a strong therapeutic relationship; history taking process and identification of other traumas. Although I had been working as a trauma therapist for a number of years I revisited my therapeutic practice choices, decisions and approach as a result of engaging in this research. I have integrated specific changes within my
practice in relation to; the way in which I engage in the assessment process with clients; the depth, detail and content of that assessment/history taking; an increase on the focus of building a safe, secure and supportive therapeutic relationship (this was reflected in the increased time given to this process prior to engaging in the therapy intervention); more focused engagement with the previous trauma history of clients; and a wider consideration of the clients support systems and sense of identity. These changes have impacted positively on my sense of connection with my clients and understanding of their issues and perspective.

A specific change that I have employed is an adaptation to part of the revisiting protocol within the Ehlers and Clark, (2000), Cognitive Therapy for PTSD model. In the model the revisiting protocol requires the therapist to invite the client to revisit the trauma from ‘before the trauma to the point after the trauma that they felt safe again’, in one continuous process. Within my adapted process I have broken this into three specific parts; part one starts before the trauma and stops just before the trauma is experienced; part two starts before the trauma, moves through the trauma and ends at first contact with others; part three starts before the trauma and moves through the trauma to the point at which they feel safe again. This adaptation was developed as a result of reflection on the nature of the fear response offered by trauma clients and has resulted in a much higher engagement and positive response to the difficult process of revisiting by my clients. Feedback from clients who were particularly anxious about this aspect of the therapy identified the ‘adaptive socialising’ effect of doing the first session of revisiting without the treat of talking about the trauma. This normalising effect has been described as enabling the client to experience the feared process in a safe and controlled manner.

This is one example of the integration of the outcomes of the research into direct therapeutic practice. Another aspect of the contribution to knowledge has been my ability to offer this research directly to trainees on the courses I teach within my role as a lecturer in counselling psychology at the University of Manchester. Presentation of method, findings and outcomes within environments where discussion, debate and critique are encouraged, offer an opportunity to develop and extend a contribution to knowledge in relation to the topics covered within this research.
5.4 Limitations of the study

Reflecting on the process of the research has identified some limitations to the study. In relation to the sample size of the study, although in line with recommendations for an interpretative phenomenological analysis the number of participants was on the higher end of the spectrum (Smith, Flowers & Larkin, 2009). This did however create difficulties in relation to the size of the data produced and inevitably led to issues of selectivity. On reflection the rationale for the larger sample was to hear the voice of a wider range of therapists, however the overwhelming amount of data resulted in the potential for some of the richness of that data to be lost. This was a further limitation and with hindsight sampling to the more accepted 4-6 participant ranges might have facilitated a more focused and in-depth outcome? Within the participant sample there was a representation of age groups from 30 to 60+ with an average age within the 45 to 50 ranges. This would reflect the absence of younger voices within the study, however, this age range was also representative of the therapists who applied for more information but did not engage within the study as a participant. As I was not offering findings as generalizable to the wider trauma therapist population and containing the analysis in relation to the lived experience of the sample participants this may not be as impactful. A wider participant age range however, may have impacted on findings within this study and could be considered a limitation. There was a balance in relation to gender with four female and five male participants (O’Neil, 2008). Although a general balance in gender existed within this study, this is not representative of the wider therapy population, which has a considerable female gender majority. The participant ethnicity was entirely European and there was no representation of other cultures within the participant sample. The lack of inclusion of participants from a more diverse multi cultural background would be considered a limitation of this study.

The therapeutic profiles of the participants were mixed in that practitioners identified working from CBT, EMDR, Integrative, Relational and Body Psychotherapy traditions. Absent from the mix of approaches was Psychodynamic, Humanistic and Solution Focused etc, and as such this could constitute a limitation to the study. Future research may want to address this lack of balance in the therapeutic make up of
the participant sample. As previously stated within this study there was not an attempt to offer global statements of a representative nature, however a more balanced therapeutic mix may have enhanced the overall outcome and findings of the research?

A key limitation of the study is reflected within the debate around PTSD diagnosis. Although the aim of the study did not hold a focus on this element specifically, and some of the debates around this issue are touched upon within the literature review, it is important to recognise the wider implication of the challenges faced when discussing the diagnosis of PTSD. Rosen et al (2008) identified a key aspect of the debate when addressing this issue, when they stated; ‘in the absence of a specific aetiology, the rationale for diagnosing PTSD lies in the distinctiveness of the clinical syndrome. This is problematic when one considers that a combination of symptoms of major depression and specific phobia fully constitutes the requisite criteria for diagnosing PTSD. This raises the concern that PTSD, at least on some occasions, is simply an amalgam of other disorders’, (2008: 3). A range of researchers have addressed this issue, Young (1995) held a focus on Vietnam veterans with PTSD and a belief that traumatic memory is a man-made object. Joseph (2011) presented his view of PTSD as a diagnostic term had been valuable, however the broadening of the criteria to include relatively trivial events has been problematic and misdiagnosis has the potential to become a self-fulfilling prophecy. The process of developing resilience and confronting adversity is proposed by Joseph as a key consideration in trauma therapy work. He identified his THRIVE model of post-traumatic growth and related concepts as a treatment process to aid traumatised people. Joseph has produced a number of publications addressing post-traumatic growth; Joseph and Masterson, (1999); Linley and Joseph, (2004); Joseph and Wood, (2010); Stockton, Hunt and Joseph, (2011). This study did not hold the process of post-traumatic growth as a core aspect of investigation and alternatively addressed the pre-trauma concept of predisposing factors to PTSD. It is however important to recognise the concept of post-traumatic growth and its impact on the field trauma therapy. Although it was difficult to include all of the debates around PTSD, due to space available and key research aims, a possible limiting aspect of this research was that there could have been a wider inclusion of the debates around PTSD diagnosis and post-traumatic growth. This does, on reflection, feel like a limiting factor and somewhat of a missed
opportunity to hear the lived experience of the participants’ views in relation to these issues?

A specific limitation of this study was the potential for movement away from the Participants’ live experience. IPA methodology has traditionally employed a double hermeneutic process, Smith et al, (2009), and this study promoted and fostered this approach. A limitation of this study was the potential for me to engage a ‘triple hermeneutic’, Alvesson and Skoldberg, (2000). That is for the researchers’ personal interpretation of the perception of the participants’ perception of their clients’ experience of PTSD. A double hermeneutic process would hold a focus on the researchers’ perception of the participants’ experience of their trauma work. It would not hold a focus on exploring the participants’ clients’ experience. This would constitute three steps away from the phenomenon under investigation. Although a clear focus was held on this potential throughout the research process it was a difficulty, at times, holding the participants’ to reflection on their own perceptions and not their projections onto their clients’ perceptions. It is not clear how much this had occurred within this study and the impact this may have had on the outcomes.

IPA acknowledges the subjective role of the researcher within the context of a reflexive stance (Smith et al, 2009). I feel I engaged this reflexivity throughout the research process. My lens as a trauma therapist had the potential to shape considerably my engagement with the data. My experience of trauma therapy and awareness helped frame and filter my response to the information produced and inevitably impacted upon my focus on specific aspects of findings. The use of co-researchers (Moustakas, 1994) to reflect wider views and opinions within the research and specifically the analysis process would have enhanced the outcomes. One way of achieving this would have been to include the participants more fully in the analysis process. I did return transcripts to participants for accuracy and content checking, facilitating deletion of identifiable information (particularly of client material). Following analysis, however I did not check with participants if their intended meaning had been accurately reflected in my analysis and findings. This is a limitation within the study and reflects a missed opportunity to engage the participants in a more collaborative process.
A key strength of the study is that of the focus on the lived experience (Patton, 2002) of trauma therapist’s experience of working with clients presenting with a PTSD diagnosis. Little research has addressed this aspect of trauma work usually holding a focus on the client within the process. This snapshot of nine therapists experience of this phenomenon provides an insight to central aspects of their thinking and meaning making (Heidegger, 1962/1927), and offers reflection on the complex interactive dynamics at the centre of that experience. Findings have described a unique environment where intensive client anxiety and fear are powerful factors in the expression of therapist’s behaviour and engagement with those clients.

**Future Research**

When considering a focus for future research in the area of trauma therapy for PTSD a number of options present themselves. In light of the findings from this study a focus on understanding more deeply the interplay between the therapeutic relationship and its place within traditionally non-relational technique based therapies for trauma would be an area for focus. Another aspect of the importance of the therapeutic relationship within trauma therapy is the nature of ‘threat’ that exists for the client within the therapeutic work engaged. Dworkin, (2005), identified key elements in this relationship and the specific challenges in the nature of trauma work when he stated: ‘An alliance is not a strong enough container for a traumatized client who comes to us short on trust, long on isolation, and knowing he will be asked to reveal and feel – perhaps for the first time, if he dissociated during the original trauma – the most terrible moments of his life. The client’s degree of fear is identical to the degree of connectedness he needs with the therapist in order to feel safe,’ (2005: 2). This study identified the participants’ experience of a strong therapeutic relationship as a core requirement for successful therapy work with their clients and indicates the potential for a focus on the relational aspect of trauma work as a fertile ground for future research studies.

A slight divergence from this approach would to be the inclusion of a wider range of practitioners from a more diverse range of therapeutic approaches, specifically from Psychodynamic and Humanistic traditions, who may hold significantly differing views about predisposition to the development of PTSD, than the participants’ of this study? This study did not have participants’ which were comprehensively
representative of the range of therapists working in the field of trauma. An area not addressed within this study, due to a ‘pre-trauma’ focus, but central to trauma work, is that of posttraumatic growth. There is scope for a future research study, which holds a focus on the lived experience of trauma practitioners in relation to predisposition, resilience factors and posttraumatic growth.

An issue that has not been fully addressed within this study was that of the impact on trauma therapists of being a ‘witness’ to others pain and suffering, specifically in relation to exposure to the traumatic stories of clients. Participants of this study touched upon this issue however, a fuller exploration would be useful in gaining a deeper understanding of the lived experience of trauma therapists. And finally research which focused upon the client’s response to the process of trauma therapy specifically in relation to what they found facilitative and what aspects created or reinforced barriers within the therapeutic relationship.

5.5 Reflexive Statement

Wilkinson (1988) proposed that a fully reflexive analysis takes into consideration two key aspects influencing research, the first is how life experience influences the research and secondly how the research has influenced the life experience this extends the circular and cyclical dynamic of the research process and demands reflection on my process within this research and the impact it has had on me. Having reflected on my personal perspective, background and experiential influences within the introduction of this research I now draw into focus the impact of this research on my experience.

This research has required a much deeper level of reflection on the process of trauma work than I had ever experienced. This has had some surprising effects. Although I have worked consistently within this field for a number of years I have always employed strategies designed to enable a distance from the work. The research process required a different level of engagement with information and stories of trauma than I had expected. From an interviewer perspective I accepted the role of witness rather than my therapist role of interactive co-constructor. The witness aspect of this process proved difficult, as I was unprepared for the cumulative impact of the
participant’s stories and the way in which I identified with some of their experience. Some of which resonated deeply with my own experience and this was particularly difficult to reconcile. With a focus on my researcher role and the reflexive positioning required this proved one of the most personally difficult aspects of the research process.

This shared experience has influenced my thinking in relation to the therapeutic work I now do. The voices of the participants resound within my thinking and there is no doubt that aspects of their experience, struggles and challenges resonated with my own. The influence of client background has been reinforced since undertaking the research and impacted upon my practice. I have now revised the process by which I engage with this aspect of history taking and included specific elements to capture a deeper level of information. A significant aspect of change that has occurred in my thinking and behaviour has been the emphasis on the therapeutic relationship. Coming from a relational theoretical background I have always valued the quality and centrality of the relationship in the therapeutic process (Rogers, 1957). A surprise from this study was the way in which therapists from, what could be considered a more technique led tradition, described the central importance of the establishment of a trusting and safe relationship before engaging with therapy intervention. I had perceived that my way of working was highly adaptive and not a common expression of therapeutic practice within trauma therapy work. The study findings from the nine participants and my discussions with them would seem to suggest that this assumption was incorrect. Participants described the unique environment of trauma therapy work as a key driver in the need to establish a therapeutic relationship that was founded upon trust and a sense of safety.

I completed this research with a stronger sense of what it is to be a therapist working with clients who present with trauma issues. Although I do not present the findings of this study as a statement of the global experience of trauma therapists, the findings are based on the subjective, personal experience of nine individual therapists who work in the trauma therapy world. The outcomes of this study have reinforced some of my previous beliefs and challenged others. My work as a therapist has an isolating aspect to it in that I work in a private setting with clients who expect and receive a high degree of confidentiality and where discussion of therapeutic issues are confined to
interactions with colleagues and within supervision. The open and candid discussions with participants and the subsequent emersion in the resulting transcripts has engendered within me a strong sense of identity and connection to those who work in this professionally challenging and rewarding environment. The process of undertaking this research has re-affirmed my connection to the world of trauma therapy and reminded me of the challenges and rewards this work brings. Statements made by two of the participants of the study capture these perfectly so I will leave the last words with them.

P5 “you know, really you’re asking someone to do something that they really believe will be harmful to them. So the amount of sort of courage they need to engage with the therapist to overcome their anxiety disorder is immense.”

P4 “I just think it literally could happen to anyone and you can’t predict how you are going to behave in that situation, and so, more than anything what I have gained from this is just a massive respect for human resourcefulness really.”
REFERENCES


Neff, K. D. (2003). The Development and Validation of a Scale to Measure Self-Compassion. Self and Identity, 2: 223–250,


APPENDIX

1, University of Manchester Ethics Approval Form
2, Participant/Study Advertisement Document
3, Participant Information Sheet
4, Consent form 1
5, Consent form 2
6, Participant Biographical Details Form
7, Semi-Structured Interview Schedule
8, Process of developing emerging themes (individual transcript)
9, Emerging themes across 9 verbatim transcripts (hand worked)
Appendix 1

UNIVERSITY OF MANCHESTER
COMMITTEE ON THE ETHICS OF RESEARCH
ON HUMAN BEINGS

Application form for approval of a research project

This form should be completed by the Chief Investigator(s), after reading the guidance notes.

1. Title of the research

Full title: The Impact of Predisposing Factors on the Expression of PTSD: A Therapist Perspective. (Working Title)

2. a. Chief Investigator

Title: Mr
Forename/Initials: Anthony P
Surname: Parnell
Post: Senior Lecturer in Counselling Psychology (University of Chester)
Qualifications: MSc, Post MSc Diploma, BSc (Hons), PGCE, Diploma Counselling, Diploma Supervision, EMDR – levels 1&2.
School/Unit: School of Education (Counselling)
E-mail: t.parnell@chester.ac.uk
Telephone: 01244-512030

b. Investigator - Not Applicable

Title:
Forename/Initials:
Surname:
Post:
Qualifications:
School/Unit:
E-mail:
Telephone:
3. Details of Project

3.1 Proposed study dates and duration

Start date: Data collection due to start April/May 2010 (following clearance from Ethics Committee)
End date: Hand in of completed thesis February 2013

3.2 Is this a student project?

Yes

If so, what degree is it for?

Professional doctorate in Counselling (6 years Part-time)

3.3. What is the principal research question/objective? (Must be in language comprehensible to a layperson.)

Research evidence points to the potential influential impact of predisposing factors on the development of Post Traumatic Stress Disorder (PTSD). Little research has held a focus on the experience of therapists working with clients with PTSD and how they make treatment decisions. This study attempts to gain a greater insight into the experience of therapists understanding of predisposing factors to PTSD and how or if they incorporate this understanding into a therapy process? From an engagement with therapists experience there is also the potential to explore the question of the potential influence of predisposing factors on the expression of PTSD. Specifically the study holds a focus on therapist’s experience, views and understanding of the following research questions:

2. Are predisposing factors influential in the expression of PTSD?
3. What are the key factors impacting on the client’s expression of PTSD?
4. Is there a link between client’s previous life experience and their response to trauma?
5. What influence does the client’s previous life experience have on therapist’s formulation of treatment protocols for PTSD therapy?

3.4. What is the scientific justification for the research? What is the background? Why is this an area of importance / has any similar research been done? (Must be in language comprehensible to a layperson.)

A central factor in the development of Post Traumatic Stress Disorder (PTSD) is the traumatised individual’s experiential process. Specifically the degree of importance that perception holds over the manner in which a traumatic event is experienced (Ozer, Best, Lipsey & Weiss 2003). The proposed study addresses the impact of predisposing factors on the development and expression of PTSD.

The aim of this study is to explore the experiences of therapists working with clients who present with a PTSD diagnosis. It attempts to engage with the therapist’s experience of therapeutic assessment and therapy with those clients. The decision to explore therapist’s experiences and not client’s experiences was an attempt to understand the therapist’s wider experience of PTSD presentation than the singular expression of PTSD experienced by the individual client. An awareness of the therapist’s decision-making process and what forms the rationale for treatment development is also explored within this study.

A substantial range of research identified factors that seemed to suggest a level of prediction of the development potential of a PTSD diagnosis following a traumatic incident(s). Ozer, Best, Lipsey, & Weiss (2003) identified: peri-traumatic dissociation, perceived support post-trauma, peri-traumatic emotions, perceived life threat peri-trauma, family history of psychopathology, prior trauma and prior
adjustment to be key factors impacting on the potential for an individual to progress to a diagnosis of PTSD following a traumatic incident(s).

Prior to this Brewin, Andrews, & Valentine (2000) had identified: Life stress, Poor social support, adverse childhood events, Trauma severity, Childhood abuse, Female gender and family psychiatric history as significant predisposing factors to the development of PTSD following a traumatic event(s).

A key study by Twaite & Rodriguez-Srednicki, (2004), identified a link between childhood trauma and an increased potential for a PTSD diagnosis following a traumatic incident in adult life, they also identified dissociation as an influential factor. Neufeld-Bailey, Moran & Pederson (2007) also identified the associations between unresolved attachment and abuse history and trauma related symptomatology. They extended empirical support for the association between dissociative processes and unresolved attachment.

Faure et al (2007) identified early life adversity as a predisposing factor in the development of psychopathology in later life, specifically depression and anxiety disorders. They go on to stress that a prior history of stressors may also be a vulnerability factor for developing PTSD in response to trauma. Research by Dieperink, Leskela, Thuras & Engdahl, (2001) studied attachment styles and PTSD and found that those with secure attachment styles scored significantly lower on measures of PTSD than did those with insecure attachment styles, and that attachment style was a stronger predictor of PTSD symptom intensity than was trauma severity. From a wider perspective Consedine & Magai (2003) also pointed to the importance of attachment profile and emotion response. Key factors in the expression of PTSD have been reported as fear, anxiety, guilt and shame. These factors are common emotional responses offered by clients who hold a PTSD diagnosis. An influential researcher in the field of predisposing factors in the development of PTSD is Allan Schore who has produced a series of research articles addressing brain development, attachment, childhood trauma and relational trauma and their impact on predisposition to PTSD.

It can be seen from this small sample of research that the potential of predisposing factors holding an influence on the development and expression of PTSD is indicated. There however been little research carried out on the experience of therapist’s working with clients with PTSD as a presenting issue. This research attempts to gain a greater insight into the experience of therapists understanding of predisposing factors to PTSD and how or if they incorporate this understanding into a therapy process?

3.5. How has the scientific quality of the research been assessed? (Tick as appropriate)

- [x] Independent external review
- [ ] Review within a company
- [ ] Review within a multi–centre research group
- [ ] Internal review (e.g. involving colleagues, academic supervisor)
- [ ] None external to the investigator
- [ ] Other, e.g. methodological guidelines (give details below)

If relevant, describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

The Research Proposal was formally reviewed by the School Review Panel on 10-2-10. The outcome of the panel was acceptance of the proposal with some statements of clarification to be included. These were completed and submitted to my Supervisor, as requested, and have been accepted.

3.6. Give a full summary of the purpose, design and methodology of the planned research, including a brief explanation of the theoretical framework that informs it. It should be clear exactly what will happen to the research participant, how many times and in what order. Describe any involvement of research participants, patient groups or communities in the design of the research.

(This section must be completed in language comprehensible to the lay person.)

This study will employ a qualitative methodology. This was selected to facilitate the subjectivity and uniqueness of narrative and elicit a deeper understanding of the individual’s experience (May, 2001). The study will focus on the experiences of practitioners within therapy interactions with clients presenting with a PTSD diagnosis. The practitioner’s experience of working with this client group and specifically their awareness of the impact of
predisposing factors on the client’s expression of PTSD will be the central focus of the study. A methodology was required to facilitate an understanding of the highly subjective and personal thoughts, beliefs and experiences of the practitioners. An approach that had the potential to capture the practitioner’s interpersonal thought processes when formulating a therapy approach and developing and maintaining a working relationship with client’s presenting with PTSD.

The choice of Interpretative Phenomenological Analysis (IPA), *Kagan, Krathwohl, & Miller*, (1963), was made with an aim to explore how individuals make sense of their personal and social world, by studying what particular experiences, events or states mean to the participant, Smith & Osborne (2008). The key aim of this approach is to reproduce the unique view of the participant, as far as possible, utilising a semi-structured interview format.

Participants

This study will have a participant population drawn from experienced trauma practitioners. Practitioners will be identified as therapists drawn from ‘core mental health professionals’. These include psychiatrists, clinical psychologists, counselling psychologists, community psychiatric nurses (CPN), UKCP accredited psychotherapists, BACP accredited counsellors, or CBT therapists. Other qualified therapists may also meet the entry criteria through their ongoing work within the area of psychological trauma. A key requirement is that the practitioner has direct experience of working therapeutically with adult clients who have experienced psychological trauma and present with a PTSD diagnosis.

Sample Size

This study will have a sample size of 8 to 10 participants. Smith & Osborne (2008) identify the difficulty in answering the question of appropriate sample size within IPA. They point to the trend of working with small sample sizes in an attempt to stay committed to detailed interpretive accounts, and an in depth reflection on participants perceptions and understanding.

Procedure

Participants will be recruited by placing a notice in the BACP journal ‘Therapy Today’, which will include an entry on the website which has a potential access to 29,000 readers. The notice will also be placed within the BPS journal ‘The Psychologist’ with a circulation of 48,500 readers; this will be in the ‘community notice board’ section along with the website entry. A secondary sampling process will be initiated if not enough participants are recruited from this approach. There are a range of networks for trauma therapists within the UK and these will be directly contacted and participant’s sort for the study. Clarification of the purpose of the study will be offered along with the inclusion criteria and a description of the requirement of a recorded one hour semi-structured interview and contact details of the researcher.

Potential participants who respond with an expression of interest will be sent a participant information sheet, (see appendix 1). Along with dual copies of the research consent form (see appendix 2). If acceptable these are to be signed and one copy will be retained by the participant and one will be returned to the researcher in the SAE provided by the researcher. Once the signed consent form has been received by the researcher the participant will be contacted by the participants’ chosen method (e-mail or telephone) and either a face-to-face or telephone semi – structured interview will be arranged. Interviews will be carried out at a venue, (suitable for confidential discussion) or in a method agreed by both participant and researcher. The interview will be a maximum duration of one hour and will follow a pre constructed semi structured question format. There will be 10 to 12 questions in the structured element (schedule) of the interview which will be constructed around and extend the four research questions identified within this proposal. All participants will be asked the same questions in the same order in an attempt to offer as much consistency as possible; however, this will be determined by the interviewee’s responses and choice of direction. It is recognised that this process will be guided by the schedule rather than dictated by it, Smith & Osborne (2008).

Data Analysis

IPA attempts to analyse in detail how participants make sense of and perceive events, which they engage in or are happening to them, Smith & Osborne (2008: 57). The semi-structured interview offers a well-utilised method of data collection from an IPA perspective. This form of interviewing offers a flexible approach to data collection, which has the potential to respond to researcher/participant movement in dialogue.

Interviews will be carried out and digitally recorded. From the recording a transcript will be constructed. The transcripts will be examined in line with the framework outlined by Smith & Osborne (2008).

3.6.1. Has the protocol submitted with this application been the subject of review by a
statistician independent of the research team? (Select one of the following)

○ Yes – copy of review enclosed
○ Yes details of review available from the following individual or organisation
(give contact details below)
√ No – justify below

Working with the Qualitative methodology of IPA it is recognised that generalised statements cannot be offered from data collected as this approach is designed to facilitate the subjectivity and uniqueness of narrative and elicit a deeper understanding of the individual’s experience.

3.6.2. If relevant, specify the specific statistical experimental design, and why it was chosen?

N/A

3.6.3. How many participants will be recruited?
If there is more than one group, state how many participants will be recruited in each group. For international studies, say how many participants will be recruited in the UK and in total.

Eight (8) to Ten (10) Participants will be recruited.

3.6.4. How was the number of participants decided upon?

If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.

Smith & Osborne (2008) identify the difficulty in answering the question of appropriate sample size within IPA. They point to the trend of working with small sample sizes in an attempt to stay committed to detailed interpretive accounts, and an in depth reflection on participants perceptions and understanding.

3.6.5. Describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Discussions generated from the recorded semi-structured interviews will be transcribed. This transcribed data will be examined in line with the framework below, outlined by Smith & Osborne (2008). Each transcript will be analysed individually through these stages:

   a) Transcription and assign each line a number.
   b) Notes made that are descriptive of general points of interest, associations, connections and early interpretations.

11. Initial Theme Identification.
   Identification of emergent themes from transcript and early notes.

12. Clustering Themes
   Themes organised into clusters then making sense of connections between emergent themes. Analytical ordering initiated.

13. Identification of Subordinate and Master Themes.
A table of themes to be drawn up. Following analysis of transcripts a master list of subordinate themes is constructed.

3.7. Where will the research take place?

The research will be carried out within the UK within a confidential public environment (e.g. university rooms). There will be a choice of both venue and method of interview process. The interview process will follow this general structure: - The participant will be contacted by the participants chosen method (e-mail or telephone) and either a face to face or telephone semi -- structured interview will be arranged. Interviews will be carried out at a public venue, (suitable for confidential discussion) or in a method agreed by both participant and researcher.

3.8. Names of other staff involved.

N/A

3.9. What do you consider to be the main ethical issues which may arise with the proposed study and what steps will be taken to address these?

This research study is constructed around and conforms to the BACP Ethical framework for Good Practice in Counselling and Psychotherapy, and the ethical guidelines for research, BACP (2009). It also complies with the BPS Code of Ethics and Conduct, and ethical research framework, BPS (2006). Three key areas for consideration within these codes are awareness of confidentiality, avoidance of harm to participants and procedures for dealing with potential distress caused to participants, McLeod, (2003).

3.9.1. Will any intervention or procedure, which would normally be considered a part of routine care, be withheld from the research participants?

☐ Yes √ No

If yes, give details and justification

N/A

4. Details of Subjects.

4.1. Total Number

Eight (8) to Ten (10)

4.2 Sex and Age Range

Male or Female, Adults 18-70

4.3 Type

This study will have a participant population drawn from experienced Trauma practitioners

4.4. What are the principal inclusion criteria? (Please justify)

This study will have a participant population drawn from experienced trauma practitioners. Practitioners will be identified as therapists drawn from ‘core mental health professionals’. These include psychiatrists, clinical psychologists, counselling psychologists, community psychiatric nurses (CPN), UKCP accredited psychotherapists, BACP accredited counsellors, or CBT therapists. Other qualified therapists may also meet the entry criteria through their ongoing work within the area of psychological trauma. A key requirement is that the practitioner has direct experience of working therapeutically with adult clients who have experienced psychological trauma and present with a PTSD diagnosis.
4.5. What are the principal exclusion criteria? *(Please justify)*

Key exclusion criteria would include:
- Therapists without experience of working therapeutically with adult clients who have experienced psychological trauma and present with a PTSD diagnosis.
- Therapists who do not hold ‘core mental health professional’ status.
- Newly qualified therapists without experience of trauma work.
- Therapists who conduct their trauma work in an NHS setting.

4.6. Will the participants be from any of the following groups? *(Tick as appropriate)*

- [ ] Children under 16
- [ ] Adults with learning difficulties
- [ ] Adults who are unconscious or very severely ill
- [ ] Adults who have a terminal illness
- [ ] Adults in emergency situations
- [ ] Adults with mental illness (particularly if detained under mental health legislation)
- [ ] Adults with dementia
- [ ] Prisoners
- [ ] Young offenders
- [ ] Adults in Scotland who are unable to consent for themselves
- [ ] Healthy volunteers
- [ ] Those who could be considered to have a particularly dependent relationship with the investigator, e.g. those in care homes, medical students.
- [ ] Other vulnerable groups

*Justify their inclusion*

N/A

4.7. Will any research participants be recruited who are involved in existing research or have recently been involved in any research prior to recruitment?

- [ ] Yes   [ ] No   [ ] Not known

*If Yes, give details and justify their inclusion. If Not Known, what steps will you take to find out?*

4.8 How will potential participants in the study be (i) identified, (ii) approached and (iii) recruited?

*Where research participants will be recruited via advertisement, please append a copy to this application*

Participants will be recruited by placing a notice in the BACP journal ‘Therapy Today’, the notice will also be placed within the BPS journal ‘The Psychologist’. A secondary sampling process will be initiated if not enough participant’s are recruited from this approach. There are a range of networks for trauma therapists within the UK and these will be directly contacted and participant’s sort for the study by offering the same notice of invitation. (see appendix 3 for draft notice).

4.9 Will individual research participants receive *reimbursement of expenses* or any other *incentives or benefits* for taking part in this research?

- [ ] Yes   [ ] No

*If yes, indicate how much and on what basis this has been decided*
5 Details of risks

5.1 Drugs and other substances to be administered

Indicate status, eg full product licence, CTC, CTX. Attach: evidence of status of any unlicensed product; and Martindales Phamacopoeia details for licensed products

<table>
<thead>
<tr>
<th>DRUG</th>
<th>STATUS</th>
<th>DOSAGE/FREQUENCY/ROUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.2 Procedures to be undertaken

Details of any invasive procedures, and any samples or measurements to be taken. Include any questionnaires, psychological tests etc. What is the experience of those administering the procedures?

N/A

5.3 Or Activities to be undertaken

Please list the activities to be undertaken by participants and the likely duration of each

An audio recorded Semi-structured interview of approximately 60 minutes will be required for this study. The key areas of focus and interview questions will be set around the 4 research questions:-

1. Are predisposing factors influential in the expression of PTSD?
2. What are the key factors impacting on the client’s expression of PTSD?
3. Is there a link between client’s previous life experience and their response to trauma?
4. What influence does the client’s previous life experience have on therapist's formulation of treatment protocols for PTSD therapy?

The transcript of the interview will be sent to the participant for verification and feedback. This will be followed by a summary of the themes identified following analysis as part of the participant feedback process. It is estimated that these activities should take approximately 60 minutes each to complete.

5.4 What are the potential adverse effects, risks or hazards for research participants, including potential for pain, discomfort, distress, inconvenience or changes to lifestyle for research participants?

There is no expectation of physical risk, hazard or adverse effect to the participant's engaging in this study. Due to the negotiated nature of the interview process it is expected that any inconvenience can be kept to a minimum. The voluntary nature and informed consent aspect of participation in the research allows for the participant to consider possible issues of inconvenience and adverse effect when deciding to engage in the research process.

5.5 Will individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during interviews/group discussions, or use of screening tests for drugs)?

√ Yes  ○ No

If yes, give details of procedures in place to deal with these issues:

The subject under discussion has the potential to be sensitive and has the remote potential to generate uncomfortable feelings. This is counterbalanced by the fact that all participants will be drawn from experienced and trained therapists. There is an initial expectation that all participants involved in the research would have the emotional and psychological robustness to work therapeutically within the area of trauma and PTSD. Participant's who are impacted emotionally by engagement within the interview or research will be offered access to therapy support provided from the BACP Accredited list of therapist’s should they wish this?
5.6 What is the expected total duration of participation in the study for each participant?

The interview will take approximately 60 minutes. For the participants who opt into the feedback process then a copy of the transcript of the interview will be sent for amendment or feedback. This will be followed by a summary of the themes identified following analysis as part of the participant feedback process. It is estimated that these activities should take approximately 60 minutes each to complete.

5.7 What is the potential benefit to research participants?

No direct benefit is expected from this research.

5.8 What is the potential for adverse effects, risks or hazards, pain, discomfort, distress, or inconvenience to the researchers themselves? (If any)

No major risks have been identified.

6. Safeguards

6.1 What precautions have been taken to minimise or mitigate the risks identified above?

The research process will adopt the School policy of ‘ongoing consent checking’. This provides participants an opportunity to decline to answer particular sets of questions or discuss particular topics. The interview process has the potential to be stopped or amended if the participant requires this.

6.2 Will informed consent be obtained from the research participants?

√ Yes  ○ No

If Yes, give details of who will take consent and how it will be done. Give details of the experience in taking consent and of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material.

If participants are to be recruited from any of the potentially vulnerable groups listed in Question 4.6, give details of extra steps taken to assure their protection. Describe any arrangements to be made for obtaining consent from a legal representative.

N/A  
If consent is not to be obtained, please explain why not.

N/A  

Where relevant the committee must have a copy of the information sheet and consent form.

Both documents are supplied with this form (See attachments)

6.3 Will a signed record of consent be obtained?

√ Yes  ○ No

If not, please explain why not.

6.4 How long will the participant have to decide whether to take part in the research?

The participants will be offered a minimum period of a two week time frame to consider the implications of volunteering for the research study.
6.5 What arrangements have been made for participants who might not adequately understand verbal explanations or written information given in English, or who have special communication needs? (e.g. translation, use of interpreters etc.)

It is expected that the participants will have the capacity to understand verbal explanations or written information and will not have special communication needs as all participants will be drawn from practicing therapists working within a UK therapy environment.

6.6 What arrangements are in place to ensure participants receive any information that becomes available during the course of the research that may be relevant to their continued participation?

If any information, pertinent to the study, becomes available as the study progresses then participants will be informed immediately. All participants will be reminded that their participation is voluntary and they retain the right to withdraw from the study at any time.

6.7 Will the research participants’ General Practitioner be informed that they are taking part in the study?

○ Yes √ No

If No, explain why not

N/A

6.8 Will permission be sought from the research participants to inform their GP before this is done?

N/A

○ Yes √ No

If No, explain why not

N/A

6.9 What arrangements have been made to provide indemnity and/or compensation in the event of a claim by, or on behalf of, participants for (a) negligent harm and (b) non-negligent harm?

Seeking cover under the terms of the University insurance arrangements.

7. Data Protection and Confidentiality

7.1 Will the research involve any of the following activities at any stage (including identification of potential research participants)? (Tick as appropriate)

☐ Examination of medical records by those outside the NHS, or within the NHS by those who would not normally have access
☐ Electronic transfer by magnetic or optical media, e-mail or computer networks
☐ Sharing of data with other organisations
☐ Export of data outside the European Union
☐ Use of personal addresses, postcodes, faxes, e-mails or telephone numbers
☐ Publication of direct quotations from respondents
☐ Publication of data that might allow identification of individuals
✓ Use of audio/visual recording devices
✓ Storage of personal data on any of the following:

☐ Manual files including X-rays
☐ NHS computers
Further details:

All information will be recorded, stored and disposed of in compliance with the Data Protection Act. The link between participant’s personal identifiers and information recorded will be separated. A focus on the development of anonymity for participants will be undertaken.

7.2 What measures have been put in place to ensure confidentiality of personal data? Give details of whether any encryption or other anonymisation procedures have been used and at what stage?

Personal data will be stored on an encrypted data stick, which will not be used on the same computer as the research database and will be stored in a secure environment. Emphasis will be placed on the separation of the two information sources. All participants will be coded with ID numbers which will be recorded against all research data, (transcripts, themes, etc). The development and maintenance of anonymity and confidentiality will be central to the study process.

7.3 Where will the analysis of the data from the study take place and by whom will it be undertaken?

The analysis will take place within a private study area by the chief researcher. No one other than the chief researcher will have access to the data.

7.4 Who will have control of and act as the custodian for the data generated by the study?

The chief researcher will act as custodian.

7.5 Who will have access to the data generated by the study?

The chief researcher will access to the data generated.

7.6 For how long will data from the study be stored?

2 Years 0 Months

Data will be stored for the duration of the study and until the research has been successfully submitted as part of the qualification for the Doctorate in Counselling. Following completion of this process all data will be destroyed by means of shredding.

Give details of where they will be stored, who will have access and the custodial arrangements for the data:

The researcher and study Supervisor will have access to the data. Data will be stored in a locked drawer, within the University. Data in electronic format will be password protected in a secure location.

8. Reporting Arrangements

8.1 Please confirm that any adverse event will be reported to the Committee

I confirm that any adverse event will be reported to UREC.
8.2. How is it intended the results of the study will be reported and disseminated?
(Tick as appropriate)

☐ Peer reviewed scientific journals
☐ Internal report
☐ Conference presentation
√ Thesis/dissertation
√ Written feedback to research participants
☐ Presentation to participants or relevant community groups
☐ Other/none e.g. Cochrane Review, University Library

8.3 How will the results of research be made available to research participants and communities from which they are drawn?

Participants will be offered feedback on the research. This will take the form of a summary of outcomes of the research.

8.4 Has this or a similar application been previously considered by a Research Ethics Committee in the UK, the European Union or the European Economic Area?

☐ Yes
√ No

*If Yes give details of each application considered, including:

- Name of Research Ethics Committee or regulatory authority:
- Decision and date taken:
- Research ethics committee reference number:

8.5 What arrangements are in place for monitoring and auditing the conduct of the research?

The research will be monitored by the research Supervisor Dr Clare Lennie.

8.6 Will a data monitoring committee be convened?

☐ Yes
√ No

What are the criteria for electively stopping the trial or other research prematurely?

Any unforeseen harm that cannot be resolved.

9. Funding and Sponsorship

9.1 Has external funding for the research been secured?

☐ Yes  √ No

*If Yes, give details of funding organisation(s) and amount secured and duration:

Organisation:
UK contact:
Amount (£):
Duration: Months

9.2 Has the external funder of the research agreed to act as sponsor as set out in the Research Governance Framework?

○ Yes √ No ○ Not Applicable

9.3 Has the employer of the Chief Investigator agreed to act as sponsor of the research?

√ Yes ○ No

9.4 Sponsor (must be completed in all cases where the sponsor is not the University)

Name of organisation which will act as sponsor for the research:
N/A

10. Conflict of interest

There is no conflict of interest at the time of application.

10.1 Will individual researchers receive any personal payment over and above normal salary and reimbursement of expenses for undertaking this research?

○ Yes √ No

If Yes, indicate how much and on what basis this has been decided:

10.2 Will the host organisation or the researcher’s department(s) or institution(s) receive any payment of benefits in excess of the costs of undertaking the research?

○ Yes √ No

If Yes, give details:

10.3 Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share-holding, personal relationship etc.) in the organisation sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes √ No

If Yes, give details:
11. Signatures of applicant(s)

..........................................................................................................
Signed .......................................................... Date 03-03-10

..........................................................................................................
Signed .......................................................... Date

12 Signature by or on behalf of the Head of School

The Committee expects each School to have a pre-screening process for all applications for an ethical opinion on research projects. The purpose of this pre-screening is to ensure that projects are scientifically sound, have been assessed to see if they need ethics approval and, if so, go to the relevant ethics committee. It is **not** to undertake ethical review itself, which must be undertaken by a formal research ethics committee.

The form must therefore be counter-signed by or on behalf of the Head of School to signify that this pre-screening process has been undertaken

I approve the submission of this application

..........................................................................................................
Signed by or on behalf of the Head of School ................................ Date
Appendix A

Participant Information Sheet

Title of the Study:
The Impact of Predisposing Factors on the Expression of PTSD:
A Therapist Perspective. (Working Title)

Introduction

You are being invited to take part in a research study, which is undertaken in part fulfilment of the Professional Doctorate in Counselling at the University of Manchester. Before you decide it is important for you to understand why the research is being undertaken and what it will involve. The following information is presented to help you decide if you would like to participate in this research study. Information is provided about the purpose of the study and what participation in this study will involve. Thank you for taking time to read this information and carefully considering your decision. If you require any further information or clarification of any points please do not hesitate to contact me and I will be happy to address your comments or queries.

Who will Conduct the Research?

Principle Researcher:

Tony Parnell, CPsychol,
School of Education
The University of Manchester
Ellen Wilkinson Building
Oxford Road
Manchester
M13 9PL

Purpose of the study:

The aim of this study is to explore the experiences of therapists working with clients who present with a PTSD diagnosis. It attempts to engage with the therapist’s experience of therapeutic assessment and therapy with those clients. The decision to explore therapist’s experiences is an attempt to understand the therapist’s wider experience of PTSD. Research evidence points to the potential influential impact of predisposing factors on the development of PTSD. Little research has held a focus on the experience of therapists working with clients with PTSD and how they make treatment decisions. This study attempts to gain a greater insight into the experience of therapists understanding of predisposing factors to PTSD and how or if they incorporate this understanding into a therapy process?
Who is invited to Participate?

You are invited to participate in this study if you are an experienced trauma practitioner. Practitioners will be identified as therapists drawn from ‘core mental health professionals’. These include psychiatrists, clinical psychologists, counselling psychologists, community psychiatric nurses (CPN), UKCP accredited psychotherapists, BACP accredited counsellors, or CBT therapists. Other qualified therapists may also meet the entry criteria through their ongoing work within the area of psychological trauma. A key requirement is that the practitioner has direct experience of working therapeutically with adult clients who have experienced psychological trauma and present with a PTSD diagnosis.

Choice to participate:

Participation in this research study is completely voluntary. Your decision to participate can be withdrawn at any point in the research process up to submission of the thesis to the University of Manchester without prejudice.

What will I have to do?

Once you have returned the signed consent form you will be contacted by your chosen method (e-mail or telephone) and either a face-to-face or telephone semi-structured interview will be arranged. Interviews will be carried out at a venue or in a method agreed by both yourself and the researcher. The interview will be recorded and be a maximum duration of one hour. The interview will follow a pre constructed semi-structured question format. This study will be conducted using a one to one interview format either face to face or by telephone. If a face to face interview is to be arranged at a venue of your choice it is important to note that consideration should be made to the choice of a suitable environment which has the potential to provide confidentiality, privacy and minimal intrusion.

Telephone interviews will be pre arranged at a mutually convenient time and at the researchers cost. With your permission once the interview has been transcribed it will be sent to you for review and amendment as required. Following data analysis the researcher will contact you (with your permission) to feedback outcomes and invite feedback you may want to offer. Contact following the interview is not a compulsory aspect of the study and you have ability to reject this option if you wish.

Confidentiality and Anonymity

All information and data collected will be held securely and in an environment that enhances confidentiality and every effort will be engaged to ensure that you are offered anonymity within the construction and presentation of the study. Written information and recordings of interviews will be stored in a locked storage cabinet and electronic information will be stored on an encrypted electronic storage device. The principle researcher will have responsibility for access and confidential containment of this secured information. Personal information stored in connection to this study will be destroyed following successful completion of the research study in compliance with The University of Manchester regulations on data retention.
What are the possible disadvantages - advantages of taking part in the study?

It is important to acknowledge the key potential disadvantage is the requirement of a time commitment. This consists of an interview that will last no more than 60 minutes. This will be followed by a feedback message, which should take approximately 30 minutes to respond to. Taking part in this study may offer the potential advantage for you to reflect on your practice and while one of the aims of this research is to gain an understanding of therapist’s thoughts and beliefs about predisposing factors to PTSD, it may also have the potential to identify practice innovations and potential developments in the understanding of the expression of PTSD. Little research has held a focus on the experiences of practitioners who work with clients presenting with a PTSD diagnosis. Engaging in this research offers the potential to influence the wider understanding how practitioners make sense of the variety of presenting issues related to PTSD therapy work and how these may impact on issues such as formulation and treatment development. It also offers the potential to be directly involved in practitioner led research.

Who has reviewed the study?

The proposal for this study has been presented to The University of Manchester Research Proposal Panel and the Ethics Committee and has been approved as a valid research study by both quality control structures.

Details of Principle Researcher and Research Supervisor

This research study is organised by the principle researcher Tony Parnell who is a student on the Professional Doctorate in Counselling validated by The University of Manchester.

Contact details:-

**Principle Researcher**

Tony Parnell, CPsychol  
Senior Lecturer in Counselling Psychology  
Psychology Department of Social & Communication  
The University of Chester  
Parkgate Road  
Chester  
CH1 4BJ  
01244 512030  
t.parnell@chester.ac.uk

**Research Supervisor**

Dr Clare Lennie, CPsychol  
Lecturer in Education & Counselling Studies  
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The University of Manchester  
Ellen Wilkinson Building  
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0161-275-8627  
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Appendix B

The Impact of Predisposing Factors on the Expression of PTSD: A Therapist Perspective. (Working Title)

CONSENT FORM

If you are happy to participate please complete and sign the consent form below.

Please

1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself.

3. I understand that the interviews will be audio recorded.

4. I agree to the use of anonymous quotes.

5. I agree that any data collected may be passed to other researchers.

I agree to take part in the above project

Name of participant                      Date                      Signature

Name of Person taking Consent            Date                      Signature

………………………………………  ………………

………………………………………  ………………

………………………………………  ………………

………………………………………  ………………
Appendix C
(Draft Advertisement notice)

The Impact of Predisposing Factors on the Expression of PTSD: A Therapist Perspective. (Working Title)

My name is Tony Parnell and I am a Student on the Professional Doctorate in Counselling at the University of Manchester. I am conducting a qualitative research study as part fulfilment of my Doctorate dissertation, which is supervised by Dr Clare Lennie (Clare.Lennie@manchester.ac.uk). (Ethics approved by the university)

The aim of this study is to explore the experiences of therapists working with clients who present with a PTSD diagnosis. This study will have a participant population drawn from experienced trauma practitioners. Practitioners will be identified as therapists drawn from ‘core mental health professionals’. Your participation in this research project would require approximately one hour of your time and would entail an audio-recorded interview which will hold a focus on your personal experiences of working with clients who present with a PTSD diagnosis. Your participation could help to provide useful information on the unique dynamics that are involved in the therapy process with this client group.

If you would like to participate in this study, please contact me by email or phone at - (t.parnell@chester.ac.uk) or 01244-512030, and I will send you a full information sheet outlining the details of the study. Thank you for taking time to read this information.
Appendix 2


My name is Tony Parnell and I am a Student on the Professional Doctorate in Counselling at the University of Manchester. I am conducting a qualitative research study as part fulfilment of my Doctorate dissertation, which is supervised by Dr Clare Lennie (Clare.Lennie@manchester.ac.uk). (Ethics approved by the university)

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If you would like to participate in this study, please contact me by email or phone at - (t.parnell@chester.ac.uk) or 01244-512030, and I will send you a full information sheet outlining the details of the study. Thank you for taking time to read this information.
Appendix 3

Participant Information Sheet

Title of the Study:
The Impact of Predisposing Factors on the Expression of PTSD:
A Therapist Perspective.

Introduction

You are being invited to take part in a research study, which is undertaken in part fulfilment of the Professional Doctorate in Counselling at the University of Manchester. Before you decide it is important for you to understand why the research is being undertaken and what it will involve. The following information is presented to help you decide if you would like to participate in this research study. Information is provided about the purpose of the study and what participation in this study will involve. Thank you for taking time to read this information and carefully considering your decision. If you require any further information or clarification of any points please do not hesitate to contact me and I will be happy to address your comments or queries.

Who will conduct the Research?

Principle Researcher:
Tony Parnell, CPsychol,
School of Education
The University of Manchester
Ellen Wilkinson Building
Oxford Road
Manchester
M13 9PL

Purpose of the study:

The aim of this study is to explore the experiences of therapists working with clients who present with a PTSD diagnosis. It attempts to engage with the therapist’s experience of therapeutic assessment and therapy with those clients. The decision to explore therapist’s experiences is an attempt to understand the therapist’s wider experience of PTSD. Research evidence points to the potential influential impact of predisposing factors on the development of PTSD. Little research has held a focus on the experience of therapists working with clients with PTSD and how they make treatment decisions. This study attempts to gain a greater insight into the experience of therapists understanding of predisposing factors to PTSD and how or if they incorporate this understanding into a therapy process?
Who is invited to Participate?

You are invited to participate in this study if you are an experienced trauma practitioner. Practitioners will be identified as therapists drawn from ‘core mental health professionals’. These include psychiatrists, clinical psychologists, counselling psychologists, community psychiatric nurses (CPN), UKCP accredited psychotherapists, BACP accredited counsellors, or CBT therapists. Other qualified therapists may also meet the entry criteria through their on-going work within the area of psychological trauma. A key requirement is that the practitioner has direct experience of working therapeutically with adult clients who have experienced psychological trauma and present with a PTSD diagnosis.

Choice to participate:

Participation in this research study is completely voluntary. Your decision to participate can be withdrawn at any point in the research process up to submission of the thesis to the University of Manchester without prejudice.

What will I have to do?

Once you have returned the signed consent form you will be contacted by your chosen method (email or telephone) and either a face-to-face or telephone semi-structured interview will be arranged. Interviews will be carried out at a venue or in a method agreed by both yourself and the researcher. The interview will be recorded and be a maximum duration of one hour. The interview will follow a pre-constructed semi-structured question format. This study will be conducted using a one to one interview format either face to face or by telephone. If a face to face interview is to be arranged at a venue of your choice it is important to note that consideration should be made to the choice of a suitable environment which has the potential to provide confidentiality, privacy and minimal intrusion.

Telephone interviews will be pre arranged at a mutually convenient time and at the researchers cost. With your permission once the interview has been transcribed it will be sent to you for review and amendment as required. Following data analysis the researcher will contact you (with your permission) to feedback outcomes and invite feedback you may want to offer. Contact following the interview is not a compulsory aspect of the study and you have ability to reject this option if you wish.

Confidentiality and Anonymity

All information and data collected will be held securely and in an environment that enhances confidentiality and every effort will be engaged to ensure that you are offered anonymity within the construction and presentation of the study. Written information and recordings of interviews will be stored in a locked storage cabinet and electronic information will be stored on an encrypted electronic storage device. The principle researcher will have responsibility for access and confidential containment of this secured information. Personal information stored in connection to this study will be destroyed following successful completion of the research study in compliance with The University of Manchester regulations on data retention.
What are the possible disadvantages - advantages of taking part in the study?

It is important to acknowledge the key potential disadvantage is the requirement of a time commitment. This consists of an interview that will last no more than 60 minutes. This will be followed by a feedback message, which should take approximately 30 minutes to respond to. Taking part in this study may offer the potential advantage for you to reflect on your practice and while one of the aims of this research is to gain an understanding of therapist’s thoughts and beliefs about predisposing factors to PTSD, it may also have the potential to identify practice innovations and potential developments in the understanding of the expression of PTSD. Little research has held a focus on the experiences of practitioners who work with clients presenting with a PTSD diagnosis. Engaging in this research offers the potential to influence the wider understanding how practitioners make sense of the variety of presenting issues related to PTSD therapy work and how these may impact on issues such as formulation and treatment development. It also offers the potential to be directly involved in practitioner led research.

Who has reviewed the study?

The proposal for this study has been presented to The University of Manchester Research Proposal Panel and the Ethics Committee and has been approved as a valid research study by both quality control structures.

Details of Principle Researcher and Research Supervisor

This research study is organised by the principle researcher Tony Parnell who is a student on the Professional Doctorate in Counselling validated by The University of Manchester.

Contact details: -

**Principle Researcher**

Tony Parnell, CPsychol  
Senior Lecturer in Counselling Psychology  
Department of Social Science & Counselling  
The University of Chester  
Parkgate Road  
Chester  
CH1 4BJ  
01244 512030  
t.parnell@chester.ac.uk

**Research Supervisor**

Dr Clare Lennie, CPsychol  
Lecturer in Education & Psychology  
School of Education  
The University of Manchester  
Ellen Wilkinson Building  
Oxford Road  
Manchester  
M13 9PL  
0161-275-8627  
Clare.Lennie@manchester.ac.uk
Appendix 4


Research Consent Form

I have consented to take part in a semi-structured interview on Post Traumatic Stress Disorder and Predisposition and hereby give my consent for the recording of this session and for the details of the session involving me to be used for research purposes. I understand that, without my further consent, the transcript and recording of the session will be used for the purpose of developing research in this area. The data generated from the Interview will be used to develop or support the researcher’s submission of a research thesis for the Professional Doctorate in Counselling at the University of Manchester.

The researcher is a Chartered Counselling Psychologist and bound by the BPS Ethical code of practice. The researcher is also a member of the BACP and subject to the requirements of the Ethical framework for good practice in counselling and psychotherapy. The researcher undertakes to comply with both organisations requirements for ethical practice in research.

The researcher will endeavour to make sure that the material used is not identifiable and if applicable, will seek further permission to use any information that may specifically identify individuals. The protocol for a semi-structured interview is that the participant has the opportunity to have access to the transcribed data and the resulting themes that may emerge. In this way the cooperative process enables greater involvement in the research and subsequent findings.

Signed (Participant) …………………………………………….. Date ………………

Print Name:………………………………………….

Signed (Researcher)……………………………………………… Date ………………

A.P.Parnell CPsychol, AFBPsS.
Appendix 5


CONSENT FORM

If you are happy to participate please complete and sign the consent form below.

Box

6. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

7. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself.

8. I understand that the interviews will be audio recorded.

9. I agree to the use of anonymous quotes.

10. I agree that any data collected may be passed to other researchers.

I agree to take part in the above project

Name of participant ................................................. Date ................................................. Signature .................................................

Name of Person taking Consent ................................................. Date ................................................. Signature .................................................
Appendix 6

Doctorate Research Interviews
Participant Details

Interview Date:-
Participant No:-
Name:-

Gender:- Male Female

Age Group:- 20-29 30-39 40-49 50-59 60+

Profession/Occupation:-

Geographical area of work:-

Clinical Experience:-

How long worked with PTSD:-

Therapy Approach:-

Individual/Group work undertaken:-

Current Therapy work Situation:-
Appendix 7


Pre-Interview

Gather participant information – gender, age group, clinical experience - qualification/profession, how long working in therapy, therapy approach/protocols used – nice etc, current situation in relation to client work/group.

Semi-Structured Interview Schedule

Thank participant for engaging in the research and review key research aims.
Identify the research questions and that they form the basis of discussion however, that the key to discussions are around the participant’s experience and understanding and that there are no right or wrong answers.

1. Could you tell me a little about the context of your work with PTSD? (CT)
2. Do you diagnose PTSD? (CT)
3. Do you use assessment or outcome tools within your treatment of PTSD? (CT)
4. What therapy approach(s) do you use when working with PTSD clients? (2)
5. When working with clients presenting with a PTSD diagnosis what are your treatment aims – what are you trying to do? (2)
6. What factors influence you when developing a formulation or treatment process for a client with PTSD diagnosis? (1,2)
7. In your experience of working with clients presenting with PTSD, does the client’s previous life experiences impact upon their expression of PTSD symptoms? (1,2)
8. What is your experience of predictive/predisposing factors for PTSD? (1,2)
9. *Can you think of a client that you have worked with who had been identified as presenting with PTSD - Could you talk me through
some of the decisions you made, in terms of assessment and treatment strategies etc (being aware of confidentiality constraints)? (1,2)

10. When you consider the range of clients you have worked with who have presented with a PTSD diagnosis, are there any aspects, factors or themes, which they share? (1,2)

11. Is there anything you would like to add to your comments about your experience of working with PTSD? (1,2)

Thank you for agreeing to take part in this research. Are you still happy, following the interview, to continue with the research and allow your discussion to be used within the research?
I will send you a transcript of this interview for you to check the accuracy of what we have discussed and for you to offer any comments you would wish.
Thank you once again.

KEY

1,2 - Research question link

CT – Context of work & Tasks undertaken
## Appendix 8

<table>
<thead>
<tr>
<th>Emerging Themes</th>
<th>Verbatim Transcript</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture (Cultural Identity)</td>
<td>P.1: Yes. Yes. And, you know, cultural factors, you know I may be working with a certain group from a certain nation, you know, across the socioeconomic spread and the different ethnic groups in that culture and the different communities across that country and the gender differences that you can see, and the culture of that individual's family, and how they have learned to view themselves. How they have learned to view themselves in relation to others and how they see their purpose and direction in life. All that will be shaped uniquely, you know, to that individual and so that then starts to shape their reaction to the trauma. But those core principles of the PTSD presentation of re-experiencing of arousal and avoidance, they are pretty stable across presentations.</td>
<td>Culture/Gender Socioeconomic, ethnicity</td>
</tr>
<tr>
<td>Gender Differences</td>
<td>R: Yes. And I suppose they need to be there in order to get the diagnosis in the first place, but it seems like you place some emphasis on these other elements. Does that influence, at all, your way of making a diagnosis or indeed of creating a formulation of the therapy.</td>
<td>Trying to dig into his process, what impacts on his therapy decisions?</td>
</tr>
<tr>
<td>Family background</td>
<td>P.1: Yes. I mean it would to some degree influence the diagnosis. The diagnosis often is pretty straightforward, based on these categories. But all the other stuff would certainly influence the formulation. I mean, you are going to get some challenging diagnostic presentations that are sort of in the grey area, and also, you know, religious factors might come into it, where a person is representing some symptoms which relate to their beliefs. When we look at abnormal psychology, it's like pathology, we need to make sure that we are not pathologising that certain culture.</td>
<td>Religion a link with symptoms and beliefs? Pathologising culture? Mistakes</td>
</tr>
<tr>
<td>Diagnosis and Formulation</td>
<td></td>
<td>How does the therapist filter the information</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
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<tr>
<td>Culture</td>
<td></td>
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<tr>
<td>Therapist</td>
<td></td>
<td></td>
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<tr>
<td>objections</td>
<td>person’s religious belief or something like that, or what’s normal in a culture or something like that. But, yes, that’s more of a good clinician’s kind of filter. How would that present itself? You know, you talk specifically about a religious perspective. Is there any example of that, a general example of that?</td>
<td></td>
</tr>
<tr>
<td>Beliefs (Religion/God)</td>
<td><strong>R:</strong> So this could be perceived as one of those grey areas then..</td>
<td></td>
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<tr>
<td><strong>P.1:</strong></td>
<td>Well, it might be things like, you know, a person holds a religious belief that the trauma happened because they sinned and God is punishing them, and God allowed it to happen because they were a sinner, and that God wants them to never forget, and so part of their religious belief is that they will always carry the cross of that burden or something like that. There is an aspect of that, that you want to try and respect and work very sensitively with, but if you are able to do some careful work on those fixed beliefs in a way that encourages a person to maybe look at the utility of that belief and whether there is an alternative perspective that might help you clarify things to a certain extent where the person perhaps achieves resolution and then it’s not really PTSD, you know...</td>
<td></td>
</tr>
<tr>
<td>Fixed Beliefs</td>
<td><strong>R:</strong> So this could be perceived as one of those grey areas then..</td>
<td></td>
</tr>
<tr>
<td>Impact of Beliefs</td>
<td><strong>P.1:</strong> It’s one of the grey areas. I mean, I mentioned it as a kind of a general kind of concept. It’s not specific necessarily PTSD, it’s you know, you look at aspects of bereavement and it has huge cultural associations with it and, you know, in the military you increasingly get coalitions of forces and you might find that, as a mental health practitioner, you are the mental health asset for a base that has other cultures other than the Western culture there. And if an incident happens, and I’m kind of referring to an actual case here. You know, you’ll find maybe one group of individuals from a certain nation are hugely emotive and you know, very</td>
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<td></td>
<td>trying to understand his example, expansion of discussion</td>
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<tr>
<td></td>
<td>The impact of the process where beliefs inform the clients response to the trauma</td>
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<td></td>
<td>Working with beliefs as a central part of the therapeutic process</td>
<td></td>
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<tr>
<td>Culture (Non-western)</td>
<td>Looking at differing cultures and how different people cope with loss and trauma in specific – culturally based ways</td>
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<tr>
<td>Cultural Difference</td>
<td>Adjusting clinical response to clients presentation based on</td>
<td></td>
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<tr>
<td>Normalising</td>
<td>vocal and very distressed, and if someone from the Western culture, you know, started to present like that, the way you would assess and try to understand that behaviour might lead you to be more concerned than you might be with that kind of foreign culture to you, because you will see that as part of their grieving process and more normalise it. And, you know that is part of training. R: One of the things that I was maybe wanting to ask you was if you could possibly give me an example from your personal experience, with the obvious constraints of confidentiality, of thinking of a client that you worked with who had been identified as presenting with PTSD, and maybe you could talk me through some of the decisions, points or the process that you engaged in when you worked with that individual. So how – you've already explained the diagnostic aspects of it, and then maybe looking at the formulation aspects and then the therapeutic intervention aspect of it. Just the general experience of something that you’ve actually done that maybe becomes more concrete. P.1: Okay. Can I just take a second here? R: Sure. Pause P.1: Yes. Okay. So you want me to just run through the presentation and my role? R: Yes. Just a kind of brief process of, mostly I suppose, it’s the things that… because you've talked to me already about – you go through a protocol – you use the DSM as your protocol structure to look at PTSD. It may well be that, I don’t know – do people come with a diagnosis, or would it be you that gave the diagnosis? P.1: Well sometimes, I mean, but generally not. Generally they have been referred to me with the query of making a diagnosis or they are self-referred. So they might be referred from their</td>
<td>Cultural awareness Normalisation process, adjusting response I am trying to get a concrete example of his work with a specific client and for him to run me through his process of understanding the key issues that are important to him when making decisions? He hesitated and this is the first time he had done this being very spontaneous and responsive</td>
</tr>
<tr>
<td>Significance of Diagnosis (Mental health illness) Formulation</td>
<td></td>
<td>A range of methods of referral used in his practice His ability to diagnose and a requirement of his job role</td>
</tr>
<tr>
<td>Ineffective treatment process</td>
<td>primary care doctor, and then usually I see individuals before I would refer them to psychiatry anyway. So I would be the one that would make the diagnosis. So, I'll just talk you through one case then. An individual who had – actually I think this case – he was already carrying a diagnosis of PTSD, and he had deployed to Iraq and then returned to the States and then got assigned to where I work and he had done a little bit of therapy at the bases out in the U.S. but it wasn't really achieving great results for him. He was still struggling an awful lot and he had been started on some medication as well, just anti-depressants, it was Sertaline, and he was looking for some additional help. So he was cleared to travel across to the base where I am at, and he was booked in to see me. So I reviewed his case. I reviewed the chart that was sent with him, and you know satisfied with the diagnosis that he was carrying. There was a secondary depression there as well, which is fairly common. You know, it has become more of a presentation. Some heavy alcohol use, but not enough for any alcohol abuse diagnosis, and no personality disorder or any intellectual impairment. Medically he had some issues, but they were being treated fairly well. So the primary issue was the PTSD. His functioning was that he was quite irritable at work, quite agitated, you know, he would be a bit distant from people and I decided to do a kind of a new formulation with him to try and see whether or not we could start afresh.</td>
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<tr>
<td>Medication</td>
<td>The process of making a diagnosis and assessment</td>
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<tr>
<td>Secondary symptoms</td>
<td>The experience of healing</td>
<td></td>
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<tr>
<td>Alcohol substance abuse</td>
<td>Not a positive outcome to client’s previous therapy experience</td>
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<tr>
<td>Assessment Formulation</td>
<td>Possibility of difficulties in engaging with the therapy process due to previous experiences</td>
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<tr>
<td>Presenting symptoms</td>
<td>Secondary symptoms Co-morbidity</td>
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<tr>
<td>Cognitions &amp;</td>
<td>Alcohol as a coping strategy</td>
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<tr>
<td></td>
<td>Assessment and history taking</td>
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<td></td>
<td>Relationship building</td>
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<td></td>
<td>General treatment received where a more focused specialist trauma based treatment process is required</td>
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</table>
| | Cognitions,
<p>| Behaviour | about his experiences in a non-directive way, I suppose. And he was still having issues of being stuck on certain cognition, if you like, and his behaviour; it had formed into some uncomfortable behaviours that were maintaining some of these symptoms. I personally wanted to get a better idea and a handle on formulation anyway, and the process would allow me to build a better therapeutic rapport with him through doing that. So we started to look at issues and his past was there too. He was an individual who had a bit of a difficult childhood – divorced parents, being moved from one to the other during that period. A sense of instability, insecure attachments. |
| Building Therapeutic rapport | Attachment issues and their impact on the clients ability to deal with the trauma |
| Attachment (Issues) | Difficult childhood series of serious setbacks in past |
| Insecure/Secure | Learned experience of developing beliefs to compensate for lived experience |
| Control | A need to be in control |
| Fixed Beliefs | Self-made man developed high standing among others |
| Self-Determination | Trauma incident described in graphic detail to therapist – what impact on therapist? Compensatory |
| Impact on Therapist Past | |
|  | |</p>
<table>
<thead>
<tr>
<th>Issues</th>
<th>Witnessing trauma</th>
<th>Impact on therapist</th>
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<td></td>
<td>perimeter security at the scene and pushing the crowd back, and he literally himself attended to the main victim in the vehicle, which was basically cut in half, and then you know, destroying the vehicle as he left. You know, you leave a detonator, it destroys the vehicle and he gets everyone into the remaining vehicles and they get out of that very volatile scene and you make sure you take all the radio stuff with you, and secret information and all that kind of thing. So very high pressure. They got the victim into the back of their own vehicles and there was blood everywhere and injured, it’s hectic, and smoke, very hot, people shouting, some returning fire, and they get back to their base and the medics take over, but then him and the rest of the team were just left standing around.</td>
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<tr>
<td>Identity</td>
<td>Previous life experience</td>
<td>Sense of responsibility</td>
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<td></td>
<td>R: So a huge burst of energy and response and stimulus and then it stopped.</td>
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<tr>
<td></td>
<td>P.1: Yes. He was the most senior person on that team that went out on that convoy and so in that high pressure situation you are the &quot;Go to person&quot;, you know, and all those sort of things that I could probably elaborate on, fit with his sense of who he was and his identity and which had emanated from an earlier time in life when he learned that if you want to get things done you get them done yourself.... you’re...</td>
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<td></td>
<td>R: A strong belief there...</td>
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<td></td>
<td>P.1: Yes, and something fell from....it’s dispositional in a sense, that you’ve let something go wrong, rather than a situation. So, as a result of this, he started to feel that incongruence and sense of distance that “Well, if I get things right in my life, it’s because I did it, and I worked hard to get there”, and it’s something like, you know “I didn’t do what I should have done”, and then we translate that sort of tablet to this situation in Iraq, and it’s like - Well, he’s now conflicted because something</td>
<td></td>
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</tbody>
</table>

- **Powerful imagery and description of trauma and the experience of the client**
- **Potential for re-traumatisation and unknown impact on therapist?**
- **The depth and detail of the story required to enable unpacking of the trauma experience has potential for negative consequences for the client**
- **Can cause avoidant strategies**
- **The impact of previous life experiences on clients identity development and maintenance**
- **Self reliance generated from childhood experiences**
- **Extended into the clients current functioning**
- **Conflicted emotional process identified and diagnosed**
| Loss of core sense of self | did go wrong and he's like "I must have failed in some way". So he then in several ways harbours that, holds on to it, it develops, the emotions then follow on from that and feed the thoughts and as a result he starts to second guess himself which in turn makes him frustrated and irritable and makes him sort of doubt who he is. He then starts to withdraw from others and gets back from his deployment and feels lost and self-doubting. Feels irritable, annoyed with other people, and then he projects that out to a certain extent, because he sees that in other people, rather than maybe fully recognising that it is how he may be feeling himself, he sort of gets annoyed with them rather than looking inwardly and thinking – he is doing some projection there and that has led to... you know, his weapon was pulled. I wasn’t happy with him carrying a weapon….. |
| Self doubt | Issues of self-doubt, frustration and irritation - therapist unpacks core emotional responses and identifies underpinning beliefs supporting them |
| Projection | Client projection – client position in relation to safety of others – therapist duel role holding responsibility for safety of other military staff and responsibility for client well-being |
| Risk to self and others | R: Some real consequences once this information was out there and you were engaged in this process with him. There were some very specific consequences to him within his job role. |
| Conflict of responsibilities | P.1: Yes. Because of the remit that I work in, it’s occupational health linked, and I have to think of safety of self and others a lot and the fact that he was having this internal turmoil, self doubt and, not homicidal ideations, but real rage at other people, and really it was a projection of his rage at himself which was coming from, you know, I suppose if you are being kind of direct, some erroneous cognitions about what had actually occurred. So he knew that, but the issues had developed where he sort of felt that he needed to get out of the military and really he was justifying that, you know “I can’t do this anymore. You know, it’s not the military I joined”. But really what it was, was he didn’t have confidence in himself any more to be in that role. |
| Safety of self and others | |
| Therapist work setting | |
| Emotional conflict | |
| Cognitions | |
| Shift in capacity | |
| Loss of confidence | |
| Shift in sense of self | |
| Cognitions | R: So when you look at this particular scenario, this particular case, actually what he brought to this process prior to the incident was fundamental almost, or it seems fundamentally in decisions that you are making with regard to treatment, with regard to formulating a treatment protocol for him, and actually the endeavour of you engaging with him in this alliance that you formed. |
| Confidence | P.1: Yes. Yes. Because then it fits into that model that I particularly like – the cognitive processing therapy model and the ideas of assimilating the experience into one’s existing belief and over-accommodating and really it was that sense of cognitive distance that he had that led him to over-accommodate. It was like “I’m no good at anything now” and the root of that was that the incorrect, if you like, or erroneous correlations that he was making between attributing blame or attributing responsibility for things, for that trauma and for what occurred. So rather than looking at things at a situational level and then distinguishing that situational view of what happened from a dispositional view – because really he didn’t do anything wrong. He did everything he was supposed to have done. But I think what was clearly also leading him to be stuck in moving more to just accommodate that and being able to heal with that and resolve that, was a sense that, you know, reinforces the idea that so much is outside of our control. And he had worked so long at being in control of his life. So even in accepting something that I suppose is maybe a bit more balanced, still leads you to come to terms with that existentialist kind of view that so much is outside of our control. |
| Coping strategy | Cognitions and the impact they have on life and functioning |
| Difficulty in assimilation | Therapist understanding of the model used with the client and how to make sense of the clients issues |
| Perception | Emotions disconnected = over-accommodation |
| Sense making | Conflict between responsibility and blame the attempt to widen the clients view of the trauma to incorporate alternative views of the trauma process |
| Re evaluation | Reconstructing the clients sense of control and identifying what is within and outside of the clients control |
| Treatment strategies | Issue of accepting alternative views and deconstructing firmly held |
| Healing | |
| Challenge of reintegration | Symptoms | World view | Shift in safety levels | Perception | Beliefs and assumptions | Narrative focus | Hearing the client | Shifts in client perspectives | Connecting Emotion to story | P.1: of making sense of that is by becoming very focussed on making the world shaped to him and not being reliant upon others. In this situation, that is an arrow that comes back – “look what the world can do to me”. |
|--------------------------|----------|------------|------------------------|------------|------------------------|----------------|------------------|------------------------|------------------------|belief about the trauma|Situational triggers the impact of these on the expression of symptoms|The world view of the client and its influence on the expression of PTSD symptoms|Mismatch in world view and the actual situation in relation to safety and security|A focus on the therapeutic model used aims and objectives|Making connections with practical story with emotional response to it|
| Of making sense of that is by becoming very focussed on making the world shaped to him and not being reliant upon others. In this situation, that is an arrow that comes back – “look what the world can do to me”. | Yes. Absolutely. And so now, more in the PTSD diagnostic level, he is extremely hyper vigilant. So being around Asian individuals, being around crowds, having his back to a door. These were all typical kind of areas where he was ticking the boxes on PTSD symptoms. Just in that one particular category. And so, yes, like the world is now a very unsafe place. But really the world is pretty much the same as it was before the trauma. It is just that he is seeing it differently. So in terms of safety levels, it is not actually any more dangerous than it was before, but it’s just that he has a sense of instability and insecurity if you like, and so that perception is clearly the big issue, one of the big factors here. | The world view of the client and its influence on the expression of PTSD symptoms | Mismatch in world view and the actual situation in relation to safety and security | A focus on the therapeutic model used aims and objectives | Making connections with practical story with emotional response to it |
Appendix 9

Figure 1: 9 participant transcripts with identification of individual themes and list of combined themes for each participant.
Figure 2: Individual participant transcript identifying 6 super-ordinate themes and related sub-themes.
Figure 3: Detail of Individual Participant transcript showing numbered representation of Super-ordinate and sub-ordinate themes.
Figure 4: Detail of Individual Participant transcript showing numbered representation of Super-ordinate and sub-ordinate themes.