Overcoming Traumatic Experiences:
Psychological Therapy, Recovery and

by

Kate Herbert

A thesis submitted in partial fulfilment of the requirements for the
degree of Doctor of Clinical Psychology

Coventry University, Faculty of Health and Life Sciences,
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# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>v</td>
</tr>
<tr>
<td>List of Figures</td>
<td>v</td>
</tr>
<tr>
<td>List of Abbreviations</td>
<td>vi</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>viii</td>
</tr>
<tr>
<td>Declaration</td>
<td>ix</td>
</tr>
<tr>
<td>Summary</td>
<td>x</td>
</tr>
</tbody>
</table>

## Chapter One: Literature Review

*Psychological Therapies for the Treatment of Trauma: A Review of the Literature*

Abstract 2

1.0 Introduction 3

1.1 Definitions of PTSD 4

1.2 Prevalence of PTSD 6

2.0 Literature Search Strategies 8

3.0 Psychological Therapy for Trauma 20

3.1 Individual Therapies 20

3.1.1 Cognitive Behavioural Therapies 20

3.1.2 Eye Movement Desensitisation and Reprocessing 27

3.1.3 Psychodynamic Psychotherapy 30

3.1.4 Integrative/Eclectic Therapy 33

3.2 Group Therapy 36

4.0 Gender and Trauma 39

4.1 Individual Therapy for Women 40

4.2 Group Therapy for Women 43

5.0 Methodological Limitations 44

6.0 Summary and Conclusions 47

7.0 Implications for Future Research and Clinical Services 49

8.0 References 51
Chapter Two: Empirical Paper

Recovery and Posttraumatic Growth after Brief Intervention for Trauma

Abstract 73

2.1 Introduction 74
   2.1.1 Posttraumatic Stress 74
   2.1.2 Treatment for PTSD 74
   2.1.3 Posttraumatic Growth 75

2.2 Rationale for Study 80

2.3 Methodology 81
   2.3.1 Design 81
      2.3.1.1 Research Question 81
   2.3.2 Participants 82
   2.3.3 Measures 83
      2.3.3.1 Psychometric Measures 83
      2.3.3.2 Semi Structured Interview 84
   2.3.4 Procedure 85
   2.3.5 Data Analysis 86
   2.3.6 Subjectivity and Reflexivity in the Research Process 87
   2.3.7 Ethical Issues 88

2.4 Results 88
   2.4.1 Quantitative Data Results 88
   2.4.2 Qualitative Data Results 92
      2.4.2.1 Underlying/Current Beliefs 97
      2.4.2.2 Impact of Trauma on Self/Identity 99
      2.4.2.3 Changes Over Time 100
      2.4.2.4 Personality Factors 102
      2.4.2.5 Influence of the Social Context 103
      2.4.2.6 Experiences of Therapy 106

2.5 Conclusions and Discussion 108
   2.5.1 Methodological Limitations 114
   2.5.2 Implications for Clinical Practice and Future Research 115

3.0 References 118
Chapter Three: Reflective Paper

Methodological Issues in Researching Trauma

3.1 Introduction 134
3.2 Methodological Issues 134
3.3 Ethical Issues Related to Researching Trauma 138
3.4 Summary and Concluding Reflections 142
3.5 References 144

Appendices

A. Notes for Contributors
B. Psychometric Assessments, Scoring and Psychometric Properties
C. Interview Schedule
D. Invitation Letters, Participant Information Sheets and Consent Forms
E. Example Interview Transcript
F. Example of Line by Line Coding
G. Ethical Approval
List of Tables

Table 1  Summary of Studies Examining the Treatment of PTSD and Trauma  10

Table 2  Background Information on Participants  83

Table 3  Means and Standard Deviations for Scores Obtained On IES, CiOQ and LOC  89

Table 4  Higher and Lower Order Codes  93

List of Figures

Figure 1  Participant Scores on the Impact of Events Scale, Pre Assessment, Post Assessment and Follow up  90

Figure 2  Participant Scores on the Changes in Outlook Questionnaire and Locus of Control Scale  92

Figure 3  Model of the Process of Recovery Following Trauma  95
### List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
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<tr>
<td>ASQ</td>
<td>Agoraphobic Cognitions Questionnaire</td>
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<tr>
<td>BAI</td>
<td>Beck Anxiety Inventory</td>
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<tr>
<td>BDI</td>
<td>Beck Depression Inventory</td>
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<td>BLRI-OS</td>
<td>Barrett-Lennard Relationship Inventory — Other Toward Self</td>
</tr>
<tr>
<td>BSQ</td>
<td>Body Sensations Questionnaire</td>
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<tr>
<td>CAPS</td>
<td>Clinician Administered PTSD Scale</td>
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<td>CAPS-2</td>
<td>Clinician Administered PTSD Scale</td>
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<td>CAPS-IV</td>
<td>Clinical Administered PTSD Scale</td>
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<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<td>CT</td>
<td>Cognitive Therapy</td>
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<td>CCQ</td>
<td>Catastrophic Cognitions Questionnaire</td>
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<td>CiOQ</td>
<td>Changes in Outlook Questionnaire</td>
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<td>CORE</td>
<td>Clinical Outcomes in Routine Evaluation</td>
</tr>
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<td>COR-E</td>
<td>Conservation of Resources Evaluation</td>
</tr>
<tr>
<td>CSQ</td>
<td>Client Satisfaction Questionnaire</td>
</tr>
<tr>
<td>CTS-2</td>
<td>Conflicts Tactics Scale — Revised</td>
</tr>
<tr>
<td>CTT-BW</td>
<td>Cognitive Trauma Therapy for Battered Women</td>
</tr>
<tr>
<td>CTQ</td>
<td>Childhood Trauma Questionnaire</td>
</tr>
<tr>
<td>DEQ</td>
<td>Distressing Events Questionnaire</td>
</tr>
<tr>
<td>DESNOS</td>
<td>Disorders of Extreme Stress Not Otherwise Specified</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of mental disorders — 4th edition</td>
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<td>EFT-AS</td>
<td>Emotional Focused Therapy for Adult Survivors</td>
</tr>
<tr>
<td>EMDR</td>
<td>Eye Movement Desensitization and Reprocessing</td>
</tr>
<tr>
<td>EOR</td>
<td>Effectiveness in Obtaining Resources Scale</td>
</tr>
<tr>
<td>GHQ-28</td>
<td>General Health Questionnaire</td>
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</table>
List of Abbreviations. continued.

HOPE Helping to Overcome PTSID through Empowerment
IE Imaginal Exposure
IES Impact of Events Scale
IPP Inventory of Interpersonal Problems
NART National Adult Reading Test
NICE National Institute for Clinical Excellence
NHS National Health Service
PDS Posttraumatic Diagnostic Scale
PFQ Personal Feelings Questionnaire
PSS-SR PTSD Symptom Scale – Self Report
PTSD Post Traumatic Stress Disorder
QOLI Quality of Life Inventory
RS Resolution Scale
SAS – SR Social Adjustment Scale – Self Report
SC Supportive Counselling
SCID Structured Clinical Interview for DSM-IV
SCL-90 Symptom Checklist
SOC Sense of Coherence
STAI State-Trait Anxiety Inventory
STRAGS-PA Sources of Trauma-Related Guilt Survey – Partner Abuse Version
TFCBT Trauma Focused Cognitive Behavioural Therapy
TLEQ Traumatic Life Events Questionnaire
TRGI Trauma Related Guilt Inventory
TSI Trauma Symptom Inventory
WAI Working Alliance Inventory
WAS World Assumption Scale
Acknowledgements

I would like to express my sincere gratitude to Dr Helen Liebling-Kalifani; my academic supervisor who has supported me throughout the duration of this research, her support, guidance and encouragement has been invaluable. I would also like to thank Dr Dan Barnard, my clinical supervisor, who helped with the initial concept of the research, accessing research participants and for his guidance and feedback. I would also like to thank Liz Blagrove and her much needed help with statistics.

I would like to thank the research participants who took the time to share their stories with me, without whom this research would not have been possible. I would also like to thank my friends on the course who have always provided laughter and support, throughout the highs and lows of training. I would especially like to thank Adam and my family for their love and support, for keeping me sane, making me laugh and listening to me whinge!
Declaration

This thesis was conducted under the academic and clinical supervision of Helen Liebling-Kalifani and Dan Barnard. Participants were recruited from Coventry and Warwickshire NHS Partnership Trust. Apart from the collaboration of the above people, this thesis is my own work. This thesis has not been submitted for a degree at another university.

The authorship of the papers from the study will be shared with the above named individuals. Chapter one is being prepared for publication in the Journal of Traumatic Stress, chapter two is being prepared for publication in Psychology and Psychotherapy: Theory, Research and Practice. Chapter three is being prepared for publication in Clinical Psychology Forum.
Summary

This research examined therapeutic approaches to trauma and posttraumatic growth and recovery as a result of brief psychological intervention. Chapter one is a critical review of current therapeutic approaches used in the treatment of trauma and posttraumatic stress disorder, PTSD. The PTSD treatment literature indicates that the therapy most rigorously assessed and currently recommended by the National Institute for Clinical Excellence (NICE) is trauma-focused Cognitive Behavioural Therapy and Eye Movement Desensitization and Reprocessing. Despite this, the literature review indicated that other forms of therapy have been effective in reducing the symptoms of PTSD. The research indicated that clinicians are successfully using psychodynamic, integrative and person centred approaches in both an individual and group therapy format. Regardless of therapeutic approach used, issues of client motivation, timing of therapy and therapeutic alliance were important determinants in outcome. Chapter two is an empirical study, which focuses on the effect of brief psychological intervention on recovery from trauma. A mixed methodological design was used and five participants took part in the research. The results indicated that those participants whose trauma symptoms reduced had experienced recovery from their trauma. Participants cited underlying beliefs towards adversity, personal and contextual factors as important in facilitating recovery. Recommendations for further research and clinical implications were discussed. Chapter three provides the authors reflections upon the research process and methodological and ethical issues that arise when carrying out qualitative research with a trauma population.
Chapter One

Psychological Therapies for the Treatment of Trauma: A Review of the Literature

Word Count (excluding titles, tables and references): 7756

Paper prepared for submission to Journal of Traumatic Stress (see Appendix A for notes to contributors)
Abstract

A review of the treatment research for posttraumatic stress disorder, PTSD, indicates that several forms of therapy are useful for reducing the symptoms of PTSD. The treatments most rigorously researched and recommended by the National Institute for Clinical Excellence are trauma-focussed cognitive behavioural therapy and Eye Movement Desensitization and Reprocessing. Despite this, the literature review indicated that other forms of therapy are being used with promising results. The research indicated that clinicians are successfully working with traumatised clients using psychodynamic, integrative and person centred approaches in both an individual and group therapy format. Regardless of therapeutic approach used, issues of client motivation, timing of therapy and therapeutic alliance are important determinants in outcome. Methodological issues, clinical implications and directions for future research are also discussed.
1.0 Introduction

The treatment literature of the past twenty years reflects an enormous interest in discovering the most effective psychological therapy for clients with a diagnosis of posttraumatic stress disorder, PTSD.

The overall aim of this paper is to critically evaluate selected literature on the effectiveness of psychological therapies. It also adds to current gaps in the existing literature by exploring the clinical implications of current therapeutic approaches.

It is suggested that despite the type of treatment provided for individuals with trauma difficulties there is ultimately a need for a flexible, integrative approach to treatment in order to deal with the complex and varying needs of individual trauma survivors. Research reveals a range of outcomes with the types of approaches outlined in this review although it is unclear who will respond best to which treatment approach. However, what is important in determining the success of any psychological treatment of PTSD is that it is dependent upon establishing and maintaining a therapeutic alliance that is strong enough for the client to experience as safe and trusting for positive emotional change to occur.
1.1 Definitions of PTSD

In the Fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (American Psychiatric Association, 1994) 'trauma' is defined as:

(a) The person experienced, witnessed or was confronted with an event that involved actual or perceived threat to life or physical integrity; and (b) the person's emotional response to this event included horror, helplessness or intense fear. Foa and Meadows (1997, p. 450).

There has been debate about whether the definition outlined in DSM-IV captures the variance in symptoms that individuals with PTSD present with. Several authors have attempted to differentiate between different subtypes of the condition. For example, Atchison and McFarlane (1994) propose that PTSD may present in two forms, one with a predominance of dissociative symptoms and the other dominated by anxiety symptoms, which has received some empirical support (Carlton, Arnold, & Dell, 2003).

In DSM-IV psychological symptoms of PTSD are categorised into three cluster symptoms: re-experiencing, avoidance/numbing and increased arousal, which arise after the person is exposed to a traumatic stressor. The recurrent re-experiencing symptoms e.g. flashbacks, nightmares, intrusive thoughts, have been considered the hallmark of PTSD (e.g. Foa & Rothbaum, 1992). The second cluster includes...
avoidance of trauma-related stimuli and numbing of general responsiveness e.g. deliberately avoiding trauma-related stimuli and symptoms of emotional numbing (Foa, Hearst-Ikeda, & Perry, 1995; Litz, 1993). The latter are considered distinguishing features of PTSD (Foa & Meadows, 1997). The third symptom cluster includes increased arousal e.g. hypervigilance, exaggerated startle response, difficulty sleeping and irritability (APA, 1994).

Herman (1992) proposed a diagnostic category of ‘complex’ PTSD. This diagnosis was identified to recognise the existence of individuals who have experienced prolonged, reoccurring trauma, particularly of an interpersonal nature. This differs from those who could be defined as experiencing ‘simple PTSD’, which would be categorised as a single incident trauma, usually occurring in adulthood. Individuals with ‘complex’ PTSD exhibit many additional symptoms to PTSD, including marked changes in their personality, particularly relating to personal identity and relating to others and a greater vulnerability to repeated harm. Empirical evidence (Van der Kolk, McFarlane, & Van der Hart, 1996; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005) suggest that traumatisation at a younger age for longer periods of time seem to produce these more pervasive symptoms consistent with a ‘complex’ PTSD explanation.

Another interpretation of Herman’s ‘complex PTSD’ definition is the Disorders of Extreme Stress Not Otherwise Specified (DESNOS), which
has also been defined within DSM-IV. DESNOS is characterised by alterations in the following six areas of psychosomatic functioning; regulation of affect and impulse e.g. anger modulation, attention consciousness e.g. dissociation, self perception e.g. shame, guilt, relations with others e.g. revictimisation, somatic experience e.g. somatisation, chronic pain and systems of meaning e.g. despair and hopelessness (see Pelcovitz et al., 1997).

1.2 Prevalence of PTSD

PTSD is one of the most common psychiatric disorders with community based studies indicating that it has a lifetime prevalence of 1 to 14%, depending on the diagnostic methods used and the type of population studied (APA, 1994). It has been estimated that between 15-24% of those exposed to traumatic events will go onto develop PTSD (see Breslau, Davis, Andreski, & Peterson, 1991; Saxe et al., 1993). Research has indicated the most common precipitating events for PTSD are combat trauma, physical and sexual assault, natural disasters and motor vehicle accidents (Breslau et al., 1991; Davidson, Hughes, Blazer, & George, 1991; Norris, 1992).

1.3 Current Government Guidelines on the treatment of PTSD

Determining effective and efficient treatments for PTSD has become a priority in light of the condition’s prevalence and the many techniques and
interventions available. The National Institute for Clinical Excellence, NICE, reviewed the most robust outcome research and produced guidelines, to inform and guide clinical practice for the psychological treatment of PTSD in adults (NICE, 2005). The guidelines were based on an independent, systematic, rigorous and multistage process of identifying, reviewing and appraising evidence for the effective treatment of PTSD. These guidelines conclude that individuals with PTSD should receive either trauma focused Cognitive Behavioural Therapy, TFCBT or Eye Movement Desensitisation and Reprocessing, EMDR. However, a distinction is made between single incident trauma and more complex presentations, and the guidelines suggest increasing the total number of sessions accordingly. Although the guidelines appear helpful for the treatment of single incident PTSD, they are arguably not as informative for treatment approaches for a large group of individuals with ‘complex’ PTSD. This presents difficulties for the clinician and client in deciding the most effective therapeutic options.

If PTSD sufferers request other forms of psychological treatment (for example, supportive therapy/non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy), the NICE guidelines recommend that:

They [clients] should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments on PTSD. NICE (2005, p.19).
There is an argument to suggest that the way in which NICE review outcome data suits manualised treatment programmes such as TFCBT and EMDR, but potentially disadvantages other therapeutic approaches including psychodynamic therapy. A considered analysis of this is beyond the scope of this review however, as it relates to a wider debate about therapeutic outcome and the way effectiveness is measured. It is important to state that research demonstrates alternative models of therapy being used with individuals presenting with single incident PTSD and positive outcomes have been reported (e.g. Blieberg & Markowitz, 2005; Gersons, Carlier, Lambers, & Van der Kolk, 2000).

2.0 Literature Search Strategies

Several techniques were used to locate relevant studies for this review. The main sources were the databases PsychARTICLES, PsychINFO, Medline, PILOTS and ZETOC. These databases were searched to locate peer-reviewed published literature, excluding dissertations. The databases were searched between August 2007 and November 2007. Articles were selected by the use of the search terms ‘PTSD’ OR ‘trauma’ AND ‘treatment’ OR ‘treatments’ OR ‘therapy’ OR ‘therapies’. A further search was completed on particular therapies: ‘humanistic’ OR ‘person centred’ OR ‘cognitive behavioural’ OR ‘exposure’ OR ‘EMDR’ OR ‘power therap*’ OR ‘alternative therap*’ OR ‘Integrative’ OR ‘eclectic’ OR psychotherap* OR ‘empowerment’ OR ‘service user’ OR ‘gender’ OR ‘culture’.
Due to the extensive literature base of this topic, the search included empirical studies published between 1997-2007. Papers were selected for inclusion if they The results were assessed for relevance and any non-empirical articles were excluded.

The literature gathering process resulted in the in-depth review of 14 studies, which were selected for relevance to the aims of this literature review. Reviewed studies are marked with an asterisk (*) in the reference list and are summarised in Table 1, according to the thematic structure of this literature review.
Table 1: Summary of Studies Examining the Treatment of PTSD and Trauma

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Number of participants</th>
<th>Length of treatment</th>
<th>Sample</th>
<th>Measures used</th>
<th>Types of measures used</th>
<th>Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham, &amp; Barrowclough, (1999).</td>
<td>Randomised controlled trial comparing effectiveness between cognitive therapy and imaginal exposure</td>
<td>62 (36 male, 26 female)</td>
<td>16, 60 minute sessions</td>
<td>Clinical</td>
<td>Clinician Administered PTSD scale, CAPS-1. (Blake et al., 1990) Penn Inventory (Hammarberg, 1992) Impact of Events Scale, IES (Horowitz, Wilner &amp; Alvarez, 1979) Beck Depression Inventory, BDI (Beck, 1988) Beck Anxiety Inventory, BAI (Beck, 1990) General Health Questionnaire, GHQ-28 (Goldberg &amp; Williams, 1988)</td>
<td>Clinician assessed &amp; self report</td>
<td>No significant differences between cognitive therapy and imaginal exposure. A significant number of participants who had imaginal exposure did not improve on measures post therapy, this difference was not found at follow up.</td>
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Table 1 continued. Studies Examining the Treatment of Trauma and PTSD

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<tr>
<th>Study</th>
<th>Design of Study</th>
<th>Number of participants</th>
<th>Length of treatment</th>
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<td>Types of measures used</td>
<td>Main findings</td>
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<tr>
<td>3. Paunovic &amp;</td>
<td>Comparing Cognitive therapy and exposure therapy for refugees.</td>
<td>16 (3 women and 13 men)</td>
<td>16-20, 60-120 minute</td>
<td>Clinical</td>
<td>Clinical Administered PTSD Scale, CAPS-IV (Blake et al., 1997) PTSD Symptom</td>
<td>Clinician assessed &amp; self report</td>
<td>No significant difference between outcome groups. Participants receiving both cognitive therapy and exposure showed significant improvement on PTSD symptoms, anxiety and depression. Results were maintained at 6 month follow up.</td>
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<td>Ost, (2000)</td>
<td></td>
<td></td>
<td>sessions</td>
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<td>Scale, PSS-SR (Foa et al., 1993) Beck Anxiety Inventory, BAI (Beck, 1988)</td>
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### Table 1 continued. Studies Examining the Treatment of Trauma and PTSD

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<th>Design of Study</th>
<th>Number of participants</th>
<th>Length of treatment</th>
<th>Sample</th>
<th>Measures used</th>
<th>Types of measures used</th>
<th>Main findings</th>
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### Eye Movement Desensitisation and Reprocessing (EMDR)

<table>
<thead>
<tr>
<th>Study</th>
<th>Design of Study</th>
<th>Number of participants</th>
<th>Length of treatment</th>
<th>Sample</th>
<th>Measures used</th>
<th>Types of measures used</th>
<th>Main findings</th>
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<tr>
<td>5. Taylor, Thorarsen, Maxfield, Feoroff, Lovell, &amp; Ogorodniczuk, (2003)</td>
<td>Evaluation of the speed, efficacy and adverse effects of EMDR, compared to exposure and relaxation training</td>
<td>60 (45 women, 15 men)</td>
<td>8, 90 minute sessions</td>
<td>Clinical and non-clinical</td>
<td>CAPS (Blake &amp; Foa, 1995) PSS-SR (Foa et al., 1993) BDI (Beck, 1987) Reactions to Treatment Questionnaire (Borkoveck &amp; Nau, 1972).</td>
<td>Clinician assessed &amp; self report</td>
<td>Results indicated that all participants experienced improvement in PTSD symptoms and depression. Exposure therapy produced significantly larger reductions in avoidance and re-experiencing symptoms and was faster at reducing avoidance. EMDR and relaxation did not differ from each other.</td>
</tr>
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Table 1 continued. Studies Examining the Treatment of Trauma and PTSD

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<tr>
<th>Study</th>
<th>Design</th>
<th>Number of participants</th>
<th>Length of treatment</th>
<th>Sample</th>
<th>Measures used</th>
<th>Types of measures used</th>
<th>Main findings</th>
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<tr>
<td>Psychodynamic Therapy</td>
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<td>6. Krupnick, (1997)</td>
<td>Evaluation of brief psychodynamic therapy for PTSD</td>
<td>1 female</td>
<td>12 sessions</td>
<td>Clinical</td>
<td>Clinician rating and participant self report</td>
<td>Clinician assessed &amp; self report</td>
<td>The clinician and the participant identified that trauma symptoms had reduced and the participant was better able to recognise past experiences and links to current trauma.</td>
</tr>
</tbody>
</table>
Table 1 continued: Studies Examining the Treatment of Trauma and PTSD

<table>
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<tr>
<th>Study</th>
<th>Design</th>
<th>Number of participants</th>
<th>Length of treatment</th>
<th>Sample</th>
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<th>Types of measures used</th>
<th>Main findings</th>
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<tr>
<td>8. Gersons, Cartier, Lamberts, &amp; Van der Kolk, (2000)</td>
<td>Evaluation of brief eclectic therapy with police officers with PTSD. Therapy vs waiting list control</td>
<td>42 (n=22 therapy group, n=20 waiting list)</td>
<td>16, 60 minute sessions</td>
<td>Self referred non-clinical</td>
<td>Structured Interview for PTSD, Si-PTSD (Davidson, Smith &amp; Kudler, 1989). Anxiety disorder interview schedule-Revised (DiNardo &amp; Barlow, 1988) Symptom Checklist, SCL-90. (Derogatis, 1994).</td>
<td>Clinician assessed &amp; self report</td>
<td>For those who received therapy, there was clinically significant reduction in PTSD symptoms, and anxiety compared to waiting list control.</td>
</tr>
<tr>
<td>9. Pavio &amp; Nieuwenhuis, (2001)</td>
<td>Evaluation of emotion focussed therapy for adult survivors of child abuse. Therapy vs waiting list control</td>
<td>32</td>
<td>20, 60 minute sessions</td>
<td>Non Clinical</td>
<td>IES (Horowitz et al., 1979) SCL-90 (Derogatis, 1994) Inventory of interpersonal problems, IPP. (Horowitz et al., 1988) The Resolution Scale, RS (Singh, 1994). Childhood Trauma Questionnaire, CTQ (Bernstein et al., 1994) Working alliance Inventory, WAI (Horvath &amp; Greeberg, 1989)</td>
<td>Clinician assessed &amp; self report</td>
<td>Participants who received emotion-focused therapy achieved significant improvements on PTSD and other areas of functioning compared to waiting list control. These results were maintained at 9-month follow up.</td>
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Table 1 continued. Studies Examining the Treatment of Trauma and PTSD

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<td>Group Therapy</td>
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<tr>
<td>10 Wallis, (2002)</td>
<td>Evaluation of the effectiveness of group therapy compared to a waiting list control</td>
<td>83</td>
<td>12 sessions</td>
<td>Clinical</td>
<td>Trauma Symptom Inventory, TSI (Briere, 1995).</td>
<td>Self report</td>
<td>There was a reduction in trauma symptoms for the therapy group, no similar reductions were found for the waiting list controls.</td>
</tr>
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Table 1 continued. Studies Examining the Treatment of Trauma and PTSD

<table>
<thead>
<tr>
<th>Study</th>
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<td>14. Lunqvist, Svedin, Hansson, &amp; Broman (2006)</td>
<td>Evaluation of group therapy for women sexually abused in childhood. Comparison of a long-term group, short-term group vs waiting list control.</td>
<td>77 ( (n=45 \text{ long term group, } n=22 \text{ short term group, } n=10 \text{ waiting list}) )</td>
<td>Long-term group=46 sessions over two year period. Short term group = 20, weekly sessions</td>
<td>Clinical</td>
<td>SCL-90 (Derogatis, 1994). Sense of Coherence, SOC (Antonovsky, 1993)</td>
<td>Self report</td>
<td>There was a reduction in PTSD symptoms and improvements in sense of coherence in both the short-term and long-term therapy groups. The changes were greater in the long term therapy group. The waiting list did not show any improvements.</td>
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3.0 Psychological Therapy for Trauma

Psychological therapy for PTSD and trauma covers a range of individual and group approaches. This review evaluates the clinical utility and effectiveness of these therapies.

3.1 Individual Therapies

A number of empirical papers have studied the effectiveness of individual psychological therapies for the treatment of trauma and PTSD. These include cognitive behavioural therapies, psychodynamic, and integrative/eclectic approaches. ‘Energy’ approaches are also used in the treatment of trauma (see Mollon, 2008 for a review) but are beyond the scope of this literature review.

3.1.1 Cognitive Behavioural Therapies

CBT is the most extensively researched therapy for individuals with PTSD (Foa & Meadows, 1997) and many studies support its efficacy in reducing symptom severity (e.g. Foa et al., 1995; Foa & Jaycox, 1996; Foa, Rothbaum, Riggs, & Murdock, 1991; Resick & Schnicke, 1992; Richards, Lovell, & Marks, 1994; Thompson, Charlton, Kerry, Lee, & Turner, 1995). However, CBT for PTSD encompasses diverse techniques. These include
exposure procedures, cognitive restructuring procedures, and combinations of both these techniques.

Exposure therapy is based on the premise that imaginal exposure to the trauma or feared situation, leads to symptom reduction. The theory argues prolonged activation of traumatic memories leads to emotional processing of the affective information, habituation of anxiety and integration of corrective information (Foa et al., 1995). Numerous studies have demonstrated that treatment based on exposure therapy is efficacious in reducing PTSD (e.g. Foa et al., 1999; Frueh, Turner, Beidel, Mirabella, & Jones, 1996; Keane, Fairbank, Cadell, & Zimmering, 1989).

Cognitive restructuring is based on the theory that identifying and modifying catastrophic and unrealistic interpretations of the traumatic experience leads to symptom reduction. Recent models have emphasised the importance of correcting cognitive distortions in the adaptive recovery of people following trauma (Ehlers & Clarke, 2000).

When exposure therapy has been compared to other forms of cognitive therapy, such as cognitive restructuring, it has proved to be more successful in reducing PTSD. Tarrier et al., (1999) compared Cognitive Therapy (CT) with imaginal exposure therapy (IE) for 72 people with chronic PTSD, and concluded that there was no significant difference between the two groups
initially or at 12 month follow up. Participants recruited were obtained from a
sample of referrals to primary and secondary mental health services and
voluntary services, indicating that they were representative of a genuine
clinical sample. However, 50% of the sample remained above clinical
significance for PTSD symptoms after treatment was completed, although
this dropped to 25% at six-month follow-up. This lack of improvement may
have been influenced by participant's failure to attend sessions regularly.
Furthermore, those who did not show improvement rated the therapy as 'less
credible' and were rated as 'less motivated' by the therapist. Therefore, it is
argued that motivation for therapy and regular attendance plays an important
role in outcome of therapy regardless of treatment model. A further limitation
of this study was that no control group was used and non-specific treatment
factors and spontaneous remission could also account for the improvements
in reported symptoms.

Bryant, Moulds, Guthrie, Dang, and Nixon (2003) studied the effects of
IE alone or IE with CR in the treatment of PTSD. They hypothesised that CR
combined with IE would result in greater PTSD symptom reduction than
exposure alone, which in turn would have greater benefits than a supportive
counselling condition. Fifty-eight civilian trauma survivors, diagnosed with
PTSD as measured by CAPS-2 (Blake et al., 1995) were randomly allocated
to one of the three conditions. Each participant received eight weekly 90-
minute sessions of either IE, CR and IE or supportive counselling.
Participants completed assessments at pre and post treatment and 6 month follow up. These measured PTSD symptoms and psychopathology. Forty-five participants completed treatment and analysis indicated that dropouts had higher scores for depression, avoidance and higher catastrophic cognitions than those who completed. Results indicated that participants receiving both IE and IE/CR had greater reductions in PTSD symptoms and anxiety than supportive counselling (SC).

The major finding of this study was that therapy involving IE and CR leads to greater reductions in CAPS-2 intensity scores than therapy involving IE alone. Furthermore, those receiving IE/CR, but not IE alone, reported fewer avoidance, depression and catastrophic cognitions than those receiving SC. The results from this study indicated that the combination of IE and CR are effective in reducing symptoms of PTSD. It can be argued that the reasons why IE/CR may have been more effective than augmented treatments in the past (e.g. Foa et al., 1999) was that the study carefully controlled for the amount of time actively spent on each treatment component. Furthermore, participants were instructed on CR before commencing IE so they understood the rationale behind the techniques prior to addressing the strong emotional components of IE. This may have increased their understanding and belief that it was a credible treatment approach.
The finding that CR enhanced the treatment gains of IE may have been mediated by several possible mechanisms. IE and CR may involve common elements, including processing of emotional memories, integration of corrective information and development of self-mastery (Marks, 2000). Combining both interventions may provide the individual with greater opportunity to benefit. CR may have lead to greater symptom reduction as it specifically addressed identification and modification of maladaptive cognitions that may contribute to maintenance of PTSD and associated problems (Ehlers & Clarke, 2000).

Paunovic and Ost (2001), compared treatment outcome data for CBT and exposure therapy for sixteen refugees with PTSD. The authors excluded those who became too distressed in the initial interview, expressed ‘a lack of confidence’ in the therapist or were misusing alcohol or drugs. Results indicated there was no significant difference between participants completing CBT or exposure therapy, being similar to Tarrier et al’s (1999) findings. Criticisms of Paunovic and Ost (2001)’s study are that participants did not use a self-report trauma measure, so although results are positive, there is no clear analysis of whether participants felt their trauma symptoms decreased as a result of the treatment. Further, it is not possible to generalise these findings to traumatised refugees in general, as this work is unique. Working with the use of an interpreter raises several ethical and sensitive issues, as the participant must be able to develop a therapeutic
alliance with the therapist and trust the interpreter (Tribe, 2007). It could be argued that participants may have been experiencing a greater degree of trauma, not least because they had not yet learned the native language.

Ehlers, Clark, Hackmann, McManus, and Fennell (2005) utilised cognitive therapy based on the cognitive model of PTSD (see Ehlers & Clarke, 2000). From this model, the aim of therapy is to modify excessively negative appraisals, correct the autobiographical memory disturbance and to remove the problematic behavioural and cognitive strategies.

In a randomised controlled trial, twenty-eight participants who were referred to a community mental health team were diagnosed with PTSD. Fourteen participants were randomly allocated to immediate cognitive therapy or a 13-week waiting list condition. Those receiving cognitive therapy had 12 weekly treatment sessions, based on the Ehlers and Clarke (2000) model of trauma focused CBT. Participants completed self-report measures of PTSD symptoms, depression, anxiety and also completed the Sheehan Disability Scale (APA, 2000). Measures were completed pre and post treatment and at 6 month follow up. Results found that CT for PTSD was superior to a 3-month waiting list condition on measures of PTSD symptoms, disability and associated symptoms of anxiety and depression. This study had no dropouts, which is a significant improvement on other studies, which yielded high dropout rates. (E.g. Tarrier et al., 1999).
Participants displayed a positive change in cognitive appraisals. The Ehlers and Clarke (2000) model suggest that two other pathways of change, change in autobiographical memory of the trauma, and dropping of maintaining behaviours and cognitive strategies as integral in reducing symptoms of PTSD. Although the treatment addressed these other two factors, these have not been systematically measured, so it is difficult to conclude whether clients experienced a change in these two areas.

Further analysis indicated that demographic, trauma and diagnostic variables did not predict treatment outcome, suggesting that the treatment is applicable to a wide range of trauma survivors. However, the degree in variation of trauma and small sample numbers suggests that this finding would not be present in a larger sample. Co-morbid depression and previous trauma history, which was present in over half the sample, did not negatively affect outcome.

The most effective CBT programs appear to be those that rely on repeated exposure to the trauma memory (Foa et al., 1999; Foa et al., 1991; Foa & Rothbaum, 1998) on cognitive restructuring of the meaning of the trauma, (Resick & Schnicke, 1992) or a combination of these methods, (Ehlers et al., 2005). Importantly, studies have concluded that trauma-focused CBT is more effective than supportive counselling (Blanchard et al., 2003; Bryant et al., 2003).
3.1.2 Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR was developed by Shapiro in 1989. This technique consists of exposing clients to selected traumatic images and cognitions while inducing saccadic eye movements; following which the client focuses on a cluster of current sensory, physiological, imagery and cognitive aspects of anxiety related to the trauma. At strategic points, clients are assisted to develop and accept a positive cognition regarding the trauma. Shapiro (1989) claimed that dramatic results could be obtained with clients using this method in as little as one session.

A positive review of sixteen published randomised controlled trials comparing EMDR to relaxation training, exposure therapy and waiting list, found that, in most cases, EMDR was effective in reducing PTSD symptoms for up to three months post therapy. EMDR was shown to be as effective as exposure therapy at reducing symptoms of PTSD. (Shepard, Stein, & Milne, 2000). Despite positive results gained from this analysis, the studies mainly had small sample sizes, low numbers of those assessing outcome were blinded to treatment allocation, and there were high rates of participants not completing follow up measures.

Taylor et al., (2003) examined the comparative efficacy, speed and incidence of symptom deterioration of three PTSD treatments, exposure
therapy, relaxation training and EMDR. These factors are important in
guiding clinicians and clients to make informed therapeutic choices.
Furthermore, there have been very few studies that have assessed each of
the four dimensions of PTSD symptoms; re-experiencing, avoidance,
numbing and hyperarousal, to determine whether treatments differed in
effectiveness. Taylor et al., (2003) gathered session-by-session data on the
four dimensions, enabling analysis of the speed of treatment effects and also
examined participants whose symptoms had deteriorated after treatment.
Sixty participants met the inclusion/exclusion criteria and were randomly
allocated to one of the three treatment groups and 45 completed treatment.
The majority of participants were female with chronic PTSD (APA, 2000).
Participants received eight 90-minute individual sessions of exposure
therapy, EMDR or relaxation training.

Results indicated that overall exposure therapy was superior to
relaxation and EMDR in reducing symptoms of PTSD. Scores indicated that
there was a significant reduction in all four dimensions of PTSD in each of
the treatment groups. Re-experiencing and avoidance symptoms responded
best to exposure therapy, which also produced the most significant clinical
improvement (Jacobson & Truax, 1991) in clients.

It is important to note that this study met all of Foa and Meadows’
(1997) gold standards for methodologically sound treatment-outcome
research. However, an important limitation is that the sample used participants with chronic PTSD, so it is difficult to generalise the findings to milder, less entrenched symptoms.

The research argues that the mechanisms underlying EMDR may just be another form of exposure (Seidler & Wagner, 2006). Dismantling research has controlled for the effects of the eye movement component, and its contribution remains unclear. Several dismantling studies have been conducted (e.g. Davidson & Parker, 2001), most of them suggesting that the effects of the eye movements are small or non-existent. However, the majority of these studies have a number of methodological flaws, such as small sample size. In addition, the treatment conditions without eye movements differ considerably. For example EMDR with eyes closed (Boudewyns & Hyer, 1996) may have different effects from EMDR involving concentration on a stationary flashing light (Devilly, Spence, & Rapee, 1998). It remains to be demonstrated whether any therapy specific components of EMDR (e.g. saccadic eye movements) differentiate its particular efficacy from that of exposure therapy.
3.1.3 Psychodynamic Psychotherapy

There have been very few studies evaluating the effectiveness of psychodynamic therapy with PTSD. Freud (1920) originally termed the recurrent intrusion of traumatic experience ‘repetition-compulsion’ and conceptualised this process as an attempt to master the traumatic event through repeated experience. Central to psychoanalytic theory is that being caught up in a traumatic event stirs up unresolved pains of childhood. A psychoanalytic approach to trauma therefore addresses directly what is most disturbing, intransigent and deeply rooted in the individual’s response (Garland, 1998).

Krupnick (1997) undertook a single case study of the effect of twelve sessions of brief psychodynamic psychotherapy with a woman who had experienced traumatic bereavement and PTSD for five months. No formal psychometric measures were used to assess therapy effectiveness; however both therapist and client reported improvement in functioning and a reduction in PTSD symptoms. This was maintained after 1.5 years. The results from this study cannot be generalised as they are based on one client. The participant had also experienced what had been defined as a ‘simple’ trauma, which was one incident, occurring in adulthood. The current literature review revealed no studies using brief psychodynamic therapy with more complex clients.
In a large-scale study comparing the effectiveness of brief psychodynamic therapy, hypnotherapy and systematic desensitisation, Brom, Kleber, and Defares (1989) used a sample of 112 people, mainly women who were diagnosed with PTSD according to DSM-III (APA, 1980). The majority of the sample, 83 out of 112, had experienced a traumatic bereavement. There was no data available on how or where the sample was recruited. Participants were randomly allocated to one of the treatment conditions or a control group. The outcome was marginal between each of the treatment groups, with significantly lower trauma symptoms reported in all three groups, compared to the control. It is also crucially important to consider how bereavement reactions differ from ‘traumatic’ bereavement reactions.

More recently, Bliberg and Markowitz (2005) completed a pilot study of the effectiveness of interpersonal psychotherapy for PTSD. This was a non-exposure based therapy, which was a time limited, diagnosis-targeted treatment, which focused on current social and interpersonal functioning. Therapy focused on interpersonal relationships that may have been affected by the trauma, and aimed to ascertain whether the therapy could have a more generalisable outcome on other traumatic effects. Subjects with a primary DSM-IV diagnosis of PTSD were recruited through clinical referral and local advertising. Of the 100 participants who were initially recruited, 25 were eligible for therapy, which focused on issues such as difficulty in
trusting and confronting others and also other ways in which PTSD symptoms interfered with relationships.

Post treatment, participants showed an overall improvement with thirteen participants no longer meeting diagnostic criteria for PTSD. All participants reported improved symptoms and improved social functioning. Furthermore, there was a low dropout rate from therapy.

These results make an important theoretical contribution by demonstrating that focusing on one aspect of PTSD i.e. interpersonal difficulties, can yield generalised improvement across symptom clusters and that PTSD improves without focussed re-exposure to the traumatic incident. The results indicate this therapeutic approach could be helpful for clients, in particular those who refuse exposure based treatment.

Bleiberg and Markowitz (2005) indicate that some of the subjects reported symptom improvement and were no longer avoiding reminders of the trauma. It would have been helpful for the numbers of clients who did this to be reported, or for this to be measured as part of the study. Other limitations to this study were the small sample size, heterogeneity of the traumas and the use of only two therapists, who were also researchers. The current author argues that it could have been helpful for a
comparison/control group to be implemented as the clinical utility of this therapy could be assessed more effectively.

Although psychodynamic therapy is common within National Health Service, NHS settings, empirical studies of its effectiveness with PTSD/trauma are sparse. This may reflect the methodological difficulties of studying this therapeutic approach, rather than a lack of effectiveness when compared to more structured therapies. Psychotherapy research has shown that the therapeutic relationship not the approach used is one of the most important variables affecting outcome, although this is beyond the scope for this current literature review. For example, Hubble, Duncan, and Miller (1999), reviewed therapeutic alliance literature and found that this accounted for 30% of all positive treatment outcomes across different theoretical approaches.

3.1.4 Integrative/Eclectic Therapy

There is growing empirical support for the integration of therapeutic methods. Gersons, Carlier, Lambers, and Van der Kolk (2000) used brief eclectic psychotherapy, which incorporated several intervention techniques also used in cognitive behavioural protocols, such as psychoeducation, imaginary guidance and cognitive restructuring. They also used a focal dynamic approach (Lindy 1993; Luborsky. 1984) as well as the use of a
farewell ritual at the end of treatment (Gersons, 1988). Forty-two police officers took part in the study. A pre-test post-test control group design was used and participants were randomly allocated to the treatment condition or a waiting list control group.

Participants were given sixteen 60-minute individual psychotherapy sessions and received no other form of treatment. The results found that the treatment was effective at reducing all three-symptom clusters of experiencing, avoidance and arousal and showed clinically significant change. Apart from clinically significant change, further outcome data indicated that there had been a return to work for 86% of treatment group, compared to 60% of waiting list group.

The authors' claim that a benefit to this type of therapy is that unlike exposure based work; the trauma is worked through at a slower pace. The aim is to integrate the memory of the trauma into the totality of the person’s memory system. However it can be argued that this is the aim of imaginal exposure or the enhanced reliving task in trauma-focussed CBT. Gersons et al., (2000) point out that one of the findings from the study was that participants only needed to work through what they perceived as their most important traumatic memory in order to gain a sense of controllability and predictability in their everyday life. A criticism of this study is that it is difficult to tease out what was effective in reducing symptomatology. The police
officers did express appreciation at use of the 'farewell ritual', however further research would need to be undertaken to ascertain the benefits of this aspect of the treatment. The sample was taken from a treatment seeking group, however the majority of those in the sample continued their work as police officers, so it could be hypothesised that the sample used within this study were highly motivated to take part in treatment and their level of disability due to PTSD has not impacted on their ability to work. Future studies would benefit from comparisons with other psychological treatments.

Paivio and Nieuwenhuis (2001) studied the effectiveness of Emotional Focussed Therapy for adult survivors of sexual abuse, EFT-AS. EFT-AS is an integrative approach grounded in emotion theory (e.g. Fridja, 1986) and experiential therapy theory and research emphasising the central role of emotion in functioning and psychotherapeutic change (e.g. Greenberg & Pavio, 1997). EFT-AS also incorporates change principals similar to ‘emotional processing’ in exposure therapies (Foa et al., 1991). However, there are features that distinguish EFT-AS from other cognitive restructuring approaches are its emphasis on the role of adaptive emotion and the therapeutic relationship in psychotherapeutic change.

Participants were recruited through newspaper advertisement and referral. Forty-six participant met the screening criteria and 32 completed therapy, which was 20, 1 hour weekly sessions of manualised therapy.
(Pavio, 1996). The results indicated that EFT-AS produced statistically and clinically significant improvements in multiple areas of functioning and symptom reduction. Therapeutic alliance was measured, with indications that therapy completers had strong working alliance throughout the course of therapy. The strong alliance that was noted may be an influencing factor in the positive therapeutic outcomes described in this research, as previous research has shown links between maltreatment, interpersonal harm and alliance quality (Paivio & Patterson, 1999). Limitations of this study included the sample being taken from a non-clinical population and being recruited through advertisement, and only around 50% of the sample met criteria for PTSD. Therefore it is difficult to generalise the results obtained to a ‘genuine’ PTSD sample.

3.2 Group Therapy

The use of group therapy in particular with adult survivors of childhood sexual abuse or complex trauma (e.g. Herman, 1992) has been well documented in the literature (e.g. Knight, 1993; Longstreth, Mason, Schriber, & Tsao-Wei, 1998; Morgan & Cummings, 1999; Zlotnick et al., 1997). A literature base is now emerging of empirical studies, which have addressed ‘what works’ in group therapy.
The efficacy of particular group processes for the treatment of trauma has been studied. Yalom (1985) identified the therapeutic factors of universality, the reduction in isolation, installation of hope and interpersonal learning as instrumental in creating healing group environments. Certain types of group therapy have been identified as effective treatments for individuals experiencing trauma/PTSD such as interpersonal transaction (Alexander, Neimeyer, Follette, Moore, & Harter, 1989) and CBT (Foa et al., 1995). Other therapeutic groups have focussed on particular problematic areas such as dissociation (Shaffer, Brown, & McWhirter, 1998), affect management (Zlotnick et al., 1997) and gender issues (Knight, 1993).

Wallis (2002) examined the effectiveness of group therapy for the treatment of adults that had experienced childhood abuse and/or neglect. Eighty-three participants took part in the study, comprising 64 women and 19 men. Fifty-six received group therapy and 17 were on a waiting list. The Trauma Symptom Inventory, TSI (Briere, 1995) was used as a method of assessing group effectiveness, however, PTSD symptoms were not formally assessed. Participants were given the TSI to complete pre therapy and at a three-month follow up. Data was collated from 11 different groups and the group programme consisted of 12 sessions. The group covered psychoeducation and other topics, which were informed by the work of Briere (1992) to make links between their past problems and present difficulties. The results indicated that there was a reduction in trauma...
symptoms as indicated on the TSI in the therapy group. No reduction in TSI scores was found for the control group. Although the results are promising, there are significant limitations to this study, such as the predominance of female participants and the unequal numbers in the experimental groups. It is therefore difficult to generalise that this type of group is equally effective for males who have experienced childhood trauma.

Payne, Liebling-Kalifani, and Joseph (2007) analysed the effectiveness of a client centred therapy group for survivors of interpersonal trauma. Six trauma survivors, 4 women and 2 men, selected from a primary care trust waiting list for psychological therapy took part in a pilot person centred therapy group. All participants were defined as experiencing 'complex PTSD', Participants attended up to 15 group sessions. In order to be client centred, group facilitators began sessions by asking participants to review their week and introduced a theme. Facilitators encouraged discussion through empathic listening, paraphrasing, reflecting, summarising and drawing comparisons across participant’s experiences. Four self-report measures were used to assess pre-post group change, which included the Barrett-Lennard Relationship Inventory – Other Toward Self (Barrett-Lennard, 1978), which assessed for the perception of core conditions in therapy. Overall the findings suggested that the quality of the therapeutic relationship was directly linked to outcome and perceived improvement. Participants who perceived that they experienced unconditional positive
regard within the group were those who displayed the most improvement in scores on the self-report measures.

Many therapeutic groups exclude those who are actively suicidal, which arguably limits understanding of the clinical profile of trauma survivors. Payne et al., (2007) did not exclude participants who were actively self-harming or suicidal and found that the participant who was the most distressed at the outset of the group was the client who benefited most. There are some limitations to the present study, most notably, the small numbers of participants and a lack of control group. Furthermore, client centred approaches are difficult to assess, as unlike CBT, they are based on the therapist creating a particular social environment.

4.0 Gender and Trauma

A history of trauma has increasingly been recognised as a factor in co-occurring mental health difficulties among women (Chilcoat & Menard, 2003). The high prevalence of sexual violence to which women are exposed and the corresponding high rates of PTSD following this, means women are the largest group affected by traumatic presentations (World Health Organisation, 2008). The National Comorbidity Survey, for women, found that PTSD tends to be associated with rape, sexual molestation, physical attack, and child abuse, all of which are more likely to happen to women
(Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). In light of this, several treatments for PTSD have been developed specifically for women and the efficacy these are now discussed.

4.1 Individual Therapy for Women

Kubany, Hill, and Owens (2003) carried out cognitive trauma therapy for battered women, CTT-BW. CTT-BW includes the assessment and correction of dysfunctional beliefs and reduction of negative self talk related to guilt and shame. Thirty-seven women of diverse ethnic backgrounds took part in the study and had been physically or emotionally abused by an intimate partner. Women qualified for inclusion to this study if they had been out of an abusive relationship for at least 30 days with no intention of reconciliation. While participating in the study, women were not required to discontinue with other therapy or support and/or prescription medication. CTT-BW was conducted in an individual therapy format for between eight to eleven 1.5-hour sessions and therapy was manualised. Participants were randomly assigned to either immediate or delayed therapy conditions and at post therapy assessment 17 out of 18 women in the immediate therapy condition no longer met diagnostic criteria for PTSD. Scores for depression had also reduced to within the normal range for 94% of participants. In comparison the women in the delayed therapy condition met diagnostic criteria for PTSD at both the first and second pre-therapy assessments. The delayed therapy condition
were then offered the same treatment, 13 out of 14 women (93%) no longer met diagnostic criteria for PTSD at post therapy assessment and 70% had scores on BDI within normal range. Three-month follow-up data from both treatment groups indicated that PTSD had remitted in 30 out of 32 of women with corresponding reductions in depression, guilt, shame and significant increases in self-esteem and 93% of women no longer met criterion C at post therapy assessment. The results were in contrast to previous studies that have shown a decrease in intrusive symptoms but have been less successful in reducing numbing and avoidance symptoms (Blake & Sonnenberg, 1998; Solomon, Gerrity, & Muff, 1992).

A positive outcome from this study is that therapy appeared to be efficacious with women of diverse ethnic backgrounds. The authors felt this may be related to observations that domestic violence issues and PTSD are universal problems, with similar manifestations that transcend culture (see Foa, Zinbarg, & Rothbaum 1992; Kubany, Bauer, Pangilinan, Muraoka, & Enriquez, 1995). Limitations to this study are that a single therapist provided therapy to all participants and all of the women in the study had left an abusive relationship, with no intention of reconciliation. These participants had already taken positive steps to improve their circumstances and it could be argued that after leaving this situation, there would be improvements in general mental health and a remittance in PTSD symptoms by virtue of their ability to change their situation. Furthermore, participants were not excluded
from CTT-BW if they were accessing other support. It is impossible to tease out whether it was CTT-BW, which produced this change or other support/therapy, which was not controlled for. For this reason, it is impossible to conclude that CTT-BW is attributable for the reduction in PTSD symptoms and improved scores in depression, shame and guilt.

In an attempt to fill the gap left by Kubany et al., (2003) study that used participants who had ended an abusive relationship and had no intention of reconciliation, Johnson and Zlotnick (2006) provided CBT to battered women with PTSD who were residing in a shelter. Johnson and Zlotnick used Helping to Overcome PTSD through Empowerment, HOPE, which is a 9-12 session, manualised CBT developed from Herman’s (1992) multistage model of recovery. Inclusion criteria included domestic abuse in the past month prior to admission to the shelter and presence of PTSD. Fifteen participants completed an average of 7 sessions and experienced significant decreases in PTSD symptoms, depressive symptoms, and significant increases in their effective use of community resources. Participants displayed a reduction in their use of resources in the first three months of leaving the shelter, which perhaps suggests that during the transition of moving on from a shelter, women benefit from continued outreach support to assist to establish their emotional and physical safety. The study also found that a large percentage of women one-week post shelter still met criteria for PTSD (60%) and the same percentage continued to report domestic abuse.
This suggests that the group of women were high-risk, and results may better reflect the difficulties faced by this population in improving their long-term safety and mental health.

4.2 Group Therapy for Women

One effective treatment for adult women sexually abused as children is trauma-focussed group therapy, with studies showing some positive outcomes with improvements in depression, anxiety, and PTSD (see Chaikin & Prout, 2004; Gatz et al., 2007).

Lundqvist, Svedin, Hansson, and Broman (2006), evaluated the effectiveness of a 2-year trauma focussed group for adult females who were sexually abused in childhood. The 46-session group therapy model was based on psychodynamic theory, with emphasis on the object -relations theory. Data was collected over an 8-year period and 45 women were treated in 10 different 2-year therapy groups. The study employed two comparison groups. One was a waiting list control and the other a short-term focussed therapy group comprising of 22 women. The group therapy model was similar to the study group but time limited to 20 weekly sessions. Inclusion and exclusion criteria were the same as for the study group. Self report measures were used pre and post therapy and at 1 year follow up.
Results indicated that women in the long-term therapy group had the greatest reduction in PTSD and other psychological symptoms, and these were maintained at 1 year follow up. Both therapy groups showed superior improvements than the waiting list control. The recruitment for the group was through professionals within the health and welfare system, therefore the women would need to have disclosed their abuse and asked to be considered for the group. Participants in this study were therefore highly motivated and this may explain the significant changes to mental health and PTSD. Another limitation is that PTSD was not measured for all participants, so the findings are based on a smaller sample than the number of women who attended the group.

Group therapy studies were limited and many included participants on the basis of reported trauma history rather than having met diagnostic criteria for PTSD. However, preliminary evidence does suggest that some group interventions lead to statistically significant reductions in PTSD symptomatology.

5.0 Methodological Limitations

Whilst the studies reviewed have helpfully added to our understanding of PTSD there are numerous limitations of the applications of the findings. One in particular is an over-reliance on non-clinical samples of participants such
that many claims of clinically effective therapy have been made from research with participants who were not within mental health systems, and despite having PTSD symptoms had not actively sought treatment.

In addition, dropout rates in studies are high, particularly for those studies that did not use a clinical sample. This might have skewed the evidence particularly with approaches that used exposure-based therapy. Furthermore, most of the studies reviewed screened out those individuals experiencing the greatest amount of distress, avoidance and co-morbidity. Therefore results are biased towards those clients who were able to tolerate treatment and whose symptoms were not as chronic. Indeed, inclusion and exclusion criteria appear to have a great impact on outcome of treatment. For example, studies with a strict inclusion criteria (e.g. no co-morbidity, substance misuse, self harm) appear to have significant improvements, whilst other studies i.e. Kubany et al., (2003), allowed participants to continue with other therapy while embarking on their therapy. This makes it methodologically difficult to ascertain exactly what has been effective in reducing PTSD symptoms. As inclusion and exclusion criteria are idiosyncratic across studies, it makes it difficult to draw general conclusions regarding treatment effectiveness with a clinical population across studies.

Studies often chose to focus therapy on identified groups, e.g. police officers. However, clients who experience PTSD do not form a
homogeneous group and further, the symptoms experienced may be diverse even within a sample of individuals who have experienced the same trauma. Treatment studies often do not control for other factors that may be important contributing factors in outcome such as the role of education, quality of the therapeutic relationship, therapeutic alliance and other non-specific factors.

The literature was generally from American, British or European sources although clearly trauma is intercultural. This raises issues about how different cultures interpret ‘PTSD’, an essentially Western concept, and also whether the treatments advocated would be effective cross-culturally. Previous research has strongly indicated that PTSD is not an appropriate term to use in non-western situations (Summerfield, 1997), hence therapeutic approaches need to account for this.

It is not clear in the majority of the research when the participant experienced the trauma, and at what point therapy started. Frequently these characteristics are omitted from studies, therefore making it difficult to compare effectiveness of studies. It is important to consider the types of clients who have been represented in the research and to look at whether it is representative of those who seek treatment. For example, in Lundqvist et al., (2006) study women who took part in their study had to have disclosed childhood sexual abuse to a mental health professional in order to be
considered for inclusion for the study. Therefore an individual’s motivation for therapy and the timing of when they commence this work plays an important role in outcome.

Finally, very little has been reported on the impact of other difficulties an individual is experiencing as PTSD can have a wide ranging impact on an individual’s quality of life and functioning and most often clients have more complex presentations. Only very few studies reviewed controlled for this variable (see Ehlers et al., 2005). This is an inherent difficulty when completing research with a trauma population as within research it is important to obtain a sample that have a similar degree of difficulties in order to assess treatment efficacy.

6.0 Summary and Conclusions

The psychological treatment literature outlined in this review focuses on the efficacy of specific PTSD therapies. It is notable that this literature is still limited and most controlled studies are confined to CBT and EMDR. Specialised trauma-focussed psychological therapies do reduce trauma symptoms although the majority of the research reviewed does not explain in depth why particular therapies are effective. Therefore, more research is needed to ascertain what aspects of therapy are most helpful to the client.
Despite the fact that most studies with positive outcomes for reducing PTSD symptoms have used a CBT approach and this has been cited as the treatment of choice by NICE (2005), other forms of therapy are being used with varying degrees of success. The research indicates that clinicians are successfully working with traumatised clients using psychodynamic, integrative and person centred approaches (Blieberg & Markowitz, 2005; Gersons et al., 2000; Payne et al., 2007). Gender specific treatments have been shown to be effective (Kubany et al., 2003) and despite methodological limitations, the use of long term and short-term group therapy has indicated that it is effective in reducing symptoms of PTSD (Lundqvist et al., 2006).

Several papers have evaluated different types of therapy according to particular groups. However, it appears that 'one size' does not fit all in relation to PTSD. In particular the issues of culture and gender are of importance (see Liebling & Ojiambo-Ochieng, 2000; Sheppard, 2000). Individual formulations of presenting problems and contexts, which informs therapy that is adapted to suit individual client's needs, may in fact be more helpful. It remains important to consider individual differences and client choice when offering trauma therapy.

Trauma therapy outcome studies are limited by the fact that sufferers usually have other mental health problems alongside PTSD such as depression or social anxiety. Evaluation of effective treatment of trauma
survivors therefore might need to go beyond medical diagnostic categories as most of the research excludes clients with co-morbid problems. A multifaceted intervention, based on clients’ own views, which addressed these other difficulties, may help reduce relapse and improve long-term efficacy of any PTSD treatment.

7.0 Implications for Future Research and Clinical Services

From the literature reviewed it appears that many therapies for PTSD have received little or no research scrutiny. As outlined in the methodological limitations section, much of the research reviewed has not used a genuine clinical sample, there are high dropout rates, widely variable inclusion and exclusion criteria, and the heterogeneity of PTSD has perhaps not yet been accounted for. It is therefore difficult to ascertain what is specifically helpful or effective within the treatment components. This seems to be the next area for consideration in research.

Further research into the optimal length of treatment and timing of therapy, the effect of co-morbidity and the differing effects of individual and group therapy approaches for traumatised clients are required. Further controlled research is needed to ascertain if the types of therapies reviewed can provide long term lasting effects in reducing PTSD symptomatology. Currently the empirical data is generally limited to the assessment of short
term, focused interventions, and it would be helpful to have controlled studies on longer-term treatment for more complex trauma cases. Further research would benefit from considering the clients views and experiences of therapy, this perspective was lacking in the literature reviewed. Service user and carer perspectives are beyond the scope of this review, however they have been highlighted as an important consideration within the NICE guidelines and therefore require further consideration in future research.

It is suggested that despite the type of treatment provided to individuals with trauma there is ultimately a need for a flexible, integrative approach to treatment in order to deal with the complex and varying needs of individual trauma survivors. A range of outcomes has been found with the types of approaches outlined in this review, it is unclear who will respond best to which treatment approach. However, what is important in determining the success of any psychological treatment of PTSD is that it is dependent upon establishing and maintaining a therapeutic alliance that is strong enough for the client to experience as safe and trusting for positive emotional change to occur.
8.0 References


Antonovsky, A. (1993). The structure and properties of the sense of coherence scale. Social Science and Medicine, 36,6, 725-733.


Chapter Two

Recovery and Posttraumatic Growth after Brief Intervention for Trauma

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Research, Theory and Practice. (See Appendix A for notes to contributors)
Abstract

Post-traumatic growth is an emerging area of research concerned with positive psychological changes that can follow the experience of traumatic events. The current study addresses this emerging literature by interviewing five individuals referred to one NHS Trauma Service. After receiving an assessment and brief psycho-education information, these individuals did not require any further psychological input. Using a mixed methodological design, the current study explored the impact of trauma, how participants managed their experiences and the usefulness of psychological assessment. Semi-structured interviews were carried out with participants and verbatim transcripts of the interviews were analysed using a grounded theory methodology. Participants also completed standardised psychometric measures. Results indicated that participants whose trauma symptoms had reduced had experienced some type of recovery from their traumatic experience with minimal psychological input and had a positive attitude towards adversity. Clinical implications, methodological issues and directions for future research are considered.
2.1 Introduction

2.1.1 Posttraumatic Stress

Research has shown that traumatic experiences can lead to severe, chronic psychological distress (Yehuda, 1998) with Post Traumatic Stress Disorder, PTSD, occurring as a result of a traumatic experiences (Kessler, Sonnega, Hughes, & Nelson 1995). Other trauma related problems include anxiety, substance misuse, marital problems, poor physical health and occupational impairment (Bremner, Southwick, Darnell, & Charney 1996). According to available evidence, psychological treatment has been shown to be effective (Bisson et al., 2007; Foa et al., 1999).

2.1.2 Treatment for PTSD

A wide range of psychological treatments for PTSD have been identified (see Herbert, Liebling-Kalifani, & Barnard, 2008) for a review. The most widely researched and efficacious treatments for PTSD are trauma focused cognitive behavioural therapy, TFCBT, which includes cognitive restructuring and exposure techniques (Ehlers et al., 2004; Foa, Zoellner, & Feeny, 2006) and EMDR (Taylor et al., 2003). TFCBT and EMDR are the treatments of choice for single incident PTSD as recommended in NICE guidelines for PTSD (NICE, 2005). Other psychological therapies, such as person centred,
psychodynamic and integrative approaches have also been found to reduce trauma symptoms (see Blieberg & Markowitz, 2005; Gersons, Carlier, Lamberts, & Van der Kolk, 2000; Payne, Liebling-Kalifani, & Joseph, 2007).

Despite many individuals experiencing trauma and high prevalence rates of PTSD, there is evidence that many individuals go on to experience positive change from this experience.

2.1.3 Posttraumatic Growth

There is evidence to suggest that the struggle with highly challenging circumstances can provide significant positive changes for many individuals coping with trauma. This has been referred to as posttraumatic growth, and has been defined as:

Positive psychological change experienced as a result of the struggle with highly challenging life circumstances. Tedeschi, Park, and Calhoun (1998, p.1)

Post-traumatic growth is different from an individual displaying hardiness or resilience towards adversity. Instead the experience of posttraumatic growth is one where the individual describes significant positive changes emerging from the struggle. Individuals do not simply survive without negative effects; they experience themselves as better than they were before the traumatic event. (Calhoun & Tedeschi, 1998).
A growing literature base now points towards individuals being able to achieve a positive outcome after experiencing seriously adverse situations, including bereavement (Calhoun & Tedeschi 1989; 1990), war trauma (Solomon, 1999), rape (Burt & Katz 1987), childhood sexual abuse (Lev-Wiesel, Amir, & Besser, 2005); breast cancer (Cordova et al., 2007; Weiss, 2002), domestic abuse (Cobb, Tedeschi, Calhoun, & Cann, 2006) prostate cancer (Thornton & Perez, 2006) and disasters (Joseph, Williams, & Yule, 1993).

It is been estimated that between 40-70% of people who experience a traumatic event will report a positive benefit emerging from it. The work of Calhoun and Tedeschi (1998; 2000) has identified three main areas where change and growth can take place. These positive outcomes include changes in one’s sense of self, changes in relationships with others (Affleck, Tennen, & Gersham, 1985) and changes in one’s spirituality or religion (Calhoun & Tedeschi, 2000) which are briefly explored below:

Changes in one’s sense of self may involve re-labelling from ‘victim’ to ‘survivor’, which is synonymous with special status and strength. A further element is a sense of increased self-reliance that can be characterised by thoughts such as, “if I survived this, I can handle anything” (Aldwin, Leveson, & Spiro, 1994). Even following serious violence and torture during war, research has shown women can reconstruct their identities and move on
with their lives (Liebling-Kalifani, Marshall, Ojjiambo-Ochieng, & Nassozi, 2007). Finally, the individual might derive benefit from a heightened awareness of his or her own mortality and the fragility of life (Calhoun & Tedeschi, 2000).

Changes in relationships with others have also been noted. For example, couples have reported that they became closer following one of them having a heart attack (Tedeschi, Park, & Calhoun, 1998). Self disclosure and emotional expressiveness appear to be a by-product of people who experience trauma who consequently learn how to disclose more about their feelings or to express themselves more openly (Laerum, Johnsen, Smith, & Larsen, 1987).

The experience of a life-threatening situation can lead to a re-evaluation of what is important and an appreciation for life (Salter & Stallard, 2004). Calhoun and Tedeschi (1998) have argued that the experience of growth may also involve spiritual, religious or existential changes.

In a review of positive changes following on from trauma and adversity, Linley and Joseph (2004) reviewed 39 empirical studies. They found positive cognitive appraisals; problem focussed acceptance and positive reinterpretation of coping, optimism and religion were traits present in individuals who had experienced growth as a result of trauma. Furthermore,
the review indicated that the people who reported and maintained adversarial growth over time were subsequently less distressed.

More recently, posttraumatic growth has been posited as a coping strategy, as distinct from merely an outcome of traumatic experience. This places posttraumatic growth within the theories of coping as an adaptive response (Zoellner & Maecker, 2006). Coping factors that have been identified include: positive reframing, mental disengagement and distraction, actively engaging in overcoming adversity/problems and support seeking, both emotionally and practically.

However, some researchers have criticised posttraumatic growth theories as being a 'positive illusion' (Taylor & Brown, 1988), an adaptive mechanism for dealing with stress that centres on perceptions of oneself, control of a situation and optimism. Posttraumatic growth may effectively result from cognitive bias that may lead people to recall events or perceive themselves in a more positive light. For instance, McFarland and Alvaro (2000) found that trauma-exposed victims reported more improvements in their own personal attributes than acquaintances observed. However, there is an emerging view that the construct is valid (Linley & Joseph, 2004) and indications that retrospective self reports following trauma exposure can be trusted (Bramson, Dirkzwager, van Erch, & Van der Ploeg, 2001).
2.1.4 Characteristics of Individuals who Experience Posttraumatic Growth

Various models have been proposed to explain why post-traumatic growth might occur in some individuals but not in others, although a full understanding of this remains unresearched. Positive relationships between posttraumatic growth and the personality dimensions of openness and extraversion, agreeableness and conscientiousness (Linley & Joseph, 2004) have been identified. Positive associations with growth have also been made with hardiness, optimism, self-efficacy, hope, humour and emotional state at the time of the trauma, (Joseph, Williams, & Yule, 1997) the nature of the traumatic event (Tedeschi, Park, & Calhoun, 1998) and their appraisal of the event (Schaeffer & Moos, 1998). Having an internal locus of control might give an individual a sense of control over a threatening situation (Solomon, Mikulincer, & Avitzur, 1988) and there has been some preliminary research that suggests that it may be an influencing factor in individuals experiencing posttraumatic growth. Some research reveals gender differences, suggesting that women may experience more positive growth than men (e.g. Liebling-Kalifani, 2008; Tedeschi & Calhoun, 1996). However other studies suggest that the relationship is tenuous since some studies have been confined to single gender or sample sizes are too small to be conclusive (Calhoun & Tedeschi, 2002). The relationship between age and growth has not yet been investigated.
2.2 Rationale for Study

From a review of the recent research, it appears that posttraumatic growth is possible after experiencing trauma (Linley & Joseph, 2004). The reasons why some individuals experience this type of growth after a trauma is still unclear however. This current research is intended to extend the knowledge in this area. There is currently no literature concerning whether positive growth could possibly be facilitated, for instance following a psychological assessment by a trauma therapy service as in this study. Furthermore this study expands knowledge about other possible un-researched factors that may be associated with growth, such as social support and locus of control.

The present study investigates the factors associated with individuals who present to a service with trauma related symptoms who, after an extended assessment, no longer require any further psychological intervention. A mixed design approach was considered appropriate for the study. Qualitative methodology is used to explore areas in which little is known (Strauss & Corbin, 1998) and are particularly suited to uncovering meanings that people assign to their experiences (Henwood & Pidgeon, 1995). As the current study wished to explore in depth participants’ attitudes to their experiences of trauma, a grounded theory approach was considered to be the most appropriate methodology. This approach lends itself to the emergence of a theory from the information gathered and ensures that the
researcher does not begin with a preconceived theory in mind (Giles, 2002). Furthermore, a grounded theory approach has shown to be helpful in the area of trauma research (Liebling, 2004).

2.3 Methodology

2.3.1 Design

A mixed methodological design was employed in the study. Five participants completed psychometric measures, similar to those they has completed pre- and post-assessment. Semi-structured interviews that explored experiences of trauma were carried out with participants. A grounded theory approach (Giles, 2002) was used to guide qualitative data collection and analysis.

2.3.1.1 Research Question

The research aimed to explore client’s unique experiences following trauma, particularly their views regarding assessment and therapy in the recovery process.

2.3.2 Participants

Participants were recruited from a Specialist Trauma Service, which forms part of a Community Mental Health Team within Coventry and Warwickshire
NHS Partnership Trust. All participants had received an assessment for suitability for trauma focussed psychological therapy from this service. All had been assessed by a Clinical Psychologist. The Trauma Service only accepts referrals of people who have acute and/or post-traumatic symptomatology as defined by DSM-IV (APA, 1994). Inclusion criteria for this study was that all participants needed to have been assessed within the trauma clinic, displaying symptoms consistent with a diagnosis of acute and/or posttraumatic symptomatology and have received between 1-4 assessment/follow up sessions. All participants needed to have made a decision in collaboration with their therapist that further therapy was not required and subsequently had not re-presented for therapy.

The client database was accessed for recruitment of participants who fitted the above criteria. Fifteen participants were identified as meeting the inclusion criteria and were invited to take part in the research, seven participants agreed to take part (47%). Five participants returned psychometric measures and all five agreed to take part in an interview. The ages of participants ranged from 31 to 60 (Mean = 47 years). Three participants were female and two male and all were White British. Length of contact with the service ranged from 1 to 4 sessions (mean = 2.2).
Table 2: Background Information on Participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Trauma referred for</th>
<th>Number of sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>60</td>
<td>Motor vehicle accident</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>47</td>
<td>Traumatic burglary</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>51</td>
<td>Motor vehicle accident</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>31</td>
<td>Physical assault</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>46</td>
<td>Physical assault</td>
<td>4</td>
</tr>
</tbody>
</table>

2.3.3 Measures

2.3.3.1 Psychometric Measures

The Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979) is a well-standardised 15 item self-report measure of the frequency of intrusions and avoidance following a traumatic event. The IES assesses current symptomatology, requiring participants to comment on symptoms experienced in the past week. Scores can range from 0 to 75 providing a measure of symptom severity. Higher scores indicate greater levels of distress.

The Changes in Outlook Questionnaire. (CiOQ; Joseph, Williams, & Yule, 1993), is a 26 item self-report measure designed to assess positive and
negative changes in the aftermath of adversity. Eleven items assess for positive belief changes (CiOP), and 15 items assess for negative changes (CiON). CiOP scores can range from 11 to 66, and CiON scores can range from 15 to 90. Higher scores are indicative of greater levels of positivity or negativity respectively.

Internal-External Locus of Control Scale (Rotter, 1966) is a forced choice, self-report measure with 23 items designed to evaluate the extent to which an individual believes that they can control events that affect them. Scores can range from 0-23. Scores of 12 and below are indicative of an internal locus of control. (For copies of psychometric assessments, scoring and psychometric properties please see Appendix B).

2.3.3.2 Semi Structured Interview

An interview schedule (see Appendix C) was developed based on the recommendations proposed by Giles (2002) and topics were based on the literature in the area. The guide was used flexibly to allow the direction of the interview to be established by the participant. Each participant was interviewed by the primary researcher, who has experience of conducting clinically sensitive interviews (see Liebling & Shah, 2001; Renzetti & Lee, 1993; Siber, 1993).
2.3.4 Procedure

Potential participants were identified by the lead clinician from the Trauma Service, who used his own judgement in selecting clients who would be appropriate for the research focus. An invitation letter and a participant information sheet with details of the study were sent to the selected participants. Participants who opted in were posted the psychometric measures and instructions for completion, along with a consent form. Participants completed measures prior to interviews being conducted. An invitation letter for participants to take part in an interview to discuss their experiences further and a participant information sheet was also included with the psychometric measures to consider. Participants were asked to supply their preferred contact details if they wished to take part in the interview. Participants who wished to take part in the interview were offered a mutually convenient time to do so and informed consent was obtained. Interviews took place at the Community Mental Health Team premises and lasted up to an hour. All interviews were carried out between December 2007 and February 2008, recorded onto a tape recorder and each interview concluded with a brief review of the participant’s emotional state. Participants were offered a contact point with the Lead Clinician to use if they wished. Interviews were transcribed verbatim and all identifiable information was removed (for invitation letters, participant information sheets and consent forms, see Appendix D).
2.3.5 Data Analysis

Quantitative data was analysed using the statistical package SPSS 15.0 (2007). There were some gaps within the data for the IES as two participants did not complete this measure pre-assessment. It is acknowledged that the data set is small which may impact on the power of the analysis. Despite uneven group sizes, the data did meet the assumptions for parametric analysis. Therefore, a oneway repeated measures analysis of variance (ANOVA) was carried out, which was chosen to reduce the chance of a Type 1 error.

Qualitative data was analysed using a grounded theory methodology following procedures set out by Giles (2002) (for an example interview transcript, see Appendix E). Interview transcripts were analysed line-by-line in order to generate codes which best summarised the data and minimised the effect of personal preconceptions and biases (Charmaz, 1995). The Atlas-Ti 5.2 (2006) qualitative data management computer program was utilised in the initial line-by-line coding stage (for an example see Appendix F). Codes were then broadened into categories and then further refined using a process known as axial coding (Strauss & Corbin, 1990) to form lower and higher-order concepts. When no further meanings were obtained and saturation of the data was reached, selective coding then enabled development of a model.
2.3.6 Subjectivity and Reflexivity in the Research Process

Guidelines for good practice in qualitative research have been proposed by Elliot, Fischer, and Rennie (1999). It is recommended that the researcher should ‘own one’s perspective’ and recognise the impact that the researchers values and position has on interpretation of the data. Influences to consider included that the researcher was currently on placement within the Trauma Service, and providing psychological therapy to clients experiencing PTSD. It was recognised that the position of the lead researcher as a woman Clinical Psychology Trainee, with an interest in the subject area will have impacted on the process of data analysis. However, the researcher also recognises the value of her own subjectivity and position in being able to carry out interviews in this sensitive research area (Holloway, 1989).

The author carried out ‘credibility checks’ with a fellow Clinical Psychology Trainee to ensure validity of the data (Elliot et al., 1999). This enabled discussions and reflections of the developing findings. Furthermore, the lead researcher kept a reflective research diary, to record the development of ideas and to facilitate the theory being grounded in the data (Colombo, 2003).
2.3.7 Ethical Issues

Ethical approval was obtained from Coventry University Ethics Committee, Warwickshire Research Ethics Committee and the local NHS R & D Committee (see Appendix F). Following British Psychological Society Guidelines (BPS, 2005), informed consent was obtained from participants prior to them taking part in the research. All information was kept confidential, anonymised and non-identifiable (BPS, 2005). All data stored on computer was anonymised and password protected.

2.4 Results

2.4.1 Quantitative Data Results

The following section highlights the results obtained for the psychometric measures completed by participants at pre and post assessment (IES) and the measures completed for this research (follow up).
Table 3: Means and Standard Deviations for scores obtained on IES, CiOQ and LOC.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>IES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre</td>
<td>56</td>
<td>2.65</td>
</tr>
<tr>
<td>Post</td>
<td>25</td>
<td>12.29</td>
</tr>
<tr>
<td>Follow up</td>
<td>19.33</td>
<td>9.29</td>
</tr>
<tr>
<td>CiOQ Positive</td>
<td>44.80</td>
<td>11.65</td>
</tr>
<tr>
<td>CiOQ Negative</td>
<td>29</td>
<td>7.31</td>
</tr>
<tr>
<td>LOCS</td>
<td>11.80</td>
<td>1.92</td>
</tr>
</tbody>
</table>

IES Scores

Overall scores for participants on the IES indicated that for pre-assessment participants obtained a mean score of 56 (SD= 2.65), post-assessment a mean score of 25 (SD= 12.29) and at follow-up a mean score of 19.33 (SD= 9.29). As displayed in Graph 1, below, individual scores for participants 1, 3 and 5 indicate that participants trauma related symptoms had reduced over the course of assessment and had continued to decrease at follow up. Scores for Participant 2 indicate that her scores on the IES had increased from post assessment to when she completed the measure at follow up.
A one-way repeated measures ANOVA was carried out to investigate whether there was any significant change in participant's scores over time. There was a statistically significant difference in the scores for the three time points, $F(2, 4) = 17.95$, MSE, 65.11; $p < .05$. The effect size, calculated using partial eta squared was .90, with an observed power of .94.

It was hypothesised that participants would continue to show a reduction in trauma symptoms. The results indicate that there is a significant reduction in trauma symptoms from pre-assessment to follow-up.
It was hypothesised that participants who showed a continued reduction in trauma symptoms would have an internal locus of control and have an increased positive outlook towards adversity (as measured by the CiOQ). Overall results from the CiOQ indicate that participants obtained a mean score of 44.80 (SD = 11.65) on the Positive scale, and a mean score of 29 (SD = 7.31) on the Negative scale, which indicates a greater endorsement of positive items. Individual results, as displayed in Graph 2, below, indicate that participants 1, 2, 3 & 5 all endorsed more positive items on this measure indicating that they had an increased positive outlook towards adversity.

The mean overall score for the LOCS was 11.80 (SD= 1.92). Results from this measure indicate that overall participants obtained scores below 12, which is indicative of an internal locus of control. It was hypothesised that participants would have an internal locus of control and that they would have an increased positive outlook on adversity as measured on the CiOQ. Results indicate that this hypothesis is supported by the measures.
2.4.2 Qualitative Data Results

Following analysis, 38 lower order and eight higher order categories were identified before selective coding then enabled development of a theoretical model (see Table 3). A visual representation is enclosed to aid understanding of the research findings and to demonstrate the links between the categories (see Figure 3).
<table>
<thead>
<tr>
<th>Higher Order Codes</th>
<th>Lower Order Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experiences of Therapy</strong></td>
<td>Expectations of therapy</td>
</tr>
<tr>
<td></td>
<td>Positive/helpful experiences of psychological input</td>
</tr>
<tr>
<td></td>
<td>Negative experiences of psychological input</td>
</tr>
<tr>
<td></td>
<td>Qualities of therapist that are helpful</td>
</tr>
<tr>
<td></td>
<td>Normalisation of trauma symptoms</td>
</tr>
<tr>
<td></td>
<td>Validation of experiences as traumatic by psychologist</td>
</tr>
<tr>
<td></td>
<td>Utility of self help material</td>
</tr>
<tr>
<td><strong>Experiences of other services</strong></td>
<td>Positive experiences of other services</td>
</tr>
<tr>
<td></td>
<td>Negative experiences of other services</td>
</tr>
<tr>
<td></td>
<td>Lack of knowledge of trauma service</td>
</tr>
<tr>
<td><strong>Feelings about Self</strong></td>
<td>Positive feelings about self, others and world after trauma</td>
</tr>
<tr>
<td></td>
<td>Negative feelings about self, others and world after trauma</td>
</tr>
<tr>
<td></td>
<td>Contradictory feelings regarding safety as a result of trauma</td>
</tr>
<tr>
<td></td>
<td>Psychological value of justice</td>
</tr>
<tr>
<td><strong>Changes in Self since Trauma</strong></td>
<td>Positive changes in self since trauma</td>
</tr>
<tr>
<td></td>
<td>Negative changes in self since trauma</td>
</tr>
<tr>
<td></td>
<td>Perceived permanent changes in self since trauma</td>
</tr>
<tr>
<td></td>
<td>Impact of trauma on self/identity</td>
</tr>
<tr>
<td></td>
<td>Negative changes to self/identity</td>
</tr>
<tr>
<td></td>
<td>Interpersonal difficulties as a result of trauma</td>
</tr>
<tr>
<td>Higher Order Codes</td>
<td>Lower Order Codes</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------</td>
</tr>
</tbody>
</table>
| Early Experiences  | Early positive experiences and beliefs as moderating factor in perception of trauma  
|                    | Early negative experiences and beliefs and impact on beliefs re trauma  
|                    | Previous trauma experiences  
|                    | Ability to cope/recover from previous trauma  
|                    | Underlying positive beliefs about self  
|                    | Experience of previous traumas and ability to overcome adversity  
| Support            | Support and perceived support from family/partner/friends  
|                    | Support and perceived support work colleagues  
|                    | Support and perceived support from agencies, e.g. NHS, voluntary groups  
| Beliefs            | Resilience and positive belief in ability to overcome trauma  
|                    | Loss of old self and reinventing/learning to live with New identify  
|                    | Coming to terms with trauma  
|                    | Experiencing adversity as 'part of life' not personal  
| Personality factors and coping Strategies | Psychological value of justice  
|                    | Experience of spirituality  
|                    | Underlying coping strategies to manage trauma  
|                    | Coping strategies - positive  
|                    | Coping strategies – negative  
|                    | Use of humour as a coping strategy/underlying personality trait |
Figure 3: Model of the Process of Recovery Following Trauma
The model developed from analysis of interviews indicates that underlying beliefs have an overarching impact on the recovery from trauma. It is suggested that underlying beliefs about the self, others and the world are on a continuum between positive and negative and have developed from childhood. Underlying beliefs have an influence on the impact of the trauma on the self and identity and the individual's ability for this impact to change over time. Furthermore, underlying beliefs impact on the influence of the social context and personality factors. There is a link between beliefs and therapy experiences, which impact on beliefs regarding the trauma. There is an interaction between personality factors, such as dispositional optimism, use of humour and spirituality, which influences the impact of the trauma on the self, underlying beliefs and also has an interaction with therapy experiences. The influence of the social context has an impact, whether positive or negative, on the trauma, therapy experiences and beliefs. From the model, it is suggested that when individuals have more positive underlying beliefs, influences on the social context and personality factors, alongside a positive experience of therapy, they are more likely to display greater tendency for recovery from traumatic experiences. Quotations from interviews carried out with participants highlight the main concepts identified.
2.4.2.1 Underlying Beliefs

All of the participants interviewed described an overarching attitude towards experiencing trauma and a belief that traumatic experiences are to be expected. One participant stated:

[Trauma's] are part and parcel of life... in my view they happen to people, you know, you are fortunate if you don't lose a sibling or your parents or anything like that, but it happens to us all at some point (P2; 10-12)

Another participant's acceptance that trauma was 'part of life' is illustrated as follows:

It's like when I was diagnosed with breast cancer... I never once said "oh, why me!" because I think, people do get things and I thought "oh well, why not me" (P1; 203-204)

Some of the participants believed that positive childhood experiences and role models had enabled them to manage the traumas that they had experienced in their lives. Participant one said:

... a lot of it goes back to my childhood and how my mother was. I think that has got a lot to do with it and how I am today... she must have been a strong person, she dealt with lots of things in her life and she was a very loving mother and I feel like I did have a good start in life (P1; 393-397)

Participants discussed their beliefs that they should have been able to manage the trauma they had been referred to the Service to deal
with as they had managed difficulties and traumas in the past. The reasons for these were sometimes cultural, as participant 5 states:

…and you just get on with it and forget about it...and let’s be honest...that’s what the British tend to (P5; 47-48)

They were also linked to personal beliefs, participant 2 said:

I never felt that I needed any form of counselling or anything like that you just pick up everything and get on with it... don’t you? (P2; 6-7)

Despite many participants appearing to accept that trauma was part of life and believing that early positive experience had been helpful in managing trauma, many participants commented that the trauma had altered their beliefs about themselves and the world in a negative way. One participant discussed how her beliefs regarding safety had changed and how she managed this:

Some days it has a very uncomfortable feeling, you know, there has been some noise outside or something happens in the early hours of the morning, you just sit there thinking well actually if somebody wants to come through the door they will so...you play like devil and angels as I call it, you have got one on one shoulder and one on the other and you are having this argument going on in your head and you rationalise it out in the end that actually this is really silly because nobody is going to come through the door so just go back to sleep, but of course you cant (P2; 81-88)
2.4.2.2 Impact of Trauma on Self/Identity

Analysis of the interviews demonstrated that participants’ sense of self was affected by their traumas. Participants described fundamental changes in their personality. For example, one participant commented on the changes he had recognised and how he was going to manage these:

...you are never going to be quite 100 percent the same person, but you compensate one way or the other (P5; 65-66)

After experiencing domestic violence one participant identified the differences between herself then and now:

...when I look back on it I can’t believe... It’s almost like it was a different time, strange... I feel like a different person now (P5; 50)

In particular, the trauma had impacted on participant’s ability to trust others. Despite this, participants were optimistic that these changes would not hinder them. Many participants commented on the deep impact and effect that the trauma had left on them. For example participant 2 told me:

The law of averages say that you will probably never, touch wood, its going to happen to you again, but you cant help but go through it. It’s like a primal fear and I don’t know where it comes from its like deep within you and I cannot deal with those lads with the hoodies and things, because the guys had balaclavas... (P2; 57-65)
Participants commented on changes within interpersonal relationships. One participant described difficulties with trust, a common effect of trauma. She described her relationship with her current partner:

…he is lovely, I think trusting [is difficult]…I’m not scared, physically, I am not scared, as we don’t argue. I think its more the emotional trust rather than physical. I don’t always believe what he is saying to me, you know. [with previous partner] it was such a lie all the time (P4; 70-74)

From analysis of the interviews, participants described themselves as more fearful since the trauma and also experiencing difficulties in everyday functioning. One participant described how she remained fearful of her ex-boyfriend assaulting her:

…yes it will never happen again, something bad may happen, but not that. At the moment he does know where I live, so you cant guarantee that, because he could flip off, but I don’t think he would…its not hard to break into my house, he could kick the door down and rip it apart (P4;250-254)

2.4.2.3 Changes over Time

All of the participants described how the trauma had significant effects on them, emotionally and otherwise, but were contradictory about whether these were ‘positive’ or ‘negative’ changes. Typically participants acknowledged having managed to overcome the trauma but at quite a profound cost and that they felt fundamentally changed. For example, participant 2 said:
It’s about your own make up and how you are. And I am still standing. It has made a difference in my life as I’m not so comfortable going out at night now and coming back to a house when it is empty (P2; 26-28)

Participants indicated that they had grown to be more aware of their own limitations and sought to minimise the risk to themselves in the future, for example.

... I am a lot more aware of having strangers in my house, you know if you have window cleaners in my house or being on your own…. now I will only use people that have been used by somebody that they know. Everybody now has to come recommended… I only had been in the house four weeks, we had only just moved in, so somebody followed me to see the car to come into this area and it is that thing again. You are much more aware of what you are doing in your life (P2; 69-80)

Despite some participants feeling that their safety had changed negatively over time, some participants commented that they felt safer:

Participant 5 discussed his feelings about working in a Prison:

...you see somebody at work and they will say “I know where you live, I know this I know that” and “I’ve got friends on the outside” and it doesn’t affect me remotely...I know they are locked up and they can’t do anything anyway. I used to sometimes mither about it, not worry, but I used to think, “oh you know that could happen, you never know”...now I just think, “oh sod it” (P5; 159-162)

The majority of participants identified that they had been able to make positive changes to their lives since the trauma. For example:
It's certainly given me a different perspective on life and I am doing far more things than I used to...I was more of a stay at home person...now oddly enough even though it happened when I was out, I tend to go out more (P5; 71-73)

2.4.2.4 Personality Factors

All of the participants cited that they used humour to cope with trauma and difficulties in life and described this as being integral to the recovery from their traumatic experiences. From analysis of the interviews it appeared that humour was well used by all the participants as a coping strategy. This is well described by participants 3 and 4 as follows:

I've got some good work friends and I have a laugh with them and a joke, just get by (Participant 3; 144)

I think I am a really positive person, I always look at things as positively as possible and I like to have a laugh...humour always helps... in any situation...we as a family we always end up laughing, when something goes wrong, because if you didn't, you would end up really angry (P4; 114-117)

Participants viewed themselves as optimistic, looking for positives when faced with negative or traumatic experiences. Some participants described themselves as resilient. Participants identified these personality characteristics as being integral to overcoming trauma. Participant 2 stated:
It’s probably my own resilience because you suddenly realise, its something that you would normally see in a TV programme or in a movie or something and this is something that happened to me in real life. And fortunately most of us don’t know how we are going to react in such circumstances, but you do hold it together... you can hold it together (P2; 22-28)

All participants discussed spirituality and religion and for some this had been a positive experience in recovery from trauma. One participant discussed how she felt that her spiritual beliefs had been helpful in overcoming trauma:

I do believe I am being looked after by God. I have always thought that throughout life, I still feel that now, because something worse could have happened, he did try to drag me back in the house...which, if he had done that, I don’t know what would have happened, but a neighbour came out, who is a Christian as well, and she came out and got me out of there and she actually came to Court as a witness. Whether it is a coincidence that she is a born again Christian, I don’t know, my mum and dad would say it isn’t...somebody is out there looking after me. It’s like a knowledge that somebody is there, and that is helpful (P4; 238-244)

2.4.2.5 Influence of the Social Context

Social Support

Analysis of the interviews indicated that participants felt that the support they received from family and friends in the aftermath of trauma was a moderating factor in recovery. One participant, after being assaulted by her partner stated:
I think for my children, particularly my parents have been great... especially after it just happened I needed [my mothers] help to put the children to bed, because physically I [could not do this]...she [my mother] helped me mentally because I started going out to exercise classes in the evening with my friend...and she would look after them while I was out (P4; 110-114)

Despite experiencing family support as positive, this participant found it difficult to fully disclose the domestic violence that she had experienced to her family. However, she found support in friends and said:

…I think for me emotional support from my friends was really helpful, my family were there for the girls, but my family struggled emotionally to come to terms with what had happened, so I didn’t want to burden them, when I saw them upset, I had to take a step back (P4; 233-235)

All the participants identified support from family and friends as integral in the recovery from trauma. As participant 5 told me:

…my sister has been great, I got bags of support from her. I got support from friends; I got bags of support from people I worked with and lots of support from the NHS (P5; 247-249)

One participant identified her role as a mother as important in recovering from trauma:

… having to carry on, my role as a mum, I just have to get on with it, I can’t wallow in it (P4; 226-227)
Gaining/Obtaining Justice

Analysis of the interviews indicated that there was a positive psychological value of justice and public recognition that participant’s had been a victim of a crime. Participants discussed mixed experiences on receiving justice following their trauma and how this had helped with recovery. Participant 2 said:

...well I am not a deeply religious person, but I felt very unchristian because I was quiet pleased they had got heavy sentences like that (P2;278)

However, participant 1 discussed mixed feelings towards receiving compensation and justice:

It was helpful in a way that I had got compensation, but I tell you what wasn’t. The fact that the person, the man who hit the carriage in the first place, this driver hit the carriage, then he drove off and went to the pub. Then we had to go to court, we all went to court and he never came, then it was deferred. Then the next thing was we had a letter saying they weren’t going to charge him because he said he had epilepsy, he said he had epilepsy so he never got charged and he gave up his car voluntarily for six months, and that way he got away with it Scott free (P1; 417-421)

Participant 2 discussed her desire to meet with the perpetrators of the house burglary and for them to gain an understanding of what she was subjected to:

I would quite happily meet them in prison or what have you, because they should know...I would like them to know what that feels like
because I don’t suppose that in their lives they have been in that situation...and that fear factor is awful (P2; 286-287)

2.4.2.6 Experiences of Therapy

All participants discussed their experiences of seeing a psychologist and found this helpful in overcoming their trauma. Participants found that therapy ‘normalised’ and validated their experiences of trauma and that this was very helpful in speeding the recovery process. One participant commented:

...I think properly sharing, with somebody that didn’t know me...for them then to turn around and say that it is ok, this is how you do feel or can feel it gives you permission, if you like, maybe that is what you are looking for...permission if you like to feel like that...because I didn’t know anyone else that it had happened to I couldn’t go okay this is how it happens to somebody else (P2; 240-244)

Participants commented on the helpfulness of literature they received from the psychologist on trauma symptoms and that this also had a ‘normalising’ and validating effect. Participant 2 stated:

I had two sessions and in between my first session and second session of course I had read that book. I walked into the second session and said I have cracked it! (P2; 205-206)

The participants reflected that a number of factors were salient in helping them overcome trauma:
I think I am quite a strong person and you know, my family and everything [was helpful]. When I read the information I felt that that helped me, I thought, oh yeah, you know this is quite normal (P1; 235-236).

Participants indicated that they felt that they would have been able to recover from their traumas without psychological input, due to their previous experiences of recovering from trauma. However they still credited this input as being helpful. Participant 1 stated:

I would have got there in the end, but possibly the issues would have still be there now (P1; 233)

Meeting with a psychologist appeared to enable participants to find new ways of coping with trauma, and this may have been a factor in increasing resilience; for example, participant 5 said

I don’t know whether this was the way I was supposed to do it with [the psychologist], but I use statistics, I use science, and I use logic rather than say, looking at the emotional side, saying, this might happen, that might happen. I now tend to look at the flip side of why it won’t happen (P5; 156-157)

Participants discussed their experiences of other services that they had accessed as a result of the trauma, for example, their General Practitioner and Victim Support. Participants described mixed experiences of other agencies and felt that other professionals had not
listened or understood their difficulties or been able to provide the specialist support that they had required.

2.5 Conclusions and Discussion

This study explored the unique perspectives of participants who had recovered from traumatic experiences. All participants had also had a psychological assessment and follow up appointment. There appeared to be a number of common factors that were salient in their recovery.

All the participants indicated that they had experienced a positive childhood and they felt that this grounding had been helpful in enabling them to overcome difficulties and trauma. This appears consistent with previous literature that identifies that good early childhood experiences, particularly parent-child relations, as a crucial antecedent to resilience in adulthood (Bonanno, 2002).

All of the participants described themselves as 'resilient' or attempting to reframe the trauma positively. Participants cited contextual factors, such as social support as being key in overcoming their trauma. This ties in with a wealth of previous findings where a link between social support and resilience has been identified (Hardy, Concato, & Gill, 2004; Scarpa, Haden, & Hurley, 2006; Werner & Smith, 1990).
Participants presented a number of underlying personality traits that may have played a mediating role in overcoming trauma. In particular, participants displayed a ‘dispositional optimism’, which is a stable, generalised expectancy or belief that one will experience good things in life and that future outcomes will be positive. This finding was also evidenced in the results from the CiOQ whereby the majority of participants endorsed more positive than negative statements regarding their outlook on experiencing adversity. There is evidence to suggest that there is an association between optimism and positive outcomes across a number of adverse conditions such as bereavement (Davis, Nolen-Hoeksama & Larson, 1998) and illnesses such as breast cancer (Carver et al., 1993). The literature indicates that optimists use more coping efforts, particularly problem-focused strategies. In a study of women survivors of breast cancer, investigators found that optimists took more active steps to do whatever there was to do (Carver et al., 1993). This seems consistent with how participants in this study had sought out a referral for a psychological assessment as well as support from other statutory agencies.

All of the participants spoke of positively reframing their experiences rather than focussing on negatives. This reframing may have helped individuals to integrate their experience into their worldview or see it in a more positive light (Collins, Taylor, & Skohan, 1990; Taylor, 1983). The participants in this study had undoubtedly experienced some negative effects from the traumas they had experienced. However, they displayed
an ability to shift attention between maladaptive to adaptive thought processes as well as a greater ability to deal with the emotional effects of their traumatic experiences.

Participants indicated that they had changed their self-perception following trauma, which has been previously noted in relevant literature (Aldwin et al., 1994). Participants indicated that they felt a sense of increased self-reliance since they had managed to survive a trauma. However, some participants expressed an increased sense of vulnerability and fear since experiencing trauma. Some of these changes in self-perception might reflect how assumptions that people hold can be shattered through trauma (Janoff-Bulman, 1992). Janoff-Bulman (1992) explained that the most common changes after trauma are to find the world more dangerous, unpredictable and for survivors to have developed a clear view of their own vulnerability.

Participants' perception of the self had also altered positively as a result of the trauma however, and it had enabled the emergence of new possibilities in life. For example one participant increased their social activities and one decided to work for Victim Support to help others who had experienced similar traumas.

Participants reported a change in life priorities since experiencing a trauma, for example spending more quality time with children and 'living for the moment'. This finding has been located within the literature with
greater meaning being found in intrinsically important priorities and less importance being attached to extrinsic properties (Salter & Stallard, 2004). Furthermore, research has indicated that even after torture during war women caring for their own children and orphans felt that this role helped the process of recovery (Liebling, 2004).

Humour was identified as a strategy that all the participants used when dealing with trauma. There is evidence within the current literature that humour is used as a way of managing distress (Liebling et al., 1997). Furthermore, the use of humour has also been positively associated with resilience from experiencing PTSD (Connor, 2006; Davidson, Payne, & Connor, 2005; Rutter, 1985).

Participants reported mixed views towards changes in spirituality or religion. Some participants cited their religious views as important in helping them come to terms with the trauma that they had experienced and that it was helpful in their recovery. Posttraumatic growth literature indicates that many individuals report significant growth and increased spirituality, however great loss and tragedy can lead others to lose faith and experience significant existential despair (Tedeschi & Calhoun, 2000).

Participants displayed conflicting feelings and thoughts towards the trauma they had experienced and the recovery and gains made since psychological assessment. Recent literature has attempted to explain
some of the conflicting study results regarding posttraumatic growth. Zoellner and Maercker (2006) relate growth to coping styles and propose and two component model. In this, the functional side is a self-transcending, constructive one, characterised by re-appraisal and active mastery, which elicits positive adaptation. The second side, they propose, is an illusory one, and is a less helpful cognitive avoidance strategy characterised by self-deception and distraction.

Previous literature has indicated that those who have an underlying internal locus of control are more likely to experience growth or recovery from trauma (e.g. Wollman & Felton, 1983), which this study’s results support. Participants’ scores on the CiOQ indicated that for the majority of participants, they perceived positive experiences emanating from trauma than negatives. This might suggest that underlying personality traits and optimism are linked with recovery or growth from trauma as indicated in salient literature (Linley & Joseph, 2004).

All the participants cited contextual factors as important in overcoming trauma. Social support was indicated as one of the key mediating factors in recovery. This backs up literature which has indicated that greater social support, access to more resources and people assists with development of greater resilience, even among populations facing severe adversity (Sargent, Thompson, & Warren, 2001). In addition, participants indicated that being able to disclose their trauma to others was helpful. A growing body of research has indicated
that individuals who are able to disclose in confidence to others are more resilient. Disclosure and receipt of social support may lead to resilience through a number of mechanisms. Helpful interactions with others provide opportunities to express feelings and concerns, which can help individuals to fully process traumatic events they have experienced. Social support can facilitate coping and reduce emotional distress. However, some participants indicated that support was not always helpful. An underlying assumption of the social support literature is that people need support in times of crisis and that any support is better than none (Lanza, Cameron, & Revenson, 1995). However, the efficacy of social support seems to depend on a number of contextual factors, including the timing of the support, the type of support and the source of the support (Cutrona, & Russel, 1990).

Most of the participants discussed gaining and obtaining justice and how this was important in their recovery from the trauma that they experienced. There is evidence within the existing literature that highlights that gaining public recognition for being a victim of a crime is helpful in overcoming adversity. Studies have indicating that survivors of war torture expressed the importance of campaigning for justice as assisting with recovery. (Liebling, 2004; Liebling-Kalifani, 2008; Liebling, Marshall, Ojiambo-Ochieng, & Nassozi, 2007).

Participants cited that one of the most helpful aspects in their recovery from trauma was attending an assessment with a psychologist.
All participants cited that this had been helpful as it had validated and normalised their experience of trauma. Participants indicated that they felt that they would have recovered from their trauma without the aid of the assessment, as they viewed themselves as resilient (Harvey 1996) however; participants felt that the recovery process was facilitated by this encounter.

2.5.1 Methodological Limitations

The findings of this study need to be considered in the context of a number of methodological limitations. The number of participants in the study was low, which is due partly due to the small number of participants who met criteria for the research focus. Furthermore, it is inherently difficult to recruit individuals for research purposes who have been discharged from mental health services. The motivations of those who agreed to participate in this research can also be questioned as it could be hypothesised that they are not representative of all individuals who have been discharged from the trauma service following assessment. As discussed earlier, the lead researcher's role as a trainee Clinical Psychologist working within the service may have positively influenced the interviews and the results obtained in this research. Although it is not the intention of qualitative research to produce generalisable results (Giles, 2002), it is acknowledged that the small sample size makes it difficult to generalise the results and the model developed. A strength of this study is that there was a mix of gender and ages in the participants
interviewed. Furthermore, the use of both self report questionnaires and in depth interviews have enriched the findings of this study. As the number of participants that took part in this study was low, further research with a greater number of participants may yield a more generalisable and valid results.

2.5.2 Implications for Clinical Practice and Future Research

The current study has highlighted the effects of recovery and growth on individuals who have experienced trauma and has raised a number of implications for clinical practice. Firstly, all the participants indicated that they had found the psychological assessment helpful in speeding the process of recovery. This indicates that brief intervention can have a positive and empowering effect on individuals who have experienced a trauma. However, previous research on brief intervention for trauma has received mixed reviews (see Bisson, 2001 for a review). Importantly, the participants in this study indicated that they had waited several months post-trauma before accessing a referral to Clinical Psychology. This indicates that the timing of psychological input should be considered when offering therapy to individuals who have experienced trauma.

Participants reported variable experiences of other services in the aftermath of trauma and expressed that they felt that the services that are put in place to help victims of crime are ill equipped to manage the psychological distress caused by trauma. Services need to consider the
long-term impact of trauma on an individual and it is suggested that this could be a training point for services that offer support to survivors of trauma. It may be helpful for greater communication to be put in place between statutory and voluntary agencies and for voluntary agencies to have a greater awareness of the services that are available for individuals who have experienced a trauma who may need more specialist help.

The current study highlights a number of areas that could benefit from further research. In terms of posttraumatic growth and therapy, it would be helpful for further research to provide a greater understanding of the role of therapy and the therapeutic characteristics in facilitating growth and whether an incorporation of growth perspectives would have an impact on this. As psychological assessment had a positive impact on recovery for the participants in this study, it would be helpful for this to be explored further, for example future research could look at the effects of more than four sessions of trauma focused therapy to ascertain the effects that this may have on growth.

Further research into the types of individuals who may be more resilient to trauma may be helpful in identifying clients who may respond better to a therapy approach that incorporates growth-related perspectives. Finally, this research has highlighted several factors that may have an influencing role in recovery from trauma. Further research into the effects of locus of control, cognitive processing, co-morbidity, gender differences, the psychological value of obtaining justice, previous
experience of trauma, spirituality and humour would facilitate the understanding of the factors that may effect recovery of individuals who experience trauma.
3.0 References


Chapter Three

Methodological Issues in Researching Trauma

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Paper Prepared for submission to Clinical Psychology Forum

(see Appendix A for notes to contributors)
3.1 Introduction

The aim of the paper is to explore and reflect upon my research journey. It covers reflections on carrying out research with women and men who had experienced trauma and will focus on the experiences and impact of using a qualitative methodology. Feminist research (see Oakley, 1981) has transformed the traditional interview method by advocating conscious partiality, a non-hierarchical relationship and an interactive research process. King (1996) has also highlighted a number of principals that are important to consider when carrying out qualitative research, including, self-reflexivity and emphasis on empowerment. These issues will be considered within this chapter. The ethical issues of carrying out research on a trauma population on the researcher and the researched will also be discussed.

3.2 Methodological Issues

The relationship between the researcher and the researched is integral to the success of the interview and subsequently the data obtained from this methodology. Oakley (1981) advocates adopting an interactive interviewing style, which aims to minimise the objectification of the participants. This stance views the interview as an exchange whereby the researcher and the participant engage in an interactive dialogue; the aim of which is to personalise the researcher and to equalise the power balance between the researcher and participant. I found achieving a
balance between how I would usually conduct myself in a clinical interview/therapy session and being a researcher with a different agenda a challenge. I was very grateful that participants had agreed to talk to me about their experiences and wanted to make them feel at ease, as I was aware that the subject they were coming to me to talk about was emotive. I also wanted to strike a balance where it didn't become over-friendly, thus, making it difficult to ask 'tough' questions. I was surprised at the change in my approach with the differing role, I was aware that I was less 'boundaried' with the research participants, compared to how I would be on meeting a client for therapy. I felt that this change was attributable to two reasons; firstly, I was indebted to the participants for going out of their way to speak to me. I wanted to create rapport with the participant, as I knew it would be my only chance to talk to them and secondly, I wanted them to feel comfortable and relaxed, and not regretting their decision to talk to me about their experiences. I felt that the 'tables had turned' on me within the research situation, and it was me as a researcher, that wanted help from the participants. This felt in contrast to a clinical situation, when the client is generally the person who is asking the psychologist for help.

As part of the research, I did want participants to feel as though they were getting 'something back' for offering their time and experiences to me. Patton (1990) refers to this as 'reciprocity'; that is, an emergence of an exchange relationship that renders the participant's cooperation and involvement worthwhile. As part of the research interview I offered
participants feedback on the measures that they had completed for me and I also fedback the changes over time in scores that they had completed when they came for assessment. All the participants seemed to find this information interesting, and reflected on the positive changes in themselves since seeing a psychologist. As part of this reciprocity, after one interview a participant asked me for some information about becoming a Clinical Psychologist as her niece was interested in it as a career. I was happy to offer this information to the participant with not much thought, I reflected that I may have been more reticent if it had been a therapy client who had asked me for this information on what the motivation for this might have been. Furthermore, after completing one interview and debriefing with a participant, he went on to ask me for 'my professional opinion' on some thoughts that he had been having recently which had been in conflict with his sexuality. Although I did not offer an interpretation, we were able to discuss the content of these and he was able to identify a number of reasons why he had such thoughts. He indicated that he had found it helpful to talk to me as 'it's just not the kind of thing that you want to start talking to your mates about...they will think I'm weird'. King, (1996), has indicated that 'participants are there to help the researcher, not vice versa'. Their reasons for participating may vary, but in the context of health research were characterised by Hutchinson and Wilson, (1994), as the desire or intention to achieve self-acknowledgement, self-awareness, catharsis, empowerment or a sense of purpose.
The concept of 'conscious partiality', (see Mies, 1983) stresses that partial identification with the participant based on personal interaction and the treatment of participants as subjects with real emotions and feelings is important when conducting interviews with participants. This involves the researcher assuming the role of empathic listener and neither exploiting nor manipulating the researched. This method challenges the assumption that scientists should approach their research with complete objectivity to become experts (Stanley & Wise, 1983). Mies' (1983) method places great value on the personal interaction and identification with the subject's experience. The interactive research process is empowering for both the researcher and the researched. Researchers are empowered because they are able to recognise how the research process affects them both as researchers and as women (Cook & Fonow, 1984). Research participants are empowered because they understand that their personal experiences are no longer raw material for the data mill but that they are actively involved in sharing their stories and evoking change (Bergen, 1993). The empowerment was reflected in many of the participants' accounts of why they had decided to take part in the research; they felt that they wanted to help others on the basis of their experiences.

I attempted to employ the values of conscious partiality while completing interviews with participants. I was aware that my position as a woman and as a Clinical Psychology Trainee currently on placement in the service that they had received an assessment in would impact on the
research, what participants disclosed to me and my interpretations of the interviews. I was aware of the similarities and differences between myself and the men and women that took part in the research. I had not experienced any of the traumas that the participants had experienced, however, their abilities to overcome difficulties and have strength in adversity resonated with me. I was also aware of the potential differing responses from both the men and women participants. On reflection, I felt that the women that I interviewed were much more able to open up and disclose information. I found one of my interviews with a male participant a challenge. I wondered whether the difficulties were due to gender differences. It has been suggested that when both the researcher and the researched are women, the commonalities of experience helps then to be able to share their ideals and experiences (Finch 1984; Oakley, 1981).

3.3 Ethical Issues Related to Researching Trauma

Due to the nature of the research topic, I wondered whether the participants would become distressed. I also considered how I would feel talking to participants who had experienced trauma and the effect that this may have on me. I carried out interviews with participants while I was on a specialist trauma placement within the service. The participants I saw within a clinical capacity had experienced single incident PTSD. I had been affected by the stories that my clients had told me and also at points overwhelmed by the impact that the trauma had on their lives and
the negative changes they had experienced as a result of their trauma. As a result of this, I wondered whether it would be difficult to hear so many stories from the participants, and even though the participants had been discharged from the service, I was reticent to believe that they would be feeling 'positive' as a result of their trauma. I read around the importance of carrying out ethical research on a sensitive topic (WHO, 2001; Liebling & Shah, 2002). I obtained informed consent from all the participants and ensured that appropriate support was available, if this was required.

I kept a reflective journal to record my thoughts before and after interviews with participants. While reviewing this, an occurring theme is how positive I felt after meeting the research participants. Participants described experiencing fear and helplessness at the time of the trauma and for some they were still experiencing ongoing difficulties. Despite this, they had managed to recover or thrive from the traumas that they had experienced. My feeling of positivity after meeting with the participants and hearing their stories was very different to meeting with my clients who were in therapy for PTSD symptoms.

Many authors have cited emotional distress as a potential risk for trauma survivors participating research (Draucker, 1999; DuMont & Stermac, 1996). DuMont and Stermac, (1996), indicate that it may not be sufficient to warn participants that they may potentially experience distress in response to the research in which they have volunteered for.
They suggest that trauma survivors are too fragile to endure the emotional distress of a research interview.

Despite these concerns, several empirical studies have systematically queried participants about their reactions to trauma research participation (Draucker, 1999; Walker et al., 1997). These studies have found that research participation does not re-traumatise individual and that benefits can be derived from participation even when some distress is experienced. Participants generally describe research participation as either a positive or sometimes neutral experience, which they would be willing to repeat. On reflection on the participants that were interviewed, I believe that they did not have a negative experience of the research process and all commented that they had found it helpful to discuss their experiences and hopeful that they would further understanding on trauma.

The impact of working with individuals who present with trauma related difficulties could have adverse consequences for the therapist. The term ‘vicarious trauma’ explains reactions of mental health professionals to long-term exposure to traumatic accounts by clients who have been victimised (McCann & Pearlman, 1990). A number of symptoms have been identified, including a disruption in cognitive schemas, which can cause long term changes to beliefs (Paivio, 1986), heightened emotionality, intrusive imagery, hypervigilance and avoidance (Way, van Deusen, Martin, Applegate, & Jandle, 2004). Working with
individuals who have experienced trauma can expose the therapist or researcher to these potential effects and a number of studies have highlighted the impact of vicarious trauma on the therapist (see Morrison, 2007). Despite the potential negative consequences on the therapist when working with people who present with trauma, it is important to consider the positive impact of working with and carrying out research with survivors of trauma.

Researchers and practitioners have highlighted the rewarding aspects of working with survivors of trauma (Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995). Some have even suggested that these positives outweigh the negatives, particularly if symptoms of vicarious trauma are mild (Brady, Guy, Poelstra, & Brokaw, 1999). Paradoxically, these rewards are integrally linked with some of the challenges of this work. A national survey of one thousand female psychotherapists in the United States found that therapists with a greater exposure to sexual trauma clients ranked high on levels of 'spiritual wellbeing'. It was found that the more the respondents were exposed to trauma material, the higher was their spiritual wellbeing. Practitioners who treated more abuse survivors reported a more existentially and spiritually satisfying life than those with less exposure to trauma clients (Brady et al., 1999).

While completing this research, I was concerned about the negative impact of hearing about participants' traumas. Despite hearing traumatic details from participants and empathising with their experiences, I was
surprised at how positive I felt, this was echoed in my research journal when after each interview I wrote about how invigorated and full of hope I felt that the participants had been able to overcome their difficulties. There was a real sense of positivity and on balance I felt that it was helpful to hear that within the traumatic experiences, the participants were able to take something positive from it.

3.4 Summary and Concluding Reflections

In summary, I carried out research in a sensitive area and tried to utilise reciprocity in order to equalise power relations whilst remaining aware of the value of subjectivity. In this way I hoped to make research an empowering experience for participants that had been previously disempowered by trauma.

As a woman and a Trainee Clinical Psychologist who had experience of working with traumatised individuals, I felt the research did help the participants, although initially I felt that the research was for my benefit and worried that the participants would find talking about their experiences difficult. This was not the case, and all the participants remarked that taking part in the research had been a positive experience.

It is important to emphasise that particular issues related to gender, and ethical considerations are observed when carrying out sensitive
research in this area. However, despite literature on vicarious trauma, I found the research process had a positive impact. This was a surprise to me as there is little research on the positive aspects of completing sensitive research. I believe that it is important for Clinical Psychologists to be aware of these issues and hope these positive reflections are helpful. Further research on the positive aspects of carrying out qualitative research on sensitive topics could look at this in more detail.
3.5 References


Morrison, Z. (2007). 'Feeling Heavy': Vicarious trauma and other issues facing those who work in the sexual assault field. *Australian Centre for the Study of Sexual Assault, 12, 4, 1-12.*


Appendices

Appendix A: Notes to Contributors
Instructions to Authors for Journal of Traumatic Stress

Instructions to Contributors

1. The Journal of Traumatic Stress accepts submission of manuscripts online at: http://mc.manuscriptcentral.com/jots

Information about how to create an account or submit a manuscript may be found online in the "Get Help Now" menu. Personal assistance also is available by calling 434-817-2040, x167.

Please note: This journal does not accept Microsoft WORD 2007 documents at this time. Please use WORD’s “Save As” option to save your document as an older (.doc) file type.

2. Three paper formats are accepted. All word counts should include references, tables, and figures. Regular articles (no longer than 6,000 words) are theoretical articles, full research studies, and reviews. Purely descriptive articles are rarely accepted. In special circumstances, the editors will consider longer manuscripts (up to 7,500 words) that describe complex studies. Authors are requested to seek special consideration prior to submitting manuscripts longer than 6,000 words. Brief reports (2,500 words) are for pilot studies or uncontrolled trials of an intervention, case studies that cover a new area, preliminary data on a new problem or population, condensed findings from a study that does not merit a full article, or methodologically oriented papers that replicate findings in new populations or report preliminary data on new instruments. Commentaries (1,000 words or less) cover responses to previously published articles or, occasionally, essays on a professional or scientific topic of general interest. Response commentaries, submitted no later than 8 weeks after the original article is published (12 weeks if outside the U.S.), must be content-directed and use tactful language. The original author is given the opportunity to respond to accepted commentaries.

3. The Journal follows the style recommendations of the 2001 Publication Manual of the American Psychological Association (APA; Fifth Edition), with exceptions indicated below. Contributors should refer to this publication when preparing a manuscript for submission. Manuscripts should use non-sexist language. Type double-spaced on one side of 8.5 X 11 inch or A4 white paper using 1-inch margins on all sides and a font no smaller than 12-point.

4. The Journal uses a policy of unmasked review. Author identities are known to reviewers; reviewer identities are not known to authors or other reviewers. During the submission process, authors may request that specific individuals not be selected as reviewers; the names of preferred reviewers also may be provided. Authors may request blind review by contacting jots@dartmouth.edu prior to submission in order to provide justification and obtain further instructions.
5. The title page should include the title of the article, author’s name (no degrees), author’s affiliation, acknowledgments, and suggested running head. The affiliation should comprise the department, institution (usually university or company), city and state (or nation) and should be typed as a footnote to the author’s name. The suggested running head should be less than 80 characters (including spaces) and should comprise the article title or an abbreviated version thereof. Also include the word count, the complete mailing address, telephone and fax numbers, and e-mail address for the corresponding author during the review process, and, if different, a name and address to appear in the article footnotes for correspondence after publication.

6. An abstract is to be provided, no longer than 120 words.

7. Reports of randomized clinical trials should include a flow diagram and a completed CONSORT checklist (available at http://consort-statement.org/Downloads/download.htm). The checklist should be designated as a "Supplementary file not for review" during the online submission process. As of 2007, the Journal of Traumatic Stress now follows CONSORT Guidelines for the reporting of randomized clinical trials. Please visit http://consort-statement.org for information about the consort standards and to download necessary forms.

8. Format references in APA style and list them alphabetically at the end of the text. Refer to them in the text by name and year in parentheses. In the text, all authors’ names must be given for the first citation (unless six or more authors), while the first author’s name, followed by et al., should be used in subsequent citations.

   **Journal Article**

   **Book**

   **Book Chapter**

9. Tables and figures should be formatted in APA style. Count each full-page table or figure as 200 words and each half-page table or figure as 100 words. Tables should be numbered (with Arabic numerals) and referred to by number in the text. Each table should be typed on a separate page. Only black and white tables and figures will be accepted (no color). Figures should be in Word, TIFF, or EPS format.
10. Footnotes should be avoided. When their use is absolutely necessary, footnotes should be formatted in APA style.

11. Submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere. A statement transferring copyright from the authors (or their employers, if they hold the copyright) to the International Society for Traumatic Stress Studies will be required before the manuscript can be accepted for publication. The Editor will supply the necessary forms for this transfer. Such a written transfer of copyright, which previously was assumed to be implicit in the act of submitting a manuscript, is necessary under the U.S. Copyright Law in order for the publisher to carry through the dissemination of research results and reviews as widely and effectively as possible.

12. The journal makes no page charges. Reprints are available to authors, and order forms with the current price schedule are sent with proofs.

Permission requests and other permission inquiries should be addressed to the Permissions Department, c/o John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030-5774.; Tel. 201-748-6011; http://www.wiley.com/pugwash.lib.warwick.ac.uk:80/go/permissions.
Notes for Contributors

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be
confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

4. Online submission process

1) All manuscripts must be submitted online at http://paptrap.edmgr.com.

   **First-time users:** Click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).

   **Registered users:** Click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.

2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:
   - Title page consisting of manuscript title, authors' full names and affiliations, name and address for corresponding author.
   - Abstract
   - Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors - Editorial Manager - Tutorial for Authors

Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives,
Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions.

For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.

In normal circumstances, effect size should be incorporated.

Authors are requested to avoid the use of sexist language.

Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc. for which they do not own copyright.


6. Brief reports

These should be limited to 1000 words and may include research studies and theoretical, critical or review comments whose essential contribution can be made briefly. A summary of not more than 50 words should be provided.

7. Publication ethics

Code of Conduct - Code of Conduct, Ethical Principles and Guidelines
Principles of Publishing - Principles of Publishing

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

10. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be
assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

11. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs
- Tables, figures, captions placed at the end of the article or attached as separate files
Instructions to Authors for Clinical Psychology Forum

Guidelines for Contributors

Clinical Psychology Forum (CPF) is the official monthly publication of the Division of Clinical Psychology of the British Psychological Society. Its aims are to provide a platform for the publication of members’ views, opinions and comments around the profession of clinical psychology within the UK and to update the membership via the dissemination of articles and commissioned pieces reflecting current and future good practice within clinical psychology. As well as reflecting the diverse and individual views of the Division’s membership, CPF will also publish regular updates about DCP policy and business in order to inform its membership.

CPF welcomes contributions which are original, innovative and of interest to the membership of the Division. We aim to publish a variety of contributions ranging from personal reflections on clinical practice to critiques of current health policy, innovations in service development and audit and research studies. We also publish correspondence either regarding articles published within CPF or around issues of general interest to the membership.

Articles submitted to CPF will be sent to members of the editorial collective for refereeing. Reviewers will assess each contribution in relation to the manuscript’s clarity and economy of expression, its critical and analytic stance, whether its original or innovative and, where appropriate, that methods and results are well described, methodological sound and any conclusions drawn are valid. Overall, articles must be relevant and of interest to the profession. The reviewer shall then communicate directly with the authors.

Articles of 1000-2500 words including references are welcomed. If you feel an article longer than 2,500 words is justified please contact Graham Turpin to discuss it. Please e-mail one electronic copy and post one hard copy of your contribution (details below). Please ensure that your contact details, current employer and job role are included in case the editors need to contact you.

When sending copy, make sure it is double spaced, in a reasonably sized font (no less that 11 point) and that all pages are numbered.

Give a 40-word summary (maximum) at the beginning of the paper.

Include the first names of all authors and give their affiliations, and remember to give a full postal address for correspondence.

Contributors are asked to use language which is respectful and psychologically descriptive rather than medical, and to avoid using devaluing terminology; i.e. avoid clustering terminology like ‘the elderly’ or medical jargon like ‘patients’. In addition, language should conform to the Society’s guidelines on non-sexist or discriminatory terminology. We acknowledge that language is context specific and that occasionally authors may wish to justify the use of particular terms.
commonly adopted within specific contexts. Please include any such qualifications within an accompanying footnote.

We reserve the right to shorten, amend and hold back copy if needed.

Include a word count at the end (including references).

Spell out all acronyms the first time they appear.

Give references in the format set out in the Society Style Guide. This can be found on the Society's website. If a reference is cited in the text, please make sure it is in the list at the end.

Do not include tables and figures unless they are essential and save space or add to the article. All figures should be in black and white.

Ask readers to request a copy of your questionnaire from you rather than include the whole of it in the article.

Please e-mail one copy of your completed article to Jackie Munks and also post one to her:

Jackie Munks
CPF Administrator
Professional Education Building
Rampton Hospital
Retford
Nottinghamshire DN22 0PD
Appendix B: Copies of Measures, including scoring and psychometric properties
## The Impact of Event Scale

Below is a list of comments made by people after stressful life events. Using the following scale, please indicate (with a tick) how often each of these comments were true for you **DURING THE PAST SEVEN DAYS**.

<table>
<thead>
<tr>
<th>Comment</th>
<th>Not at all</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>I thought about it when I didn’t meant to</td>
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<tr>
<td>I avoided letting myself get upset when I thought about it or was</td>
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<tr>
<td>reminded of it</td>
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<tr>
<td>I tried to remove it from memory</td>
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<tr>
<td>I had trouble falling asleep or staying asleep because of pictures</td>
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<tr>
<td>or thoughts about it that came into my mind</td>
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<tr>
<td>I had waves of strong feelings about it</td>
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<tr>
<td>I had dreams about it</td>
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<tr>
<td>I stayed away from reminders of it</td>
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<tr>
<td>I felt as if it hadn’t happened or wasn’t real</td>
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<tr>
<td>I tried not to talk about it</td>
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<tr>
<td>Pictures about it popped into my mind</td>
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<tr>
<td>Other things <strong>kept making me think about it</strong></td>
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<tr>
<td>I was aware that I still had a lot of feelings about it, but I didn’t deal</td>
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<tr>
<td>with them</td>
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<td></td>
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<tr>
<td>I tried not to think about it</td>
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</tr>
<tr>
<td>Any reminder brought back feelings about it</td>
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<td></td>
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<tr>
<td>My feelings about it were kind of numb</td>
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</tbody>
</table>

Each of the following statements has been made at some time by survivors of disaster. Please read each one and indicate, by circling the number in the appropriate box, how much you agree or disagree with it **AT THE PRESENT TIME:**

1 = Strongly disagree, 2 = Disagree, 3 = Disagree a little, 4 = Agree a little, 5 = Agree, 6 = Strongly agree.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Disagree a little</th>
<th>Agree a little</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I don't look forward to the future anymore.</td>
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<tr>
<td>2. My life has no meaning anymore.</td>
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<tr>
<td>3. I no longer feel able to cope with things.</td>
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<tr>
<td>4. I don't take life for granted anymore.</td>
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<tr>
<td>5. I value my relationships much more now.</td>
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<tr>
<td>6. I feel more experienced about life now.</td>
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</tr>
<tr>
<td>7. I don't worry about death at all anymore.</td>
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<tr>
<td>8. I live everyday to the full now.</td>
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<tr>
<td>9. I fear death very much now.</td>
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<tr>
<td>10. I look upon each day as a bonus.</td>
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<tr>
<td>11. I feel as if something bad is just waiting around the corner to happen.</td>
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<tr>
<td>12. I'm a more understanding and tolerant person now.</td>
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<tr>
<td>13. I have greater faith in human nature now.</td>
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<tr>
<td>14. I no longer take people or things for granted.</td>
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<tr>
<td>15. I desperately wish I could turn the clock back to before it happened.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Disagree a little</td>
<td>Agree a little</td>
<td>Agree</td>
</tr>
<tr>
<td>---</td>
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<tr>
<td>16.</td>
<td>I sometimes think it’s not worth being a good person.</td>
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<tr>
<td>17.</td>
<td>I have very little trust in other people now</td>
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<tr>
<td>18.</td>
<td>I feel very much as if I am in limbo.</td>
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<tr>
<td>19.</td>
<td>I have very little trust in myself now.</td>
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<tr>
<td>20.</td>
<td>I feel harder towards other people.</td>
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<tr>
<td>21.</td>
<td>I am less tolerant of others now</td>
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<td></td>
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<tr>
<td>22.</td>
<td>I am much less able to communicate with other people</td>
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<tr>
<td>23.</td>
<td>I value other people more now</td>
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<td></td>
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<tr>
<td>24.</td>
<td>I am more determined to succeed in life now.</td>
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<tr>
<td>25.</td>
<td>Nothing makes me happy anymore</td>
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<tr>
<td>26.</td>
<td>I feel as if I’m dead from the neck downwards</td>
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</tbody>
</table>

Rotter's Locus of Control Scale

For each question, indicate which statement you most agree with, by placing a tick next to it.

1. a. Children get into trouble because their parents punish them too much.  
   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.  
   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.  
   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run people get the respect they deserve in this world.  
   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students is nonsense.  
   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. a. Without the right breaks, one cannot be an effective leader.  
   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. a. No matter how hard you try, some people just don't like you.  
   b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays the major role in determining one's personality.  
   b. It is one's experiences in life which determine what they're like.

9. a. I have often found that what is going to happen will happen.  
   b. Trusting fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student there is rarely, if ever, such a thing as an unfair test.  
    b. Many times, exam questions tend to be so unrelated to course work that studying in really useless.
11. a. Becoming a success is a matter of hard work. luck has little or nothing to do with it.
b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.
b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.
b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.
b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.
b. Many times we might just as well decide what to do by flipping a coin.

16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
b. Getting people to do the right thing depends upon ability - luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.
b. By taking an active part in political and social affairs the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
b. There really is no such thing as "luck."

19. a. One should always be willing to admit mistakes.
b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.
b. How many friends you have depends upon how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.
b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
22. a. With enough effort we can wipe out political corruption.
b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.
b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.
b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.
b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.
b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too much emphasis on athletics in high school.
b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.
b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.
b. In the long run the people are responsible for bad government on a national as well as on a local level.

Scoring for Psychometric Measures

**Impact of Events Scale**

Score

0 = Not at all
1 = Rarely
2 = Sometimes
3 = Often

**Changes in Outlook Scale (CIOQ)**

Score

1 = Strongly Disagree
2 = Disagree
3 = Disagree a little
4 = Agree a little
5 = Agree
6 = Strongly agree

**Rotter’s Locus of Control Scale**

Score:

1 point for each of following responses:

2a, 3b, 4b, 5b, 6a, 7a, 9a, 10b, 11b, 12b, 13b, 15b, 16a, 17a, 18a, 20a, 21a, 22b, 23a, 25a, 26b, 28b, 29a.
Psychometric Properties

The Impact of Events Scale (IES; Horowitz, Wilner, Alvarez, 1979).
Is a well-standardised 15 item self-report measure of the frequency of intrusions (7 items), and avoidance (8 items) following a traumatic event. The IES is scored using a 4-point likert scale (0 = not at all; 1 = rarely; 3 = Sometimes; 5 = Often), recording how often the statements were true for the participant during the past week. Higher scores indicate greater levels of intrusion and avoidance. The IES is one of the most extensively used instruments in trauma research, and has good psychometric properties (Joseph 2000).

The Changes in Outlook Questionnaire. (CiOQ; Joseph, Williams and Yule, 1993), is a 26 item self-report measure designed to assess positive and negative changes in the aftermath of adversity. Items are scored using a 6-point Likert scale. (1 = strongly disagree; 6= strongly agree). The CiOQ has two subscales: Positive changes (11 items; e.g., "I feel more experienced about life now," "I value other people more now"), with a range of 11 to 66; and Negative changes (15 items; e.g., "I no longer feel able to cope with things," "I have very little trust in myself now"), with a range of 15 to 90. The CiOQ has good psychometric properties, with a recent review supporting the factor structure, internal consistency reliability and validity of the measure (Joseph et al 2005).
Internal-External Locus of Control Scale (I-E Scale; Rotter, 1966). This is a forced choice, self-report measure with 23 items designed to evaluate generalised expectancies about how reinforcement is controlled (i.e. externally or internally). In addition, there are six filler items randomly interspersed throughout the assessment intended to make its purpose more ambiguous. The score on the I-E Scale is the total number of external choices selected. Initial assessments of the psychometric properties of the I-E Scale were completed with undergraduate psychology students. Rotter (1966) reported high internal consistency for females ($r = 0.79$) and high test-retest reliability for females one month following initial administration ($r = 0.83$). Since its publication the I-E Scale has been used extensively and in particular has been used in trauma research (Noon, 1995; Bolstad & Zinbarg, 1997; Porter & Long, 1999).
Appendix C: Interview Schedule
Interview Schedule

Opening questions:

Tell me about yourself and current situation

Prompts
- current job
- Family

1) Tell me about traumatic experiences that you have had.
   - number of experiences
   - type of trauma
   - when they happened
   - What happened? Psychological/physical/social/financial implications
   - were you able to tell anyone about this
   - did you receive any therapy for previous trauma?

Do you think what you went through has been helpful in anyway?
   - has anything positive come out of the experience
     - could you describe in what ways it has been helpful?
   - has the traumatic experience changed your life?
     thoughts
     relationships
     world view
     understanding/empowerment

Do you feel your experience has enabled you to control/make decisions about your life?

Do you believe that you had the ability to overcome your trauma? Why/how?

2) Tell me about when you came for your meeting with the psychologist

When you met, what experience did you have?
   - focus on Stratford experience specifically
   - was it helpful/unhelpful
   - anything else?
   - did you know what type of treatment you were going to have (eg CBT)
   - did you know when it was going to end

3) Do you think you would have recovered from your traumatic experience without meeting a psychologist?
Why were you discharged after X sessions?

After you were discharged, why have you not needed to come back to the service?

- Have you received support from somewhere else?
- Did you seek any other treatment to help you, apart from psychological?

4) What other factors in your life have been important in dealing with the traumatic experience you have had?

- social support (effect of trauma on relationships)
- practical support
- legal
- emotional
- work
- family
- spiritual/religious

How have the above been important?

4) Is there anyway in which the service could be improved?

- What else might have been helpful?

Do you think there is anyway in which services, in general, for people who have had traumatic experiences could be improved?

5) Is there anything else that we haven’t discussed that you wanted to say to me?

Thank you for taking part
Appendix D: Invitation letter, participant information sheets and consent forms
Dear ( ),

I hope you don’t mind my bothering you. You may remember that you were referred by (GP/referrer) in (date) to be assessed for psychological therapy in relation to a trauma you experienced. I am writing to offer you an opportunity to take part in a research project. A Trainee Clinical Psychologist who is supervised by me is carrying out a piece of research as part of her Doctoral Thesis. The research will focus on individuals’ experiences after receiving brief intervention for trauma.

Little is known about this topic. This research could help improve the understanding of individuals who experience trauma and the treatment that they receive. As a result, I would be extremely appreciative if you could participate in this research.

I have enclosed a participant information sheet, which gives an explanation of the research. If after reading this information you feel that you would like to take part, then please complete the proforma, (within two weeks) indicating that you would be interested and return to Kate Herbert. If you decide that you would like to take part, Kate will contact you again by letter and will include a consent form and questionnaires that she would like you to complete as part of the study.

If you have any questions, then please feel free to contact me on 01789 415440 or Kate Herbert 02476 888328.

Thank you for taking the time to read this letter.

Yours Sincerely,

Dr Dan Barnard
Chartered Principal Clinical Psychologist
Part 1:

Participant Information Sheet

Study Title: Posttraumatic growth after brief intervention for trauma: An exploratory study.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Please feel free to contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

1. What is the purpose of this study?

After experiencing a trauma, many individuals seek psychological treatment to help them overcome or make better sense of this experience. However, after a few sessions, some individuals decide that they no longer require any more treatment. Relatively little research has been carried out on why some individuals recover from a traumatic experience with minimal psychological input. It has been suggested that people who have a more positive attitude towards adversity may require less psychological input. The aim of this study is to explore the reasons why you decided that you no longer required psychological treatment.

2. Why have I been invited?

Individuals who have experienced a trauma, have received psychological treatment for this and have been discharged from the psychology service are being asked if they would like to participate in the study.

3. Do I have to take part?

It is up to you whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form, to show that you have agreed to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason.
4. What will happen to me if I agree to take part?

If you agree to take part, there are two parts to the study. The first part will involve me posting you several questionnaires to complete. Some of the questionnaires may be similar to some that you completed at the beginning and end of your treatment. This should take no longer than 20 minutes to complete. I will also include a consent form for you to initial and sign.

As part of the study, I would like to access relevant parts of your notes. The reason for this is so I can access your previous results on the questionnaires that you completed before and after you received treatment. It is entirely up to you to decide whether you want me to have access to your file. There is a section on the consent form for you to initial if you agree.

I will provide you with a pre-paid envelope to post the questionnaires and consent form back to me. I will also ask you if you would like to take part in an interview to talk further about your experiences, it is entirely up to you to decide if you want to take part in this part of the study.

For the second part of the study, if you decide that you do want to take part in an interview, I will arrange a one-hour meeting with you to talk to me about your experiences. This would be at Stratford Health Care Centre. During our meeting I will not ask you to go into detail about the traumatic experience, but instead about how you dealt with it. I will also ask you about your experiences of therapy why you have not needed to come back for further treatment. If you consent, I would like to audiotape the interview. The audiotapes will be stored in a secure place following the appointment and will be anonymous.

If you decide to complete the interview, you will be given a further patient information sheet, which will provide more information on what will happen if you take part in the interview.

5. Will I be paid for taking part?

There will be no payment for taking part, however, all postage costs will be covered. If you attend the interview part of the study, then reimbursement of car parking expenses are available.

6. What will I have to do?

If you agree to take part in the study, you will be asked to complete several questionnaires and post these back to the researcher. If you decide to also take part in an interview to talk further about your experiences, you will attend one interview with the researcher.

7. What are the disadvantages and risks of taking part?

It is not anticipated that there will be any major disadvantages to you if you decide to take part in the study. Completing the questionnaires or attending the interview in which you talk further about your experiences could be distressing for some people.
8. What are the possible benefits of taking part?

Although there are no immediate benefits to taking part, it is hoped that the information gained will help develop our understanding of how individuals cope with traumatic experiences and this in turn could provide more effective treatments.

9. What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in part 2.

PART 2:

10. What will happen if I don’t want to carry on with the study?

If you decide that you do not want to carry on with the study for any reason, then any information that you have already provided as part of the research will not be included as part of the study.

11. What if there is a problem?

If you have a concern about any aspect of this study, you can speak to the researcher who will do her best to answer your questions, who is contactable on: 02476 888328. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details of this can be obtained from the Stratford Health Care Centre.

12. Will my taking part in the study be kept confidential?

All information that is collected about you during the course of the research, for example questionnaires and an audiotape of the interview (if applicable) will be anonymised, stored as a code and kept in a secure location. The data collected will be used for this study only and the researcher and her supervisors to the study will be the only individuals who have access to the data. After the research is completed, Coventry University will be the custodians of the data, who will keep this in a secure location and dispose of the data securely in line with the guidelines set out by the Data Protection Act 1998.

13. Will my General Practitioner/Family doctor (GP) be informed?

If you decide to take part in the research by completing the questionnaires, I would like to inform your GP. This would involve me sending them a letter briefly outlining the nature of the research and what you would be expected to do. The decision to inform your GP is entirely up to you and you would need to provide your consent if you are happy for your GP to be informed.
14. What will happen to the results of the study?

The results will be included in a thesis that will be submitted as part of my Clinical Psychology Doctorate. It is also hoped that the results will be written into a paper and submitted to a Clinical Psychology Journal for publication. You will not be identified in any publication. You will be offered an opportunity to receive a brief report on the findings of the study.

15. Who is organising and funding the research?

Coventry University are organising and funding the research project as part of the Doctorate in Clinical Psychology

16. Who has reviewed the study?

All research in the NHS is looked at by the Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Warwickshire Research Ethics Committee.

17. Who can I contact for further information?

If you would like more information of any aspect of the study, then please do not hesitate to contact me by telephone on 02476 888328. Please leave a message and your telephone number, and I will call you back as soon as possible. If you would like to seek independent advice about the research project, this can also be accessed through Coventry University on the above telephone number.

Kate Herbert
Trainee Clinical Psychologist
Coventry & Warwick University

Supervised by:
Dr Dan Barnard
Dr Helen Liebling- Kalifani
**Exploration of posttraumatic growth following brief intervention for trauma**

Please complete the following questions. All information provided will remain confidential.

Thank you for your cooperation

**Demographic information**

Age..............................

Gender (please circle) Male Female

Please describe your ethnic group........................................................................................................

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

Please describe your Religion (if any) ..................................................................................................

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

Profession.................................................................................................................................

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

When did you receive treatment for your traumatic experience at Strafford Mental Healthcare Centre?

1) Date to .................... From ..............

How many sessions did you attend?

1) ..............

Have you received any psychological treatment prior to or since you received treatment for your traumatic experience at Stratford Mental Healthcare Centre? Please describe briefly below

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

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

Thank you for taking time to complete this questionnaire.
CONSENT FORM

Title of Project: Exploration of posttraumatic growth after brief intervention for trauma

Name of Researcher: Kate Herbert

Please initial box

1. I confirm that I have read and understood the information sheet dated June 2007 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected

3. I agree to my GP being informed of my participation in the study

4. I agree that relevant sections of my psychology notes (i.e. previously completed questionnaires) may be accessed by the researcher. I give permission for the researcher to have access to my records.

5. I agree that information submitted to the Chief Investigator may be looked at by responsible individuals within the research team. I give permission for these individuals to have access to this information.

6. I agree to take part in the above study

If you wish to withdraw your participation after taking part in the study, please telephone 02476 887782 quoting your Participant Identification Number (top of this form)

_________________________  __________________________  __________________________
Name of participant                  Date                        Signature

_________________________  __________________________  __________________________
Name of Researcher                  Date                        Signature

Copies: 1 for participant, 1 for researcher
Dear ( ),

Thank you for agreeing to take part in my research project looking at people's experiences after brief psychological work received following a trauma. I have enclosed again the participant information sheet that gives an explanation of the research. If you are still happy to participate, I have enclosed a consent form, which I would like you to read through and put your initials against the points that you give consent to. I would also appreciate it if you could sign and date the form in the space provided. I have enclosed a pack of questionnaires and a demographic sheet for you to complete and return to me in the envelope provided.

As part of this study, I would like to offer you an opportunity to take part in a one hour interview to talk further about how you dealt with your experience, how you found therapy and why you have not needed to come back for further treatment. If you decide that you would like to take part in the interview, please indicate this on the pro-forma provided. Please post this back to me (in the enveloped provided) with your completed consent form and questionnaires. I will contact you at a later date to arrange a convenient time for the interview to take place.

If you have any questions or queries regarding completing the questionnaire, or any part of the study then please feel free to contact me or Dr Dan Barnard on 01789 417440.

Thank you for taking time to read this letter.

Yours Sincerely,

Kate Herbert
Clinical Psychologist in Training

Under the supervision of:

Dr Dan Barnard
Dr Helen Leibling-Kalifani
Participant Information Sheet

For participants taking part in a one hour interview

You have kindly agreed to complete some questionnaires, which are part of a research study titled: 'Posttraumatic Growth after Brief Intervention for Trauma: An exploratory Study'. The second part of this research is a one hour interview.

1. What will happen to me if I agree to take part?

If you decide that you do want to take part in an interview, I will arrange a one-hour meeting with you to talk to me about your experiences. This would be at Stratford Health Care Centre. During our meeting I will not ask you to go into detail about the traumatic experience, but instead about how you dealt with it. I will also ask you about your experiences of therapy why you have not needed to come back for further treatment.

I would like to audiotape the interview, as this will make it easier to remember what you have told me during our meeting. It is up to you to decide whether you would allow me to do this. At the interview, I will ask you to sign a consent form if you agree to take part in the interview and will ask you to indicate on the consent form whether you agree to have your interview audio taped.

2. Will I be paid for taking part?

There will be no payment for taking part, however, all postage costs will be covered. If you attend the interview part of the study, then reimbursement of car parking expenses are available.

3. What will I have to do?

If you agree to take part in the interview to talk further about your experiences, you will attend one interview with the researcher at Stratford Health care centre, you will also be asked to sign a consent form to show you have agreed to take part.

4. What are the disadvantages and risks of taking part?

It is not anticipated that there will be any major disadvantages to you if you decide to take part in the study. Attending the interview in which you talk further about your experiences could be distressing for some people.
5. What are the possible benefits of taking part?

Although there are no immediate benefits to taking part, it is hoped that the information gained will help develop our understanding of how individuals cope with traumatic experiences and this in turn could provide more effective treatments.

6. What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you can speak to the researcher who will do her best to answer your questions, who is contactable on: 02476 888328. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details of this can be obtained from the Stratford Health Care Centre.

7. Will my taking part in the study be kept confidential?

All information that is collected about you during the course of the research, for example questionnaires and an audiotape of the interview (if applicable) will be anonymised, stored as a code and kept in a secure location. The data collected will be used for this study only and the researcher and her supervisors to the study will be the only individuals who have access to the data. After the research is completed, Coventry University will be the custodians of the data, who will keep this in a secure location and dispose of the data securely in line with the guidelines set out by the Data Protection Act 1998.

8. Will my General Practitioner/Family doctor (GP) be informed?

If you decide to take part in the interview, I would like to inform your GP. This would involve me sending them a letter briefly outlining the nature of the research and what you would be expected to do. The decision to inform your GP is entirely up to you and you would need to provide your consent if you are happy for your GP to be informed.

9. What will happen to the results of the study?

The results will be included in a thesis that will be submitted as part of my Clinical Psychology Doctorate. It is also hoped that the results will be written into a paper and submitted to a Clinical Psychology Journal for publication. You will not be identified in any publication. You will be offered an opportunity to receive a brief report on the findings of the study.

10. Who is organising and funding the research?

Coventry University are organising and funding the research project as part of the Doctorate in Clinical Psychology.
11. **Who has reviewed the study?**

All research in the NHS is looked at by the Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Warwickshire Research Ethics Committee.

12. **Who can I contact for further information?**

If you would like more information of any aspect of the study, then please do not hesitate to contact me by telephone on 02476 888328. Please leave a message and your telephone number, and I will call you back as soon as possible. If you would like to seek independent advice about the research project, this can also be accessed through Coventry University on the above telephone number.

Kate Herbert  
Trainee Clinical Psychologist  
Coventry & Warwick University  

Supervised by:  
Dr Dan Barnard  
Dr Helen Liebling-Kalifani
CONSENT FORM

Title of Project: Exploration of posttraumatic growth after brief intervention for trauma

Name of Researcher: Kate Herbert

1. I confirm that I have read and understood the information sheet dated June 2007 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected

3. I agree to my GP being informed of my participation in the study

4. I agree that information submitted to the chief investigator may be looked at by responsible individuals within the research team. I give permission for these individuals to have access to this information.

5. I agree that my interview can be audio taped by the researcher

6. I agree to take part in the above study

If you wish to withdraw your participation after taking part in the study, please telephone 02476 887782 quoting your Participant Identification Number (top of this form).

________________________________________________________________________
Name of participant                      Date                      Signature

________________________________________________________________________
Name of Researcher                       Date                      Signature

Copies: 1 for participant, 1 for researcher
Appendix E: Example interview transcript
Participant 2 - Interview Transcript

Interviewer (I): Thank you for filling in the demographic form, in that you said you hadn’t received any previous therapy for trauma, I was wondering if you had experienced any previous traumas in your life?

Participant (P): Yes I had a divorce and I had my brother die just before I was 21 and he was only 17 and those are probably two major events in my life... that's part and parcel of life and you deal with it, so I never felt that I needed any form of counselling or anything like that you just pick up everything and get on with it., so you?

I: so they felt like they were traumatic events but actually..

P: But they are part and parcel of life... in my view they happen to people you know you are fortunate if you don't lose a sibling or your parents or anything like that ... but it happens to us all at some point

I: um

P: none of us are immortal.
I: and thinking about what happened with the traumatic incident, I won't ask you to go into that

P: It's ok we can talk about it

I: thinking back to that particular experience, do you think that there is anything positive that came out of that happening to you?

P: Yeah, it's probably my own resilience cause you suddenly realise, it's something that you would normally see in a TV programme or in a movie or something and this is something that happened to me in real life. And fortunately most of us don't know how we are going to react in such circumstances, but you do hold it together... you can hold it together still find, as I did something amusing about the whole episode. Um... Because I was joking with the police about, I don't know if you are old enough to remember the milk tray advert, there used to be a guy that would come in all dressed in black, and I said that they didn't even leave me the box of chocolates you know.

I: Hum (laugh)

P: (Laughing) It's about your own make up and how you are. And I am still standing. It has made a difference in my life, as I'm not so comfortable going out
at night now and coming back to a house when it is empty

I: um, ok

P: but I will do it, as I said to Dan, they are not going to stop me from doing those things.

I: and that is quite a positive way of looking at that, a difficult thing has happened and you are making a joke with the police

P: well you have to... to me I believe in anything... if anything disastrous is happening, if you can find some humour in it, its never as bad as perhaps it seems to the outside world, but to me there is always a funny element and I think if you look at comedians and such like they take an everyday life situation and find the funny side of it. Ok funerals are not amusing neither is being beaten up or having something stolen, but again, find the humour in it... it's only a possession

I: um

P: I am still perfectly ok, my son is still perfectly ok, so does it really matter or a scale of things now.
I: And just thinking about that way of thinking, do you think that is what you have applied to previous difficulties?

P: yeah, I do it all the time...when my brother died at 17 and I was coming up to 21 I decided in life that nothing is given...you should live everyday like it is your last one as you don't know as he had an accident ..So what the hell, just go out there...as long as you don't hurt anyone else...just do it..Becuase there is no point in saying if only when you get to the pearly gates in my view, just live your life
Appendix F: Example of line-by-line coding
Participant (P): Yes I had a divorce and I had my brother die just before I was 21 and he was only 17 and those are probably two major events in my life... that's part and parcel of life and you deal with it, so I never felt that I needed any form of counselling or anything like that you just pick up everything and get on with it, so you?

Interviewer (I): so they felt like they were traumatic events but actually...

P: But they are part and parcel of life... in my view they happen to people you know you are fortunate if you don't lose a sibling or your parents or anything like that ... but it happens to us all at some point

I: um

P: none of us are immortal.

I: thinking back to that particular experience, do you think that there is anything positive that came out of that
happening to you?

P: yeah, its probably my own resilience cause you suddenly realise, its something that you would normally see in a TV programme or in a movie or something and this is something that happened to me in real life. And fortunately most of us don't know how we are going to react in such circumstances, but you do hold it together... you can hold it together still find, as I did something amusing about the whole episode..um..Because I was joking with the police about, I don't know if you are old enough to remember the milk tray advert, there used to be a guy that would come in all dressed in black, and I said that they didn't even leave me the box of chocolates you know.

I: hum (laugh)

P: (laughing) It's about your own make up and how you are. And I am still standing. It has made a difference in my life, as I'm not so comfortable going out at night now
and coming back to a house when it is empty

I: um, ok

P: but I will do it, as I said to Dan, they are not going to stop me from doing those things.

I: and that is quite a positive way of looking at that, a difficult thing has happened and you are making a joke with the police

P: well you have to...to me I believe in anything...if anything disastrous is happening, if you can find some humour in it, its never as bad as perhaps it seems to the outside world, but to me there is always a funny element and I think if you look at comedians and such like they take an everyday life situation and find the funny side of it. Ok funerals are not amusing neither is being beaten up or having something stolen, but again, find the humour in it...it's only a possession
I: um

P: I am still perfectly ok, my son is still perfectly ok, so does it really matter or a scale of things now.
Appendix G: Ethical Approval
1. Reference No. PG22.07 Kate Herbert

2. Title of study. Exploration of posttraumatic growth after brief intervention for trauma

3. Scientific background, design, method and conduct of the study.
Extensive background is provided on this interesting area, with reference to relevant literature. The aims, hypotheses and research questions are clearly stated. A mixed design using both qualitative and quantitative methods will be used. Participants will complete psychometric measures and be interviewed. Established psychometric measures will be used. Interviews will take place in the Psychology Dept. and will be audio recorded. Data analysis is covered.

4. Recruitment of participants
20 participants will be recruited from a specialist trauma service. Letters of invitation will be sent to potential participants. Inclusion and exclusion criteria are covered in the COREC form.

5. Care of researcher and participants and protection of research participants' confidentiality.
Participants will be offered support at the end of the interview. Data storage has not been addressed in the proposal. Data should be stored in a locked cabinet and/or on a password-protected computer. This is addressed on the COREC form. Anonymity and confidentiality of data are addressed on the COREC form.

6. Informed consent.
This issue has been addressed comprehensively.

7. Community considerations:
No direct gains for the participants. May be of benefit to future sufferers of trauma.

8. Information sheet.
COREC format has been used, but the usual 13 sub-headings have not been included. This may not be acceptable to a LREC. To be on headed paper

COREC format used. To be on headed paper

10. Comments on the ethical aspects of the proposal.
Post trauma sufferers are potentially a vulnerable population. BPS ethical guidelines will be followed. The wording in A35-1 and A35-2 on the COREC form are not the standard wording concerning indemnity.

11. Recommendation
Approval with no amendments.

Please return this form to Rhoda Morgan in RCG17.
DO NOT CONTACT THE APPLICANT DIRECTLY.
29 June 2007

Miss K Herbert
Trainee Clinical Psychologist
Coventry University
Clinical Psychology Department
James Starley Building
Priory Street, Coventry
CV1 5FB

Dear Miss Herbert

Full title of study: Exploration of posttraumatic growth after brief intervention for trauma
REC reference number: 07/Q2803/64

Thank you for your letter of 21 June 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>1</td>
<td>04 May 2007</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>1</td>
<td>19 April 2007</td>
</tr>
<tr>
<td>Protocol</td>
<td></td>
<td>19 April 2007</td>
</tr>
<tr>
<td>Covering Letter</td>
<td></td>
<td>04 May 2007</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>26 March 2007</td>
</tr>
<tr>
<td>Peer Review</td>
<td></td>
<td>06 March 2007</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>04 May 2007</td>
</tr>
<tr>
<td>Questionnaire: CiOQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaire: Test Booklet</td>
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</tr>
</tbody>
</table>
R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.


Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

With the Committee's best wishes for the success of this project
Warwickshire Research Ethics Committee is an advisory committee to West Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England
Yours sincerely

Paul Hamilton
Chair

Enclosures:  
Standard approval conditions
Site approval form

Copy to: Associate Pro-Vice-Chancellor Professor Ian Marshall
R&D office for NHS care organisation at lead site
Warwickshire Local Research Ethics Committee
LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

<table>
<thead>
<tr>
<th>REC reference number:</th>
<th>07/Q2803/64</th>
<th>Issue number:</th>
<th>1</th>
<th>Date of issue:</th>
<th>29 June 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Investigator:</td>
<td>Miss K Herbert</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full title of study:</td>
<td>Exploration of posttraumatic growth after brief intervention for trauma</td>
<td></td>
<td></td>
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</tbody>
</table>

This study was given a favourable ethical opinion by Warwickshire Local Research Ethics Committee on 29 June 2007. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Post</th>
<th>Research site</th>
<th>Site assessor</th>
<th>Date of favourable opinion for this site</th>
<th>Notes (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miss Kate Herbert</td>
<td>Trainee Clinical Psychologist</td>
<td>Coventry and Warwickshire Partnership NHS Trust</td>
<td>Warwickshire Local Research Ethics Committee</td>
<td>29/06/2007</td>
<td></td>
</tr>
</tbody>
</table>

Approved by the Chair on behalf of the REC:

________________________________________________________________________ (Signature of Chair/Co-ordinator)

________________________________________________________________________ (Name)

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.
Kate Herbert
Trainee Clinical Psychologist
Universities of Coventry and Warwick
Clinical Psychology Doctorate
James Starley Building
Coventry University
Priory Street
Coventry, CV1 5FB

ref: PAR140507

Dear Kate

I am pleased to confirm that Coventry & Warwickshire Partnership Trust have reviewed the research entitled “Exploration of posttraumatic growth after brief intervention for trauma” and give approval for this study to take place within the Trust on the condition that the Trust suffers no additional costs as a result of this study being undertaken. Your research has been entered into the Trust’s Research database (if applicable this will be entered onto the National Research Register).

Please reply to this letter confirming the expected start date and duration of the study. As part of the Research Governance Framework it is important that the Trust is notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. We may also request brief updates of your progress from time to time, dependent on duration of the study. Similarly, if at anytime details relating to the research project or researcher change, the R&D department must be informed.

If you have any further questions regarding this or other research you may wish to undertake in the Trust please feel free to contact me with your research.

Yours sincerely

Clare O'Neill
R&D Office – West Midlands South RM&G

cc Prof Scott Weich, R&D Clinical Lead - Coventry & Warwickshire Partnership Trust