

London Metropolitan University  
School of Social Sciences

# How do clinicians work with the shift between stabilisation-work and exposure- work in PTSD-treatment?

Interviewing Clinicians – A Grounded Theory Study

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Sarah T N Hellegren

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## Abstract

The objective with this doctorate thesis is to examine how clinicians work with the shift between the stabilisation-phase and the exposure-phase in PTSD-treatment. Specifically, the aim is to explore how clinicians conceptualise exposure-readiness and how they evaluate when clients are ready to initiate exposure-work. For this, semi-structured interviews with psychologist providing trauma-focused treatments in PTSD secondary care services within the NHS were conducted. Data was analysed using grounded theory, from which the core concept: “clinicians are managing their role and resources in relation to the treatment-model” emerged. This core concept was further expressed through interrelated components termed:

1. Clinicians view exposure-readiness to be determined by more than traditional stabilisation-work due to the psychological and social complexity of PTSD-clients.
2. Clinicians view that treatment needs to be more integrative as opposed to solely conducting trauma-therapies in order to meet clients’ complex needs.
3. Clinicians advocate that the concept of exposure-readiness needs to be re-evaluated to make treatment more effective.
4. Clinicians feel that the prescribed treatment-model pose challenges to providing effective treatment.

These findings will be discussed in relation to literature, along with the theoretical conceptualisation this data gave rise to. Qualitative research on how clinicians are working with exposure-readiness and the shift between the treatment phases in PTSD-treatment is limited. Therefore, this study helps to crystallise these elusive clinical processes, and constitutes a valuable scientific contribution which can help improve PTSD-treatment.

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# 1. Introduction

## 1.1. Overview

This introduction contains a rationale for conducting this study, followed by an overview of the development and perpetuation of post-traumatic stress disorder (PTSD). Subsequently, a section of theoretical understandings of PTSD will be provided. However, due to word limitation and as cognitively-based treatments are the focus of this thesis, non-cognitive models will not be considered in-depth. Lastly, an introduction to exposure-based treatments is provided.

## 1.2. Rationale for this study

PTSD is among the psychological disorders with the highest individual and societal costs (Hoge et al. 2004). It often comes with high rates of comorbidity, long-term or chronic course of the disorder, heightened suicidal ideation and associated physiological problems arising from the trauma (Sharpless & Barber, 2011). International conflicts, terrorism and natural disasters has brought heightened awareness to PTSD, with speculations of millions of people suffering from PTSD (McLean & Foa, 2011; Galea et al., 2003). Given the severity of PTSD, examining the psychological treatment process in-depth is important as it can improve understanding and quality of PTSD-treatment. Additionally, as qualitative research in the field of PTSD-treatment is scarce (Carr, 2005), this study contributes with an important angle that can enhance understanding of how clinicians work with exposure-based PTSD-treatment.

## 1.3. Overview of PTSD

PTSD is a psychiatric disorder that can arise following exposure to severe stressors such as accidents and interpersonal violence, either by direct involvement or by witnessing a traumatic event. It is estimated that 1% among the global population reach diagnostic criteria for PTSD. However, this number is somewhat higher in areas of armed conflicts (American Psychiatric Association, 2013; Bisson, Cosgrove, Lewis and Robert, 2015).

The epidemiology of PTSD is complicated and not fully understood, but has been found to involve genetics, neurological, biochemical and psychological factors (Schnurr, Friedman and Bernardy, 2002). PTSD-symptoms are often divided into three main symptoms: re-experiencing, hyper-vigilance and avoidance. Re-experiencing the trauma can happen through nightmares, dissociation, flashbacks or intrusive images. To this comes negative thoughts and rumination about the trauma. Hyper-vigilance is believed to be caused by a hyper-activated fear-response that causes the person to constantly scan the environment for danger. Adverse emotions like shame, guilt, anger, fear, sadness or emotional numbness are

also common. These overwhelming symptoms are often managed by avoiding (cognitively, emotionally and behaviourally) stimuli that might trigger memories and emotions of the traumatic event (Bisson et al., 2015). Avoidance often leads to gradually increased isolation, de-skill and deactivation of formerly enjoyed or important activities like work, hobbies and relationships. This has a negative impact of several areas in peoples' lives and often leads to depression (Taylor, 2004). Moreover, symptoms can be even more severe if the traumatic experiences are prolonged or repeated such as in the case of childhood sexual abuse or experiencing war. To capture this symptomatic difference, some researchers argue that there is a clinical distinction between "PTSD" and "Complex PTSD" (CPTSD). CPTSD is, in addition to the symptoms of regular PTSD described above, often chronic with severe trust and attachment difficulties and often include frequent spells of dissociation and a loss of a coherent self (Courtois, Ford and Cloitre, 2009). However, this distinction is not accepted in the fifth version of the diagnostic and statistical manual of mental disorders (DSM-V) or in the tenth version of the international classification of diseases (ICD-10) (Friedman, 2014) but is in the moment of writing up for consideration for ICD-11 (Karatzias et al., 2017).

#### 1.4. Development and perpetuation of PTSD

A distinct symptom of PTSD is flashbacks (reliving) of the trauma. Flashbacks involve sensory memory of the traumatic event (e.g. smells, images, physical sensations) and can be triggered by internal and external cues. During flashbacks, patients believe they are back in the traumatic moment and are unable to recognise it as a past event. Thus, the inability to create a memory that is fixed in time and space is believed to be involved in the development of PTSD (Schauer, Neuner & Elbert, 2005). Some researchers like Ehlers and Clark (2000) suggests this happen because the brain processes and stores regular memories differently from traumatic memories. This is outlined in the section below.

#### 1.5. Memory and PTSD

##### 1.5.1 Declarative and non-declarative memory

Neuropsychological models based on Squire (1994) have explained this by differentiating between declarative (explicit) and nondeclarative (implicit) memory. Declarative memory involves facts and knowledge of the world as well as personal memories. Declarative memories can be deliberately retrieved, for example recalling the capital of France or thinking about ones' graduation. Nondeclarative memory on the other hand, involves conditioned responses and emotional and sensory associations that cannot be deliberately recalled. Instead, it can be triggered by unconscious cues. It is believed that flashbacks are involuntarily recollection of nondeclarative memory-aspects of a traumatic experience.

Tulving (2001) built on this theory by adding episodic and semantic memory. Episodic memory involves information of “when, where and what” of an event, and can be consciously recalled. Additionally, episodic memory involves associated sensory-perceptual elements of a memory. Semantic memory involves facts and knowledge (e.g. knowledge of capitals) and, in contrast to episodic memory, does not necessarily trigger any sensory-emotional aspects when recalling a fact. These different aspects of memory are often described as nodes in a neural network with associations to each other. This means that triggering of one aspect leads to activation of all other aspects of a memory. In traumatic memories, this neural network is referred to as a fear network. Fear-networks differ from networks of “normal” memories by getting more easily involuntarily activated. Fear-network activation also comes with powerful sensory-perceptual aspects of the traumatic memory, such as fear, olfactory, visual, sensory and auditory memory fragments (Conway, 2001).

### 1.5.2 Autobiographical memory

Ehler and Clark (2000) argue that the inability to experience traumatic memories as a *past* event happens as it does not get stored in the autobiographical memory. According to their model, during non-threatening regular events, memories get processed and stored in the autobiographical memory. There, the hippocampus weaves factual and contextual information of the event into cohesive memories with a “time stamp” of *when* the event took place. Normally, the autobiographical and the nondeclarative memory systems (emotional, sensory and perceptual aspects of an event) are closely interacting to recall fuller memories, but during a traumatic event they are thought to become disconnected. As a result, the person is left remembering the nondeclarative aspects of the traumatic memory but without the factual context and a sense of *when* it happened. According to this model, the integration of the autobiographical and nondeclarative memory systems allows for the brain to “time stamp” the memories and store them in the autobiographical memory, which is then experienced as a “normal” memory. Thus, this integration is thought to help the brain identify the trauma as a *past* event as oppose to an ongoing one, which is how a person perceives a traumatic event if the integration of the autobiographical and non-declarative memory systems has not taken place (Samuelson, 2011).

### 1.6. Maladaptive coping

Frequent involuntary activation of the fear-network (flashbacks) are thought to underlie avoidance which is another central symptom of PTSD. As flashbacks are highly distressing, people start to avoid cues that can trigger them. However, this is thought to prevent integration of the factual and sensory aspects of the traumatic memory (Schauer et al., 2005). It is believed that as the integration helps people recognise the trauma as a past event, which

in turn helps them make sense of what happened to them which allows for healing, the traumatic memory keeps entering awareness as a way of instigating this integrative process (Van Marle, 2015). Therefore, it is the integration of the different memory aspects that is targeted in trauma-focused treatments. This happens through repeatedly making the patient remember details of the trauma. This is referred to as exposure-therapy, because the patient is exposed to the traumatic memories.

### 1.6.1 Neuropsychological support of incomplete memory processing

Memory-based theories of the development of PTSD has support by neuroimaging studies that has shown several abnormalities in brain regions involved in autobiographical memory such as hippocampus, amygdala and prefrontal cortex (Samuelson, 2011). These brain structures are involved in processing the sensory-perceptual-emotional aspects of memory and are also involved in assessing threats and regulating and expressing fear. Research has also identified that stress hormones released during trauma can have significant detrimental effects on the hippocampus' capacity to process memories and put them into factual context (Cardinal, Parkinson, Hall & Everitt, 2002). However, neuropsychological factors are limited as a sole explanation of PTSD as psychological factors like early life experiences and existing beliefs about oneself and the world has been identified as antecedents for the development and maintenance of PTSD (Ozer, Best, Lipsey and Weiss, 2003).

## 1.7. Cognitive models

As this thesis aims to explore exposure-therapies, the focus will be on cognitive models. This is because theories of PTSD often build on a Pavlovian conditioning model within a cognitive-behavioural paradigm (McLean & Foa, 2011). Consequently, some researchers argue that therapy should focus on unlearning conditioned responses through repeated exposure to the feared stimuli to decrease fear-response and PTSD-symptoms (McLean & Foa, 2011). Three cognitive models that has been influential in terms of informing exposure-based treatments (Maercker & Horn, 2012) will be briefly outlined below.

### 1.7.1 Emotional-processing theory

Foa and Kozak's (1986) emotional processing theory propose that PTSD develops as a result of excess fear. It holds that fear felt during a trauma becomes represented as a cognitive fear-network containing three factors: cognitions about the feared stimuli, behavioural fear response and meaning making of the event. For example, the fear network of someone that was held up at gunpoint may be activated by hearing a loud noise (fear stimuli) which can instigate a fear response such as heart palpitations. The meaning-making can be "I am in danger". These structures are interrelated and activation of one activates the entire fear-

network and elicits PTSD-symptoms like flashbacks. Foa and Kozak (1986) argue that PTSD arises when the fear-network persists to non-threatening situations and is perpetuated as the person avoids situations that can activate the fear-network. This deprives the person to test the accurateness of their fear-driven beliefs. To reduce PTSD-symptoms, the authors argue that treatment should activate the fear-network whilst providing information inconsistent with the exaggerated fear-related thoughts. However, critique to this model hold that it fails to account for other emotions than fear (Brewin & Holmes, 2003).

### 1.7.2 Schema theory PTSD

Another cognitive model is Horowitz's (1986) schema-theory of PTSD. Schema refers to internal representations of knowledge and procedures about situations and interpersonal interactions. These internal representations help people navigate and predict the environment and functions as a filter of which new information is compared against (Young, Klosko & Weishaar, 2003). Horowitz (1986) applied schema-theory to PTSD and developed a theory that holds that people tend to fit new information with inner schemas, called the completion tendency. Horowitz argue that following a trauma, this completion process gets disrupted to prevent traumatic memories to enter awareness and lead to emotional overload. Instead the traumatic information gets stored in what Horowitz call active memory. Active memory aims to finalise the completion-process by repeating its content in the form of flashbacks. Existing schemas can impact this completion-process and impact the course of PTSD. First, the strength of defence mechanism a person has to keep existing schemas from activation can impact perpetuation of PTSD. For example, a person with pronounced schema-avoidant strategies may be at risk of developing chronic PTSD as they suppress and avoid thinking of the trauma and thereby contributes to its perpetuation. Secondly, the nature of existing schemas can increase the risk of PTSD as maladaptive schemas of oneself and others can increase risk of developing excessive fear or self-blame, which can lead to PTSD. Although this model considers early interpersonal experiences, memory processing, cognitions and avoidant behaviours, it has been criticised by Dalgleish (2004) for not adequately account for active memory, e.g. what type of mental representation it is (e.g. schema or cognition) and how it fits with other cognitive theories.

### 1.7.3 Ehlers and Clark's cognitive PTSD-model

Ehlers and Clark (2000) hold that PTSD occurs as a result of unhelpful cognitive appraisals made during or after the trauma, which becomes encoded in memory and leads to a sense of current threat. The model holds that a person avoids stimuli that can trigger these appraisals and the traumatic memories, which is believed to keep a person from reconstructing the cognitive evaluations, which Ehlers and Clark believe perpetuates PTSD. For example,

trauma survivors often exaggerate the likelihood of the trauma happening again (for example stops driving after having had a traffic accident). Other common appraisals made during or following a trauma are thinking one could have done more to prevent it or that they somehow brought the trauma on themselves. Ehlers and Clark argue that such appraisals generate negative affect like guilt, shame, anger and fear. These thoughts and emotions are managed by avoiding anything that can trigger them, which reinforces them as they remain unchallenged. Additionally, Ehlers and Clark endorse the theory that traumatic memories do not become properly processed in the autobiographical memory as the emotional and sensory aspects of the traumatic memory becomes separated from the contextual aspects. Ehlers and Clark believe that integration of these memory-aspects can occur by repeatedly recall and talk about the traumatic event in detail, which would reduce the sense of current threat.

#### 1.7.4 Critique toward Ehlers Clark by Dalgleish

The Ehler and Clark (2000) model is often held as the most prevalent theory of PTSD. However, it is not without criticism. Dalgleish (2004) argue that the model is not clear of the process of *how* appraisal changes following a trauma and thus lack in explanatory power. Additionally, Dalgleish notes that whilst their model emphasises the role of appraisals in the maintenance of PTSD, it lacks in specificity in how general appraisals a person holds prior to the trauma can impact the severity and course of PTSD, which weakens the predictive power of the model. Dalgleish further argue that it is unclear how a person sometimes can talk about traumatic memories without activating the fear-network or generate strong affect, whereas at other times emotions, imagery and facts can be triggered without the person being able to narrate it. Although Dalgleish credits Ehlers and Clark's model for its robustness as it highlights both the role of cognitions as well as memory-processing, it still renders some aspects of the development of PTSD unclear.

#### 1.7.5 Socio-Interpersonal model of PTSD

Though cognitive and neurological models provide a substantial understanding of PTSD, Maercker and Horn (2012) argue that they do not adequately consider socio-interpersonal factors. Interpersonal and social factors have been found to be important risk factors as well as protective factors in the development of traumatic stress. Therefore, it is surprising that prominent cognitive models of PTSD, such as Ehlers and Clark's (2000), emphasises the role of appraisals without considering the context in which appraisals have developed. Maercker and Horn (2012) argue that whilst clinical work with PTSD includes reframing a persons' view of others, themselves and the world, these contextual factors are not reflected in current theoretical models. Therefore, Maercker and Horn (2012) developed the socio-interpersonal model. It proposes that socio-interpersonal processes exist on three levels;

individual, interpersonal and distant social level. The individual level involves social affective states such as feelings of revenge or shame. The interpersonal level refers to social support and negative social experiences. The distant social level entails social and cultural factors in the environment that the PTSD sufferer lives in, such as prejudices and stigma. According to this model, these levels interact and together impact risk of developing PTSD and has implications for severity and treatment-outcomes.

The theoretical models described above provides an understanding of why *exposure* is central in treatments. The following sections will discuss exposure-based treatments further.

## 1.8. Trauma-focused treatments

PTSD-treatment commonly involves both psychopharmacology and psychotherapy. Because PTSD involves conditioned maladaptive behavioural and cognitive responses to trauma-related stimuli, cognitive approaches have proved helpful in challenging these responses by re-scripting them (Zayfert, 2012). Particularly, treatments containing trauma-exposure has high evidence-support and is the most recommended treatment by the National Institute for Health and Care Excellence (NICE) (NICE, 2005) and the International Society for Traumatic Stress Studies (ISTSS) (Foa, Keane, Friedman & Cohen, 2009). Trauma-exposure treatments can be referred to as trauma-focused therapies and can include different modalities such as eye-movement desensitisation reprocessing (EMDR), narrative exposure therapy (NET) and trauma-focused cognitive behavioural therapy (TFCBT) (Ehlers et al., 2010). Trauma-exposure can be of two types: imaginal and in vivo. Imaginal exposure refers to encouraging clients to think and talk about details about the trauma, whilst in vivo refers to exposing clients to trauma-related stimuli, e.g. places, objects and situations (Foa & Rothbaum, 1998). As has been described earlier, a main intention behind trauma-exposure is to integrate the factual and emotional-sensory aspects of memory to enable it to be stored into the autobiographical memory. This is thought to reduce involuntarily triggering of the memory and thereby reduces flashbacks and other PTSD symptoms (Zayfert, 2012). Additionally, repeated exposure also intends to teach clients to regulate intense fear and difficult emotions associated with the trauma. By repeatedly practising staying relaxed during exposure, habituation takes place, which allows the client to think about the trauma without experience extreme distress. However, exposure-based treatments are not without controversy, which will be discussed in the literature review.

## 1.9. Reflexivity

*Having completed this thesis, this section provides retrospective reflections of my relationship to this study; why I chose this topic, how I might have influenced the research-process, and how the research-process has impacted me.*

*The choice of research-topic stemmed from my interest and clinical experience with PTSD. This interest in PTSD stems from my interest in social affairs and politics and specifically the impact socio-political climate can have on mental health and wellbeing. My interest in social affairs led me to obtain a BSc in political science but I realised my interest in psychology was stronger which inspired me to pursue a psychology degree. I believe my interest in PTSD is because it offers a combination of the fields of social affairs/politics as well as psychology. PTSD offers a way to understand the impact of socio-political factors on mental health directly, for example in terms of people who have experienced war or suppression for being a minority or political dissident but also how sociocultural attitudes might affect which schemas develop for victims of sexual abuse. Moreover, I believe I am drawn to PTSD as it gives me a rewarding feeling of working with societal injustice and making a positive contribution. As I cannot personally eradicate war, poverty, injustice and inequality, supporting people whose mental health difficulties partially have arisen from those kinds of factors makes me feel like I am at least indirectly doing something meaningful and counteracting bigger issues that I cannot change. Because of this interest, I sought a PTSD-placement as my first placement upon starting the doctorate and was lucky enough to secure one. Whilst there I was introduced to the phased treatment model and I also saw the challenges the psychologists encountered with this treatment setup. Specifically, I noticed that clients who returned after the mid-treatment interim often would have destabilised and needed to recap phase 1. Additionally, the complexity of the clients meant that clinicians had to support them with social factors as well which meant less time for psychological interventions. These factors appeared to contribute to the exposure-phase of the treatment being postponed. Therefore, I wanted to explore how clinicians work with moving clients between the stabilisation and exposure phases in services that operated with the mid-treatment interim. However, perhaps as I was a trainee at that stage and new to the UK, I did not consider the impact the NHS financial frameworks have on services and delivery of treatment. Nor did I ascribe clients' exposure-readiness as being as impacted by non-psychological factors as this study showed them to be. Thus, this research has widened my understanding of how political and financial factors affects treatment-models, clients and clinicians. It also made me more aware of how clients' socioeconomic status impacts their wellbeing, and how mental health services needs to incorporate this into treatment.*

*Moreover, as outlined in the literature review, I initially expected that clinicians would report using subtle emotional, behavioural and cognitive signals from clients to inform them when to shift treatment-phase. However, this study showed that these "implicit signs" were not central in clinicians' process of working with the treatment-phases. Instead, external factors relating to the treatment-model and the complexity of clients psychological and social issues were formative in how the clinicians*

*worked with the treatment-trajectory. I believe the discrepancy between my expectations and actual findings reflects success in allowing the data to speak for itself.*

*When considering my impact on the research-process, I wonder if my experience of working in a service with the same treatment-model as the one studied here influenced my interview-questions and interpretations of the data? Although memoing and supervision aimed to mitigate my biases, it nevertheless made me start from the preconception that the treatment-model studied here is problematic. Consequently, it is possible that this made me focus more on strands reflecting my stance.*

*Lastly, this research-process has made me come to appreciate qualitative research, where phenomenology is central (Milton, 2010). I believe my engagement with this research has refined my reflective abilities, which has transpired into my clinical practice. Thus, I believe this process has strengthened my identity as a scientific-practitioner anchored in values of counselling psychology, where phenomenological experience is central (Haarhoff, 2006).*

## 2. Literature review

### 2.1. Organisation of the literature review

The literature review focused on three main areas: prevailing discussions about trauma-focused treatments, the concept of exposure-readiness and how clinicians evaluate and work with exposure-readiness.

### 2.2. Conduct of literature review

A range of sources were used when searching literature: databases, treatment-manuals and grey literature, i.e. information produced by organisations not controlled by commercial publishing, for example governmental or quasi-governmental bodies (Booth, Papaioannou & Sutton, 2012) such as NICE and ISTSS. Bibliographic mining was also employed.

Glaser (1998) advocates that instigating a literature review prior to the empirical element of a study risks biasing the researcher towards areas raised by the literature at the expense of areas not encountered. Particularly, he voices concern that researchers become literature-led as oppose to allowing the themes raised through data-collection play the role of first violinist. Glaser also argues that what constitutes as relevant literature can only be known following data analysis, and that literature reviewed prior to data-collection may wound up irrelevant. However, to comply with academic standards, literature was reviewed as a first step to identify research-foci. However, care was taken to formulate interview questions so not to reflect the literature consulted prior to data collection too closely to avoid forcing data. Moreover, this study employed theoretical sampling which allows for flexibility in which literature is pursued, and thereby constitutes a data-driven approach.

### 2.3. The Controversy of Exposure-treatments: Symptom Exacerbating or Symptom Reducing?

Exposure-work has vast support from randomised controlled trials (RCTs) (Cahill, Rothbaum, Resick, & Follette, 2009). Yet, from contemplating the literature it is also held as a controversial element of trauma-treatment. This is because trauma exposure can be highly stressful for the client and is thought by some to cause symptom-exacerbation, which can lead to premature termination of the treatment (Cloitre, Petkova, Wang & Lu, 2012). This controversy has arisen as it has been observed that thinking or speaking about traumatic experiences in detail can activate a full fear response, which can cause clients to panic or dissociate. Frequently cited studies by Pitman et al. (1999) and Tarrier et al. (1999) argued that trauma-exposure can be directly harmful and lead to significant levels of symptom-worsening and treatment dropout. However, their results have been critiqued for having

limited methodology, such as not defining what worsening of symptoms meant (Imel, Laska, Jakupcak, & Simpson, 2013). Nevertheless, the fact remains that dropout levels in PTSD-treatments are high with estimations ranging from 20-50% (Imel et al., 2013). Although reasons for these dropout-statistics are not yet understood, symptom worsening elicited by exposure-therapy is frequently suggested as a cause. However, two meta-analyses by Imel et al. (2013) and Schottenbauer et al. (2008) argue that due to the wide range of statistical analyses used, and vaguely defined terminology, direct comparisons between individual studies on dropout rates are not fruitful. For example, Tarrier et al. (1999) and Pitman et al. (1999) have neglected to elaborate reasons for dropout and stage in treatment of dropout, which makes inferences difficult as someone may drop out due to difficulties accessing treatment rather than symptom-exacerbation following exposure-therapy. Therefore, Imel's (2013) and Schottenbauer's (2008) studies conclude that there is not enough evidence to support that exposure-therapy causes dropout. Moreover, several recent studies have rejected the notion of a causal relationship between exposure-therapy and symptom exacerbation and dropout (Imel et al., 2013; Foa, Zoellner, Feeny, Hembree & Alvarez-Conrad, 2002; Hembree, Foa & Dorfan, 2003; Hassija & Gray, 2007). However, the notion that exposure-based therapies can generate strong emotional distress remains a concern, which has been addressed by more recent research. Carhart-Harris et al. (2014) proposes that methylenedioxymethamphetamine (MDMA) can facilitate exposure-based treatments by decreasing negative emotional response during recollection of painful memories. Thus, although it is recognised that exposure-based treatments can lead to emotional distress, Carhart-Harris et al. (2014) do not discredit it is a treatment but proposes approaches to make it more tolerable.

### 2.3.1 Exposure-therapy Necessitates Phased Treatment

Recent research has moved beyond the dichotomous discussion of exposure-therapy as either harmful or not harmful, towards a more nuanced approach to thinking about the stress caused by exposure-therapy and how this might need to be considered in treatment. For example, Cloitre et al. (2012) found that the risks associated with exposure-therapy are significantly reduced if clients are sufficiently prepared before starting exposure-work. This suggests that exposure-therapy is not harmful, but prematurely entering it can be. Therefore, clients need to build up sufficient tolerance for exposure-therapy before embarking on it. This is referred to as exposure-readiness. Consequently, treatment commonly contains a preparation-phase prior to the exposure-phase, with the purpose of increasing tolerance for exposure-therapy (Turner & Herlihy, 2009). This first phase is generally referred to as the stabilisation-phase and aims to educate clients about their symptoms to help them make sense of them and also teaches clients how to regulate fear and strong affect, which helps them to

disrupt, soften or prevent negative affect, flashbacks and dissociation that can occur during exposure-therapy (Follette & Ruzek, 2010). This phased approach is held by the ISTSS as being especially important in CPTSD as the adverse symptomology and trust difficulties often present in these clients, requires tentative pacing to build up rapport and sufficient exposure-tolerance (Cloitre et al., 2012). Although this phase-oriented treatment has long tradition (Herman, 1992), the notion that sufficient exposure-readiness increases exposure-tolerance, that in turn is associated with reduced PTSD-symptoms, did not yield empirical support from RCTs until relatively recently (Cloitre, et al., 2012; Cloitre, Koenen, Cohen, & Han, 2002). Evidence-based support for exposure-therapy is discussed in the following section.

### 2.3.2 Empirical Support for Phased Treatment

The advantages of including a stabilisation-phase prior to the exposure-phase was given empirical support in a study by Cloitre et al. (2002). They developed a preparatory intervention programme consisting of skill training in affect and interpersonal regulation (STAIR) designed to increase exposure-tolerance. Their study consisted of two conditions in which one group of PTSD sufferers were given 8 weekly sessions of STAIR before having 8 weekly sessions of exposure-therapy. Whereas the control group was on a minimum-attention waiting-list and did not receive any preparatory interventions prior to exposure-therapy. The STAIR condition targeted three symptom domains: PTSD-symptoms, emotional regulation and interpersonal skills deficits. The authors hypothesised that the STAIR interventions would facilitate patients' use of exposure-therapy if they were trained in emotional regulation. Additionally, this preparatory-work would also provide time to develop rapport with the therapist. They further hypothesised that STAIR would lead to significant reductions of PTSD-symptoms, emotional regulation deficits and interpersonal skills deficits. The results confirmed these hypotheses by showing that compared to the control group, the STAIR-group showed significantly improvements in PTSD-symptoms, emotional regulation skills and interpersonal skills. These symptom-improvements were present during a three and nine months follow up. Moreover, the authors concluded that the development of a strong therapeutic alliance in the preparatory phase predicted higher success in the exposure-phase (measured as reduced PTSD-symptoms). This is interesting as this was the first study to provide empirical evidence for the role the therapeutic alliance has on symptom reduction in exposure-therapies. Additionally, out of the STAIR-group, only 1% experienced symptom-exacerbation. This supports the point that the exposure-component is unlikely to cause symptom worsening, but that it is caused by insufficient exposure-readiness.

Although their study provides support for phasing trauma treatment, a limitation was that they did not include a follow up for the waiting list group, with the consequence that the

symptomatic improvement seen in the STAIR group could be argued to have been the result of the passage of time rather than as a direct consequence of the STAIR interventions.

Another point of interest is the way the skill-interventions in phase 1 were assessed. For example, some of the measures for emotional problems were assessed with the Negative Mood Regulation Scale (NMR; Catanzaro & Mearns, 1990) and the State Trait Anger Expression Inventory (Spielberger, 1991). PTSD symptoms were tested using the Dissociation Scale (DISS) (Briere & Runtz, 1990) and the Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1995). However, Cloitre et al. (2002) do not discuss any other indications of shifts in symptomatology or emotional functioning than those shown by the psychometrics. For example, they do not mention any other signs of exposure-readiness such as signals from clients that clinicians interpreted as increased or decreased exposure-tolerance. This begs the question of whether exposure-readiness can be fully captured by the measures used in their study. It also leads to the question of what clinical actions would or should have been taken if the measures, or symptoms observed in sessions, indicated symptom deterioration. Nevertheless, their study shows that preparatory-work increases tolerance for exposure and thereby decreases the risk for symptom exacerbation. Thus, sufficient stabilisation is thought to help clients to effectively make use of treatment, which in turn can improve treatment outcomes (Ford et al., 2005; Courtois & Ford, 2009). However, Foa et al. (2009) argue that there is not enough evidence to support that the implantation of affect and interpersonal skills-training before exposure has a true effect on PTSD-remission. They argue that because Cloitre et al.'s (2002) study lacks a dismantling design, i.e. where different variables of a study are tested in isolation or in various combinations to locate the effect of each variable, it is not possible to ascribe the noted benefits of STAIR or similar preparatory interventions alone. Although, Foa et al. (2009) do not deny that STAIR-training prior to exposure-therapy can have a positive effect on PTSD reduction, they reason that this intervention may not be necessarily as a default component of trauma-focused treatments for all clients. Therefore, they refrain from implementing it as a routine feature as some clients may enter treatment with sufficient emotional tolerance to endure exposure.

### 2.3.3 Potential Disadvantages of Phased Treatment – A Macro Perspective

Despite the empirical support for stabilisation-work, Hamblen et al. (2015) offers another perspective by pointing out potential disadvantages with stabilisation-work. They conducted a study that revealed the ambiguity clinicians and service-providers seem to hold towards phased treatment. They interviewed clinicians and service directors that provided exposure-based treatments with PTSD outpatients and found that although most clinicians and service managers were positive to exposure-treatments, many voiced concerns that exposure-

therapy could cause symptom-exacerbation. This made some services reluctant to provide exposure-based treatments to avoid causing clients harm. To mitigate the believed risks, several services implemented unnecessarily long stabilisation-phases prior to the exposure-phase. Whilst research support that stabilisation-work reduce the risks that can come with exposure-work, Hamblen and colleagues stand out by highlighting that too long stabilisation-work can come with risks of its own. Their argument for this is that treatment-manuals for PTSD, which are based on RCTs, commonly recommend stabilisation-work to last for approximately two to three sessions, whereas the services in Hamblen and colleagues' study often offered much longer stabilisation-phases. Consequently, these services do not follow evidence-based guidelines, and thus risk making treatment less effective. Specifically, the authors warn that this comes with two types of risks. First, if PTSD-treatment is not delivered in accordance with evidence-based support, it might impact on the quality of treatment. Secondly, if clinicians' caseloads are saturated by lengthy phase 1 treatment, it blocks the waiting lists and delays treatment for new clients. From this, one could argue that the authors highlight a macro versus micro dilemma with phased treatment, in that there may be tensions between what is best for individual clients and what is best for services. Thus, both Hamblen et al. (2015) and Cloitre et al. (2002) studies represent different reasons of why knowing when clients are ready to move between treatment-phases is important. Not only does it decrease risk of symptom-exacerbation, but it can also create more flow in care-paths and reduce long waiting lists. However, this may cause a clinical dilemma for clinicians undertaking such phased PTSD-treatment of what to prioritise, that have up until now not been researched.

Although results from Hamblen et al.'s study are restricted as some participants gave vague answers to how they thought about and worked with the stabilisation-phase, and some questions were not followed up on, the results are in line with other studies that found that clinicians are disinclined to implement exposure-treatment due to fear of causing harm to clients (Cook, Schnurr, & Foa, 2004). Crucially, Hamblen and colleagues argue that one reason for excessive stabilisation-phases is that clinicians lack knowledge of how to determine exposure-readiness. The authors therefore request further research on this topic. To do this, Hamblen and colleagues (2015) suggest that client and clinician characteristics that influence decisions to initiate phase-shifts should be categorised and standardised to allow for empirical testing of when sufficient exposure-readiness has been achieved. Thus, there appears to be a need for standardised measures for exposure-readiness.

Thus, despite the consensus that seems to exist about the importance of achieving sufficient readiness before initiating exposure-work, there are some aspects of the decision-making process that are portrayed rather ambiguously in the literature. Most noticeable is what exposure-readiness means and how clinicians work with the stabilisation and exposure phases

in everyday clinical practice (Hamblen et al., 2015). These two areas (conceptualisation and practice) should not be viewed as separate entities, but as symbiotic. That is, if different clinicians conceptualise exposure-readiness differently, it will likely influence how they evaluate it and the timing and pace in which they move clients between the treatment-phases. Therefore, the following sections will focus on how exposure-readiness is conceptualised, evaluated and worked with.

## 2.4. Exposure-readiness – a multifaceted concept

When viewing the literature, it becomes clear that exposure-readiness is a multifaceted concept with interrelated properties. The different facets of exposure-readiness that were discerned from the literature could be summarised as:

- how exposure-readiness is conceptualised
- how sufficient exposure-readiness is evaluated
- how different definitions and methods of evaluating exposure-readiness influences the practical work of initiating or deferring exposure-work.

### 2.4.1 Conceptualisation of exposure-readiness

The first step towards understanding how clinicians work with the shift between preparatory-work and exposure-work is by examining how exposure-readiness is conceptualised. By revisiting the study by Cloitre et al. (2002), an example of how exposure-readiness is defined can be obtained through their STAIR-program. Specifically, STAIR targets affect and interpersonal regulation skills, which hence reflects what Cloitre and colleagues consider crucial components of exposure-readiness. In fact, affect-regulation, which refers to clients' ability to regulate strong affect through self-soothing techniques, is perhaps the most widely acknowledged indicator of exposure-readiness (Follette & Ruzek, 2010; Parnell, 2007; Courtois, Ford & Cloitre, 2009; Pearlman & Caringi, 2009).

However, the literature on exposure-readiness also reveals a broader conceptualisation with other types of readiness-factors than emotional regulation skills. For example, the EMDR-manual by Leeds (2009) advocates that exposure-readiness should be assessed on five areas: 1) medical concerns, 2) social and economic stability, 3) behavioural stability, 4) mood stability and 5) comorbid axis 1 and axis 2 diagnoses with particular attention to dissociation, substance abuse and severe organic mental illness such as bipolar disorder, OCD and schizophrenia.

A similar conceptualisation of readiness is outlined in Geiss-Trusz et al. (2011) who in an ambitious study identified several areas that impeded readiness for TF-CBT. These

readiness factors were divided into two types; factors of clinical nature such as comorbidity and self-harming behaviours, and factors of socio-economic and logistical nature such as housing difficulties, on-going legal procedures and difficulties accessing transport to the service. Additionally, they identified a good therapeutic relationship as a key factor in making up exposure-readiness.

Foa, Hembree and Rothbaum (2007) advocate in their manual for prolonged-exposure therapy (PE) that exposure-readiness should be evaluated on a cluster of exclusion criteria: (a) imminent threat of suicidal or homicidal behaviour, (b) serious self-injurious behaviour in the past 3 months, (c) current psychosis, (d) current high risk of being assaulted (e.g., living with domestic violence), and (e) lack of clear memory or insufficient memory of traumatic event(s) and (f) severe dissociation. Noteworthy is that whilst they emphasise clinical and risk factors, they do not mention socio-economic factors.

In another manual for PE, Riggs, Cahill & Foa (2009) broadly outline exposure-readiness to consist of psychoeducation about PTSD and self-soothing techniques. Importantly, they argue that stabilisation-work should only take place for two sessions and that exposure-work should start on the third session out of nine-12 total sessions. They also stress a good therapeutic relationship to be of importance in exposure-treatments, which ought to be established over the first two sessions. However, although they advocate flexible and client-led practice, how treatment is phased or exposure-readiness evaluated when it does not proceed as linear as depicted in their manual, is not discussed.

In the practice guidelines from ISTSS (Foa, Keane, Friedman & Cohen, 2009) it is recommended that the following factors are present in clients prior to exposure-work: a) psychoeducation of how their symptoms are related to their traumatic experience, b) transparency of what exposure-work entails, i.e. that the client understands that they will have to describe their traumas in detail, c) affect regulation and d) interpersonal skills. However, they stress that due to lacking evidence to support the benefit of affect and interpersonal skill training, it should not be routinely practised prior to exposure-work. Specifically, they argue that previous research has lacked in cohesive definitions of psycho-education and whether affect-regulation and interpersonal-skills have been used in combination with other treatment foci.

Literature on CPTSD do not seem to differ significantly from less severe PTSD in terms of what factors are thought to constitute exposure-readiness. In the treatment manual for CPTSD by Courtois, Ford and Cloitre (2009), the authors list six factors that should be achieved in the stabilisation-phase, and which thereby can be viewed as indicating what the authors hold exposure-readiness to consist of:

1. Personal and interpersonal safety. This refers to as far as is possible, creating a safe zone for patients, such as safety from interpersonal violence and risks to self
2. Emotional-regulation skills
3. Resolving avoidance. The authors stress that although targeting avoidance begins in phase 1, it remains a point of foci throughout all treatment phases and must include both obvious and more subtle forms of avoidance.
4. Psycho-education about PTSD.
5. Building self-awareness of one's identity, values, strengths and relational capacities. The authors highlight that the stabilisation-phase is where insight in how patients' unhelpful schemas have developed, and where new schemas and interpersonal skills can be developed through a safe therapeutic relationship.
6. Assessing suitability and readiness for initiating exposure-work. This shift is determined by the client's magnitude of symptoms, their willingness to proceed to exposure-work and their capacity (i.e. readiness) to undertake exposure-work. The authors describe this shift as sometimes being explicitly initiated by the clinician, and at other times flowing naturally from the stabilisation-phase to the exposure-phase.

Courtois and colleagues put forward more implicit signs of exposure-readiness, which are generally less depicted in the literature. For example, they highlight that avoidance can take subtle forms that therapists must look out for, as failure to challenge these avoidance strategies can jeopardise symptom remission. However, descriptions of how these subtle ways may manifest are unfortunately not outlined. Additionally, they emphasise clients' sense of self to be targeted in the stabilisation-phase. Although avoidance and self-identity are recognised as important in the trauma-treatment literature, the extent to which Courtois et al. emphasise it as something to be specifically targeted in the stabilisation-phase, makes their readiness-conceptualisation stand out. However, this is likely because their manual is written for CPTSD, where the type of trauma often is of interpersonal nature with disturbed self-identity as a consequence. Nevertheless, it reflects the challenges clinicians can encounter when working with exposure-readiness.

#### 2.4.2 Summary

Taken together, when viewing the literature on how exposure-readiness is conceptualised, noticeable overlap was discovered. Specifically, the literature seems to suggest three main types of readiness-factors, which applies for both PTSD and CPTSD:

- client factors (such as emotional regulation skills)
- clinical factors (such as comorbidity and risk)
- social factors (such as financial or legal problems).

Thus, there seems to be a general agreement that these three groupings constitute a good representation of how exposure-readiness appears to be understood among researchers and clinicians. However, the emphasis on these factors differs between clinicians, and these types of factors also differ in their measurability, which potentially can impact the delivery of treatment.

## 2.5. Variations in readiness-conceptualisations and its potential implications.

Although the way different researchers conceptualise exposure-readiness seem to overlap greatly, there are some differences in how different factors are weighed when deciding whether clients are ready to start exposure-work. These variations are not merely terminological but can have real clinical implications. This becomes particularly clear when examining what factors different researchers hold as exclusion-criteria for exposure-work, which was shown in the study described below.

Harned, Jackson, Comtois and Linehan (2010) examined access to, and effectiveness of PTSD-treatment for comorbid patients diagnosed with borderline personality disorder (BPD) and PTSD. Many of the clients displayed symptoms that are commonly held as exclusion-criteria for exposure-therapies. These symptoms include self-harm, substance abuse and suicidal ideation, which often exclude clients from exposure-therapies as they are thought to cause too much risk in patients. The exclusion-criteria they applied for their study were derived from Foa et al. (2007): 1) imminent threat of suicidal or homicidal behaviour, 2) serious self-injurious behaviour in the past three months, 3) current substance disorder and 4) severe dissociation. Of note is that Foa et al. (2007) give different weighing to these criteria when evaluating clients' capacity to undertake exposure-work. Whilst criteria 1 and 2 excludes *all* clients, criterion 3 and 4 does not necessarily exclude clients from exposure-treatment but depends on the severity of these symptoms. From this, Harned et al. (2010) created two different sets of exclusion-criteria. The first definition included *only* criteria 1 and 2, and the second definition included all four criterions. This meant that the exclusion-criteria based on definition one (criteria 1 and 2), automatically excluded clients for treatment if they displayed harmful behaviours to themselves or others. For the second definition, all four criteria were weighed equally, which gave more leeway for the clinicians to decide whether the clients had overall sufficient capacity to undertake exposure-work. Consequently, clients whose exposure-capacity was solely assessed based on the first definition (i.e. exposure-readiness assessed on criteria 1 and 2) were more likely to be excluded from treatment than those whose exposure-capacity was based on all four criteria. This created a catch 22 as suicidal or self-harming clients were more likely to be excluded from PTSD-therapy. That is, as these clients were less likely to benefit from stabilisation-work due to their complexity, they were also more

likely to be debarred from proceeding onto exposure-work. Thus, more complex clients, who might be in greater need of treatment, were less likely to access exposure-based treatments, which worsened their chances of PTSD remission. This may ironically increase the self-harm behaviours that excluded them from entering treatment in the first place. From this the authors propose that it might be necessary to make exposure-treatment more accessible for clients who do not pass common exclusion-criteria. The authors further note that the exclusion criteria outlined by Foa et al. (2007) have not been empirically tested but based on clinical experience. Thus, there may be scope for standardising the conceptualisation of what exposure-readiness should entail and how its different components are best weighed.

### 2.5.1 Subtle components of exposure-readiness

In addition to the three main types of readiness-factors (client skills, clinical factors & social factors), there might be other readiness-factors that these three types are too broad to capture. Such factors may be subtle behavioural or emotional shifts in the client or changes in the therapeutic process, from which clinicians inform their evaluation of clients' readiness. Although such implicit signs have not been discussed as much in the literature as the more palpable readiness- factors, they have not been entirely overlooked. For example, Carr (2005) advocates that in-depth research of the therapeutic process in trauma-therapies is a neglected area in need of research. Ford et al. (2005) acknowledges that there may be implicit signs of exposure-readiness from the client, which can take bodily, affective, cognitive and behavioural forms. They further suggest that clients may be unaware of emitting such signs, and that it is therefore the therapists' task in phase 1 to increase the client's mastery and awareness of these experiences. Thus, the literature suggests that there is insight to be gained by looking at the subtle signs from clients and how clinicians respond to these. Although subtle signs of exposure-readiness can be difficult to assess, they may be equally important indicators of exposure-readiness as the more gaugeable factors. Thus, attempting to identify possible implicit exposure-readiness signs, and how clinicians weigh and work with them, can help clarify this process and lay the foundation for standardising practice.

### 2.5.2 Manifestation of subtle readiness signs – an example

Although the literature on subtle exposure-readiness signs is scarce, Schauer et al. (2005) outline some behavioural and cognitive shifts they urge clinicians to look out for. However, these signs are described as signalling clients' capacity to tolerate exposure-work *during* it after already started it, rather than signs of when to *instigate* exposure-work. Nevertheless, as signs of tolerance during exposure-work, ought not to be too dissimilar from signs of readiness to start it, the authors' description may provide insight in how subtle signs of exposure-readiness signs may manifest.

First, Schauer et al. (2005) holds an appropriate level of emotional arousal to be essential when deeming exposure-readiness. This is as habituation cannot take place unless clients are able to allow painful memories and emotions to surface, but at the same time regulate them, so not to get overwhelmed by them. Signs of this balanced arousal-level to look out for are:

- Physical signs of emotional upset such as trembling and crying
- being able to regulate difficult emotions
- show awareness of the present time. This can be detected by the grammatical tense the client use, by speaking about the trauma as a past event rather than something on-going.

Secondly, Schauer et al. (2005) urge clinicians to pick up on signs when the highest point of arousal has subsided following exposure-work. This is important to identify, as exposure-work should not stop before this has occurred.

Behavioural and physiological signs of decreased emotional distress:

- muscle tension reduction
- smiling
- face colour returning to normal
- more relaxed body posture
- Reduced physical sensations related to the trauma that were reported during the exposure-narrative.

Cognitive signs of decreased emotional distress:

- Noticeable shifts in clients' attention from a focus on their internal mental state to the external environment.
- Changed meaning making of what happened to them and improved view of themselves and others.

Schauer and colleagues' description of these signs as relevant to clients' exposure-capacity is noteworthy as it is considerably less emphasised elsewhere in the literature. Thus, exploring whether clinicians evaluate clients' exposure-readiness on such subtle signs can help understand their work with shifting treatment-phase.

## 2.6. Measuring exposure-readiness

Having considered how exposure-readiness is conceptualised, the subsequent question is how clinicians assess these factors. Whilst researchers and clinicians seem largely in

agreement of which factors indicate exposure-readiness, less is written of how these factors are evaluated, and what importance they attach to them in terms of informing treatment-phase. For example, how well do clients need to master emotional-regulation before considered safe to embark on exposure-work, and is there a limit in strength of suicidal ideation that is considered too risky for exposure-work? This is recognised by Ford et al. (2005) who expresses concern that although several factors that influence exposure-readiness have been identified, little is known of how their acuity and severity is determined. They argue that this makes for poor predictability of when to safely and accurately move clients between the stabilisation and exposure-phase. They hold that the vagueness surrounding how sufficient exposure-readiness is assessed, reveals a need for further empirical research to elucidate these clinical strategies. Thus, crystallising this process in trauma-focused therapies can enable researchers to develop fuller and clearer theoretically based clinical guidelines.

However, one study that has examined the area of measuring readiness for PTSD-treatment comes from Geiss-Trusz, Wagner, Russo, Love and Zatzick (2011). They conducted a study that first identified factors that impeded treatment-readiness, from which they developed a psychometric for testing PTSD-clients' readiness to engage in TFEBT. This was done by content analysis on clinicians' notes that contained attempts to offer TFEBT to trauma-survivors. The results showed that both psychological and logistical factors were major hindrances for entering and completing the treatment. Specifically, lack of engagement between the patient and treatment-provider was found to have the biggest impact in preventing entry for treatment and predicting premature dropout. Engagement was measured as degree of reciprocity in the client-clinician relationship. This was measured as: patient-initiated interactions, patients' availability when clinicians tried to contact them, and frequency of contact. However, the authors stress that further research is needed to better understand what factors contributes to low engagement. The second largest factor that impeded readiness for treatment were of social and logistical nature and included problems with finances, housing and legal issues. It also included accessibility to the service, for example if clients had their own car, or if they were dependent on public transport. Other key factors that reduced readiness were crises such as suicidal ideation, substance misuse and poor ability to manage emotional distress. Based on these findings, they created a treatment-readiness tool that considers social factors as well as psychological factors. However, a limitation with their study is that they did not test how well their readiness-tool predicted entering and completion of treatment. Thus, predictability of their measurement needs further research. Nevertheless, their findings show that exposure-readiness entails more than emotional-regulation skills and also includes logistic and social factors.

## 2.7. Two routes of assessing exposure-readiness

In the absence of a specific psychometric for measuring exposure-readiness, two main routes to how clinicians commonly go about evaluating exposure readiness can be discerned from the trauma-treatment literature; clinical judgment and a range of psychometrics. Which route is used appears to depend on which readiness-factors are being assessed. For example, to assess for more overt readiness-factors such as risk and comorbidity, it is often recommended in the literature that validated psychometrics should be used rather than leaving such assessments to clinical judgment alone. In contrast, it seems to become less clear-cut when it comes to how clinicians evaluate less tangible readiness-factors, such as emotional regulation skills, emotional avoidance and social factors.

However, some researchers have used psychometrics to assess for some of these more implicit exposure-readiness factors. For example, Cloitre et al. (2002) used different psychometrics for interpersonal functioning, emotional regulation and the quality of the therapeutic relationship. However, it could be argued that these tests were used for the comparative, scientific purpose of their study, and may not reflect clinical everyday practice. Similarly, Courtois et al. (2009) suggests that standardised tests should be used for both core diagnostic PTSD symptoms, like flashbacks and dissociation, as well as for associated PTSD –symptoms like self-concept and adverse emotions.

Clinical judgment to evaluate exposure-readiness is portrayed in the literature as a common tool in everyday practice. It is surprising then that several manuals and guidelines casually directs clinicians to assess exposure-readiness using their clinical judgment, but without discussing what factors to base these evaluations on. For example, Leeds (2009) offers a helpful index of areas clinicians should consult when assessing exposure-readiness, but also adds that despite such aid “good clinical judgment will always be the final guide for determining when patients are ready to begin EMDR reprocessing” (p.97). Though, how clinicians arrive to the decision that sufficient exposure-readiness has been achieved is up for debate. Similarly, vague descriptions are found in Parnell (2007) who in her EMDR manual writes; “You should not begin EMDR trauma processing until the clients are sufficiently stabilized and have affect management skills” (p.79). Although Parnell lists different exposure-readiness skills needed prior to exposure-work, there are no specifications of what a sufficient level of these management skills are. Cloitre and Rosenberg (2009) states in a discussion of which type of clients are suitable for exposure-treatment that “The judgment remains with the clinician to determine the degree of coping skills available to the patient to manage states of high distress as well as the degree of his or her motivation...” (p.339).

In conclusion, whilst clinical factors like PTSD-symptoms are more easily assessed using psychometrics, the more implicit factors like emotional-regulation skills, seem to be deemed by clinical judgment. This may have the implication that what constitutes as sufficient exposure-readiness varies between clinicians and services. Thus, data on what clinicians perceive as sufficient exposure-readiness and how they evaluate it, may help form a more streamlined conception, which can help standardise treatments across services.

## 2.8. How accurate is clinical judgment?

Although clinical judgment is frequently referred to in trauma treatment manuals as a main tool to decide when to start or pause exposure-work, its accuracy has been debated. This is as a considerable amount of research has argued it to be unreliable and prone to heuristics, i.e. cognitive shortcuts that only takes a limited amount of information into consideration when forming a judgment (Hardman, 2009).

One method of testing the accuracy of clinical judgment is by comparing clinician's judgments with psychometric or client-reported measures. This design was carried out in two studies, one by Hatfield, McCullough, Frantz and Krieger (2010) and the other by Zoellner et al. (2011). Both studies tested clinicians' ability to detect features commonly held as central to exposure-readiness. The study by Hatfield et al. (2010) consisted of two parts; first, therapists were asked what they considered to be signs of symptom deterioration, and secondly, their ability to detect signs of negative change was tested. This was tested by comparing the clinicians' notes with how the clients rated their own symptoms prior to each session. Although this study covered varied patient-presentations and therapeutic models, detecting symptom-deterioration is crucial in exposure-therapy, and thereby provides relevance for the current study.

The signs that the therapists categorised as indicating symptom-worsening were of two main categories; client-variables and therapeutic process variables. The client-variables were divided into two subcategories: 1) symptom worsening and 2) change in functioning. Symptom worsening was merely described as observable symptom-worsening, but what exactly this meant was unfortunately not elaborated on. Change in functioning included deterioration in social relationships, ability to work, decreased motivation to change and heightened suicidal ideation. Therapeutic process variables were described as worsening of the therapeutic alliance, treatment goal failure, missed appointments and frequency in which the client contacted the therapist between sessions. This is an important study as it acknowledges subtle factors of exposure-readiness that may occur within sessions, but which can be so subtle that formal psychometrics may be too blunt to evaluate them. The results of Hatfield et al. study showed that even though therapists stated that they would be able to detect

these signs of symptom-worsening, the congruency between how the therapists rated their client's symptom and the client's self-reports was poor. The authors held the results to be viewed as a wake-up call, highlighting the need to implement systematic and standardised use of self-reports to aid clinical judgment. However, the findings in Hatfield et al. study should be treated with caution as progress notes are of subjective nature with low reliability, as it is possible that change was detected but was not entered in the notes. However, it raises the question of whether therapists are generally poor at detecting symptom-worsening, or whether clients display other signs of deterioration not commonly conceptualised by therapists as typical signs of symptom-worsening in the context of exposure-readiness? Research should therefore further investigate such cues and how clinicians interpret and act on them.

## 2.9. Clinical Judgement may detect what psychometrics may not

Although findings indicating clinical judgement as inadequate may feel disheartening, there are contradicting views stating that clinical intuition has high degree of accuracy (Woolley & Kostopoulou, 2013). This is echoed by Zoellner et al. (2011) who in their study tested clinicians' ability to detect an appropriate arousal-level during exposure-work. Appropriate arousal-level is crucial to ensure safe and effective interventions, as over-engagement with the traumatic memory during exposure-work can spill over to flashbacks. Similarly, under-engagement during exposure-work can be a sign of avoidance, which hinders habituation from taking place (Schnurr et al., 2003). Zoellner and colleagues found that clinicians used two indicators to help them decide whether a client should continue exposure-work or return to stabilisation-work:

1. clients' grammatical tense to gauge whether the traumatic memories were talked about as a past or current event
2. transference, by observing their own levels of stress and emotional arousal from hearing the clients' trauma-narratives.

The conclusion Zoellner et al. (2011) draws is in line with the prevailing notion that psychometrics should be utilised to aid clinical judgment. However, they also attach positive attributes to clinical judgment and argue that it has a unique role to play in deeming engagement-levels, which is fundamental to exposure-capacity.

They found that clinicians were good at detecting changes in clients' mental states and in the therapeutic process, which may not be registered by psychometrics. This view is supported by Wooley & Kostopoulou (2013) who argue that psychometrics may be too blunt a tool which may risk missing fine-grained information as clients may not report symptomology truthfully, or they may not be aware of some of their unhelpful cognitive and emotional patterns (Beutler, 1999). Thus, Zoellner (2011) and colleagues offers a different

view of that to Hatfield et al. (2010) about the value of clinical judgment in evaluating exposure-readiness. However, the validity and generalisability of Zoellner et al. (2011) findings are limited as they obtained the data by asking about clinicians' (including the authors' own) clinical experience which is presented in a descriptive fashion without applying methodological analyses of the data. Nevertheless, their study represents the need to better understand how therapists evaluate exposure-readiness and shifting treatment phase.

## 2.10. Manuals to assist timing of phase-shift

In addition to psychometrics, another source of support to aid decisions of when to shift treatment-phase is treatment-manuals. However, the utility of manual-adherence in general has been a topic of discussion. Some studies have argued that it improves treatment outcomes (Moretti & Obsuth, 2009), whilst others have found that more flexible, individualised treatment produces better treatment-outcomes (Edwards, 2013). A common concern with treatment-manuals is that they are based on randomised controlled trials (RCTs), and thus were tested in a controlled environment that can be very different from real clinical settings (Edwards, 2013). Thus, RCTs are sometimes criticised for having limited validity and generalisability (Chorpita, 2002). Although this concern is applicable across clinical presentations, Edwards (2013) holds that this can be particularly precarious when treating PTSD. According to him, this is as PTSD-symptoms can vary in severity, and because comorbid diagnoses are common. Moreover, patients with CPTSD are often excluded from RCTs. Edwards (2013) argue that this makes PTSD-treatment-manuals based on RCTs less applicable to patients in real clinical settings as they assume less complex clients.

Another concern is that treatment-manuals often follow a schedule with specific phase-interventions for specific sessions. For example, Schauer et al. (2005) states that exposure-work should start promptly on the third session with no discussion of patients' exposure-readiness. Thus, it might be worth asking whether RCT-produced PTSD-manuals may cause a conflict for clinicians between being responsive to client-needs and manual-fidelity, and if this impact the way they work with phase-shifts?

## 3. Methodology

### 3.1. Chapter overview

This section will outline the rationale of why classic grounded theory (CGT) was employed for this study. Considerations of the historical, epistemological and ontological underpinnings of CGT will also be provided. Additionally, brief reflexivity-sections are provided throughout this section (highlighted in *Italic*) about the authors' process of deciding methodology.

### 3.2. Research Design

#### 3.2.1 Qualitative methods

Creswell (2003) advocates that the choice of methodology should be one that best answers the research question. Qualitative methods aim to describe and explain a phenomenon without hypothesis testing or predicting outcome or causation, which are the main objectives in quantitative research (Paton, 1990). As this study does not seek to confirm or disconfirm a hypothesis, or establish a cause-effect relationship, qualitative methods seemed appropriate. Willig (2008) describes qualitative research as being concerned with in-depth questions of processes such as the “how” and “what”, which constitutes a good fit to frame the current research question. Qualitative research also seeks to obtain knowledge of how phenomenon occur in their natural settings (Morrow & Smith, 2000), which can be contrasted with the sometimes decontextualised or manipulated contexts in quantitative research. Thus, qualitative research methods arguably tend to hold high ecological validity. Silverstein, Auerbach and Levant (2006) holds that qualitative research is particularly well-adapted to examine clinical practice, which fits the purpose of this study.

### 3.3. Grounded theory

Having identified the broad methodological brush, the subsequent step was to decide *which* qualitative method would be most suitable to employ for this study. The choice of adopting grounded theory (GT) was based on the purpose of GT which is to generate theories by providing an explanatory framework in which to understand the phenomenon being studied (Corbin & Strauss, 2008). Moreover, Creswell (2008) suggests that GT is appropriate when existing theories about a process or phenomenon are inadequate or even non-existent, and a broad explanatory framework is needed. As theoretical frameworks of the current research question are scarce it was decided that GT could lay down the first bricks of a theoretical foundation from which further research can build upon. This organic approach to the

generation of theory reflects Glaser's stance that theories produced through GT do not claim "truth" but a platform from which they can be modified (Glaser, 1992).

GT was developed by sociologists Barney Glaser and Anselm Strauss in the 1960's as a way of providing a research method that could develop empirical data into theory (Holton & Walsh, 2017). This approach stood in stark contrast to the positivistic, hypothesis-driven tradition which had dominated research up until this time (Creswell, 2008). Specifically, GT is an inductive approach that aims to generate theoretical frameworks about a phenomenon through rigid analysis of ecologically collected data. This data is coded and categorised in increasingly advanced levels of conceptualisation that generates the emergence of meaning of the data (Willig, 2008). Grounded theory is sometimes referred to as a constant comparative method. This is because already coded data is constantly compared with new data and concepts at each level of theory-development until a sufficient theoretical framework has been obtained (Glaser & Strauss, 1967). Data-collection and analysis occurs concurrently, which allows for the theory to be built gradually, advancing from coding, to conceptual categories, to theory (Schreiber & Stern, 2001).

### 3.3.1 Grounded theory over other qualitative methods

Given the theory-producing objective for this study, GT was chosen over other qualitative methods such as interpretative phenomenological analysis (IPA), which primary intent, according to Rapport (2005), is to explore subjects' experiences on a descriptive or interpretive level. This can be compared to GT, which aims to capture experiences and processes on a conceptual level. Glaser (2002) describes the difference between IPA and GT as whilst GT aims to provide an explanatory framework about behavioural patterns on a conceptual level, IPA tells the stories of individual participants' subjective experiences. Cohen, Kahn and Steeves (2000 p.3) recommend phenomenology when the "... task at hand is to understand an experience as it is understood by those who are having it". Thus, since this study is not concerned with examining how the participants' narratives are constructed in relation to the specific social context they are narrated within, GT permits moving beyond a pure descriptive study of experience. Therefore, GT is better equipped to answer the research question than IPA.

### 3.3.2 Versions of GT

Having identified GT as the appropriate methodology, the subsequent step was to decide which versions of GT would be most suitable for this study. From the original GT-version created by Glaser & Strauss, different tenets of GT developed, which vary in analytic procedures and ontological and epistemological assumptions. Ontology refers to the nature of

reality, whilst epistemology is the study of how one can obtain knowledge of that reality (Morrow, 2007). The main tenets of GT are classic GT, Straussian GT and Constructivist GT. Breckenridge and Jones (2009) claim that novice researchers tend to avoid engaging in choosing one GT-version and instead combine a mixture of them that does not consider their innate incompatibilities. To avoid this, it was required of the researcher to explore the main purposes of the different versions of GT and their epistemological and ontological foundations. Additionally, the researchers' own philosophical stance and its possible impact on the research-process needed to be considered. These considerations will be discussed below.

### 3.3.3 Classic Grounded Theory

CGT refers to the original version of GT developed by Glaser and Strauss. However, since its development, Strauss and Glaser went their separate ways as they came to disagree about methodological approach. Strauss created another version of GT, sometimes referred to as Straussian GT, together with Juliet Corbin, whereas Glaser stuck to their original version (Higginbottom & Lauridsen, 2014).

A central aspect of CGT as advocated by Glaser (1992) is the encouragement of the researcher to limit engagement in literature prior to data collection, to avoid forcing the data to match frameworks gleaned from the literature. Breckenridge et al. (2012) holds this to reflect Glaser's trust in CGT to allow theory to emerge from the data, rather than from the literature. This posed a dilemma for me as a literature review was a required part of this study. My approach to this is outlined in section 3:2. Another central aspect of CGT according to Glaser (1978) is its aim to conceptualise participants' behaviour, rather than give a topic an interpretive or descriptive framework, which he argues that other tenets of GT are more prone to. Thus, it can be argued that CGT can provide conceptual explanations of a phenomenon rather than descriptive details of particular incidents in the data (Holton & Walsh, 2017). By focusing on abstracting the collective experience of the participants to understand and explain the research-question, it allows for exploring the data for concepts that remains constant despite individual variability in the data. Whereas constructivist and Straussian GT might be better suited when the aim is to elucidate multiple individual perspectives surrounding the phenomenon of interest (Locke, 2001). Additionally, CGT advocates that 'everything is data', which includes treating the researcher's own perspectives as yet another source of data to analyse (Glaser, 1978). *This encouraged me to not attempt "bracketing" my thoughts and impressions of the data, but rather engage with them through memo-writing. This made me more aware of times when I held "pet theories" and helped me separate between repeated occurrences in the data and themes I expected or wanted to see.*

### 3.3.4 Philosophical foundation of CGT

The development of GT was partially motivated by providing an alternative to the positivistic research-approach often used in sciences (Stern, 2009). Positivism is based on an ontology of realism that holds that knowledge exists as an independent, objective entity, which can be observed in its “true” form (Morrow, 2005). Positivism hold that the objective knowledge or reality, can be discovered though deductive methods and hypotheses (Manafi, 2010). Positivism is often associated with an epistemology of objectivism that hold it possible for researchers to capture reality in its pure form without influencing it through their interaction with the data, which would be considered contaminating it (Ponterotto, 2005; Charmaz, 2006). This stands in contrast to Glaser’s encouragement for the researcher to immerse themselves in the data and treat their own views as another dataset (Glaser,1978). *When viewing literature on the philosophical foundations of CGT, I felt confused of the varied portrayals I encountered. It was therefore a relief to find that I was not alone in having this experience.* For example, Holton (2009) acknowledges that there is confusion in terms of which philosophical framework has been attributed to GT and suggests that this might be due to an inconsistency in which terminology has been used to address issues of methodology, ontology and epistemology. She notes that CGT is often incorrectly positioned as being positivistic. For example, Charmaz (2000) argue CGT to be predominantly ontologically realist and epistemologically positivistic. Others has suggested it as resting on a post-positivistic, critical-realist ontological foundation (Devadas, Silong & Ismail, 2011) that holds that reality can be captured through scientific observation and analysis (Mills, Chapman, Bonner, & Francis, 2007). Madill, Jordan and Shirley (2000) describe CGT as having an epistemology of realism, where findings are thought to reside within the data, which can be revealed to the researcher through rigorous methods. However, Glaser (2003) holds that CGT is not bound to any epistemological or ontological framework. As the goal in CGT is conceptual abstraction as oppose to a descriptive account of the context in which the data is constructed, CGT is ontologically and epistemologically flexible (Holton & Walsh, 2017). This claim of neutrality has generated criticism from other GT-researchers as stating one’s philosophical position is increasingly required for qualitative researchers (Grix, 2002). However, Holton (2007) argues that the general nature of CGT (i.e. that it is applicable to both qualitative and quantitative studies) and its inductive methodological nature that strives for abstract conceptualisation, makes the explicit positioning of theoretical frameworks unnecessary. Breckenridge et al. (2012) argue that the philosophically neutral foundation of CGT allows it to be theoretically specific to each different study. This can be contrasted to constructivist GT which already prescribes a theoretical lens through which data is approached. According to this understanding of CGT, it may not be appropriate to assign a specific theoretical framework

prior to conducting a CGT study, but rather to let the final theoretical product determine the theoretical positioning of the study (Breckenridge et al., 2012). This stance is captured in the following quote:

*“the potential for classic grounded theory to assume any theoretical perspective may soon be more willingly embraced... classic grounded theory is perhaps more aligned with the direction in which modern healthcare research is travelling; seeing philosophical positions not as discrete, incompatible opposites, but as offering multiple and complementary approaches to understanding social phenomena”.*

—Breckenridge et al., 2012, p.69

Although CGT positions itself as philosophically neutral, it holds the process and product of the study to be shaped by the researchers’ philosophical stance (Holton & Walsh, 2017). Therefore, it is required of the researcher to consider how her own positioning may have shaped the research-process.

*The process of understanding the philosophical tenets, and positioning myself in them, was not a straightforward journey. However, through developing my reflective skills, I became more aware of how I view reality and how different methodological approaches are like tools - each with its specialism that equips it for understanding certain aspects of reality. Upon having experienced “novice qualitative research insecurity” where I felt overwhelmed, confused and indecisive by the philosophical canons, I have gradually come to position myself as a critical-realist with an ontological stance of realism and an epistemologically relativist view. This perspective acknowledges reality as nuanced and as perceived differently between different individuals, but at the same time believe reality to contain a domain that transcends individual perceptions (Zachariadis, Scott & Barret (2013). Mingers (2004) hold that the aim of critical-realism is to discover underlying patterns, which reflects my aim and research-question as well as the objective with CGT. Perhaps this stance made me focus on data providing a nomothetic explanation for the area of interest with less attention to idiographic experiences. This might have made me less sensitive to data not fitting prevalent concepts in my search for the emergence of a dominant pattern. Moreover, though I experienced CGT’s absence of firm ontological and epistemological anchoring as confusing at first, I later found that the theoretical and philosophical flexibility facilitated me to approach the data without viewing it through a “readymade” philosophical and theoretical lens. I believe this eased some of my anxiety of inadvertently forcing categories and concepts to “match” a specific academic framework.*

To further demonstrate the choice of CGT, a brief overview of two other versions of GT will be provided.

### 3.3.5 Constructivist GT

Similar to Glaser, Charmaz rejected the tradition of positivism in sciences (Manafi, 2010). Criticism towards positivism developed from the postmodernist paradigm from which a relativistic perspective grew. Relativism states that reality is constructed and thereby relative and pluralistic and rejects the positivistic notion of a single independently existing reality (Burr, 2003). From this, a constructivist version of GT (constructivist GT) was developed by Charmaz. Constructivist GT emphasise postmodernist values such as relativism, pluralism and context, and the notion that knowledge is constructed (Charmaz, 2006). Charmaz holds knowledge or reality to be socially and context-dependent and emphasises that researchers co-construct the research-process and inevitably leave their imprint on the developed theory. Charmaz (2003) herself advocate that constructivist GT lays between postmodernism and positivism. Appleton and King (2002) describes constructivist GT to have a relativistic epistemological foundation that holds that individuals construct their own reality and attach meaning to the world through their own individual lens. From this philosophical background, it is not surprising that Charmaz (2006) advocates that GT ought to reflect the individual nuances of participants' multiple views and experiences. This illustrates a difference from CGT, which instead is more concerned about capturing conceptual understanding of patterns of individual's behaviour that transcends individual differences (Glaser, 2003). Consequently, constructivist GT produces a theory consisting of multiple perspectives, whereas CGT seeks to identify a main concept to describe the process of interest (Martin, 2006). *As I personally embrace the constructivist notion that an individual's experience is shaped by their idiographic context, Charmaz' GT-version was appealing at first. However, I adopted CGT for this study as my interest laid in explaining a pattern underlying the studied area, and to conceptualise the participants' experiences on an abstract level, rather than the "...portrayal of subjects experience in its fullness" (Charmaz (2003, p.269).*

### 3.3.6 Straussian GT

As mentioned earlier, Glaser and Strauss came to disagree on methodological facets in GT. A main methodological difference between CGT and Straussian GT is the approach to coding. Specifically, the element of axial coding in Straussian GT sets the two schools of GT apart. Kendall (1999) describes axial coding as an analytic process where the links between categories and concepts are highlighted using a prescriptive coding paradigm. This paradigm compares concepts on several areas that considers the phenomenon (the context in which the phenomenon arose), its conditions (contextual properties), action interface stratagem (how a process is carried out) and effects (consequences of the process of the phenomenon) (Strauss & Corbin, 1990). Though meant to strengthen the connection between the categories, Glaser argues that the rigidity of the coding paradigm hampers a theory that is truly anchored in the

data by forcing the data to fit into preconceived categories (Harry, Sturges & Klingner, 2005). Arguably, axial coding allows more space for context and pluralism in the data. Moreover, the analytic procedure to understand nuances, reflects an ontological lens of pragmatic relativism that argue that a phenomenon is coloured by its historical context (Mills et al., 2007). Strauss and Corbin (1994) argue that their GT-version produces a theory that considers the history and moments in which theories are embedded, which are factors that also needs to be considered when revising theories. *Had I sampled data from a more varied range of sources, such as different health-care providers, Strauss' approach could have facilitated in-depth understanding of the unique history and contexts of the differences between the sources. However, as my sources were all NHS-services where standardised care is central, focus on context and pluralism was not my primarily aim. Moreover, as I was interested in capturing an overarching conceptualisation of the process of interest, rather than in-depth understanding of the nuances, I held the CGT approach to be better equipped to generate a theory surrounding the research question.* Glaser has argued that CGT is better suited for producing a theory, whereas he holds Strauss' GT to be more appropriate for descriptive interpretations of the data (Locke, 1996).

## 4. Method

This section will outline ethical considerations and steps taken for collecting and analysing the data. By transparently outline method, replicability is facilitated thereby enhancing this study's reliability. Additionally, measures taken to enhance the quality of this study are discussed.

### 4.1. Participants

As GT requires data from sources able to provide expert knowledge of the area of interest (Andrews, Higgins, Waring Andrews & Lalor, 2012), a purposeful sampling strategy was employed. Participants for this study were chartered counselling and clinical psychologists who were currently active in providing trauma-focused therapies in specialised PTSD-teams within the NHS. Of the current sample, eight were clinical psychologists and one was a counselling psychologist (see Appendix A for participant demographics). The lack of counselling psychologists was coincidental and will be further discussed in the limitation-section of this study. The inclusion criteria for the participants were:

- Clinical or Counselling psychologist working in a PTSD-service
- At least six months experience of providing trauma-focused therapies.
- Fluency in the English language

The reasons for including psychologists and thereby excluding other therapeutic professions was to recruit participants who are likely to be knowledgeable in the topic at hand (Bryant & Charmaz, 2007). Moreover, the participants were recruited from secondary care services and thereby had experience of CPTSD. This is valuable as empirically based treatment-guidelines for CPTSD are limited (Courtois et al., 2009).

### 4.2. Procedure

#### 4.2.1 Recruitment process

To gather a sample with relevant expertise, purposive sampling methods (i.e. a non-probability method based on choosing participants on a characteristic meaningful for the study) were used. Therefore, participants were recruited from different PTSD-services within the NHS in England. The purpose of recruiting from multiple services was to add breadth to the data, as a diverse sample is recommended in GT (Glaser, 1998). Upon obtaining ethical approval from London Metropolitan University and the Health Research Authority (HRA) (see Appendices B and C respectively), team-managers of the identified PTSD-teams were sent an email enquiring the participation of members of their teams meeting the inclusion criteria. For

teams who accepted, official invitation emails were sent back to the team managers, who in turn forwarded the invitation emails to team-members meeting the inclusion criteria. The invitation email contained contact details to me so that further correspondence could be directly between me and participants. For those accepting participation, interviews were arranged at times and locations convenient to them. To obtain consent, participants were informed in writing through the invitation email, briefing sheet and consent form (see Appendices D, E and F) of what participation involved, and how they could withdraw from the study. Additionally, a verbal briefing was given prior to each interview, and participants were asked if they had understood what participation involved and if they had any questions. If they accepted, they were asked to sign the consent form.

### 4.3. A GT approach to interviewing

Data were collected through semi-structured one on one interviews. Semi-structured interviewing is a compatible method of data collection in GT, which allows for flexibility for the interviewees to speak within a thematic framework yet is structured by some questions and prompts (Allan, 2003). The interview scheme (see Appendix G) was tested in a pilot interview to allow for adjustments and clarification of the interview questions. Questions were open-ended to allow for in-depth data (Kvale, 1996) and to let the participants' narrative inspire further questions. Upon analysing the five first interviews and forming an initial theoretical model, the interview questions used for the second round of interviews were amended to further explore the themes already identified. See Appendix H for the second interview schedule. Interviews were recorded using a Sony audio recorder and transcribed by the researcher in Word.

#### 4.3.1 Pilot interview

A pilot interview was carried out to bring to awareness any difficulties with the interview, such as language, construction of the questions or technical issues with the recorder. For a realistic pilot interview, a psychologist from a PTSD-team was recruited. This participant represented a service that was not part of the services involved in this study. From this, a few issues needed to be addressed. First, the researcher needed to develop more confidence in operating the recorder, so not to risk poor recording quality. Secondly, in order to allow more flow in the interview, a higher degree of familiarity with the questions was needed in order to become less dependent on the interview schedule.

#### 4.3.2 Considerations with interviewing techniques

Concerns has been raised that analysis of interview-generated data tend to treat data at face-value and lack in taking the context into consideration (Potter & Hepburn, 2005). To

manage this, Willig (2008) stresses that the researcher needs to remain reflective about the process of interviewing, and to not presume the interviewee's words as objective. Birks and Mills (2011) holds that interviewing in GT requires particular attention to what participants are saying in order to stay theoretically sensitive, and to help set out direction for subsequent data collection. *To remain theoretically sensitive, the researcher engaged in memo-taking in order to adopt a reflexive approach to the research process. This exercise helped with the sometimes-ambiguous task of being immersed in the data, but at the same time keep a reflective distance from it to reduce the risk of pursuing pet concepts.* Although Husserl (1931) holds it as possible for researchers to bracket their own presumptions so to not impact the data, the author of this study views that as impossible. Instead, the researcher holds Heidegger's (1962) notion of bracketing as neither necessary nor possible due to the interpretive nature of phenomenological research-process.

*Although endorsing Heidegger's stance, I aimed to reduce the degree to which my views influenced the research-process. I became aware of my imprint on the research when I realised that I held expectations of what to find in participants' narratives. This became clear upon having analysed the first few interviews as the participants brought themes that were unexpected to me. I anticipated that clinicians' decisions on when to shift treatment-phase would be informed by subtle emotional and behavioural signs from clients, as indicated by some authors for example Carr (2005) and Ford et al. (2005). Instead, clinicians talked more about external obstacles to commence exposure-work rather than factors within the clients. Thus, I may have missed opportunities to ask further about this in the first interviews. From this, I learned to rely less on my interview-schedule to allow interviews to be more participant-led. This made me engage further in memo-writing which helped me to more consciously explore my own perspectives when analysing the data. This facilitated treating my own views in line with Glaser's notion to handle the researchers' own stances like any other data (Glaser, 1978). Perhaps my expectations of cues in the therapeutic process being formative in evaluating exposure-readiness comes from my counselling psychology training, where the therapeutic process is central (Rizq & Target, 2008).*

### 4.3.3 Researcher-interviewee interaction

One aspect of interviewing is the inevitable power imbalance, as the researcher has the control by asking the questions, and ultimately analyses the interviewees' accounts (Willig, 2008). Therefore, it was important to balance between maintaining control of the interviews yet allowing space for the participants to elaborate their views. To help with this, Kvale's (1996) advice was kept in mind during the interviews; whilst the interviewer should lead the participants towards certain themes, they ought not to shape their opinions on these themes. This was done by asking open-ended questions without a set order to allow participants to assert some authority over the interviews. Moreover, as the researcher was a trainee asking for

the participants' expertise, it helped level the power balance. Additionally, therapist skills like warmth and active listening facilitated rapport (Morrow, 2007).

#### 4.4. Ethical considerations

Interaction with participants and handling and storage of data was in accordance with BPS Code of Human Research Ethics (2014) and the Data Protection Act 1998. Participants were made aware how their data would be used and protected. To protect their identity, names of people and services have been censored. Participants were asked if they wanted any characteristic language to be removed from the transcripts, as this could be an identifying cue. Participants were informed that only the researcher could access the audio-files, but that the researcher's supervisor and members of the examination board, might read the transcripts. Anonymity was upheld by giving each participant a code consisting of a letter. Only the researcher kept a record in a safe location of which code belonged to which participant. Audio files and transcripts were stored separately and could only be accessed by the researcher. In line with the Data Protection Act 1998 and London Metropolitan University Research Ethics Policy and Procedures (2014), the audio files will be held up to completing the thesis before being safely deleted.

Moreover, as talking about trauma-related work can cause vicarious traumatization in professionals (Rothschild & Rand, 2006), participants were given a debriefing form (see Appendix I) containing references to self-help literature for professionals at risk of vicarious traumatization. A distress protocol (see Appendix J) was in place to be used if needed. Furthermore, time was set aside following each interview for debriefing, where participants were encouraged to raise questions, comments and concerns about the interview and the study. Participants were informed that they could have a copy of their audio-files, transcripts and the final thesis upon request. Participants were further informed that quotations from the transcripts would be used in the final thesis and that a copy of the thesis might be accessed via the university library and database, and that it might be submitted for publication.

#### 4.5. Analysis

The researcher cycled between data-collection, coding, constant comparison and memo-writing. This emergent research design allows for directing what information to next pursue (Holton, 2008). The researcher collected and analysed five interviews from which an initial theoretical model was developed. Subsequently, theoretical sampling was employed, and data from four further interviews were conducted to fill the gaps in the evolving theory. Each transcript underwent repeated rigorous analytic steps of coding, constant comparison and memo-writing. Care was taken to stay close to the language used by interviewees when

forming codes and categories to allow the emerging theory to remain grounded in the data (Birks & Mills, 2011).

#### 4.5.1 Coding

Holton (2010) describes coding as the analytic procedure of grouping interrelated themes emerging from the data. CGT involves two types of coding: *substantive coding*, which includes both open and selective coding, and *theoretical coding* (Holton, 2010). The researcher first engaged in open coding, which is a way of breaking down the data into meaningful codes that are of relevance to the interviewee. *This initial analytic coding helped me become familiar with the data and familiarised me with the analytic procedures.* In accordance to recommendations by Birks and Mills (2011), line by line coding was repeatedly done on each transcript, until categories started to form and further codes were redundant. The subsequent stage of coding, referred to as focused or selective coding, involved identifying which codes best reflected the data. These codes were then given more abstract conceptualisations. Birks & Mills (2011) recommends special attention on generating conceptualisations to identified core categories in this stage. This is refined by drawing connections between and within cluster of codes and categories (Glaser, 1998). The process of open and selective coding does not occur in parallel but overlaps. This process helps verifying that the emerged initial codes and concepts are relevant to and anchored in the data. To facilitate this process, the researcher asked herself a set of questions recommended by Glaser (Glaser, 1998, p.140):

*‘What is this data a study of?’*

*‘What category does this incident indicate?’*

*‘What is actually happening in the data?’*

*‘What is the main concern being faced by the participants?’*

*‘What accounts for the continual resolving of this concern?’*

As the coding process proceeds, codes with shared characteristics were consolidated into conceptual categories, and more abstract meaning were attached to them. This is referred to as transferring the initial codes from lower level to higher level conceptual categories (Glaser, 1994). *When going through the stages of coding, I found that the categories became increasingly abstract in nature, and eventually, certain categories with higher frequency and more pronounced connections to other categories emerged. This proceeded until a core component arose that constituted the proposed emerging theory.* Generating categories also involved outlining their properties and dimensions (Birks & Mills, 2011). This meant considering the depth and breadth of the phenomenon the categories represented, to attach more meaning to them. For example, the component “service cooperation” was given the property “enhancing exposure-readiness”, and dimensions that stretched from views advocating PTSD being treated

separately with no input from other services, to advocating simultaneous input from multiple services alongside PTSD-treatment.

Subsequently, the researcher engaged in theoretical sampling by recruiting more participants to fill gaps in the emerging theoretical model. Interview questions were changed accordingly to pursue these concepts further. Glaser (2002) suggests returning to participants for further interviews to clarify and elaborate on relevant material. For this study, one participant was asked to do a second interview. The choice of inviting this participant was as she was engaging and elaborative without needing much prompting in the first meeting and had much to say about categories that were frequent and formative in the data. Additionally, three new participants were interviewed in order to incorporate new material with the existing data.

The final step of coding, theoretical coding, involved analysing identified codes and categories for how they relate to each other as hypotheses that make up the theoretical framework of the emerging theory (Holton, 2010). To demonstrate the analytic process and the different stages of coding, an example is provided in Appendix K.

*I found the process of coding frustrating at first as my codes appeared too descriptive. However, as I gradually learnt to trust the process of making comparisons within and between dataset, as well as my own thoughts about the data, I began to notice concepts that conveyed meaning about the phenomenon of interest. Thus, accepting my own role in the research-process initially felt overly "subjective" and "unscientific", but by cycling between the analytic stages I began to see why Willig (2008) describes GT as offering both scientific rigour as well as leaving space for creativity.*

#### 4.5.2 Memoing and constant comparison

Constant-comparison was undertaken throughout the analytic process and involved comparing segments of data within and between datasets. This helped discerning and solidifying links between conceptual and core categories. Additionally, as advocated by Pidgeon and Henwood (1997) the researcher engaged in memoing as a quality enhancing tool. This involved taking notes about the analytic process of coding, comparisons and the rationale and development for themes and categories. This process facilitated remaining reflexive about the data, detecting patterns and interrelations between the codes and aided the building of progressively theoretical conceptualisations. An example of memoing is provided in Appendix L.

#### 4.5.3 Theoretical sufficiency

Glaser & Strauss (1967) states that data collection should continue until reaching theoretical saturation, i.e. when new concepts and themes no longer emerges. The term

“saturation” has been questioned by some researchers. For example, Dey (1999) proposes the term “sufficiency” instead as theories are inherently organic as they continuously can be modified. However, this may be more of a semantic difference as Glaser and Strauss do not appear to view theories as reaching a point of static as they hold the development of theories as a never-ending process (Glaser & Strauss, 1967). This stance seems to be captured by Willig’s (2008) more recent argument that theoretical saturation is an aim rather than a reality. The current researcher does not claim her research to have reached a status of finite stagnation but considered the point where her data did not kindle novel theoretical discernments, as being where theoretical sufficiency occurred.

#### 4.5.4 Ensuring quality

Creswell (1998) holds that the analytic steps of GT provides sufficient scientific rigour and verification. However, other researchers like Henwood (1996) argues that further steps can be taken to enhance quality of a GT study. One such method is through respondent validation, i.e. asking participants for their feedback of the researchers’ interpretation of their narratives. However, the utility of this method has been debated among researchers. Henwood (1996) holds it to enhance a study’s trustworthiness, whereas Angen (2000) argue that it leads to a moot discussion of whether the respondents’ or the researcher’s interpretation is most valid. Other researchers such as Cowie and Salm (1998) and Birks and Mills (2011) argue that the rigid analytic process, such as constant comparison and theoretical sampling, makes member-checking redundant. Though recognising the advantages with respondent validation, it was decided not to employ it for this study. This decision was made upon the argument that the analytic procedures provide sufficient quality. Specifically, by keeping a reflective diary, it enabled a chance to view the data from different angles, which made further analyses of participants’ feedback on the emerging abstractions excessive. However, other steps were taken to ensure rigour of the study. First, as mentioned before, the researcher engaged in memoing and constant comparison strategies throughout the research process, which according to Morrow (2005) enhances trustworthiness of the study. Secondly, regular supervision further aided the researcher to recognise held pet theories and facilitated viewing the data from different perspectives. Having to provide rationale for one’s thinking and theoretical conceptualisation of the data through memoing, constant comparisons and supervision, increases awareness of held preconceptions, which is described by Fassinger (2005) as enhancing reflexivity.

Qualitative research has been criticised for being anecdotal and lacking scientific rigour, as conventional criteria like validity and reliability used in quantitative research to monitor its quality, do not apply (Padgett, 1998; Cutcliffe & McKenna, 2004). Therefore,

Bowen (2009) encourages qualitative researchers to enhance trustworthiness of one's study through four factors: credibility, transferability, dependability and confirmability. Credibility can be enhanced through utilising more than two data sources. As participants were recruited from four different services, this criterion is argued to have been met. Transferability refers to the ability for other researchers to apply the findings of this study to their own. This was achieved through transparently describing the analytic process and the provision of quotes to illustrate interpretations. Dependability means that the findings remain stable over time, and credibility refers to the existence of congruence between the data and the findings. Bowen (2009) argues that the last two factors can be accomplished simultaneously through providing an audit trail which for this study was in the form of an independent audit.

The independent audit, which was examined and approved by my supervisor, shows the successive coding from an individual quote to the higher-level categorisation of that quote. This audit offers a transparent trail of what was done with the data, and how the researcher arrived at the theoretical conceptualisations. Thus, this facilitates for future researchers to adjust or build on the theory generated from this study. For an example of the independent audit see Appendix M and Appendix N for a full transcript.

Moreover, to strengthen the validity of the data, the researcher engaged in negative case analysis (Kolb (2012)). This means attending to instances that did not seem to "fit" previously collected data. For example, different subcomponents subsumed under component 1, was initially viewed as not fitting together. However, subsequent analysis showed that the different subcomponents bore varied but interconnected relevance to the same component. *Thus, this exercise enabled me to capture the nuances and complexity in the data, which together developed into a more comprehensive theory.*

## 5. Findings

### 5.1. Introduction to findings

This section will present the findings of this study. To remind the reader, the research question for this study is: how do clinicians work with the shift between the stabilisation-phase and the exposure-phase in PTSD-treatment? The rigorous analytic procedure revealed thematic and lingual patterns that informed the components and core concept. In line with GT, the findings are encapsulated in four components and one core category, which entail the theoretical abstractions made from the data.

Analysis revealed four interrelated components, each of which encompassed subcomponents:

1. Clinicians view exposure readiness to be determined by more than traditional stabilisation-work due to the psychological and social complexity of PTSD-clients.
  - Traditional PTSD symptom-management skills
  - Understanding PTSD and the treatment rationale and having motivation to undergo the treatment
  - Social stability
  - Clinicians advocate increased service co-operation alongside trauma-focused work to meet clients' complex social needs
2. Clinicians' view that treatment needs to be more integrative as opposed to solely conducting trauma-therapies in order to meet clients' complex needs.
  - Clinicians working integratively alongside trauma-focused work to support clients' social needs and other psychological needs not immediately related to PTSD. However, trauma-focused work remains the central model.
3. Clinicians argue that the concept of exposure-readiness needs to be re-evaluated to make treatment more effective.
  - Clinicians think the concept "exposure-readiness" is ambiguous, which makes it difficult to evaluate
  - Clinicians view the concept "exposure-readiness" to be an unhelpful idea that generates uncertainty among clinicians
4. Clinicians feel that the prescribed treatment-model poses challenges to providing effective treatment.
  - Clinicians approve of the different phases in PTSD-treatment but oppose the interim between them

- Fading exposure-readiness and general destabilisation during the mid-treatment interim hampers the treatment trajectory
- Limited exposure-work sessions risk not having enough time for full exposure-work
- Clinicians advocate interventions and support for clients during the interim as opposed to treating it as a passive phase
- The prescribed treatment-model induces pressure on clinicians

Further analysis revealed that these components were subsumed under a core category of which the components bore thematic relations to. This core category was:

- Clinicians are managing their role and resources in relation to the prescribed treatment-model.

This core concept began to emerge during analysis of the fifth interview, during which it became evident that themes related to the core category were present in each interview. Upon having analysed the fifth interview, further theoretical sampling commenced. Data from the latter interviews strengthened the position of the core category. From this, a theoretical framework was constructed that serves to understand and explain the research question.

In the below sections, a summary of the theoretical model will be given, followed by a presentation of each of the components and their subcomponents. Each component is presented with a table showing which participants contributed to which (sub)component. Subsequently, a presentation of the core category is provided.

## 5.2. Summary of theoretical framework

The analysis and interpretations of the participants' narratives generated a theoretical framework in which the research question can be understood. This is depicted in figure 1. This framework illustrates the challenges the clinicians encounter when working with the shift between the stabilisation and the exposure-phase. Firstly, these challenges arose due to the complex needs clients presented with and because of the way the treatment-model is set up. These challenges put pressure on the clinicians. For example, many of them described feeling as if the treatment-model undermined practicing effectively. However, as seen in the model, the clinicians were responding to meet and manage these challenges. For example, clients' complex needs often meant that they required support with social issues like housing, asylum issues, benefits and legal issues which meant that clinicians often had to support clients with social issues in addition to the trauma-focused work. To respond to this, the clinicians and their teams engaged in co-operation with different services and professionals like social-workers and lawyers to help with clients' social and legal issues. Moreover, the clinicians also

practiced integratively in addition to trauma-focused work to better meet clients' complex psychological needs.

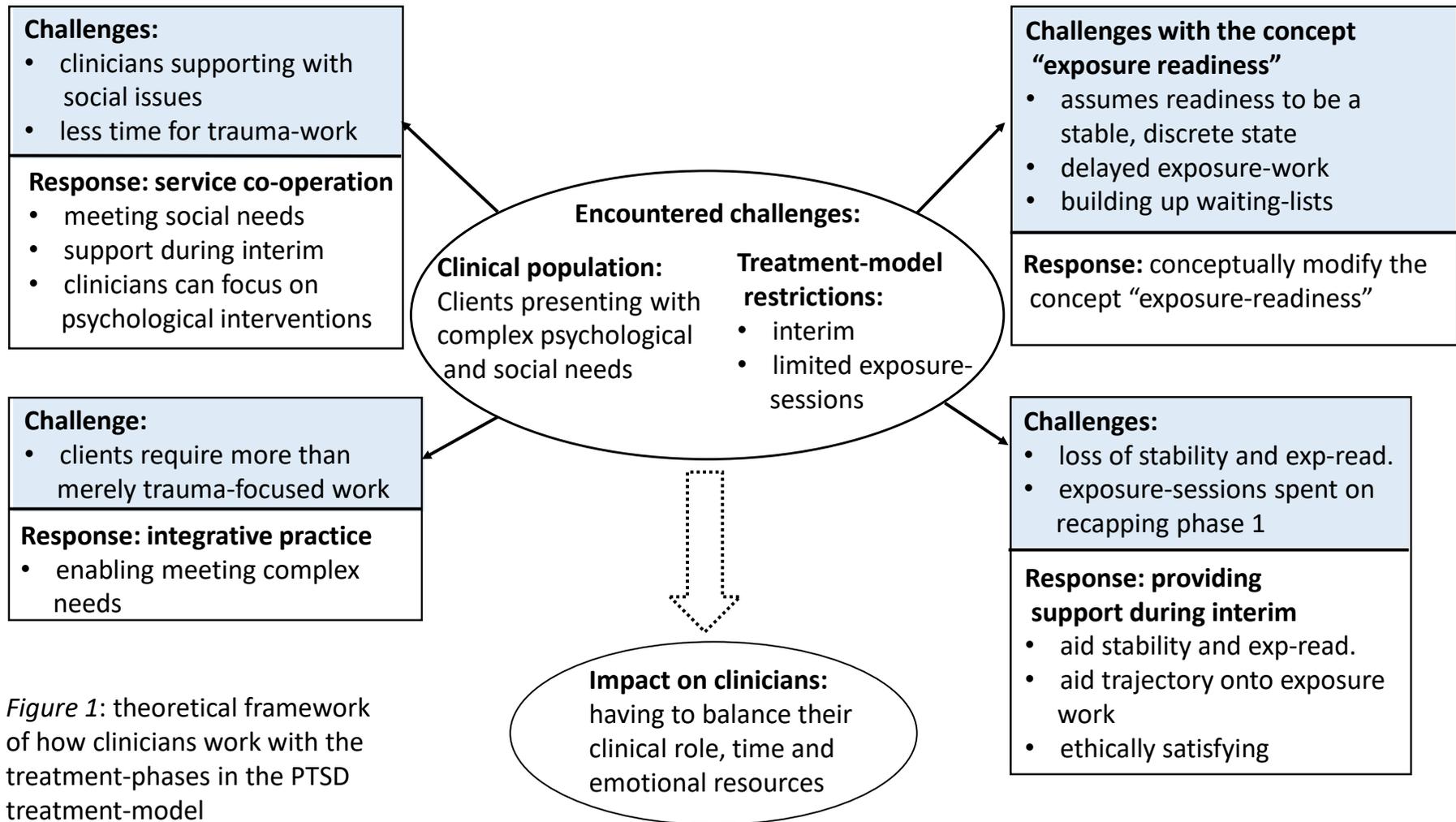


Figure 1: theoretical framework of how clinicians work with the treatment-phases in the PTSD treatment-model

Next, several of the clinicians thought the concept of “exposure-readiness” is unhelpful as it assumes that exposure-readiness is a discrete state that can be obtained, and once obtained, cannot be lost. However, their experience showed that clients’ exposure-readiness indeed often was lost during the interim. Thus, it seemed to be believed among the sample that these assumptions may underlie the treatment-model with the interim in that it may not be viewed as necessary to provide continuous interventions to maintain exposure-readiness. However, by re-thinking the concept “exposure-readiness” in a way that reflects that it needs continuous support in order to be upheld, it may change the way treatment is structured. To manage the negative effects of the interim and the limited exposure-sessions, some of the clinicians advocated that thinking about “exposure-readiness” differently may change the way treatment is approached.

Lastly, the other main challenges were caused by the treatment-model itself. This involved the interim between the stabilisation and exposure-phase, which was described as having arisen due to large caseloads and too few clinicians with expertise to conduct exposure-work. Consequently, upon completing the stabilisation-phase, clients were put on a waiting list for the exposure-phase. This wait lasted between six months to over a year. Additionally, scarce service-resources meant that clients were given little or no interventions during this time. As a result, the exposure-readiness that clients had gained in the stabilisation-phase, would often have faded. Consequently, clinicians would spend several sessions in the exposure-phase on re-capping phase 1 which created another challenge as the number of exposure-work sessions were limited. This meant that there was not always time to conduct a full exposure-based treatment. Thus, the clinicians had to balance the limited sessions between recapping phase 1 yet leaving enough time to do exposure-work. To respond to this, the clinicians reported that their teams were in the process of discussing how more support could be implemented during the interim. This was believed to help maintaining clients’ exposure-readiness and general life-stability, which would reduce the need of recapping-phase 1 and thereby leave more sessions for exposure-work. Supporting clients’ during the interim also appeared to be a more ethically satisfying way of working for the clinicians.

This model portrays the challenges clinicians are faced with in terms of clients’ complexity as well as with the treatment-model. Although they found ways to respond to these barriers, the setup of the treatment-model appeared to counteract their efforts and caused strain on clinicians, treatment, clients and services. These challenges and the way the current sample responded to them will be presented below.

### 5.3. Components

5.3.1 Component 1: Clinicians view exposure readiness to be determined by more than traditional stabilisation-work due to the psychological and social complexity of PTSD-clients.

Subcomponents	Contributors
Understanding PTSD and the treatment rationale and having motivation to undergo the treatment	A,B,C,D,E,F,H,I
Traditional PTSD symptom-management skills	A,B,C,D,E,F,G,I
Social stability	A,B,C,D,E,F,G,H,I
Clinicians advocate increased service co-operation alongside trauma-focused work to meet clients' complex social needs	A,B,C,E,F,G,I

This subcategory encapsulated clinicians' understanding of what make clients exposure-ready.

#### 5.3.1.1 *Understanding PTSD and the treatment rationale and having motivation to undergo the treatment*

Two psychological factors that frequently featured in the data as important for exposure-readiness were: *motivation* for doing the treatment and *understanding* the treatment rationale.

*CL42-45: I think understanding the commitment of it and that you will get worse to begin with [...].I suppose [...] an openness to "I will try it" ...*

The clinicians appeared well aware of how distressing exposure-work can be for clients. This is reflected in Clara's words above. It seemed that this awareness was a reason for why understanding what exposure-work entails and willingness to undergo it, was held as an important part of exposure-readiness. The clinicians also held understanding the cause of PTSD-symptoms as part of understanding the treatment-rationale. This is shown in Danielle's quote below:

*DL9-16: they need to know what PTSD is [...] why they have their flashbacks and their nightmares as a result of poor processing when the trauma happened and that exposure work is targeted at helping that memory [...].*

#### 5.3.1.2 *Traditional PTSD Symptom-management skills*

Unsurprisingly, most of the clinicians stated emotional regulation-skills as a central sign of exposure-readiness. Such skills are part of traditional stabilisation-work such as self-soothing techniques, grounding techniques and breathing exercises. This finding was expected

as research holds emotional-regulation skills prior to exposure-work as indispensable (Cloitre et al., 2002). Clara's words of "compulsory" reflects its importance for exposure-readiness.

*CL79-82: ...grounding, learning to manage flashbacks and nightmares - and we say that's compulsory because if you don't want to [...] manage them something tells me you won't do trauma-focused therapy.*

#### *5.3.1.3 Social stability*

The clinicians also reported that clients' social circumstances were highly important for exposure-readiness. This was because CPTSD-clients often live in socially unstable and chaotic circumstances in terms of their accommodation, financial and legal situations. The clinicians described these social matters to often be at the forefront of clients' minds which made it difficult for clients to concentrate on the therapy and take on the treatment-rationale or engage in emotional-regulation techniques. A quote from Anna is given below.

*AL4-8: Our phase 1 work is supporting them to achieve stabilisation in different aspects of their lives [...] asylum or immigration issues, housing issues, benefit issues – we'd either be supporting them with that or referring to the appropriate service to help them with those types of issues.*

Anna describes supporting clients with social issues through signposting them to other services but also supporting clients with these kinds of issues themselves. This shows that clinicians' work often stretches beyond the remit of traditional phase 1 work. Thus, clients would often divide sessions between trauma-focused work as well as directly or indirectly provide support with social matters. However, the sample also reported a high level of co-operation with other services that could offer specialised support with clients' social issues. This is outlined in the subcomponent below.

#### *5.3.1.4 Clinicians advocate increased service co-operation alongside trauma-focused work to meet clients' complex social needs*

The clinicians' narratives revealed that one main challenge with building and maintaining exposure-readiness in the stabilisation and the exposure-phase was clients' complex social needs. Specifically, it appeared to be the multiple non-psychological areas clients needed support with that made it difficult for clinicians to focus on trauma-focused work. A way the clinicians managed these challenges were by cooperating with other services. That is, other agents supported clients with different areas of their lives, predominantly social issues like housing and legal issues. Beatrice's use of the words "rely on" and "use a lot of" below show that frequent co-operation is a necessity for PTSD-treatment and shows the need for holistic care.

*BL422-425: I think we rely a lot on third-sector organisations and there are some great services out there that, that we probably use a lot.*

A consequence of clients' complex needs was that clinicians would often support clients with social issues in addition to therapy. This meant that less time was left for psychological-interventions. Thus, an advantage of having other services support clients with non-psychological issues, like housing and legal issues, was that it facilitated for clinicians to focus on therapy.

*CL491-493: We might refer them to step-IV services for depression afterwards [...] but we need to focus only on the PTSD, otherwise treatment would never stop.*

*EL149-153: If someone had housing difficulties I might ask one of the social workers to come on board [...] it might be possible to continue our sort of psychological intervention whilst social worker was also doing an additional piece of work with them.*

Clara's and Erica's quotes above shows that clinicians are balancing clients' multiple needs at the same time as they are aiming to maintain the trauma-focused trajectory. Thus, service co-operation appeared a way of managing time and clinical focus. Moreover, clinicians emphasised that additional support were to be ongoing alongside trauma-focused therapy. As seen in Fiona's quote below, simultaneous support is needed due to the complexity of clients' presentations.

*FL249-254: ...the care coordinators are part of the PTSD team so they manage... they sort of hold clients and, and work with all the other issues that need to be worked with [...]....and allows us to continue with trauma-focused therapy.*

The fact that trauma-therapy and other social input were done in parallel shows that the clinicians and their teams accepted clients onto trauma-work even if they had unstable life-circumstances. This is noteworthy as it challenges the notion that clients need to be stable prior to engaging in trauma-work. This stance was particularly pronounced for Anna and Henry who worked in two different services that wanted to develop capacity to treat clients with comorbid PTSD and substance use disorder (SUD). Clients with SUD are commonly excluded from doing exposure-therapy as they are considered too risky. Thus, their views reflect ambition to provide holistic care rather than excluding them from trauma-treatments or treating one issue at the time.

*AL727-730: ...how best to work with someone that is using substances [...] it's finding that window of working with them where they're substance use is at a level that they will still benefit from the emotional processing...*

However, despite the strong advocacy among the clinicians for multidisciplinary input they still held that service-cooperation needed to be improved. Particularly, it was raised that coordination and communication between services needed to improve to prevent miscommunication and for clients being bounced around in the system.

Lastly, service co-operation also seemed to serve the purpose of aiding exposure-readiness during the interim between the stabilisation-phase and the exposure-phase where clients would be put on the waiting list for the exposure-phase upon completing the stabilisation-phase. Clients' exposure-readiness would often fade during the interim, which risked them being discharged at the start of the exposure-phase if they were not considered to have maintained enough exposure-readiness at this point. Thus, the idea that co-operating with other services could counter some of this effect during the interim was raised among the sample as indicated in Gina's quote below:

*GL216-218: ...we try and work out how to support them so they don't have to be discharged [...]. It's important to co-operate with other services to support clients with different problems, especially after having been on the waiting list for perhaps a year.*

In summary, service co-operation appeared a way to ensure that different professionals helped with clients' different needs. This in turn helped keeping clients stable and enabled clinicians to focus more on trauma-related issues. By involving other services, they could also aid in keeping clients stable during the mid-treatment interim. Thus, service-cooperation seemed to serve the purposes of meeting complex individual needs and facilitated transition to exposure-work after the interim by providing support for clients whilst they were waiting for the exposure-phase. Thus, utilising multi-agent work seemed to serve the function of both providing the *type* of input that was out of the remits of trauma-focused psychological input as well as providing support at *times* when the services were unable to, like during the waiting-list.

To summarise component 1; although it emerged from the narratives that exposure-readiness involves more than psychoeducation about PTSD and the ability to regulate emotional distress which is commonly the main content of stabilisation-work, such traditional stabilisation-work were still considered a key component before instigating exposure-work. However, the complexity of clients' needs put strains on the clinicians as they would often support clients with social needs as well as providing psychological interventions which left

less time for trauma-work. The way they responded to meet these challenges were by advocating increased service co-operation and holistic care. Moreover, due to the complexity of clients' needs, the clinicians also worked integratively to respond to clients' complex psychological needs as purely sticking to trauma-focused therapies was not always sufficient. This is captured in Component two.

### 5.3.2 Component 2: Clinician's view that care needs to be more integrative as opposed to solely conducting trauma-therapies in order to meet clients' complex needs.

Subcomponent	Contributors
Clinicians working integratively alongside trauma-focused work to support clients' social needs and psychological needs not immediately related to PTSD.	A,B,C,D,E,F,G,H,I

#### 5.3.2.1 *Clinicians working integratively alongside trauma-focused work to support clients' social needs and psychological needs not immediately related to PTSD.*

This component captured clinicians' experience that clients often benefit from more integrative therapy as opposed to strict adherence to trauma-focused therapy. Many clinicians found this particularly helpful for clients with interpersonal, developmental traumas like childhood sexual abuse. As these clients would often hold unhelpful beliefs about themselves and others, some clinicians found that targeting areas like self-worth and relationships facilitated exposure-readiness in clients. Thus, working integratively enabled clinicians to target associated symptoms of PTSD as opposed to solely focusing on managing flashbacks and nightmares. These associated symptoms referred to dysfunctional relationships, self-blame, destructive behaviours and lack of self-compassion. From the clinicians' accounts, practising integratively appeared to be a way to conduct formulation-driven therapy and lessen the manualised element of exposure-work. Models that clients reported using were predominantly compassion-focused therapy and mindfulness-based therapies like acceptance and commitment therapy (ACT), but also psychodynamic and systemic models. Integrative work occurred in both the stabilisation phase and the exposure-phase but seemed to be particularly practiced in phase 1. This suggests that traditional stabilisation skills may not be sufficient to build exposure-readiness.

*AL589-608: we also offer a compassionate mind group [...] because our referrals have experienced torture [...] or sexual abuse [...]. They wouldn't be doing that instead of the symptom-management group [...] but it might be for people that require [...] self-compassion to be able to tolerate the trauma-focused work.*

Thus, using an integrative approach appeared to serve the dual purpose of a) aiding exposure-readiness and b) targeting associated PTSD-symptoms. This reveals the complexity clinicians are working with and shows how they balance clinical foci to best meet the clients' needs.

Anna's wording of "also" in the quote above reflects that despite working integratively to enhance exposure-readiness, trauma-focused models remained central. This appeared a common way of working among the clinicians with several of them emphasising that non trauma-focused models were to be used as a supplement. For example, Fiona said that she uses other approaches *alongside* trauma-focused work. This dual clinical focus is captured in Ingrid's and Danielle's quotes below:

*IL280-282: ...It's important to always holding the memory processing work in mind and that that should be the predominant intervention so you don't suddenly end up doing other things than exposure work.*

*D92-97: [...] I do lots of stabilisation work [...] but I might weave in some CBT techniques [...] So you're not only working on exposure [...] but you're doing more kind of building their self-esteem.*

In addition to wanting to provide more individualised care, some clinicians appeared in favour of integrative practice as they believed exposure-work insufficient and argued that trauma-treatment ought to involve more than merely habituation and include areas like shame and altered self-perception. One clinician, Clara, even described NET as "torturous". Two other clinicians worked in services that were in the process of developing an alternative trauma-treatment that steps away from exposure-work and instead will involve imagery-work and building resilience.

In conclusion, it can be surmised from this component that the clinicians often found that the need of PTSD-clients stretched beyond stabilisation and exposure-work due to the complexity of clients' backgrounds. To respond to this, clinicians employed a flexible, integrative clinical approach.

### 5.3.3 Component 3 Clinicians advocate that the concept of exposure-readiness needs to be re-evaluated to make treatment more effective

Subcomponent	Contributors
Clinicians think that the concept "exposure-readiness" is ambiguous, which makes it difficult to evaluate	A,B,C,E,F

Subcomponent	Contributors
Clinicians view the concept of “exposure-readiness” to be an unhelpful idea that generates uncertainty among clinicians	A,B,E,F,H

*5.3.3.1 Subcomponent 1 Clinicians think that the concept “exposure-readiness” is ambiguous, which makes it difficult to evaluate*

This subcomponent refers to the uncertainty some of the clinicians appeared to experience when evaluating exposure-readiness. Although there are a few studies, for example Cloitre et al. (2002) and Geiss-Trusz et al. (2011) that have explored factors important to measuring exposure-readiness, none of the participants reported using a validated measure specifically for exposure-readiness. However, two of the participants worked in a service that had developed a screening tool to evaluate clients’ exposure-readiness. Although, as seen in Anna’s quote below, this test was not used as a sole source of deeming exposure-readiness and was not equipped with a scoring-system.

*AL25-29: It's something we discuss a lot as a team. Um, we, we have developed some um measures that look at before-and-after symptom-management interventions um which include understanding their symptoms as well as having ways of managing certain symptoms relating to their PTSD. Um, but we haven't developed any specific cut-offs, it's more used as an indicator.*

However, all participants reported using other psychometrics at the end of phase 1 and at the start of the exposure-phase to obtain an indication of exposure-readiness. The most used test was the PTSD check-list civilian version (PCL), which measures PTSD-symptoms. However, some participants, like Beatrice, stressed that PTSD-symptoms and exposure-readiness are separate, and that high PTSD-symptoms does not necessarily make clients incapable of exposure-work. Thus, there appeared to be uncertainty of how to evaluate exposure-readiness, and this was something that was being discussed in the clinicians’ team.

*5.3.3.2 Subcomponent 2 Clinicians view the concept of “exposure-readiness” to be an unhelpful idea that generates uncertainty among clinicians*

In addition to the uncertainty of how to assess exposure-readiness, several of the clinicians argued that the concept of “exposure-readiness” is unrealistic and unhelpful. Moreover, “exposure-readiness” was held to be an ambiguous concept, and several of the participants found it difficult to conceptualise what “exposure-ready” really meant.

*EL3-5: I think there is [...] an idea that you have to do months [...] of stabilisation and there is a point that you will get to and then it's going to be that the person is ready to do the exposure.*

Erica's words suggest that the term "exposure-readiness" has shaped an unhelpful way among clinicians of thinking about readiness as a discrete state. This may lead clinicians to work towards obtaining an unnecessarily high degree of exposure-readiness in clients. Additionally, some of the participants believed that striving for a high level of exposure-readiness in clients induced concern in clinicians about causing harm by instigating exposure-work too soon. This in turn may lead to services offering unnecessarily long stabilisation-phases, which may cause delay in delivering exposure-therapy.

Additionally, if a high level of social stability is considered a necessary part of exposure-readiness, clients whose lives are socially unstable may not be considered exposure-ready, despite being motivated to do the treatment. This leads to the question of whether clients from certain socioeconomic groups are more likely to be excluded from treatment? This is captured in Henry's quote:

*H153-158: In some ways it would be easier for us if we said everything needs to be very stable or we won't do trauma-work, but I don't think that would be fair on patients, because [...] things are getting more difficult for people at the bottom of the heap, it would mean that they would not access therapy...*

Thus, it appeared as if the clinicians experience conflict in relation to the way they think of and work with exposure-readiness. On the one hand there may be an exaggerated concern about achieving a high degree of exposure-readiness in clients, whilst on the other hand, clinicians also question the utility of "readiness" and to what level it is really needed before instigating exposure-work.

It appeared as if the sample questioned the helpfulness and utility of the concept of "readiness". Specifically, they expressed that the concept "readiness" in terms of exposure-work hold an unhelpful assumption that "readiness" is a concrete, achievable state that looks similar for all clients. Moreover, the clients expressed uncertainty about *how* stable clients need to be before considered ready enough. Therefore, it appeared as if the sample called for re-evaluation of the concept of "readiness". On a more practical level, some of the services the clinicians worked in, had or were in the process of developing a psychometric of exposure-readiness, signalling the lack of validated psychometrics used in everyday care and the need for evidence-based and streamlined guidance on what exposure-readiness is. Research on exposure-readiness is scarce, however there are some papers expressing the need for this, which will be outlined in the discussion.

### 5.3.4 Component 4: Clinicians feel that the prescribed treatment-model poses challenges to providing effective treatment.

Subcomponents	Contributors
Clinicians approve of the different phases in PTSD-treatment but oppose the interim between them	A,B,D, E, F, G, H
Fading exposure-readiness and general destabilisation during the mid-treatment interim hampers the treatment trajectory	A,B,D,E,F,G,H,I
Limited exposure-work sessions risk not having enough time for full exposure-work	A,B,C,F,H
Clinicians advocate interventions and support of clients during the interim as opposed to treating it as a passive phase	A,C, D,E,F,G,H
The prescribed treatment-model induces pressure on clinicians	A,B,D,E,F,G,H,I

This theme was central in the data with all participant raising dissatisfaction with the way the treatment-model impacted the clients and the treatment.

#### 5.3.4.1 *Subcomponent 1: Clinicians approve of the different phases in PTSD-treatment but oppose the interim between them.*

The data revealed strong support for phased PTSD-treatment in the sense that the stabilisation-phase was considered needed prior to the exposure-phase. However, there was strong agreement among the sample that these phases should be conducted as a cohesive course of treatment without a break between them. This is shown in Gina's quote:

*GL197-198: ...my view is that you don't need a hugely long break between Phase I and Phase II; I think actually kind of keeping up the momentum would be um more beneficial.*

The loss of momentum was given as a reason for why interventions during the interim was considered important. Several of the participants attributed the mid-treatment interim to having arisen because of lacking NHS resources rather than a way to allow for phase 1 skills to consolidate. This leads to the question whether the long separation between the phases have scientific support? This will be considered in the discussion of this thesis.

#### 5.3.4.2 *Subcomponent 2: Fading exposure-readiness and general destabilisation during the mid-treatment interim hampers the treatment trajectory*

It was when talking about the mid-treatment interim the clinicians expressed most concern. This was as the long wait, with minimum or no psychological support, made clients lose momentum from phase 1. Thus, by the time clients were called for the exposure-phase, most would have forgotten symptom-management techniques taught in phase 1.

Consequently, this often meant that their PTSD-symptoms often remained the same or had worsened. Moreover, many clients with unstable life-circumstances would often destabilise further during this time, which made them less able to safely conduct exposure-work. This is reflected in Anna's quote below, and was an experience shared by all the participants.

*AL341-344: ...the negative is that they can do the work, they've attended the stabilisation-group [...] but in the waiting for a year, their circumstances might have changed, they forget and then the clinicians have to redo phase 1.*

This impeded treatment-flow also caused frustration among clinicians as shown in Danielle's quote below:

*DL270-271 [...] it's almost like a waste of time doing that stabilisation [...] and then not doing the trauma-focused work...*

This shows the pressure clinicians are under when starting the exposure-phase as several exposure-sessions are spent on recapping the previous phase.

#### *5.3.4.3 Subcomponent 3: Limited exposure-phase sessions risk not having enough time for full exposure-work*

Having a restricted number of sessions is not unusual in public mental health services. However, this was a critical problem for the participants in this study as several sessions in the exposure-phase were taken up with recapping phase 1. This is captured in Beatrice's quote below:

*BL99-107: Our phase 2 is a maximum of 30 sessions [...] If you haven't got them stable [...] you starting to feel anxiety because [...] I've finally got them stable and ready and then we haven't got anywhere near the time needed to adequately treat the trauma...*

Limited number of exposure-sessions appeared to come with two main problems for the clinicians. First, it risked not leaving enough time to conduct a full course of exposure-work. For clients with multiple traumas this was particularly damaging. Some of the clinicians described not always having time to cover key traumas, and described feeling that they had to choose a small fraction of clinical material, despite believing each trauma needed reprocessing-work. Though restrictions in sessions are unavoidable in public health services, it is of concern that the clinicians feel as if treatment-effectiveness is jeopardised.

Secondly, the tendency for clients' exposure-readiness to fade during the interim and the restricted number of exposure-sessions also had a negative psychological impact on the clinicians. This is captured in the subcomponent discussed below.

#### 5.3.4.4 *Subcomponent 4: Clinicians advocate interventions and support of clients during the interim as opposed to treating it as a passive phase*

There was a strong sentiment among the sample to provide support and interventions during the interim between the stabilisation and the exposure-phase to help clients maintain their exposure-readiness and thereby facilitate the transition into the exposure-phase. Moreover, the clinicians seemed ethically motivated to make sure clients were cared for during the interim. This was shown by their explicit disapproval for leaving clients without support, as seen in Erica's and Ingrid's quotes below:

*EL176-177: I don't know how you manage that wait. It would be helpful if clients felt thought and cared of between phase 1 and 2...*

*IL307-315 ...clients have already have their human rights violated repeatedly [...] then they are coming into a NHS system that may feel cold and uncaring...*

The strong desire among the sample to manage the challenges the mid-treatment interim caused was to eliminate the interim altogether. However, the more economically attainable interventions that were proposed were about providing different types of support during the interim. These interventions varied in terms of costs and ranged from having mental health workers conducting phone reviews with clients during the interim, to regular psychologist led group-sessions. One participant, Clara, reported that the service she worked in put clients on the waiting list for phase 1 and the exposure-phase at the same time to reduce the wait between them. However, the ideal type of support was described as regular and holistic. For example, Henry described an idea about creating a new pathway specifically for PTSD-clients and Fiona expressed a wish for a holistic care-centre where PTSD-clients could come for different types of psychological and social support.

*GL83-85: I'm meeting some men for a compassionate mind group and then we'll also be running a compassionate women's group [...] in the next few months [...] but there'll be probably at least 40 people on our waiting list...*

*AL346-347: ...the waiting list has grown [...] it's something that we're still trying to [...] think about how best to manage the people that are waiting for treatment.*

Gina's and Anna's quotes point to the challenges services and clinicians face in terms of demand on the services. There was a sense of frustration among the clinicians in that they wanted to provide fuller support but that there were not enough resources for doing so. This shows the clinical as well as emotional strains the treatment-model put on clinicians.

Some of the services the clinicians worked in had already installed some interventions during the interim. Among these interventions were monthly stabilisation top-up sessions. The participants who worked in services that were unable to provide face-to-face meetings during the interim reported that their teams called clients every third month. These phone calls include monitoring clients' PTSD-symptoms using the PCL. Additionally, some services offered support with social matters like housing, as shown in Erica's quote below. The need to support clients with issues not directly related to PTSD further points to the complexity of the clients and suggests that care needs to be continuous and holistic.

*EL311-314: [...] within our team [...] we try holding people in different ways whilst they're on the waiting list. [...] we have a drop-in that people can come to if things come up in relation to housing [...].*

In summary; the clinicians seemed to experience concern about how the delivery of the PTSD-treatment impacted on clients' emotional wellbeing. Thus, in addition to causing disruption to the treatment-trajectory, the lack of support during the interim could also be psychological damaging for clients. Furthermore, the mid-treatment interim also had implications for services. This is because faded exposure-readiness requires more time to recap phase 1 instead of doing exposure-work. This may impact treatment negatively and risk leaving some clients remaining symptomatic and as a result may return for further treatment thereby adding pressure to services. Therefore, the extensive mid-treatment break may not only have clinical implications but financial. Thus, providing interim-interventions appeared a way to manage the challenges to treatment and services caused by the treatment setup.

#### *5.3.4.5 Subcomponent 5: The prescribed treatment-model induces pressure on clinicians*

Some of the participants described feeling forced into a clinical dilemma as a result of the treatment setup. This dilemma was between starting exposure-work as soon as possible to guarantee enough sessions to do full exposure-work yet taking time to get clients sufficiently exposure-ready. As clients would often have forgotten what they learnt in phase 1, and as the passage of time had often destabilised them, taking time to stabilise and prepare them was important. Several clinicians described feeling "nervous" or "anxious" about not having enough time to do thorough exposure-work. Thus, constant awareness of whether they had enough sessions for exposure-work appeared to be a noticeable source of stress. Moreover, many of the clinicians expressed concern about the clients' wellbeing whilst they were on the mid-treatment interim and expressed strong disapproval of the lack of support during this time. For some participants, it made them feel a need to "make it up" to the clients:

*IL172-183: ...if someone has been waiting a long time, then a lot of pressure can be placed on those trauma therapy sessions which is hard if you're*

*working to very limited sessions [...] it puts a lot of pressure on the clinician [...] you feel a bit responsibility to fix people more...*

*FL47-50: ...quite a bit of the stabilisation needs to be repeated at the point at which trauma-focused work is taken up. Sometimes I think as a clinician, we feel more responsible to fix client after they have had to wait without support.*

Fiona's and Ingrid's words "responsible" and "fix clients" indicate feeling responsible to compensate for what the service cannot offer. Thus, the clinicians appeared to constantly be weighing their time and focus to manage clients' loss of exposure-readiness against the limited number of exposure-sessions.

The restrictions with the treatment-model also appeared to have an emotional impact on the clinicians. Specifically, feeling as if they were part of a system that provides unethical treatment to clients was evident among the group. For example, the lack of interventions during the interim was described with words like "unethical", "uncaring", "uncompassionate" and "atrocious". Additionally, many of them opposed that the stabilisation-phase and the exposure-phase were often conducted by different clinicians. This was described to further contribute to loss of exposure-sessions as time is spent on building trust before starting exposure-work. Several participants also held the change of clinician as being an uncompassionate way of treating clients.

Furthermore, there was a sense among the sample of feeling prevented from conducting best possible care. For example, the disrupted treatment pace and the scarce time for exposure-work, meant that clinicians' treatment plans could not always be executed the way they intended. Henry was one of the clinicians describing this:

*HL243-244: It's really difficult as a clinician cos obviously you're wanting to do the best that you can but having long wait times becomes a problem...*

Henry's quote suggests that although clients are ultimately at the receiving end, it also affects clinicians – clinically and emotionally.

In fact, the negative impact the treatment-model had on the clinicians appeared to some degree underlie the way they responded to the challenges as a way of managing them and mitigate the experienced pressure. That is, it appeared as if it was not solely clinical reasons but ethical that made clinicians want to change the way PTSD-treatment was delivered. Specifically, in addition to aid clients' exposure-readiness, the need to manage resources differently partially seemed to be motivated by a desire to deliver care in a more compassionate manner and enable more holistic and idiographic care than what the current treatment-model could offer. As outlined above, the clinicians strongly expressed disapproval

for leaving clients without interventions during the mid-treatment interim. In fact, there was a shared strong view among them that the treatment-setup lacked compassion and failed to “hold” clients whilst on the waiting-list. The emphasis on “holding” and to deliver care sensitive to clients’ needs reflects values that are central to the ethos of psychologists. For example, Harlow (2010) describes idiographic care as crucial for effective treatment-outcomes and the BPS’ practice guidelines (BPS, 2017) promotes working in ways to fully meet individual and complex needs. Although the participants’ narratives reflected these values, the way the PTSD-treatment model was set up failed to reflect these. The data showed that the clinicians did not only describe the treatment-model as making care ineffective but that the uncompassionate delivery of it also had an emotional impact on them. Although the pressure they appeared to be experiencing when feeling obstructed from providing highest possible ethical care, it also appeared to motivate them to voice concern with the current treatment-model and make changes, such as providing support during the interim. Nevertheless, this component reveals that the treatment-model is clinically and emotionally unsustainable. Thus, research exploring this further is important to highlight this as a step towards mobilising change.

#### 5.3.5 Core category: clinicians are managing their role and resources in relation to the prescribed treatment-model

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Contributors

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A,B,C,D,E,F,G,H,I

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From the four components, the researcher interpreted the overarching concept to be “clinicians are managing their role and resources in relation to the prescribed treatment-model”. Although the participants worked in different services, they experienced similar challenges imposed by the NHS. The participants described these as undermining clients’ exposure-readiness and as impeding the transection from the stabilisation-phase to the exposure-phase. Additionally, they generated psychological pressure on the clinicians. It emerged that the challenges the treatment-model created impacted services, the treatment, clinicians and clients. The challenges that the clinicians held as most problematic were:

- clients’ complex needs and social instability
- the mid-treatment interim
- limited number of exposure-work sessions

Specifically, it emerged that clinicians appeared to be constantly managing resources of three kinds: time, clinical and emotional. These will be considered below. See figure 1 for a graphic representation of this. Although these challenges impacted services as well as

clinicians, the focus of this study is on the clinicians' way of working with them in relation to PTSD-treatment. Thus, how services respond to these demands will not be considered here.

#### *5.3.5.1 Time and clinical resources*

The data showed that clinicians were directly affected by the challenges identified above by having to treat complex clients within a short timeframe. Gina's and Anna's quotes below show how scarce service-resources directly impact their work, with management of time and treatment-focus as a result.

*GL250-255: ...cuts in a trauma service when you have um such long, yeah, er... The amount of referrals we have has increased and the amount of staff we've had has massively reduced so it's, yeah, trying to work out the best way of managing that, and [...] also having enough time to see as many clients as possible so it's kind of finding that balance really.*

*AL74-80: working for the NHS we have 30 individual treatment sessions for a patient and that's really the amount that we're meant to offer. So if we use a huge number on stabilisation work [...] the dilemma would really be thinking about it impacting on how much time would be left for exposure work...*

Moreover, clients' complex social needs often required that clinicians supported them with non-psychological matters, like housing issues. Additionally, many of them also had complex psychological needs that required other interventions than merely trauma-focused approaches. Thus, clinicians had to manage their time and clinical resources between varied psychological interventions, as well as supporting clients with social factors.

#### *5.3.5.2 Emotional resources*

Moreover, clinicians also seemed to be managing their emotional resources. This seemed to be because of the pressure that was put on them as a result of treating complex clients with scarce service-resources. For example, they had to make difficult decisions of how much time they could spend on re-capping phase 1 in the exposure-phase, as they risked not having enough exposure-sessions left to do a full PTSD-treatment. This sometimes seemed to impede them from providing care effectively, which many of them described as feeling frustrating. Awareness of limited sessions also induced anxiety in some of the clinicians, as seen in Beatrice's quote below. Additionally, their narratives reflected disapproval of the way the system left clients without support during the interim. They described the NHS-system as being "uncaring" "uncompassionate" and "atrocious". Thus, the clinicians also appeared to be managing their emotions in response to challenges arising because of the treatment-model.

*BL99-103: ...you know they need to be stable and they're not gonna be able to engage in phase II if you haven't got them stable but then you're kind of looking at your watch going "Yeah, well that was session 4... That was session 5... That was session 6... oohh" and you're kind of starting to feel that anxiety IL315-318 ... when sitting with a client who literally have 40 years of trauma and you only have 12-16 sessions to offer them, and that can feel quite hard [...] it is not ideal in terms of being ethical...*

Additionally, it could be argued that the current treatment-model also has a financial impact on the services. The loss of readiness and destabilisation during the interim and the need for recapping phase 1 in the exposure-phase, leads to less time for conducting full PTSD-treatment. Thus, clients risk remaining symptomatic after finishing treatment. This in turn may increase chances for clients returning to the services, which would add to the financial strain. Moreover, some of the clinicians voiced concern that the long interim increased risk for premature dropout, which has been identified to cause financial pressure on services (Imel et al., 2013). Thus, the incapacity to provide continuous care to help clients maintain their exposure-readiness, may have economic consequences for services.

### 5.3.6 Summary of findings

The participants were asked questions based on the research question: *how do clinicians work with the shift between the stabilisation and exposure-phase in PTSD-treatment?* The narratives the participants generated were rich and nuanced as reflected by the four components, which were all captured by the core concept of “clinicians re managing their role and resources in relation to the treatment-model”. The data showed that the clinicians often worked outside the remits of trauma-focused work in order to: 1) help clients build and maintain exposure-readiness, and 2) meet their complex needs. This was challenging to accomplish as the treatment-model undermined the stabilisation-work conducted in phase 1. This was due to the lengthy interim and the limited exposure-sessions. To this came clients’ complex psychological and social needs, which often meant that they required more holistic care than solely trauma-focused interventions. To manage the negative effects this had on clients, treatment and themselves, the clinicians appeared to engage in practical and conceptual responses.

The practical responses were:

- practicing integratively to meet clients’ complex psychological needs
- cooperating with other services to meet clients’ complex social needs, and allow more clinical time to be spend on trauma-treatment

- working towards providing support during the interim to prevent loss of exposure-readiness

The conceptual responses were:

- acknowledging that exposure-readiness is determined by more than merely traditional stabilisation-work
- re-evaluating the concept “exposure-readiness” and challenge the notion that it is a discrete state that can be reached, and once reached remains stable

Critically, the participants voiced concern that the treatment-model with its interim and limited exposure-sessions posed risks to conducting a full PTSD-treatment, which put pressure on the clinicians. The implications of these findings and suggestions for further research will be considered in the discussion section.

## 6. Discussion

### 6.1. Introduction

This chapter will discuss the findings in the context of literature, potential implications for practice and suggestions for further research.

### 6.2. Chapter orientation

First, the challenge of the complexity of clients will be discussed with emphasis on the implications this had for the treatment and the clinicians. Specifically, the multiple roles clinicians had to assume to meet clients' needs and the need for integrative and holistic care will be discussed. Subsequently, the concept of exposure-readiness and its possible impact on the treatment will be discussed. This is followed by a discussion of whether the current treatment-model that includes an interim has support in evidence-based research. Additionally, the strains experienced by the clinicians are considered as well as what can be done to improve the treatment-model. Suggestions for further research is also discussed. Lastly, the researcher's expectations prior to undertaking this study is outlined as well as limitations and strengths with the study and a brief discussion of the current findings' relevance to counselling psychology is provided. First however, a summary of the main findings is provided.

This study revealed different types of challenges the current sample encountered when conducting PTSD-treatment, but it also portrayed how the clinicians responded to these challenges. These findings were encapsulated within the four components and the core category generated by this study:

- Component 1: Clinicians view exposure readiness to be determined by more than traditional stabilisation-work due to the psychological and social complexity of PTSD-clients.
- Component 2: Clinician's view that care needs to be more integrative as opposed to solely conducting trauma-therapies in order to meet clients' complex needs.
- Component 3 Clinicians advocate that the concept of exposure-readiness needs to be re-evaluated to make treatment more effective
- Component 4: Clinicians feel that the prescribed treatment-model poses challenges to providing effective treatment.
- Core category: Clinicians are managing their role and resources in relation to the prescribed treatment-model.

The first two components outlined how complex presentations required more support than merely common stabilisation-work. For example, in addition to traditional stabilisation-

work clinicians also had to support clients with social issues which was taking time away from trauma-work. These complex presentations also made several clinicians feel it necessary to practice integratively in order to meet clients' complex psychological needs, as captured in the second component. Furthermore, as seen in the third component, the clinicians expressed uncertainty about how exposure-readiness should be defined and how it ought to be measured. For example, not one of the clinicians worked in services that used a validated psychometric specific to exposure-readiness which might reflect the paucity in research in this area. The fourth component reflected the concern the clinicians raised about the treatment-model itself and specifically the mid-treatment interim between the stabilisation and the exposure-phase. This disrupted the treatment momentum as clients would destabilise during the interim and needed to spend the exposure-phase on recapping stabilisation-work which left fewer sessions to conduct exposure-work. What all these challenges had in common was the negative impact they had on treatment, clinicians and services. As a result of these challenges, the sample continuously had to manage their time, clinical role and emotional resources to manage these pressures. This is captured in the core category "clinicians are managing their role and resources in relation the prescribed treatment-model". To remind the reader, these ways of managing included advocating for increased service co-operation to support clients with social issues to ease the burden on clinicians and allow for them to focus on psychological interventions. Another way they had to manage their clinical time was by balancing between conducting trauma-therapy in addition to drawing on other models to address associated symptoms like self-loathing and interpersonal difficulties. This was as they found that solely conducting trauma-therapy was insufficient in targeting these additional difficulties often seen in CPTSD. The uncertainty the sample expressed about the term "exposure-readiness", specifically the absence of a psychometric to measure it, was not a challenge the clinicians could meet and manage on a practical level but was something the clinicians had reflected upon and the possible implications the exposure-readiness concept had on the treatment. When it came to respond to the negative implications the mid-treatment interim had, it became clear that this caused the most harm to the treatment as well as causing the most emotional distress to the clinicians. It appeared as if the interim had occurred as a result of lacking funding within the NHS and thus was nothing the teams could directly eliminate or change, which might have contributed to the emotional stress it caused. However, some of the teams that the clinicians worked in offered some limited interventions during the interim to mitigate the negative effects the interim otherwise had. Furthermore, all clinicians strongly advocated minimising the length of the interim or alternatively implement ongoing support during it to help maintain clients' exposure-readiness and general stability to allow them to focus on exposure-work when embarking on the exposure-phase.

Taken together, the complexity of the clients and the delivery of the treatment-model put strains on the clinicians and services and impacted the pace of the treatment negatively. These aspects will be discussed below.

### 6.3. Service cooperation and integrative care – clinical and financial advantages

A central theme identified in this study was that clients' social needs appeared to negatively impact the building and maintenance of exposure-readiness. The sample also described that clients' preoccupation with social issues made it difficult for them to take trauma-work on board.

Not only did this mean delay in evidence-based treatment (exposure therapy) but also indicates how social factors interacts with mental health. The interaction between social factors and mental health has support in literature. For example, Goulden & D'Arcy (2014) showed that people with lower income levels are at higher risk of developing mental health difficulties. Other socio-economic factors that have been found to increase risk of developing mental health problems are living standards and social state support (Goldie, 2015; WHO, 2013). It is also acknowledged that ability to commit and engage in treatment occurs in the context of an individual's social and life circumstances (Dixon, Holoshitz & Nossel, 2016). Thus, approaches that target these potential roadblocks to increase engagement ought to be considered when planning treatment.

The impact of social issues could be seen to reflect Maslow's (1946) hierarchy of needs which advocates that if basic needs like housing are not sufficiently met, achieving psychological change will be more difficult. Moreover, as PTSD often affect multiple life areas (Taylor, 2004) treatment should reflect this by providing support for issues beyond PTSD-symptoms. As outlined earlier, to target clients' social needs the clinicians promoted service co-operation and multidisciplinary work. Multidisciplinary approaches have support in research. For example, the Mental Health Commission (2005) highlights that social problems are often present in people with mental health issues and that treatment therefore needs to be coordinated within multidisciplinary teams. They further ascribe multidisciplinary teams to be able to deliver more comprehensive care and is especially useful for clients with long-term mental health difficulties. Moreover, The College of Social Work's Mental Health faculty recommends that NHS-trusts should increase collaboration between mental health workers and social workers to enhance quality of care (Allen, 2014). Additionally, service collaboration could ease the financial burden on one single service (Shafran, Bennett & McKenzie, 2017). Thus, research establishing whether service co-operation has clinical and financial advantages for services with similar PTSD-treatment models as portrayed in this

study could help establish how service co-operation can reduce the burden of multiple tasks for clinicians and allow them to focus more on psychological interventions.

The need to support PTSD and CPTSD clients with social matters seem to be recognised in the literature and is also outlined in NICE guidelines for PTSD, NICE stating that these social stressors can negatively affect engagement in and success of treatment (NICE, 2018). To meet such complex needs, NICE refers to multi-services involvement if necessary. They recommend that multi-agency care should be as smooth and continuous as possible, which they argue could be achieved if involved staff and services understand their role and responsibility and that services engage in clear communication with each other and the patient. Although the current sample engaged in service co-operation, what appeared to be missing for them was a clear division and agreement between services of role and responsibility. Perhaps consequently, the current sample took on a lot of responsibility for social factors in addition to the psychological interventions, often with delays in embarking exposure-work as a consequence or not having enough sessions left for exposure-work.

Perhaps the strains on clinicians, treatment and services shown in this study reflects the current socio-political context with increased population in combination with austerity, cuts and increased unemployment leading to more pronounced social needs in a relatively short space of time so that a clear policy and plan of how to treat and meet these complexities in a clinical context has lagged behind. Thus, evidence-based policies on effective service co-operation is needed to inform a working model that ensures cohesive and holistic care. Specifically, this could increase likelihood for exposure-element of the treatment to be delivered sooner in the treatment as well as leaving time for more exposure-sessions. This is vital as exposure-treatment is viewed as the active ingredient for PTSD symptom remission, and NICE and other researchers urge timely treatment and avoidance of delaying exposure-treatment (NICE, 2018; Foa et al., 2009). Moreover, if clients who are more socially and psychologically vulnerable meet more barriers for exposure-treatment, such as being viewed as too “chaotic” or preoccupied with social issues to start exposure-treatment, it could be argued that it could risk increasing divisions in treatment with clients from more socially deprived backgrounds being less likely to access or benefit from PTSD-treatment. Although the services represented in this sample did not operate with strict exclusion criteria, clients’ social issues and the fact that the psychologists were heavily involved in supporting clients with these matters nevertheless meant a delay in instigating exposure-work.

Another aspect to consider is that the clinicians in this study appeared to prioritise stabilising clients before starting exposure-work, for example by supporting them with social factors. Why this occurs would be the next question to explore. Is it due to the anxiety of

causing harm by starting exposure-work “prematurely”, as raised by some clinicians in the current sample as well as among some researchers (Hamblen et al., 2015)? Or has it more to do with the uncertainty about the concept of “readiness” and not knowing what it “should look like”? This is especially relevant as recent literature questions the utility of stabilisation-work altogether or at least advocating a shorter stabilisation-phase (De Jongh et al., 2016). Investigating this could help shed light on how much stabilisation-work is needed and support clinician’s decision making between stabilising clients in terms of their social issues and instigating exposure-work. To summarise, research on how to divide work between cooperating services and length and content of stabilisation-work is needed to establish an effective working-model that takes these factors into consideration. This could be done for example by testing different length of stabilisation-work with different client groups with various degree of social stability as well as with various models of service-cooperation. Thus, if the social and complex issues faced by many clinicians were more recognised, it could improve chances to grant funds for changes in clinical approach. Improved service-resources to enable co-ordinated, holistic care may reduce the need for clinical multitasking for clinicians. This could help them manage their time and clinical resources more effectively. Also, enabling more holistic care may reduce feelings of being part of an inadequate, uncaring system which was a sentiment found among the participants. Thus, studies capturing these challenges is needed to raise awareness and encourage clinicians’ involvement in research and policy making.

In addition to complex social needs, clients with CPTSD also had complex psychological presentations such as unhelpful self-schemas, interpersonal difficulties and substance misuse in addition to regular PTSD-symptoms. To work with this, the clinicians in this study described that they needed to practice integratively as just conducting stabilisation and exposure-work would not target these additional symptoms. One example of this was that some of the clinicians worked in services who allowed substance misusing clients to receive treatment for their misuse (often from another service) whilst at the same time engaging in exposure-treatments. This is noteworthy as substance misuse is often held as an exclusion criteria from exposure-treatments as it is considered to increase client-risk (Foa et al, 2007). Thus, the services who allows this dual input reflects an integrative approach. This integrative stance has support in research, for example (Najavits, 2002) developed the seeking safety model that advocates that substance misuse should not exclude treatment for PTSD but ought to be done in parallel. Integrative therapy can be viewed as part of a postmodernist paradigm as it employs pluralistic approaches to understand and treat mental health problems, where people’s contexts are taken into consideration (McLeod, 2013; Meleis, 2012). Moreover, the holistic and integrative element of care can be argued to reflect systemic theory (Finlay, 2015)

as it emphasises that socio-economic and political factors starkly impact mental wellbeing, and therefore should be considered in treatment. Given the social complexity the current sample encountered, it is understandable that integrative practice was a common form of treatment. Integrative therapy for PTSD has some support in research. For example, Cloitre et al. (2012) emphasise that targeting destructive interpersonal behaviours is essential in CPTSD and should be part of treatment. Similarly, Raja (2013) argues that because clients diagnosed with PTSD often have a comorbid personality disorder as well as difficulties with self-acceptance, drawing on DBT and ACT helps people overcoming trauma. However, critiques of integrative therapy argue that it risks therapist-drift resulting in therapy without evidence-based support (Byrne, Salmon & Fisher, 2018). Furthermore, NICE guidelines hold that exposure-treatment is the most effective in reducing PTSD-symptoms and does not outline an integrative approach. However, RCTs commonly exclude participants with CPTSD (Edwards, 2013), which could explain why there is little support for treatment drawing on different models for this clinical population. However, with the recent inclusion of CPTSD as a distinct diagnosis in ICD-11 (World Health Organisation, 2018) as well as a greater specification of associated symptoms of traumatic stress disorder in the fifth version of DSM (American Psychiatric Association, 2013), research on different approaches to treat CPTSD may be under-re-evaluation. In fact, some of the clinicians in this study expressed a wish for treatment to be more inclusive of associated PTSD symptoms, and some of them worked in services that were in the process of developing treatments that stepped away from a purely exposure-oriented treatments. This highlights the need for practising clinicians to get involved in research and policy-making as they have first-hand experience of the needs of this client-group. Thus, this study contributes a valuable insight into the realities of the clinical presentations of PTSD and CPTSD -clients and sheds light on where current treatment could be improved to meet the needs of this clinical population.

## 6.4. Issues with the conceptualisation of exposure-readiness

### 6.4.1 Measuring exposure readiness

This study clearly showed that social stability, as deemed from the perspective of the clinicians, without the use of a validated measure, strongly impacts on exposure-readiness. Although a readiness-measure for PTSD-clients has been developed by Geiss-Trusz et al. (2011), which takes certain practical and social factors into account, a more nuanced measure of non-clinical factors like socioeconomic issues and social support may be needed. Including these factors may better reflect the complexity of PTSD-clients and help plan what non-psychological support is needed alongside trauma-focused work.

#### 6.4.2 Exposure-readiness as a discrete state

Some clinicians thought that the term “exposure-readiness” assumes that clients can *reach a point* of readiness, and that it is a discrete state. Several of the clinicians described this as being unrealistic and unhelpful. Additionally, some of them also expressed uncertainty in how to evaluate exposure-readiness. Thus, the concept of “exposure-readiness” appeared to be thought of as ambiguous, both in terms of what it should contain and how it could be measured. This section will consider these issues further.

The rhetoric around exposure-readiness does seem to suggest it is thought of as a discrete state. Moreover, as there is, to my knowledge, no discussion in the literature on how to *maintain* readiness, it further suggests that it is thought of as a stable stage once reached. This may have resulted in interventions to *maintain* exposure-readiness being viewed as unnecessary (as focus appears to be solely on *becoming* exposure-ready). However, as evident in this study, readiness fades if not maintained. Thus, it is possible that conceptualisations of exposure-readiness as a discrete and stable state has shaped the treatment-model where no interventions to maintain it during the interim are provided. This might have formed the expectation, which appears to exist, that clients themselves are responsible for maintaining phase 1 skills during the interim. Thus, changing the way exposure-readiness is conceptualised might alter what support is being put in at various treatment-stages. Additionally, heeding the clinicians’ call to actively aid clients’ exposure-readiness may promote viewing exposure-readiness as a shared responsibility between services and clients, as opposed to leaving it up to clients alone.

#### 6.4.3 Socio-economic status to determine exposure-readiness

Another potential problem with conceptualising “exposure-readiness” exclusively with a high degree of general life-stability, is that it risks excluding more vulnerable clients from trauma-treatment. It has been found that people from socially and financially deprived backgrounds are more likely to have multiple social issues, as well as physical and mental health problems (World Health Organisation, 2014). Moreover, PTSD often coincides with secondary problems like comorbid presentations and financial and relationship problems (NICE, 2005). Thus, excluding “unstable” clients may risk making socio-economic status determine access to treatment.

#### 6.4.4 Three stages of exposure-readiness

As discussed, the literature of exposure-readiness is commonly focused on how it is built up. However, from examining the data from this research, the author suggests that exposure-readiness develops over three stages: building, maintaining and regaining. These

stages could be applied to different stages in treatment: the stabilisation-phase, the interim and the exposure-phase respectively. These different stages of exposure-readiness appeared to require slightly different emphasis of interventions. Although these stages did not appear to be consciously thought of among the participants, it might be an area for future research to explore further. Taking these three stages into account can help enhance clients' exposure-readiness by tuning interventions to match each stage. However, these findings are specific to services which operate a phased PTSD-treatment with a lengthy separation between the stabilisation and exposure phase and may thus not be applicable to other treatment-models. A brief overview of these different stages of exposure-readiness is provided below.

#### *6.4.4.1 Building*

Building tolerance for exposure-work took place in phase 1. This study indicated that clinicians felt if clients were given support with social issues, in addition to common stabilisation-work, clients might be better able to take stabilisation-work on-board. This might be an area for further research to test by comparing two groups of clients, one with and one without social support alongside trauma-treatment to establish whether there are differences and which group is better able to take stabilisation-work on-board and report higher level of exposure-readiness.

#### *6.4.4.2 Maintaining*

Maintaining exposure-readiness refers to preventing the loss of exposure-readiness during the interim. Specifically, if a minimum level of psychological and social interventions were provided during the interim, clients would be aided in maintaining symptom-management skills and general stabilisation.

#### *6.4.4.3 Regaining*

The regaining-stage refers to reducing the number of sessions spent on recapping phase 1 at the start of the exposure-phase. This could be done by helping clients maintain their exposure-readiness during the interim. Alternatively, planning and allocating a few sessions for recapping could help clinicians plan treatment in a more focused way.

### **6.5. Evidence for treatment-model**

#### **6.5.1 Length of stabilisation-phase**

As mentioned above, some of the clinicians held that an underlying problem with working with exposure-readiness, is the concept of "exposure-readiness" itself. Specifically, some argued that it made clinicians feel exaggerated fear of causing harm to clients by instigating exposure-work too soon. This came with the risk of conducting an unnecessarily long phase 1. This has support in research: Hamblen et al. (2015) found that the majority of

the service-directors in their study prescribed longer stabilisation-work than what evidence-based research recommends. Hamblen et al. (2015) found that fear of doing harm and risk of premature dropout lay behind the prolonged stabilisation-work.

This leads to the question of what evidence-based research recommends in terms of length of stabilisation-work. NICE guidelines (NICE, 2016) state that although it is necessary to establish rapport and emotional stabilisation prior to starting trauma-focused interventions, an entire course of treatment (i.e. stabilisation and exposure work) should involve 8–12 sessions for single traumas. For multiple traumas, NICE recommends that the number of sessions should extend beyond 12. Although no specific number of stabilisation-sessions is given for complex PTSD, the total number of sessions recommended for less complex PTSD suggests that length of stabilisation sessions should not extend beyond what is necessary.

However, other treatment recommendations have been more precise about length of stabilisation-work. For example, Schauer et al. (2005) recommend in their NET manual that exposure-work should start no later than the third session. This is based on their argument that as it is exposure-work that influences PTSD-remission, the majority of sessions should be spent accordingly.

Moreover, Foa et al. (2009) argue that the exposure-element of PTSD-treatment ought to start as soon as possible, around the second session or as soon as treatment-rationale has been explained and client-consent given. Both Foa et al. (2009) and Hamblen et al. (2015) argue that there is no empirical evidence supporting that clients must reach a point of readiness for exposure-treatments to be effective and argue that clients may be unnecessarily delayed in receiving evidence-based exposure-treatments. This stance is supported by De Jongh et al. (2016) who argues that existing studies advocating that stabilisation-phase is fundamental for tolerating exposure-work and contributes to better treatment outcomes is limited due to the varied methodologies used. The authors warn that current treatment guidelines for CPTSD therefore risks being too conservative and risk delaying the start of exposure-work unnecessarily long. They also recommend that more RCTs involving clients with CPTSD is needed to establish the utility of the stabilisation phase. One such study is currently being undertaken by Van Vliet et al. (2018) where two groups of people with CPTSD are compared, one which has a stabilisation-phase prior to exposure-work and one that goes directly into the exposure-work without a preceding stabilisation-phase. However, as this trial is still on-going, results are not yet available. However, given the paucity of research in this field, the fact that studies are being carried out is perhaps a sign that this area is receiving increasing attention.

Taken together, previous studies in this field as well as the findings of the current study suggest that that the notion of exposure-readiness may need to be re-evaluated and that

more research to establish guidelines of an estimated range of number of stabilisation-sessions is needed. Although the exposure-readiness is individual, having an evidence-based range of numbers of stabilisation sessions may help reduce clinicians' fear of doing harm and reduce delays in providing exposure-treatment. Additionally, avoiding unnecessary delays in initiating exposure-work may help keep waiting-lists down.

### 6.5.2 Evidence-based support for interim

A core concern raised in this study was the way the treatment-model was set up with the interim between the stabilisation and exposure-phase being viewed as particularly problematic as clients would often lose the readiness and stability they had built up prior to the interim. This leads to the question of whether the presence of an interim has evidence-based support. NICE (2005) explicitly outline that care should be regular and continuous for PTSD and more complex PTSD. Thus, the treatment-model provided in several NHS services directly defies NICE guidelines' direction of continuity in care. Continuity in care has further support from a study by Lyons-Reardon, Cukrowicz, Reeves and Joiner (2002) who investigated the interaction effects between number of sessions and duration of treatment to treatment outcome in adult outpatients seen in a community mental health clinic. They found that when analysed as separate bivariate measures, more sessions and longer duration of treatment were associated with worse treatment-outcome. However, when interacting, fewer sessions and shorter duration of therapy correlated with improved treatment-outcomes. From this, the authors encourage clinicians not to spread out treatment but rather to offer fewer sessions in a shorter space of time and promote clinical advantages of continuity of sessions. However, due to missing diagnostic data, they were unable to establish whether the patients reached criteria for diagnostic disorders, which make their findings limited in comparing it to the PTSD-treatment within the NHS.

Furthermore, not adhering to evidence-based treatment can have a negative effect on clinicians' wellbeing. It has been shown that clinicians who practice evidence-based treatments are at lower risk of compassion-fatigue and secondary traumatic stress, and report higher levels of compassion-satisfaction (Craig & Sprang, 2010). As work satisfaction is associated with less risk of sick leave (Faragher, Cass & Cooper, 2005) and better treatment outcomes (Garman, Morris & Corrigan, 2002), diminishing the length of the interim could have advantages for services, staff and clients.

## 6.6. Strains on clinicians from the treatment-model

The model presented in this study shows the challenges clinicians encounter when working with PTSD in the current treatment-model. To manage these challenges, the clinicians

appeared to be balancing trauma-therapy as well as treating other complex psychological needs and supporting clients with social issues. To this came the dilemma of balancing stabilisation-work and exposure-work with a limited number of exposure-sessions. This was particularly challenging as clients needed to re-cap what they learnt in the stabilisation-phase having been put on the waiting-list for the exposure-phase for several months, which left fewer exposure-sessions. Consequently, the clinicians appeared to constantly have to manage their role and resources.

### 6.6.1 Multiple roles

The finding showed that the clinicians were practising different clinical approaches to meet the complex psychological needs of the clients at the same time as they aimed to keep trauma-focused therapy central. Additionally, the clinicians shared concerns about not having enough exposure-sessions to conduct full trauma-work. This clearly shows the strains clinicians are under. Although they showed high motivation to provide the support that was needed, it raises the question of what the long-term consequences of this way of working may be for the clinicians' wellbeing. Wellbeing among trauma-therapists is of particular concern due to the risk of vicarious traumatisation (Craig & Sprang, 2010). Adding the experienced pressure they reported from working within the restricted treatment-model may increase their vulnerability for work-related stress. A study by Sodeke-Gregson, Holttum and Billings (2013) found that psychologists working with trauma in secondary care in the NHS are at higher risk of developing secondary traumatic stress (STS) than their counterparts in other countries. Their study found that caseload size did, surprisingly, not predict higher STS. Instead, the authors suggest that it may be extraneous service settings that contributes to the enhanced risk of STS, such as financial cuts and reduced posts. Although this is an area in need of further research to establish correlations, it indicates that service setup is important for the wellbeing of clinicians working with trauma. Given the high levels of pressure due to the lack of staff and other resources found in the current study, it would be interesting to compare perceived work dissatisfaction in services with different treatment-models. However, the authors prescribe caution as they were among the first to use the self-reported online measure for CS and STS. Moreover, they did not include a control group, which means it cannot be ascertained whether their findings apply to therapists working with other clinical populations.

The pressures and strains experienced by the clinicians from multi-tasking and often assuming roles akin to support workers and social workers is recognised in the field of organisational psychology. For example, (Millward, 2011) identified that role conflict and role ambiguity contribute to work stress with increased anxiety and staff turnover as a consequence. However, Newton (1995) argue that most work/stress theories have focused on how

individuals perceive and manage work stress as opposed to focusing on organisational issues, which disguises and decontextualizes organisational problems. More recent researchers support this view and state that little is known about effective interventions to reduce work stress – both on an individual and an organisational level (Giga, Cooper & Faragher, 2003). Thus, research addressing systemic factors and its impact on staff and the quality of care provided is needed to stop further cuts of the NHS that can be argued to have contributed to the challenges faced by the clinicians in the first place (New Savoy Partnership, 2017).

Other theories to help understand the emotional impact on clinicians and how that in turn may impact treatment, can be drawn from Gilbert's compassionate mind theory (2010). This theory holds that a person's compassion is increased when one's internal soothing system is activated. In contrast, feeling under threat reduces compassion for oneself and others. This can be applied on an organisational level. For example, Cole-King and Gilbert (2011) hold that organisations need to be compassionate in order to deliver compassionate care. This is achieved through staff feeling safe and supported by colleagues and management. However, how exactly feeling safe and supported is defined and measured is not clearly outlined. In contrast, contextual factors contributing to reduced compassion among staff are inadequate staffing and targets that feel unrealistic, which was a frequent theme raised among the current sample in this study. Similarly, other studies have found that clinicians working with chronic and complex presentations contribute to anxiety and clinical uncertainty, in turn contributing to reduced compassion for clients as well as for oneself (Teater & Ludgate, 2014). This is applicable to the current study given the clinical complexity, working outside one's remit and the uncertainty clinicians experienced in relation to how exposure-readiness ought to be defined and measured.

### 6.6.2 Bottom-up changes

Having crystallised the strains that are put on clinicians, it leads to the question of how well they feel they are able to shift the treatment-model. The clinicians in this study seemed to have autonomy to use their clinical judgment to decide when to work integratively to target complex psychological needs. Thus, this was a response they could engage in on their own initiative. In contrast, ways to increase service-cooperation and how to manage clients during the interim were discussed as team and service-approaches. Although many clinicians described the restrictions with the treatment-model as frustrating, it was evident that the issues they encountered were reported back to the service-leads, and that the services were discussing how to best address the challenges. Nevertheless, it is necessary to improve channels to voice the clinicians' experiences, and to develop avenues to negotiate the delivery of the treatment-model. Thus, this begs the question of what services can do to improve the channels of

negotiating the service-model. Times of political turmoil and financial hardship force NHS managers to maintain safety and high-quality care, with fewer resources. Cuts and staff redundancies have often been short-term solutions, at the expense of sustainability. Some research has shown that this top-down approach risks being detrimental both financially and in terms of clinical results (Ham, 2014; Francis, 2013). To counter this, it has been suggested that frontline clinicians need to be involved in management and service-development (Ogunlayi & Britton, 2017; Ham, 2014; Francis, 2013). For example, Vaucher et al. (2016) showed that when medical practitioners' suggestions for treatment-improvement were responded to, it led to improved staff satisfaction and improved treatment outcomes. However, although the participants were varied in terms of medical profession (GPs, psychiatrists and specialists) it did not include psychologists which limits the comparable value to the current study.

However, although calls for bottom-up changes are discernible in the literature, lacking staffing and funding appear to be more frequently given as causes by the current sample for the problems with the current treatment-model as opposed to limited involvement by clinicians in policy-making. Staffing and funding problems are also frequently debated topics in the media as well as in parliament. For example, Kings' Fund (2018) identified staff shortage and insufficient budgeting to mental health as detrimental to the quality and access of mental health care as well as holding it as cost-ineffective in the long-term. To turn this around, several recommendations were made such as increased communication between primary and secondary care and mandatory mental health placements for GP and nursing trainees were outlined. However, although these recommendations are directed towards policy making organisations such as clinical commissioning groups (CCGs), psychologists' direct involvement in such organisations are not among the points of recommendation. Thus, although funding and staffing are fundamental problems with a direct impact on services, having too few frontline psychologists involved in policy-making organisations may also be contributing to ineffective treatment-models, such as the ones seen in this study, being rolled out. Therefore, hearing from practising clinicians, as in the current study, is an important step towards encourage psychologists' involvement in research and policy-development in order to achieve change from the inside and is a main recommendation from this study.

## 6.7. Suggested directions for future research

The current study illustrates the gulf between politics, management-policies and frontline clinicians and supports the notion that change needs to take a bottom-up approach, where clinicians and patients are actively engaged and listened to. For this to happen, research to identify challenges is a first step, which this study has contributed towards. Thus, the

findings of the current study offer several platforms upon which further research can build. For example, quantifying the financial costs to services as a result of the interim might add weight to the call to discuss the effectiveness of the treatment-model. However, though quantitative data can monitor clinical outcomes and financial costs, it cannot capture contexts and nuances. Qualitative research can provide more precise data on where clinical processes need to change and portray the emotional costs to people directly affected by service-structures. Such research areas may include examining the journey through the treatment-phases from the clients' perspective. It is clear from this study that the clinicians are working hard to provide care that is both more tailored to clients' needs, and more humanistic in its delivery. Thus, given the financial, clinical and emotional implication the current treatment-model have on services, clients and clinicians, more research to support the call for change is paramount.

Additionally, as the data showed that many of the clinicians were uncertain of how exposure-readiness should be measured, seemingly due to an absence of a validated psychometric, one strand for further research would be to address such a tool. To approach this scientifically, it is suggested that a mixed method study is carried out. The qualitative part could be to gather rich data on what clinicians with relevant experience in PTSD hold as important for exposure-readiness. Based on this data, a test questionnaire on readiness can be tried out among the clinicians for them to rate the relevance of the suggested items on the questionnaire. This is something that the author of this study is planning to undertake and has been in contact with biostatisticians to aid in developing the design of this endeavour. Regardless of research methodology on this field, understanding exposure-readiness better could help with forming a shared definition of what exposure-readiness is and how it can be quantified. This in turn could help clinicians identify when appropriate preparation for exposure-work has been built up. This is important as literature referred to in this study has warned that exposure-work risks getting delayed due to fear of not having established sufficient exposure-readiness. Thus, aiding clinical judgment with a psychometric can help prevent unnecessary delay of exposure-work.

## 6.8. Strengths and limitations

There are methodological and contextual limitations with this study that needs to be considered.

### 6.8.1 Methodological limitations

This study acknowledges that the theoretical framework and its underlying psychological process are anchored in data that was shaped by the unique context of the

participants and the interaction between the participants and the researcher. Consequently, due to the contextual and interpretive nature of qualitative research, this study does not assert the findings to be generalisable or objective (Glaser & Strauss, 1976). Moreover, although it was deemed that theoretical sufficiency was reached for this study, it is acknowledged that theory building is an organic process, from which new insights and concepts is infinite (Rennie, 2000). Thus, the data and its potential for generating further concepts and insights is not held as having been exhausted.

### 6.8.2 Contextual limitations

Although this study did not set out to investigate counselling psychologists' approaches to working with PTSD-treatment, it can be held to be a limitation that only one participant was a counselling psychologist. A more mixed sample might have shown differences in ways of experiencing and working with the treatment-model. Thus, future research may wish to include a more balanced sample in terms of professional identity.

Another limitation relating to the sample is that although I aimed to record number of years of post-qualification experience along with number of years of experience of working in PTSD-services, I simply forgot (yes forgot) to record these details for some of the participants. To correct this, I contacted them after the interviews, but some did not reply and one of them had left their post. Thus, it is recommended that this data is recorded for future research in this field as it could provide insight in matters such as whether there are differences in clinicians' approach to work depending on years of experience or whether the turnover rate is similar in trauma services compared to other services.

Although the participants worked in four different services, the findings are restricted to services that operate a phased PTSD-treatment with a long interim. Thus, this study does not proclaim the findings to reflect NHS services in general and future studies may wish to investigate the research question in different service settings.

Another limitation of the study is that literature on exposure-readiness or how clinicians work with the phased PTSD-treatment is very scarce and the few papers that do exist are American and thus may lack in comparative relevance to UK care settings. However, the present study contributes to change this and may open an interest for further research in this area.

Lastly, although the theoretical model generated from this research has shown the challenges and implications of the treatment-model, it does not present a solution. Nevertheless, by identifying strains and challenges, it offers a platform from which further research can build and actions can be taken.

### 6.8.3 Strengths

This is a novel body of work that highlights an under-researched area. Thus, strengths include illumination of several aspects of PTSD-treatment; the need to develop a validated psychometric for exposure-readiness, how the setup of the treatment in some services has a negative clinical and financial impact and lastly this study provides rich data on how clinicians work with the phased treatment and the impact it has on them. These findings offer avenues for further research. Furthermore, to the researcher's knowledge no study has addressed the challenges with PTSD-treatment in services operating with a mid-treatment interim in the NHS and thus offers valuable insight. Lastly, rigorous approaches to the GT process, as discussed throughout this thesis, were taken to maximise the quality of this study and to allow it to be data-driven.

### 6.9. Prior expectations about the current research topic initially held by the author

I find it relevant to state that prior to undertaking this study my objective was to examine whether clinicians deemed exposure-readiness in clients based on subtle behavioural, cognitive and emotional "cues" from them that functioned as an estimate on clients' degree of readiness for exposure-work. My idea was to ask clinicians whether they were aware of such signs within the sessions and if they based their decisions on which treatment-phase to work on based on such subtle signs. However, it became evident early in the data collection process that the respondents did not provide data on such signs of exposure-readiness and instead brought up issues related to set up of the treatment-model and the clients' complex presentations as being the factors that impacted exposure-readiness and clients' journey through the treatment-phases. Consequently, I had to draw the conclusion that exposure-readiness is not predominantly manifested by subtle shifts in their cognitive, behavioural or emotional demeanour but rather more influenced by external service factors and social and psychological complexity. This could explain why I was unable to find literature on how clinicians interpret client-signs of exposure-readiness. Additionally, the finding that signs of exposure-readiness was not of high relevance to the participants, appears to be captured in some of the narratives where participants wanted to work in a more holistic and integrative way. Some even suggesting creating a new PTSD-pathway that steps away from traditional exposure-based treatments. This in turn can be argued to reflect that the way in which clinicians work with the treatment-phases in PTSD-treatment far exceeds determining when a client is exposure-ready or that determining exposure-readiness is the most crucial part of treatment. This can be compared with the majority of studies on PTSD-treatment (although few in number) as they have often focused on exposure-readiness in relation to length of the

stabilisation-phase, giving the impression that this indeed is the most essential part of treatment. Thus, this study broadens the understanding of what PTSD-treatment entails and which factors impact treatment. Moreover, this discrepancy between my expectations and the actual data required me to change the second interview schedule which moved away from asking about subtle signs of exposure-readiness and instead explored about the impact of the interim on clients and treatment. However, although I was not successful in exploring my initial objective, I was able to allow the data to speak for itself which led me to intriguing findings that shows how the clinicians and clients are directly affected by the treatment structure and funding of the NHS. These findings are important as they open the avenue for further research and call for change to develop a more clinically and financially sustainable NHS.

### 6.10. Relevance to Counselling Psychology

One purpose of a literature review is to identify what voices are represented in the literature (Booth et al., 2013). However, it also ought to be about identifying which voices are *not* heard, and what that silence tells us.

As mentioned, there was only one counselling psychologist among the participants. It would therefore be interesting for future research to explore the ratio of counselling and clinical psychologists in PTSD-services, and if an imbalance is found, reasons for this. Although holistic and person-centred care are central principles in counselling psychology, this study found the participants to strongly advocate these values. This suggests a shared value ground for the clinical and counselling psychologists. However, despite the effort the clinicians made to provide a more continuous and holistic care, the treatment-model posed hindrances to that. A reason for this is that most of the research underlying evidence-supported treatments is quantitative and produced in research settings that often involve psychiatrists, researchers and clinical psychologists (Camic, Rhodes & Yardley, 2003). Thus, it appears as if counselling psychology has an important role to play here. Specifically, counselling psychologists ought to be encouraged to enter academia and research. This could provide opportunities to be involved in outlining evidence-based treatments that emphasises the humanistic element of care, which is central in counselling psychology (Bury & Strauss, 2006). Also, the findings of this study show that the treatment-model is unable to “hold” clients. “Holding” clients is central to the practice of counselling psychology and refers to clients feeling safe and emotionally contained in the therapeutic relationship (Gravell, 2010). Thus, transferring these philosophical underpinnings into care-paths and treatment-models, can contribute to a more humanistic care-system. It could arguably also facilitate clients’ exposure-readiness and journey through the treatment-phases.

It is encouraging that the clinicians in this study worked towards care to be more effective as well as more compassionate. However, these values need to be heard by policy makers, and translated into practice. To achieve this, avenues for bottom-up change need to be created. This can for example entail encouraging trainee and working psychologists to get involved in service-development. As this study shows that the current treatment-model needs values central to the ethos of counselling psychology, psychologists need to take a more active role in organisational structuring to represent these humanistic and person-centered values. Given the current unstable state of the world with environmental disasters, multiple conflicts and tense international relations, improving the delivery of PTSD-treatment is paramount.

### 6.11. Conclusion

What can be extrapolated from this study is that the current treatment-model risks making treatment ineffective, and puts pressure on the clinicians. Moreover, the clinicians held that the human element of the way care is delivered needs to be improved. This study further showed that clinicians and their teams are managing these challenges on a conceptual and a practical level, to better meet the clients' complex psychological and social needs. In addition to making treatment more holistic, a call to improve the continuity of care was raised, to provide more compassionate care and to manage the destabilisation that occurred during the interim. Although the clinicians' concerns were heard within their teams, with some changes having already been implemented, channels for improved communication between frontline clinicians and NHS-leads and policy-makers need to be improved. To enable this, psychologists are needed in research and service-development. Specifically, psychologists are needed to ensure that values of humanistic and person-centred care are present in both the content of care as well as the way it is delivered.

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## Appendix A: Participant overview

<b>Participant Code</b>	<b>Participant pseudonym</b>	<b>Gender</b>	<b>Qualification</b>
<b>A</b>	Anna	F	Clinical psychologist
<b>B</b>	Beatrice	F	Clinical psychologist
<b>C</b>	Clara	F	Clinical psychologist
<b>D</b>	Danielle	F	Clinical psychologist
<b>E</b>	Erica	F	Clinical psychologist
<b>F</b>	Fiona	F	Clinical psychologist
<b>G</b>	Gina	F	Counselling psychologist
<b>H</b>	Henry	M	Clinical psychologist
<b>I</b>	Ingrid	F	Clinical psychologist

## Appendix B: London Metropolitan University ethical approval



**LONDON  
METROPOLITAN  
UNIVERSITY**  
LIFE SCIENCES & COMPUTING

**London Metropolitan University,  
School of Psychology,  
Research Ethics Review Panel**

I can confirm that the following project has received ethical approval to proceed:

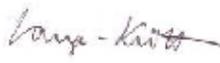
*Title:* How do clinicians work with the shift between preparation work and trauma-exposure in PTSD-treatment?

*Student:* Sarah Hellegren

*Supervisor:* Dr. Philip Hayton

Ethical clearance to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: 

Date: 7 June 2016

Prof Dr Chris Lange-Küttner  
(Chair - School of Psychology Research Ethics Review Panel)

Email [c.langekuettner@londonmet.ac.uk](mailto:c.langekuettner@londonmet.ac.uk)

## Appendix C: Health Research Authority (HRA) approval



### Health Research Authority

Ms Sarah Hellegren  
PhD student Trainee Psychologist  
London Metropolitan University  
London Metropolitan University School of Psychology  
Rm T6-20, Tower Building  
166-220 Holloway Road  
London N7 8DB

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

12 September 2016

Dear

Letter of HRA Approval

<b>Study title:</b>	<b>How do clinicians work with the shift between preparation work and trauma-exposure in post-traumatic stress disorder (PTSD)-treatment?</b>
<b>IRAS project ID:</b>	<b>205764</b>
<b>REC reference:</b>	<b>16/HRA/3873</b>
<b>Sponsor</b>	<b>London Metropolitan University</b>

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

[Appendix B](#) provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read [Appendix B](#) carefully**, in particular the following sections:

- [Participating NHS organisations in England](#) – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- [Confirmation of capacity and capability](#) - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- [Allocation of responsibilities and rights are agreed and documented \(4.1 of HRA assessment criteria\)](#) - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from [www.hra.nhs.uk/hra-approval](http://www.hra.nhs.uk/hra-approval).

## Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

## After HRA Approval

The attached document [“After HRA Approval – guidance for sponsors and investigators”](#) gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

## Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

## User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at [hra.approval@nhs.net](mailto:hra.approval@nhs.net). Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

## HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is **205764**. Please quote this on all correspondence.

Yours sincerely

Steph Blacklock  
Senior Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

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*Copy to: Professor Dominic Palmer-Brown, Chief Investigator*  
*Ines Hofer, Lead R&D Contact*

## Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

<u>Document</u>	<u>Version</u>	<u>Date</u>
Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only) [Letter confirming insurance]		15 June 2016
Interview schedules or topic guides for participants [Interview questions]	1	07 July 2016
IRAS Application Form [IRAS_Form_09082016]		09 August 2016
Letters of invitation to participant [Invitation letter]	2	07 September 2016
Letters of invitation to participant [Invitation letter (reminder)]	2	07 September 2016
Other [Ethics clearance certificate]	1	07 June 2016
Other [HRA Statement of activities - Barnet]	1	07 July 2016
Other [HRA Statement of activities - Haringey]	1	07 July 2016
Other [HRA Statement of activities - Camden]	1	07 July 2016
Other [HRA Statement of activities - Central; North West London]	1	07 July 2016
Other [HRA Schedule of events]	1	07 July 2016
Other [Distress protocol]	1	07 July 2016
Participant consent form [Participant consent form]	2	07 September 2016
Participant information sheet (PIS) [Participant briefing]	2	07 September 2016
Participant information sheet (PIS) [Participant debriefing]	2	07 September 2016
Research protocol or project proposal [Research proposal]	1	07 July 2016
Summary CV for Chief Investigator (CI) [CV - Sarah Hellegren (CI)]	1	07 July 2016

## Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

**For information on how the sponsor should be working with participating NHS organisations in England, please refer to the, [participating NHS organisations, capacity and capability](#) and [Allocation of responsibilities and rights are agreed and documented \(4.1 of HRA assessment criteria\)](#) sections in this appendix.**

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Ms Sarah Hellegren

London Metropolitan  
 University  
 sah1022@my.londonmet.ac.u  
 k 07472449797

**HRA assessment criteria**

<b>Section</b>	<b>HRA Assessment Criteria</b>	<b>Compliant with Standards</b>	<b>Comments</b>
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	Applicant has updated the participant information sheet (briefing and debriefing) consent form and invitation letters to version 2 in order to include the IRAS reference and full study title.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A statement of activities and schedule of events has been provided for all participating organizations and no other form of agreement will be used.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study.

<b>Section</b>	<b>HRA Assessment Criteria</b>	<b>Compliant with Standards</b>	<b>Comments</b>
4.3	Financial arrangements assessed	Yes	There is no external funding acquired for this study and therefore as per the Statement of Activities participating organisations will not receive any funds for participation.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	Applicant has confirmed that potential participants will be given applicant's email address to contact her directly if interested. Also confirmed that individual site files should be kept securely and restricted to research team only.
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	Not Applicable
5.3	Compliance with any applicable laws or regulations	Not Applicable	Not Applicable
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	Not Applicable
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	Not Applicable
6.3	Devices – MHRA notice of no objection received	Not Applicable	Not Applicable
6.4	Other regulatory approvals and authorisations received	Not Applicable	Not Applicable

## Participating NHS Organisations in England

*This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.*

This is a multisite, student, staff study with only one site type. In patients with post-traumatic stress disorder, (PTSD) trauma exposure is where patients are asked to think and talk in detail about a trauma under the guidance of a therapist. This can be distressing and worsen symptoms so therapists often include a prep phase to tolerate exposure by teaching patients to regulate their emotions when thinking about the trauma. Therefore the aim of this study is to conduct interviews with psychologists to determine how clinicians decide when clients are ready for exposure. This data will then be analysed by the student involved to gauge themes and commonalities.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at [hra.approval@nhs.net](mailto:hra.approval@nhs.net). The HRA will work with these organisations to achieve a consistent approach to information provision.

## Confirmation of Capacity and Capability

*This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.*

Participating NHS organisations in England that are providing potential participant contact details and holding staff interviews **will be expected to formally confirm their capacity and capability to host this research.**

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capability will be confirmed is detailed in the [\*Allocation of responsibilities and rights are agreed and documented \(4.1 of HRA assessment criteria\)\*](#) section of this appendix.
- The [Assessing, Arranging, and Confirming](#) document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

## Principal Investigator Suitability

*This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).*

As per the Statement of Activities the Chief Investigator for the study will act as the Principal Investigator at all the participating sites and therefore no further assistance in identification is required.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations.](#)

## HR Good Practice Resource Pack Expectations

*This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken*

The student in the study is interviewing all staff at the local sites and will require a letter of access at each site whereby honorary access isn't already in place.

### Other Information to Aid Study Set-up

*This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.*

- ☐ The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

## Appendix D: Invitation letter

Study title: How do clinicians work with the shift between preparation work and trauma-exposure in post-traumatic stress disorder (PTSD)-treatment?  
IRAS reference:205764.

My name is Sarah Hellegren. I am a second year Trainee Counselling Psychologist at London Metropolitan University. As part of my doctorate training, I am undertaking my research project that will be on PTSD-treatment.

Specifically, I am interested in knowing more about how clinicians work with the shift between preparatory work and trauma- exposure in PTSD-treatment, and how exposure-readiness is evaluated in clients. To obtain data on this, I will be conducting semi-structured interviews with psychologists providing trauma-focused therapies in secondary care specialising in PTSD.

### **What will participation involve?**

I will collect data through semi-structured interviews that will be audio recorded and transcribed verbatim for analysis using grounded theory. Grounded theory requires two rounds of interviews with a proportion of the participants. Therefore, I might ask you to conduct a second interview with me, however, note that I in some cases may only need one interview. The choice of whom I contact for a further interview will depend on the material brought from the first round of interviews. This will be

transparently disclosed during the interview process. These interviews will take place a few weeks apart and will take approximately one hour each.

You will be asked questions about how you detect and evaluate when you deem clients to be ready to start trauma-exposure, and how you work with the shift between preparatory-work and exposure-work when providing a trauma-focused treatment.

Please note that this is not about evaluating your clinical practice, but to get an in-depth understanding of how clinicians work with phase-transition and exposure-readiness.

### **When & where?**

For your convenience I will come to your workplace, but I can be flexible if you prefer another location. I recognise that participating will require some of your time, however, your contribution will be highly appreciated and is also well needed as the research in this field is limited. Unfortunately, I am not able to offer any financial compensation for your time, but I will provide refreshments and snacks for the interviews.

### **Anonymity & ethics**

All scientific undertaking will be in accordance with the British Psychological Society's Code of Ethics and Conduct (2009) and Code of Human Research Ethics (2014), and precautions to guarantee anonymity and safe storage of data are given highest priority. The interviews will be audio-recorded and transcribed verbatim by me alone. Only I will

have access to the audio recordings, and only I and my supervisor will have access to the transcribed interviews. No senior or other member of staff from your workplace or any other person will have access to any material you contribute to this study. Direct quotes from the transcripts will be used in the final product, however these will be strictly anonymous.

### **What if I no longer want to continue?**

You will have the right to withdraw from the study up to three weeks after an interview without any prejudice. Further instructions on how to withdraw your participation will be given once you accepted participation in this study.

### **How to accept participation**

If you would like to be a part of my project, please contact me via the details provided below and we can agree on when to meet for the interview. Please do not hesitate to contact me if you have any questions regarding the study.

Many thanks for your time and I hope to meet with you in person!

Best wishes

Sarah Hellegren

### **Contact details for the researcher:**

Sarah Hellegren

T:074 72449797

Email: [sah1022@my.londonmet.ac.uk](mailto:sah1022@my.londonmet.ac.uk)

Alternative email: [sarahellegren@hotmail.com](mailto:sarahellegren@hotmail.com)

**Contact details for my research supervisor:**

Dr Philip Hayton London Metropolitan University

Department of Psychology

T6-20, 166-220 Holloway Rd

London, N7 8DB

Email: [p.hayton@londonmet.ac.uk](mailto:p.hayton@londonmet.ac.uk)

T: 0207 133 2685

**References:**

British Psychological Society. (2009). *Code of ethics and conduct*. Leicester: BPS.

British Psychological Society. (2014). *Code of Human Research Ethics*. Leicester: BPS.

## Appendix E Briefing sheet

Study title: How do clinicians work with the shift between preparation work and trauma-exposure in post-traumatic stress disorder (PTSD)-treatment?

- IRAS reference:205764.

Thank you for participating in my doctoral research project.

### **Background and purpose of the current study**

As part of my course (Professional Doctorate in Counselling Psychology) I am undertaking a research project. The purpose of my research is to examine how clinicians work with the shift between preparatory work and trauma-exposure in PTSD treatment and how they detect and evaluate exposure-readiness in clients.

### **Summary of key literature**

Although the importance of including a stabilisation phase prior to the exposure-phase when treating PTSD is recognised by researchers and clinicians, formal measures of when clients are stable enough for exposure-work are lacking (Geiss Trusz, Wagner, Russo, Love, & Zatzick, 2011), and how clinicians work with these phases in everyday clinical practice is scarce (Hamblen et al., 2015). This is in spite a vast body of empirical evidence showing that the exposure-phase can be highly distressing to the client and can cause symptom-exacerbation which can lead to dropout (Cloitre, Petkova, Wang & Lu, 2012). Furthermore, exposure work is considered the “active ingredient” for reducing PTSD symptoms and is recommended as a part of treatment by both NICE (2005) and the International Society for Traumatic Stress Studies (ISTSS) (Forbes et al,

2010). Thus, being sufficiently stable enables clients to tolerate exposure-work and benefit from the treatment and reduces risks of symptom worsening and dropout. However, staying too long in the stabilisation phase may risk saturate clinician's caseloads thereby adding to long waiting lists (Hamblen et al. 2015). Hence, enhancing knowledge of this specific aspect of PTSD treatment is important for treatment outcomes and service improvement.

### **Data collection & participating**

I will collect data through semi-structured interviews that will be audio recorded and transcribed verbatim for analysis using grounded theory. Grounded theory requires two rounds of interviews with a proportion of the participants. Therefore, I might ask you to conduct a second interview with me, however, note that I in some cases may only need one interview. The choice of whom I contact for a further interview will depend on the material brought from the first round of interviews. This will be transparently disclosed during the interview process. These interviews will take place a few weeks apart and will take approximately 1 hour each. I recognise that participating will require some of your time, however, your contribution will be highly appreciated and is also well needed as the research in this field is limited. Your participation can therefore help to produce material that can improve treatment outcomes for clients.

**Where will this take place?**

For your convenience, I will aim to conduct the interviews at your workplace. Upon accepting participation, you will be contacted with dates and times for the interviews of which you can choose your preferred slot. Alternatively, we can do the interviews at any other location and time that is convenient for you. Interviews are likely to start from August 2016.

**During the interviews**

Estimated time for each interview is about an hour. You will be asked questions regarding how you detect and evaluate when you deem clients to be ready to start trauma-exposure, and how you work with the shift between preparatory-work and exposure-work when providing a trauma-focused treatment. Please bear in mind that this is not about evaluating your clinical practice, but rather to get an in-depth understanding of how clinicians work with phase-transition and exposure-readiness. Unfortunately, I am not able to offer any financial compensation for your time, but I will provide refreshments and snacks for the interviews.

Please find attached consent form where you can familiarise yourself with what consent involves. You can either print and sign this document and bring it to the interview or sign a hard copy which I will bring to the interview.

### **Anonymity and right to withdraw from the study**

All the data will be collected and stored anonymously in line with the British Psychological Societies' Code of ethics and conduct (2009). Signed consent forms and printouts of transcribed interviews will be stored separately from each other in locked cabinets of which only I have access to. Transcribed material will only be viewed by me and my research supervisor. Thus, no senior or other members of staff of your workplace will have access to any material you provide. Storage and handling of electronic files of the audio-recorded material will be in line with the Data Protection Act 1998, and will be kept on a laptop which requires dual passwords to access. Only I will have access to the audio files. As I am using qualitative research methods, direct quotes from the transcripts will be used in the final thesis, however these will be strictly anonymous.

To guarantee anonymity, you will be given a code that will be put on all printed transcripts. That way, only I will know whom the transcribed interview belongs to.

You have the right to withdraw from this study up to three weeks after the interviews without prejudice. If you wish to do so, your data will be immediately destroyed.

Otherwise, data will be kept until the research project is completed and approved after which it will be safely destroyed.

### **After the interviews**

You will be debriefed upon completion of the interviews. The final research results can be sent to you should you be interested. Also, you can have your audio-recordings and

transcripts sent to you upon request. Should you find any aspect of this research project distressing or offensive, please do not hesitate to bring this up with me or my supervisor, or alternatively bring it to your service managers. Should you have any further questions, please do not hesitate to contact me on the email address provided below at any time during the research process.

If you wish to take part in this study please sign the consent form.

Many thanks

Sarah Hellegren

**Contact details for the researcher:**

Sarah Hellegren

T:074 72449797

Email: [sah1022@my.londonmet.ac.uk](mailto:sah1022@my.londonmet.ac.uk)

**Contact details for my research supervisor:**

Dr Philip Hayton London Metropolitan University

Department of Psychology

T6-20, 166-220 Holloway Rd

London, N7 8DB

Email: [p.hayton@londonmet.ac.uk](mailto:p.hayton@londonmet.ac.uk)

T: 0207 133 2685

## References

Cloitre, M., Petkova, E., Wang, J., & Lu, F. (2012). An examination of the influence of a sequential treatment on the course and impact of dissociation among women with PTSD related to childhood abuse. *Depression and Anxiety* 29, 709–717.

Geiss Trusz, S., Wagner, A.W., Russo, J., Love, J., & Zatzick, D.F. (2011). Assessing Barriers to Care and Readiness for Cognitive Behavioral Therapy in Early Acute Care PTSD Interventions. *Psychiatry* 74, 207-223.

Hamblen, J.L., Bernardy, N.S., Sherrieb, K., Norris, F.H., Cook, J.M., Louis, C.A., & Schnurr, P.P. (2015). VA PTSD Clinic Director Perspectives: How Perceptions of Readiness Influence Delivery of Evidence-Based PTSD Treatment. *Professional Psychology: Research and Practice*. 46, 90-96 doi.org/10.1037/a003853

International Society for Traumatic Stress Studies (ISTSS). (2012). *Expert Consensus Guidelines for Complex PTSD. The ISTSS Expert Consensus Treatment Guidelines For Complex PTSD In Adults*. Retrieved from www.istss.org

NICE. (2005). *Post-traumatic Stress Disorder (PTSD): the Management of PTSD in Adults and Children in Primary and Secondary Care*. NICE clinical guideline 26. Available at <http://guidance.nice.org.uk/CG26>

## Appendix F: participant consent form

London Metropolitan University  
Faculty of Life Sciences and Computing  
School of Psychology



Title of study: How do clinicians work with the shift between preparation work and trauma-exposure in post-traumatic stress disorder (PTSD)-treatment?

- IRAS reference:205764.

Name of investigator: Sarah Therese Nelum Hellegren

---

### Study participant statement

I have been informed of and understand the purpose of this study and its procedures, and I agree to take part in the named research project.

I understand that agreeing to take part means that I consent to:

- ◆ Providing my demographic details (gender, age etc.) in the understanding that any identifying information will be separated from the data I provide, so my anonymity will be maintained.
- ◆ Completing one or two interviews on a topic related to this study
- ◆ The interviews will be audio recorded.
- ◆ I may be asked to take part in up to two interviews.
- ◆ The audio-recorded interviews will be transcribed verbatim by the researcher.
- ◆ Direct quotes from the transcripts will be used in the final project, and that these will be strictly anonymous.
- ◆ The data I provide may be used in publications and/or conferences but with no way of identifying me.
- ◆ I have the right to withdraw from the study at any time during my participation and up to three weeks after the interview.
- ◆ There will be a debriefing session at the end of my participation where I will have further opportunities to ask any questions about the study.

- ◆ I will not be financially compensated for my participation.
- ◆ I have been provided with the contact details to the researcher and the researcher supervisor, and that I can contact the researcher at any time if I have questions, concerns or would like to withdraw from the study.
- ◆ I understand that the data collected for this study is strictly confidential and I will not be identifiable in any report of this study.

Print

name .....

.....

Signature .....

.....

Date .....

#### INVESTIGATOR'S STATEMENT

I have informed the above named participants of the nature and purpose of this study and have sought to answer their questions to the best of my ability. I have read, understood, and agree to abide by the British Psychological Society's Code of Conduct, Ethical Principles and Guidelines for conducting research with human participants.

Signed .....

.....

Date .....

## Appendix G: First interview schedule

### **Intro:**

My aim: understand more about decision making processes clinicians undergo when deciding when to start exposure.

What does readiness look like in a session? What signs are clinicians looking out for and how do they evaluate signs of readiness and what level of readiness is good\_enough?

So I will ask what readiness means to you and how you spot it in your clients and how you measure and evaluate it, and what makes you move clients between phase 1 and 2.

**Preamble:** The following questions will ask you about how you think about trauma-exposure readiness. Specifically, I am interested in knowing which factors you believe go into being ready. Remember there are no right or wrong answers; I am just interested in how you think about and work with this.

1) What do you think is required in clients before starting exposure?

**Prompt:** If you were to list skills/factors you hold as necessary for a client to master before starting exposure? What would they be?

**Prompt:** How can you tell when clients are good enough\_at these skills?

Prompt: In your experience, are some skills or factors more important than others?

2) Does the number of stabilisation sessions a client has already had influence your judgment about when to start exposure?

Prompt: If a manual says the stabilisation-phase should consist of x sessions, and your client have had 10 and is still not ready, how would that impact your decision-making?

Prompt: How do you negotiate time between moving therapy onwards yet taking time to get clients sufficiently ready for exposure?

Preamble: So you told me about what ingredients readiness consists of, now I'd like you to tell me about how you can tell when a client is exposure-ready and what that actually looks like in the sessions.

3) So can you tell me how you decide when a client is ready to begin trauma-exposure?

Prompt: Are there subtle signs and signals from the client you think indicate

exposure readiness? What are these signs?

Prompt: Are there shifts in affect, cognitions, behavioural factors that indicate exposure-readiness? How do these manifest in the sessions?

Prompt: Are there changes in the process or therapeutic relationship that you think indicate readiness for exposure? What are these changes and how do they manifest?

Prompt: Do clients verbalise when they feel exposure-ready?

4) Some psychological theory suggests that avoidance is a core symptom in PTSD and is part of what keeps the problem going. Understandably clients can be reluctant to talk about their traumas. Are there times when you feel conflicted about what is avoidance from the client and what are genuine signs of insufficient stabilisation?

Prompt: How can you tell the difference between client trying to avoid exposure and client being too unstable to start exposure?

Prompt: How do you work with that so as to not collude with their avoidance yet ensure they are sufficiently prepared for exposure?

5) Do you use any psychometric tests to assess for readiness?

Prompt: which tests?

Prompt: Would you say that the scores from those tests are reliable in terms of deeming readiness for trauma-exposure work?

Prompt: Are there times when there is a discrepancy between the degree of readiness that a test indicates and the degree of readiness that you sense from the client in sessions?

Preamble: Lastly, I'd like you to tell me how you think about the phased treatment in PTSD and how you implement and work with the shift between preparatory work and exposure?

6) What do treatment phases mean to you?

Prompt: In your view, are there any pros and cons with thinking about trauma-therapy in this way where a distinction between stabilisation and trauma-exposure is often made?

Prompt: Do you view preparatory work as only a means to an end or a treatment in its own right?

7) How do you negotiate moving back and forth between the preparation and exposure phases if you think that would be necessary?

*Prompt:* How do you work with clients that initiated trauma-exposure but who you thought needed to go back to focus on stabilisation factors?

*Prompt:* Are there times when a client, in spite of thorough preparatory work, has not reached sufficient readiness? For example, they may lack the cognitive resources to comprehend the rationale for trauma-exposure, or their emotional regulation skills may not have improved. If so, in your opinion, what were the reasons the client remained non-ready, and how did you work with that?

8) Do you follow any manual (which one?), and how closely do you adhere to it in terms of when to initiate exposure-work?

*Prompt:* What factors does the manual you use prescribe as requirements for starting exposure?

*Prompt:* Some manuals hold certain factors, such as self-harm, as automatic signs of not being ready for exposure. This can create a potential dilemma as these symptoms are often part of PTSD and thereby exclude patients from the treatment that could help reduce the very symptoms they are being excluded for. How would you approach this?

Thank you very much for your time. Your contribution to this research is valid and can help shed light on how clinicians work with exposure-readiness which can help enhance the treatment we provide for trauma-clients. Please do not hesitate to contact me, should you have any questions regarding this research or your participation.

## Appendix H: Second interview schedule

- 1) Could you tell me a bit about what, if anything, is being done to monitor clients during the waiting list stage?

Prompts:

Are there for example any psychometrics being used? Which? When – how long into the wait are these used?

- 2) Can you tell me about what your view and experience is on data collection from the clients whilst they are waiting for the exposure-phase?

Prompts:

- Do you/your service use any means of data collection from your clients after they have finished phase 1 and are on the waiting list for the next phase?

-

If so, what are the purpose of that data collection, and what info do you aim to gather?

- 3) When you start seeing someone at the exposure phase, can you tell me about what you do to assess their readiness and capacity to undertake exposure work?

Prompts:

- Can you think of ways the process of finishing the waiting list-stage or starting the exposure-phase could be improved from the clinicians' or the clients' point of view?

- 4) What is your experience of dropout rates during waiting list?

- 5) In your view and experience, what do you think helps clients build up sufficient phase 1 skills and emotional tolerance and general stability to undertake exposure work?

Prompt:

- When do you think consolidation of phase 1 skills takes place? Is it during phase 1 or in the interim between the stabilisation phase and the exposure phase?

- 6) In your view and experience, what do you think can make the skills learnt in phase 1 start to fade?

.\_Prompts:

What is your experience, do patients keep their skills up during the wait or do they tend to fade?

When do you think the skill decay starts to set in? What do you think influences that decay?

- 7) How does that (skills decay present at start of the exposure-phase) impact how you work with that client when you see them for exposure-work?
  - What would like to do about it, or what do you or others try to do about it?
  
- 8) How much does the waiting list-stage shape what you do in phase 1? How much in phase 1 is taken up by preparing clients for the wait for exposure-work phase?

## Appendix I: Debriefing form

Study title: How do clinicians work with the shift between preparation work and trauma-exposure in post-traumatic stress disorder (PTSD)-treatment?

- IRAS reference:205764.

Thank you so much for participating!

The purpose of this study was to obtain in-depth knowledge of how clinicians work with the shift between preparatory-work and trauma-exposure in PTSD treatment, and how exposure-readiness is detected and evaluated.

By your valued participation you have contributed to research in this important field that hopefully can lead to generating theoretical frameworks that can aid clinicians in making these critical treatment judgments and thereby enhancing PTSD treatment for the clients.

All data will be treated and stored confidentially in line with ethical guidelines as outlined by the British Psychological Society's (BPS) Code of Human Research Ethics (BPS, 2014) and the Data Protection Act 1998. The data will be generalised, kept anonymously and will only be used as research material in publications and/or conferences. All printouts of the transcribed interviews will be given a code to ensure anonymity. Only the researcher will be able to identify the codes. The transcripts will only be viewed by the researcher and the research supervisor, and only I will have access to the recorded interviews. Upon completing this study, all data will be safely destroyed.

### **How to withdraw from the study**

You have the right to withdraw up to three weeks after an interview. After this time, data will have already been analysed and integrated in the research project. If you wish to withdraw please contact me and I will remove and destroy your data immediately without any prejudice to you.

### **Issues, questions or concerns following participation in this study**

If any distress has arisen as a result of participating in this study, or if you have any questions or concerns regarding this study, please do not hesitate to contact me or my supervisor via the contact details provided below. Alternatively, you can raise any concerns with your service managers or the research and development department within your NHS trust. As working with trauma can be distressing at times with a risk of developing secondary traumatisation, I have enclosed some references to self-help literature should this be a need for you following discussing your work with providing trauma-treatments in the interviews. Please find these references below.

Should you be interested in the final results of this study, please contact me and I will send this to you upon completion. Also, if you would like your audio-recordings or a copy of the transcribed interviews, these can be sent to you upon request.

Many thanks for your time and contribution,

Sarah Hellegren

#### **Contact details for the researcher:**

Sarah Hellegren

T:074 72449797

Email: [sah1022@my.londonmet.ac.uk](mailto:sah1022@my.londonmet.ac.uk) T:074 72 449797

**Contact details for my research supervisor:**

Dr Philip Hayton London Metropolitan University  
Department of Psychology  
T6-20, 166-220 Holloway Rd  
London, N7 8DB

Email: [p.hayton@londonmet.ac.uk](mailto:p.hayton@londonmet.ac.uk)

T: 0207 133 2685

**Self-help of secondary traumatisation**

Because clinicians working with traumatised clients can themselves experience symptoms of distress due to repeated exposure of trauma narratives, I have provided some references of literature and a website that offers support of how to manage and mitigate potential distress. I would encourage you to make use of these should you feel the need, and do not hesitate to contact me if you are interested in further references for self-help.

**Books:**

Baker, E. (2003). *Caring for Ourselves: A Therapist's Guide to Personal and Professional Well-Being*. New York: American Psychological Association.

Kottler, J. A. (2012). *The Therapist's Workbook: Self Assessment, Self Care, and Self Improvement Exercises for Mental Health Professionals* (4<sup>th</sup> ed.). New Jersey: John Wiley and Sons Inc.

Rothschild, B., & Rand, M. (2006). *Help for the Helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York: Norton.

**Links:**

[www.vicarioustrauma.com](http://www.vicarioustrauma.com)

## Appendix J: Distress Protocol

Protocol to follow if participants become distressed during participation:

This distress protocol has been developed to address the possibility that some research participants may experience distress or agitation during their participation in a research interview conducted to explore their experience of working with phased PTSD treatment and how they judge client readiness for trauma-exposure. Although the current participants are all qualified psychologists experienced in working with PTSD and CPTSD, it is possible that some may potentially be experiencing some degrees of psychological distress as a result of thinking about the traumatic narratives of their clients.

The researcher, who is currently undergoing professional training in Counselling Psychology and who has a history of working in the field of complex PTSD, has experience of monitoring and managing situations where distress might occur. A detailed three-step plan has been developed below to monitor and manage signs of participant distress during the researcher's interview. The researcher does not anticipate that extreme distress will occur, or that the distress protocol below will become necessary as the participants for this study is not considered a vulnerable population. Additionally, participants were provided with information of the nature of the research interview before accepting to participate. Prior to commencing the research interview, participants will be advised that they can take a break from the interview or withdraw from the study at any time should they feel distressed.

**Mild distress: Signs to look out for:**

- . 1) Tearfulness.
- . 2) Voice becomes choked with emotion, difficulty speaking.
- . 3) Participant becomes distracted, restless

**Action to take:**

- . 1) Ask participant if they are happy to continue
- . 2) Offer them time to pause and compose themselves
- . 3) Remind them they can stop at any time they wish if they become too <sup>SEP</sup>distressed

**Severe distress: Signs to look out for:**

- l) Uncontrolled crying, wailing, inability to talk coherently
- . 2) Panic attack e.g. hyperventilation, shaking
- . 3) Intrusive thoughts or images or flashbacks of specific traumatic narratives they have been exposed to (or experienced personally)
- 4) Difficulty concentrating on the research interview

**Action to take:**

- . 1) The researcher will intervene to terminate the interview.

- . 2) The debrief will begin immediately
- . 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
- . 4) If any distress arises during the interview, the researcher will validate their
  - SEP: distress, but suggest that they discuss these with their personal therapist or other mental health professionals and remind participants that this is not designed as a therapeutic interaction
- . 6) Offer participants the option of calling a friend or family member to receive further support
- . 7) Details of counselling/therapeutic services available will be offered to participants

**Extreme distress: Signs to look out for:**

- . 1) Severe emotional distress such as uncontrolled crying/ wailing
- . 2) Severe agitation and possible verbal or physical aggression
- . 3) In very extreme cases, expression of suicidal ideation or plans/ psychotic
  - SEP: breakdown

**Action to take:**

- . 1) Maintain safety of participant and researcher
- . 2) If the researcher has concerns for the participant's or others' safety, she will
  - SEP: inform them that she has a duty to inform any existing contacts they have

with <sup>[L]</sup><sub>SEP</sub> mental health services, such as a personal therapist or their GP.

- . 3) If the researcher believes that either the participant or someone else is in <sup>[L]</sup><sub>SEP</sub> immediate danger, then she will suggest that they present themselves to the <sup>[L]</sup><sub>SEP</sub> local A&E Department and ask for the on-call psychiatric liaison team.
  
- . 4) If the participant is unwilling to seek immediate help and becomes violent, <sup>[L]</sup><sub>SEP</sub> then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency.)

## Appendix K: The analytic stages of coding

<b>Quote</b>	<b>open code</b>	<b>Subcomponent</b>	<b>Component</b>
<p>FL33-37: Cooperation with other services that support clients with different things alongside the trauma focused-therapy can help keep clients stable and help them continuing with exposure work</p>	<p>Support workers to help with practical issues</p>	<p>Service co-op aid readiness and stability</p>	<p>Clinicians engage in service co-operation, alongside trauma-focused work, to meet clients' complex needs</p>
<p>FL315-318: It can feel quite hard when sitting with a client who had 40 years of trauma and you only have 12-16 sessions to offer them</p>	<p>Limited phase 2 sessions can feel hard for clinicians</p>	<p>Clinicians feeling conflicted between service and client needs</p>	<p>Clinicians feel that the prescribed treatment-model poses challenges to providing effective treatment.</p>
<p>AL35-37: Knowing what a good enough level of exposure-readiness is something our team has discussed a lot but we have no clear answers.</p>	<p>Team discussion of what good enough readiness level is</p>	<p>Exposure readiness is an ambiguous concept</p>	<p>Clinicians advocates that the concept of exposure-readiness needs to be re-evaluated to make treatment more effective</p>

## Appendix L: Example of memoing

### November 2016

Having analysed the first two interviews, the strongest feeling I sense from the participants are frustration about the way exposure-readiness is hampered by the break/waiting list after the stabilisation phase. It was prominent how strongly they felt that the long break mid-treatment is damaging but at the same time they did not hold any resentment towards their services/service managers, they viewed this as a top down problem created by politics. They seemed very aware of NHS financial structures. Top down issues directly effecting clinicians, treatment and clients. These themes seem to fit in to the codes relating to therapists' emotions. Their negative affect seems to be related to the frustration about disrupted treatment through the break.

This makes me think of the current state of funding for the NHS and the discussion about privatising it. If clinicians and clients are already negatively affected it would get worse if further funding cuts are a reality. Am I perhaps projecting my own concerns about waiting lists and the mid treatment break and how I feel about cuts to the NHS?

What also struck me about these interviews is how the interviews came to be on more practical issues about readiness such as the waitlist/break and not on subtle signs from clients that they would interpret as readiness. I realise I had expectations/presumptions here. I thought they might list non-verbal signs from clients that would signal an increase or decrease in clients' readiness levels, but they talked more about concrete factors such as housing and asylum issues. I have coded these as social factors that impacts readiness. It is interesting that social environment is an exposure-readiness factor for clients as the treatment-model in NHS may be less effective due to external "social factors" relating to the NHS/budget/finances/not enough staff. This might be points to bring up in reflexivity section...

Another thing that struck me upon having attempted to initially code both transcripts were that they were both so driven and caring about the clients' welfare. This makes me think about a shared code among psychologists that is both professional but also personal. They oppose a structure within NHS that harms treatment by making it ineffective, but they stressed concern about clients during waiting list as they have multiple problems.

I want to go through both interviews again and need to look for similarities/differences between them more closely.

## Appendix M: Independent audit

Levels of coding from quote to one component: Clinicians feel that the prescribed treatment-model poses challenges to providing effective treatment.

Quote	Open code	Lower level category	Higher level category	Component
EL174-175: ...when people come in to the trauma-focused therapy they can have a bit of a recap over some of that stuff at the beginning...	Recapping phase 1 in phase 2	Phase 1 material fades during the interim and requires recapping in the exposure phase	The interim delays start of exposure-work and disrupts the treatment flow	Clinicians feel that the prescribed treatment-model poses challenges to providing effective treatment.
AL153-155: Obviously in the year-wait it's likely that they might forget. So the individual clinician would obviously recap on those things.	Clients forget phase 1 material during the interim and need to recap in phase 2			
BL61-63: so at the moment our waiting list is around a year - so whenever I start to see someone for phase II, it's not really starting phase II, I'm doing like a recap of phase I.	Recapping phase 1 in phase 2			

Quote	Open code	Lower level category	Higher level category	Component
GL238-240: Destabilisation and loss of phase 1 skills mean I completely have to redo phase 1 which takes about 10 sessions out of 30 reliving sessions	Loss of phase 1 skills means recapping phase 1 which takes about 10 out of 30 exposure-sessions			
BL61-66: our waiting list is around a year – so [...]the first few sessions I'll do a reassessment, and then half the time they don't remember what they've done in symptom-management so I'm having to recap that, um, and, and then kind of do any other kind of bits of stabilisation. So I would say, generally, the first four or five technically phase II sessions aren't phase II sessions they're phase I sessions.	Very long interim means the start of phase 2 is spent on recapping phase 1			
CL223-227: before we usually begin therapy with them we have a brief run-through of "Right, you've remember what PTSD is; let's just go through it. Do you remember grounding? Do you remember how you've been using it? What, what's working, what isn't?" Just a quick kind... not quick, but we would assess kind of coping strategies, so we wouldn't go straight into trauma-focused therapy	First few sessions in phase 2 is spent on recapping phase 1			

Quote	Open code	Lower level category	Higher level category	Component
IL164-166: I mean we have, unfortunately have really long waiting times here. I mean I think, I think what it probably means in practice is you probably spend more time recapping what's been covered in previous phases...	First part of phase 2 is more about recapping phase 1 than exposure-work			
GL232-233: ...a long waiting time means you just end up doing the Phase I.	WL means clients forget and needs to recap phase 1			
FL47-49: quite a bit of the stabilisation needs to be repeated at the point at which trauma-focused work is taken up.	Recapping of phase 1 is needed at start of the exposure-phase, which takes up time for exposure-work			
HL41-43: Clinicians have to re-do phase 1 skills and spend quite a while recapping those skills at the start of the exposure phase as clients have lost their phase 1 skills during the waiting list, which is missing the whole point of preparing clients to be able to tolerate trauma focused-work in the exposure phase.	Clinicians have to recap phase 1, which is missing the point of preparing clients			

Quote	Open code	Lower level category	Higher level category	Component
<p>IL166 -170: if they've gone through their psycho-ed and symptom management and there's been a long wait [...] it's likely, more likely that that's dropped off that over the longer time. So you just have to spend more time covering that material again with people to get the necessary stuff in place.</p>	<p>Psycho education and symptom management skills drops off during the interim</p>	<p>Clients forget phase 1 material during the interim</p>		
<p>IL382-383: ...we have to recap things that people have been shown before and were using really well and then it's tailed off...</p>	<p>Clients' phase 1 skills tails off during the interim</p>			
<p>BL64-66: ...and then half the time they don't remember what they've done in symptom-management so I'm having to recap that</p>	<p>Clients forget phase 1 skills during the interim</p>			
<p>AL434-444: obviously during the course of treatment something can happen that means doing trauma-focused work at that point um is not gonna be very therapeutic and [...] they might need a kind of recap stabilisation...</p>	<p>Exposure readiness obtained in phase 1 can be thwarted during the interim</p>			

Quote	Open code	Lower level category	Higher level category	Component
DL270-271: {...}it's almost like a waste of time doing that stabilisation and just leaving someone and then not doing the trauma-focused work[...]because by the time you get to the point where you're doing some trauma-focused work they've pretty much forgotten	Doing the stabilisation-work is like a waste of time if the trauma-focused work does not start soon after phase 1 as clients forget phase 1 material			
HL39-41: Our team has found that often clients come to do trauma focused-work after having been waiting a long time for it and they have kind of lost those gains learnt from phase 1. Maybe as a result of not having continued practising phase 1 stuff during the wait for exposure work.	Clients lose phase 1 skills during the interim, perhaps as they have not continued to practice it			
AL694-699: I've recently assessed someone who had [...] been on the waiting list and then, um, because during the wait had finding it hard to manage [...] had a crisis admission and then they came for their treatment 'cos they were at the top of the waiting list [...] and we recommended that they have some additional emotional stabilisation work with the PD service but then they get referred back to us...	Clients get too unstable for exposure-work during the interim	Clients destabilise during the interim, which may delay the start of exposure-work.		

Quote	Open code	Lower level category	Higher level category	Component
<p>AL320-327: obviously because of our waiting times as well, um, where we initially was doing this group work there was a six-month waiting list and now there's, um, over a year so even if they might sort of seem a bit more ready that might have changed massively in the year whilst they have been waiting and they might have forgotten things so, yeah, there's, it's not an ideal scenario.</p>	<p>Clients can seem exposure-ready at assessment, but this can change massively during the one year waiting list</p>			
<p>AL799-808: from our experience I think there's a lot of people that, um, get so far and then need one, but you know use another service and put, well they go to a detox, absent for nine months or something and then by the time [laughs] while they've been waiting for that nine months then obviously they're coping with, they're trying to manage their nightmares and flashbacks, means they've been using substances but then they relapse because they haven't had the support they need so I think, yeah, that's where the joined-up working could be better.</p>	<p>From our experience, clients are ready for phase 2 but during the interim they destabilise, goes into crisis and can no longer do exposure-work</p>			

Quote	Open code	Lower level category	Higher level category	Component
GL114-117: Long waiting list can destabilise and decrease client's exposure capacity as their life circumstances can change, for example bereavement, crisis or birth	Clients can destabilise during the interim			
AL435-439: The negative consequences of the long wait between phase 1 and 2 is that clients life circumstances may have changed, which can have destabilised them, or they have forgotten the phase 1 skills so that the clinician have to re-do phase 1 work when starting phase 2.	Clients destabilise and forget phase 1 skills during the interim, so clinicians need to recap phase 1 in phase 2			
GL153-155: Phase I is meant to be stabilisation so that's the problem if you have a very long waiting time then you have the Phase I stabilisation and then you have a long break and then things destabilise...	The long waiting list after phase 1 risks destabilise clients			
HL88-90: If clients have used crises services during the wait for exposure phase we may think they may not be ready for trauma focused work	Clients may have crises during interim, and may not be ready for exposure-work			

Quote	Open code	Lower level category	Higher level category	Component
D502-508: Sometimes people are on the waiting list after phase 1 and they deteriorate [...] what's irritating is when they go into crisis everyone goes "Oh they're not stable enough for trauma work". But they were until they lost all their skills because time went by and they became hopeless and depressed...	It is irritating that clients were stable enough for trauma-focused work before going on the waiting list before phase 1 and 2			
GL136-147: Drop out rates are high, between 30-50% after phase 1. I think drop out occurs as things changes in their lives whilst they are on the waiting list like bereavement, relapses if they are misusing substance	Risk or dropout increases during the interim as risk for crises increases	Clients' life circumstances can destabilise during the interim, which may increase risk of dropout	The lack of continuous care in the treatment-model may increase risk of premature dropout	
HL260-272: Obviously you don't know whether patients drop out because of the long wait but my clinical impression is that the long wait for exposure work does increase drop out rates	It is my impression that the interim increases risk of dropout	The lengthy interim increases risk of dropout		

Quote	Open code	Lower level category	Higher level category	Component
<p>BL98-100: ... I think it is hard when you're working to er 30... so our phase II would be a maximum of 30 sessions, so yeah there does come a point where you know they need to be stable and they're not gonna be able to engage in phase II if you haven't got them stable...</p>	<p>Having limited exposure-sessions can feel hard as several sessions are spent on phase 1</p>	<p>Clinicians find the limited exposure-sessions difficult, as many of them are spent on recapping phase 1 as oppose to doing exposure-work</p>	<p>The treatment-model risks not leaving enough time to do full a full course of exposure-work</p>	
<p>CL393-395: we've got this limited number of sessions and you want to make the best use of them, it makes us aware of how we spend them</p>	<p>Restricted number of phase 2 sessions makes clinicians aware of how many of them are spent on recapping phase 1</p>			
<p>BL98-103: ... I think it is hard when you're working to er 30... so our phase II would be a maximum of 30 sessions, so yeah there does come a point where you know they need to be stable and they're not gonna be able to engage in phase II if you haven't got them stable but then you're kind of looking at your watch going "Yeah, well that was session 4... That was session 5... That was session 6... oohh" and you're kind of starting to feel that anxiety</p>	<p>Limited exposure sessions generates anxiety of getting clients sufficiently ready</p>			

Quote	Open code	Lower level category	Higher level category	Component
CL394-397-418: The long waiting time between phase 1 and 2 is not ideal as we haven't got forever to do exposure work	The long wait between phase 1 and 2 is not ideal as the number of exposure-sessions are limited			
BL117 -122: you kind of get half way through and you think "Well actually, to really solve that I need to also address that and that, but I just... I don't have the time to do that". And then of course then you lose extra time because you're trying to actually get that really detailed formulation without also then dipping in, unpacking a lot of trauma stuff that you may not wanna unpack if you're gonna go there and do anything with.	Too few exposure-work sessions forces clinicians to choose which traumas to focus on			

Quote	Open code	Lower level category	Higher level category	Component
<p>AL71-80: I mean it is a dilemma, not I think in the service [2-second pause] obviously we try to offer evidence-based treatments, um, but we work with very complex cases [...]. However, working for the NHS we have um 30 individual treatment sessions for a patient and that's really the amount that we're meant to offer. So if we use a huge number on stabilisation work... So I think the dilemma would really be thinking about it impacting on how much time would be left for exposure work I think.</p>	<p>Felt dilemma between starting exposure-work and recapping phase 1 in phase 2</p>	<p>Limited number of exposure-session creates a clinical conflict between starting exposure work and recapping phase 1 to enhance exposure-readiness</p>		

Quote	Open code	Lower level category	Higher level category	Component
<p>IL207-219: So that's what it's always, it's always about kind of looking forward to taking the next step. So er ra... so spending the minimum amount of time necessary to get them ready to do the exposure. Um, so here we're quite flexible, um so would probably, you know if we spend kind of... have to spend two or three sessions at the start of therapy would probably would still give them their 17 or 20 memory-processing sessions [...] I think it's chicken-and-egg, right? If you're being tighter on your sessions you're gonna have shorter waiting lists, 'cos whilst you're spending ages with one person someone else is waiting. [...] but equally if you do have to spend time doing that they're probably gonna lose... you know they're... it's gonna be coming out of their, their session total.</p>	<p>NHS treatment-model creates a conflict between doing a longer piece of exposure-work or a shorter one to keep waiting lists down</p>			

Quote	Open code	Lower level category	Higher level category	Component
<p>IL213-215: I think it's chicken-and-egg, right? If you've got, if you're being tighter on your sessions you're gonna have shorter waiting lists, 'cos whilst you're spending ages with one person someone else is waiting</p>	<p>Balancing getting clients sufficiently exposure-ready and having time for exposure-work is like the chicken and the egg problem</p>			
<p>EL229-236: I'm feeling this person isn't ready to do the exposure work and I got limited time [...] and I didn't have enough time to do the exposure work in full then I wouldn't go into it. I think that would be unhelpful.</p>	<p>I would not start exposure-work if too many sessions were spent on recapping phase 1</p>			
<p>CL118-120: it's always a bit of a tricky one isn't it? On the one hand you want to move forward to trauma-therapy, on the other hand they may need longer...</p>	<p>Clinicians experiences conflict between getting clients sufficiently exposure-ready and having enough time for exposure-work</p>			

Quote	Open code	Lower level category	Higher level category	Component
<p>BL108-111: ...because do you have enough time to a good enough and a safe enough piece of work on a portion of their trauma, or not, um, or, you know, 'cos all our clients have such complex traumas I think it's very rare that we treat all of someone's trauma in one set of sessions anyway, but then you're having to make decisions with the client about "Well, OK, we've got 20 sessions left, or we've got, you know, 18 sessions left, 16 sessions left.</p>	<p>If clients are not exposure-ready in phase 2, I count down the sessions left and start to feel anxious</p>	<p>The treatment-model induces time pressure on clinicians in the exposure-phase in terms of weighing spending time on stabilisation-work yet having enough sessions to do full exposure-work.</p>		
<p>IL348-350: I guess if you feel you haven't got enough it can be quite... I guess it can be quite difficult right? And quite anxiety-provoking and &lt;laughing&gt; probably makes you feel quite guilty.</p>	<p>If there is not enough time for full phase 2 work, it can generate guilt</p>			
<p>BL107-108: ...because do you have enough time to a good enough and a safe enough piece of work on a portion of their trauma,</p>	<p>Limited time for phase 2 may compromise doing a safe piece of trauma work</p>			

Quote	Open code	Lower level category	Higher level category	Component
IL301-304: ...I've felt, not so much to do it safely but more maybe something about doing it in an ethical way if that makes sense? So I wouldn't think it's gonna place a patient's, a patient at risk because there's lots of other ways of managing that within lim... you know limited number of sessions.	Limited time for phase 2 may not leave time for an ethical delivery of exposure-work but it does not put clients at risk			
IL316-319: ...you sit in a room with someone, you're possibly offering them 12-16 sessions and they have literally got 40 years of trauma from the age of three, and that can feel quite hard.	The limited number of exposure-sessions can feel quite hard	Clinicians find the treatment model to be clinically and ethically inadequate	The lack of time and continuity in the treatment-model induces emotional pressure on clinicians	
EL165-167: I think the long waits are atrocious just for the NHS in general, you know, I think most trauma services in London the wait for a trauma-focused therapy is somewhere between one and two years which is unbelievable and is unacceptable.	The interim feels atrocious and unacceptable			
HL243-244: The long wait for exposure work is very difficult for clinicians as obviously you want to do the best you can but the long wait is problematic	The long interim is very difficult for the clinicians			
EL286-287: The NHS constrains and the long wait between phase 1 and 2 makes me feel quite frustrated	The interim feels frustrating for clinicians			

Quote	Open code	Lower level category	Higher level category	Component
GL44-47: the wait for the exposure phase makes clients feel quite abandoned	Clinicians concerned that the interim can make clients feel abandoned			
IL172-178: ...if someone's been waiting a long time in your service then a lot of pressure can be placed on those trauma therapy sessions and then it can be very hard to maintain if you're working to very limited sessions. So you know here we might be seeing people... We've got, we've got flexibility but say 17-20 sessions and someone's been waiting 15, 18 months for those sessions then it puts quite a lot of pressure on the clinician.	Clinicians wanting to compensate clients for the long interim			
IL184-190: ...'cos you know they've just been waiting so long and you know that if they, if that you're discharge them from the service when they come back they'd be waiting again so therefore you feel you need to do more [...] that's the thing that I kind of think is probably more unhelpful about the long waits.				



⑭ 27-34: clients' capacity for exposure-work should be tested during Phase 1 by testing their ability to talk a little about their traumas before fully starting Phase 2 as ability to talk about trauma is an indicator of exposure-readiness

⑮ 28-34: If clients are able to name and describe their trauma a little bit <sup>(good sign)</sup> during exposure-work, it's a good sign of exposure-tolerance. <sup>(good sign)</sup> If clients can name and describe their trauma a little bit during exposure-work, it's a good sign of exposure-tolerance. <sup>(good sign)</sup> If clients can name and describe their trauma a little bit during exposure-work, it's a good sign of exposure-tolerance. <sup>(good sign)</sup> If clients can name and describe their trauma a little bit during exposure-work, it's a good sign of exposure-tolerance.

28 talking, so either... I suppose it's maybe not a clear-cut distinction between phase I and phase II but maybe starting something very gentle like a timeline of key traumas and seeing kind of how they're responding to that: are they able to tolerate naming things or putting a bit of description to it. Actually if the clients are able to do that relatively easily it's... it's a good sign for me that they'll be able to start talking much more depth in phase II. If they're really struggling with something like a timeline then I would be thinking "Hmm, I'm, I'm not sure that they are ready to move" or whether they actually really want to make that shift into talking. Um... Can you just repeat the question for me?

36 I Um, what do you think is required in the client before starting exposure?

37 P OK, so: stable background; affect regulation; some capacity to talk; then to be on board with the treatment model. And I suppose yeah, the kind of the risk is relatively stable, and I suppose partly that comes along with affect regulation - if they can manage their affect in a relatively kind of um... safe way and then I suppose that they're not, they're not misusing substances massively because then you take them into the reliving work and then they're not gonna get the benefit of the processing if they're then going home, drinking a lot or smoking cannabis and those kind of things. Um, I suppose the other big one is social support: that they're not doing it in isolation, there, there is a person or two - be that friends, family or someone in their hostel - who is around enough that they're not coming, talking about these awful things and then going away for the rest of the week with, with kind of nothing - no kind of active... no meaningful activity to fill their time and no kind of meaningful point of contact, and obviously the more our client has the better, but I think for our clients they really don't, and it's just having a key one or two people that are around.

50 I OK, so you mentioned quite a lot of interesting things like social factors and emotional regulation skills and social support. Something that caught my attention was you said you wanna look for some evidence that they have some tolerance for trauma and you said like um maybe you're not thinking about the phases as discrete but to try out a little bit before

⑯ 27-34: If clients are able to name and describe their trauma a little bit during exposure-work, it's a good sign of exposure-tolerance.

54 starting exposure. And will that happened... er, because if you see people in a group how  
55 would you try that out once they start the individual phase II or...?

56 P Ah, OK, that's a really, that's a really good question 'cos in my mind when you asked that  
57 question I completely not thought about that for a lot of people they would do phase I in a  
58 group. So I suppose when I was talking like that what I would mean is - and I don't know if  
59 this is an artefact of where the service is at at the moment - but often what's happened is  
60 that people are assessed and then given symptom-management relatively swiftly, then  
61 they're on a waiting list for a very long time - so at the moment our waiting list is around a  
62 year - so whenever I start to see someone for phase II, it's not really starting phase II, I'm  
63 doing like a recap of phase I. So the first few sessions I'll do a reassessment, and then half  
64 the time they don't remember what they've done in symptom-management so I'm having to  
65 recap that, um, and, and then kind of do any other kind of bits of stabilisation. So I would  
66 say, generally, the first four or five technically phase II sessions aren't phase II sessions  
67 they're phase I sessions. So sorry, all of the answers I've given to that I suppose allude to  
68 when I've got an individual client when do I feel like I've done enough of the recapping  
69 phase I before I move them into phase II. If we were thinking about doing it as a, as, when  
70 do we move them from the phase I proper into phase II I think that is much more, it's it's  
71 much more bounded by kind of the end of intervention, or time, so I think... you've  
72 completed the group and you've kind of, well, we either do a half-day workshop or we do a  
73 kind of a group, a weekly group of varying lengths, so generally around four to five sessions  
74 and as long as you've kind of been to enough of those - so you've been to, say, three or four  
75 out of the four or five - you've seemed relatively engaged and there was nothing kind of  
76 really str... um, you know, kind of key flagged up at the assessment then what would happen  
77 is you'd just be put on the waiting list for phase II, but it would, th... I suppose that comes  
78 with caveat that the s... the phase II clinician that picks them up would basically be doing a  
79 reassessment and any... it would actually be the phase II clinician that would make the

*Phase 1 often done in a group setting (forget to mention this).*

*waiting list between phase 1 + 2 can be very long.*

*w/c means start of phase 2 is phase 1 recap. (4-5 weeks) + reassessment.*

*clients forget phase 1 work while on w/c.*

*Phase 2 starts only after phase 1 recap of 1-5 weeks (usually).*

*(4) 77-78. The caveat with the long waiting time between Phase 1 and 2 is that the Phase 2 clinician must re-assess client's exposure - readiness*

*change of clinician between phase 1 + 2 (new clinician must be reassessed).*

80 clinical call of "Can I actually start doing phase II work or do I need to do a bit more of the  
81 phase II?"

82 I Right, so given the structure within the NHS and this serve, it's the, the actual phase II also  
83 includes a bit of phase I and that's where the difficult decisions comes in.

84 P Yeah

85 P Because it's... I think if we were doing, um, if we had a shorter waiting list time then it may,  
86 that decision may get moved forward, it may be the clinicians that did phase I that make a  
87 decision about phase II, or it might be that we had a more streamlined model where you  
88 saw the same clinicians for all of it, but at the moment it's... we try and do phase I early so  
89 they've got something to use while they're sitting on a waiting list and so I think those more  
90 tricky decisions when you, when that person gets to the top of the waiting list and you kind  
91 of... 'Cos technically they should be ready, but if they've been waiting for a year you're  
92 basically having to reassess to see what, what the situation is and see what's coming on ...

93 I Of course, and a lot can happen in, in one year.

94 P Yeah, exactly

95 I OK, so this kind of also leads me into the next set of questions 'cos you kind of mentioned  
96 this already: When you're thinking about number of sessions someone already has - have  
97 had - do you ever experience like a dilemma between moving therapy onwards towards  
98 exposure or making sure that they really are truly, sufficiently ready?

99 P Yes. All the time. Um... I think it is hard when you're working to er 30... so our phase II would  
100 be a maximum of 30 sessions, so yeah there does come a point where you know they need  
101 to be stable and they're not gonna be able to engage in phase II if you haven't got them  
102 stable but then you're kind of looking at your watch going "Yeah, well that was session 4...  
103 That was session 5... That was session 6... oohh" and you're kind of starting to feel that

25 89-92: The most tricky decisions are when a client from phase 1 is on top of the waiting list for phase 2 as they at that point should be ready, but the long wait often decreases their obtained exposure-readiness.

phase 1 as a way of using the w/c period. (can wait up to a year!)

"All the time" has dilemma about moving forward vms creating level 1 work (esp. in 30 sessions limit work)

26 99-101: The restricted number of phase 2 sessions some PHS trusts implements makes it difficult to do a full phase 2 phase 1 work to regain their readiness that diminished during the wait between phase 1 and 2.

28 100-104: if clients are not yet exposure-ready even if in phase 2, you start to count down the limited number of sessions you have left and you start to feel anxious.

104 anxiety because you're thinking "Right, am I... Is this gonna turn into one of those really  
105 tricky where I've finally got you stable enough and ready to engage and then really sadly we  
106 haven't got anywhere near the length of time that we needed to adequately treat the  
107 trauma" and then you're having to make very difficult decisions for the... about "Is.. is it  
108 appropriate to take you into phase II" because do you have enough time to a good enough  
109 and a safe enough piece of work on a portion of their trauma, or not, um, or, you know, 'cos  
110 all our clients have such complex traumas I think it's very rare that we treat all of someone's  
111 trauma in one set of sessions anyway, but then you're having to make decisions with the  
112 client about "Well, OK, we've got 20 sessions left, or we've got, you know, 18 sessions left,  
113 16 sessions left. We're not going to get everything done. Where do we focus?" And I  
114 suppose it's then trying to get... we do a formulation with them about what's distressing  
115 them the most... but also where was it manageable to kind of carve off a chunk of trauma  
116 work to work on where you're not... it's not gonna bleed into other areas or you're not  
117 gonna encounter that difficulty where you're trying to chip away certain part of the trauma  
118 but you're struggling because the affect really links to different pockets of trauma or the  
119 meanings really link, because then you kind of get half way through and you think "Well  
120 actually, to really solve that I need to also address that and that, but I just... I don't have the  
121 time to do that". And then of course then you lose extra time because you're trying to  
122 actually get that really detailed formulation without also then dipping in, unpacking a lot of  
123 trauma stuff that you may not wanna unpack if you're gonna go there and do anything with.

124 I So it is a real dilemma and, like you said, it might be that you don't have time to cover  
125 everything that in fact might have been good for the client if it was covered.

126 P Yeah

127 I And thinking about all those skills that you listed and factors that you think like "this goes  
128 into being ready", knowing those how can you tell when someone has those skills good  
129 enough? You talked a little about that but can you tell me some more?

29 104-107: Therapists feel worried if they have started  
Phase 2 and feel that there may not be enough number  
of sessions left to provide a full Phase 2 treatment  
as some clients takes long to get sufficiently ready  
even if they are in Phase 2.

30 107-109: The restricted number of Phase 2 sessions can  
force a difficult decision for clinicians of whether it's  
appropriate to move clients into exposure-work as the time  
restriction may risk compromise doing a good enough and safe piece  
of trauma-work as clients often are not sufficiently exp-ready  
when starting Phase 2 due to the long wait after Phase 1

31 113-121: It can be difficult for clinicians having to  
prioritise multiple traumas as they are all linked and should  
be treated, but there is not enough Phase 2 sessions to  
cover all traumas.

32 121-123: it can be difficult managing the balance  
between getting a detailed enough client-formulation without  
dipping into a lot of trauma-stuff that you don't want to  
unpack if you don't have enough time to cover them  
(see code 30.331)

before to make more sense.

(33) 130: knowing the threshold or cut off - level for when clients are sufficiently exposure-ready, is difficult to determine. Eg how well should they manage symptom-swells, or how stable

Social factors like housing should be

(34) 131-137: Testing clients' exposure-readiness involves frequently asking them whether they practice symptom-management techniques between the sessions.

(35) 113-138: Signs of exposure-readiness involves that clients truthfully report, either when asked or without being prompted, that they practice symptom-management between the sessions.

(36) 137-139: A sign of exposure-readiness is for clinicians to see that clients are actively using symptom-management techniques in the sessions.

(37) 140-147: Exposure readiness involves that clients can regulate distress and calm themselves down in the session. Eg...

(38) 148-152: A sign of exposure-readiness is when clients need less prompting to tell the clinician about their feelings. too simple, loses detail.

You're starting to lose too much detail here, with codes becoming more like summaries + losing a bit too much detail.

P It's really tricky isn't it to put your finger on like specifically what it is. I mean I think, I think some of it is like client report of what they're doing in the week, so if you're constantly checking in with them: "Are you doing your breathing, are you doing your grounding, da da" and that they're giving... the responses that they're giving you is that they're using it regularly, they're finding it helpful and those kind of feel like genuine responses and they're not just telling you what you wanna hear - and sometimes that I think can be tricky because I think sometimes they know what they should say versus what they're actually doing - um, but if someone's consistently kind of reporting that, that's a good sign. If you see someone actively using the strategies spon... you know, without prompting, that's even better 'cos you can see it live in the room so someone who you um know used to dissociate quite quickly, but you can see them actually spotting when that's happening and actively grounding themselves without you having to take a lead on that or someone you know who might get a bit upset in session and then you realise they've their hand in their pocket 'cos they've got their stress ball there or they're asking can they have the oils. So those kind of spontaneous kind of uses of it. Um, people who you can see are able to tolerate becoming upset and, and can allow themselves to become upset to a certain degree and then and then are able to modulate that and kind of bring it back down, so you can see them regulating their own affect kind of independently of you in the session. Um, just generally people reporting that life is stable enough. Um, and I suppose the fact that clients might start to spontaneously tell you a little bit more about their history, again without masses of prompting or you know, that they'll start... when you do prompt them they'll be able to tolerate talking about a little bit more and they like to share, might want to show a little bit more detail about it I guess.

I OK so some initiative from the client and some... you, you can see evidence that they can in fact master their techniques, groundings and relaxation. OK, so this is quite similar to what I just asked, but sitting there live in the room with someone what other subtle... more subtle signs do think that really indicates that someone is ready?

redo this one.

167-169  
39) ~~167-169~~  
Cognitive and emotional shifts in clients during sessions that indicates exp. readiness is when clients can hold themselves in ~~an~~ a window of optimal arousal level. i.e. that clients that are usually easily over-aroused can diffuse strong emotional responses, and contrary, clients that are commonly responses, numb are able to engage emotionally during these 2-weeks.  
170 = .....  
161-164.....

For example, are there any shifts in affect or cognition or behaviour?

I suppose the behavioural stuff is the stuff that we've just been talking about and you'll... it's a really tricky one... it's a really tricky one to answer because you, you get those clients who are on the extreme end of emotional arousal where they're too aroused, and what you need to see is that they can modulate that arousal back down to a kind of an optimum level. Then you'll get those other set of clients are compl... too emotionless and what... and they're managing by just blocking everything so what you need to see from them is that they're being able to let themselves become a little bit more in touch with their emotions, so actually you wanna see the opposite from them: you wanna see a bit more affect in the session. So it's... it's... then it's really hard to kind of get that blank... it's... so, what I'm trying to say: that you're getting indicators from them that they can hold themselves in a window of kind of optimal emotional arousal, and you're seeing that by the level of emotion that they present in the room as well as some signs. You can see affect increasing or decreasing so you have a sense that they are somewhat in control of that I guess.

Yeah. So it can be like either shutting down completely would be a sign of under-arousal or under-engagement and the opposite, maybe even a flashback in the room or like uncontrollably crying, which would be like over-arousal, over-engagement.

OK, and thinking about shifts that has more to do with the process and the therapeutic relationship is there anything that you think indicates readiness?

I mean, I think as a therapist you kind of have to feel like they trust you enough, and that's really hard... I think that's a really hard one to kind of put your finger on: when do you get that sense, other than it's a kind of a gut feeling with a lot of people I think. I mean, sometimes it... I think if you do a proxy indicator of: do they turn up; do they turn up on time; do they seem to be kind of engaged in a session to a... you know, to a certain extent. Um, I think the fact that they can for a lot of clients - and I think you've got to be mindful of cultural backgrounds there - but for a lot of clients, particularly our male clients, if they can

40) 176-184; Shifts in the therapeutic relationship that indicates exp. readiness is when therapists feel that clients trusts them enough to talk in detail about their trauma.

41) 179-184; An indicator that clients have developed some trust in the therapist is that they show up on time engage in sessions, and that they are able to get in touch with their emotions and talk more and more about their traumas.  
42) 176-180; Knowing when a client is sufficiently exp. ready and when they have enough trust in you is difficult to put your finger on, it's more a gut feeling.

43 182-184: Cultural factors must be considered when deeming exp. readiness, e.g. men may be more resistant to get in touch with their emotions and talk about their traumas.

44 187-190: Sometimes clinicians need to take the risk and test whether clients are ready for exposure by actually starting and try out some trauma-work

45 190: Sometimes it's only by starting exposure work that clients' level of engagement will shift and make them become more exp. ready

46 194-197: If therapists can tolerate the risk and initiate Phase 2-work without feeling certain that clients are exp. ready, to test how clients will respond to Phase 2 work, it may be a positive experience for the client will run with you.

47 197-199: The longer Phase 7 is dragged out, it risk building up clients' avoidance and can disengage clients

48 197-200: if Phase 7 goes on too long, clients may worry that they can't handle exp. work or that the therapist can not hold them during exp. work

49 200-201: The longer exp. work is postponed, clients can become more anxious about starting exp. work.

183 start to get in touch with their emotions with you or they can start to talk about these  
184 events in a little bit of detail with you I think that's often a sign that they're engaged well  
185 with you because generally it's such a no-no - you wouldn't do that - but the fact that they  
186 can do that indicates some, some kind of trust that developed there.

P It's tricky 'cos I think... I think sometimes it's also... you have to take a little bit of a risk of "I  
187 think this person is ready; I kind of hope that they are" and actually sometimes it's... it's "but  
188 I'm not entirely sure" and sometimes it's dipping your toe in the water with them and trying  
189 them out. Sometimes it's that shift that actually really engages them because up until this  
190 point you've been talking about breathing and relaxation and la la la and they're kind of  
191 sitting there thinking "Mmm, what are you doing?" like. And it's actually... we know that it's  
192 the reliving and the updating of that work that's gonna get the shift for them then I think  
193 sometimes if, if you can tolerate as a therapist moving into that and they can tolerate that  
194 with you sometimes having the experience of doing that and having a positive experience of  
195 it, that's sometimes the thing that really engages them and then they'll just go, they'll kind of  
196 run with it with you, whereas I think sometimes potentially the more we drag out the early  
197 stages, for some clients it's helpful but for some clients maybe it's not because actually they,  
198 it... they disengage, or it builds up avoidance and they worry that they can't... you think they  
199 can't handle it or they think that you can't handle it, and actually the, the, the longer you  
200 leave it the more the kind of anxiety around it kind of amounts, I guess.

I OK so sometimes as a therapist you need to just start exposure and just see how much they  
202 can tolerate it.

P I think... I mean I would never go into it cold without... no, no. But I think you do a sensible  
204 amount of preparation work and then I think it's almost like three, there's three kind of  
205 types of clients: one's where you just know because of all those indicators we've spoken  
206 about that "Yes, I think they're fairly solid, we can give it a go"; then there are a whole group  
207 of clients where you think "Do you know what, this still feels way too risky" because of the  
208

Starting exp. work to determine if clients are exp. ready or not can be a good way of testing exp. readiness with clients you feel uncertain of in terms of their capacity for exp. work.

50 210-213:

209 things we've been talking about; and then there's this kind of like "Err, you know, err, not  
210 quite sure" clients and I think those are the ones where you end up kind of thinking about it  
211 in supervision or you end up talking about it with colleagues and some of those ones you,  
212 you decide to maybe push and they either engage with it or they don't, or there might be  
213 ones where you go "Err, err, do you know... do you know what, let's, let's give it another  
214 kind of few weeks, or is there something else that we kind of need to consider?"

215 I Yeah, well that makes sense. And you mentioned also it can be sometimes difficult to tell the  
216 difference because client may say what they think you want to hear as a therapist and in  
217 PTSD avoidance is what keeps problems going and we understand that exposure is really  
218 something that people might want to avoid. But, do you think that... are there times when  
219 you think it's difficult to tell the difference between someone just avoiding exposure or  
220 when someone is genuinely not stable enough to do it?

221 P I mean I suppose it's... then what you're, what you're trying to make a judgement call about  
222 is: are they stable enough and just not wanting to do it, or are they, or is... is the... or are  
223 they not stable enough? I always think in some respects, I don't know how much I'd use  
224 any... hmmm. Would I use avoidance of talking about it as an indicator of readiness? I think  
225 that really comes down to the formulation you've got with the client 'cos just thinking back  
226 over the people that I've seen there are a lot of clients who are actually very stable in their  
227 lives and I think could potentially manage to talk but were quite ambivalent about treatment  
228 and so avoided talking or didn't really want to talk, so I think they would be, they would have  
229 been stable but still avoiding, and then there are clients who do avoid because to talk about  
230 it opens up stuff that they just can't manage to talk about in a... in a way that feels kind of  
231 safe for them. So it... yeah, avoidance can be an indicator that they're not stable, but I think  
232 it's also quite a good indicator of their... their ability and willingness to engage in the therapy  
233 itself. Sorry I'm not sure I'm being particularly coherent there.

51 226-228: Some clients can technically be exp. ready (stable housing etc and good symptom-management skills) but still be avoidant and reluctant to talk about their traumas.

52

52 231-233: Clients avoidance of talking about their traumas can be an indicator that they are not exp. ready, but it can also indicate that they don't have the willingness and motivation to do exposure-work even if they are otherwise stable.

234 I Well I think what you're saying there is it's... you can tell the difference most of the times if  
235 you know the client and if it's avoidance has been a thing in the formulation, er, you might  
236 get an indicator from there if the avoidance is just not being stable enough, er, or if they just  
237 maybe are stable in their lives and in themselves but just don't really wanna do the  
238 exposure.

239 P Yeah, I suppose what I'd be... what probably as you say within the formulation you'd be  
240 looking at are there other indicators of stability and instability a... you know, as separate  
241 from whether they're avoidant or not avoidant. So someone was, you know, had a, had a  
242 stable... I'm just thinking of a client who had a stable family background, was financially  
243 stable, um, no significant kind of risk history, decent enough early life so we could  
244 hypothesise that his attachment relationships were fine and therefore his fundamental  
245 emotion regulation capacities should be OK, so you would think ticking a lot of the stability  
246 points, was turning up for his appointments, stable, didn't wanna talk. Um, and he was... so  
247 he was a..., he was avoiding, he was turning up but he was avoiding talking about it so I think  
248 he would have been stable whereas, yeah, if there was a client who didn't seem like they  
249 wanted to talk and also they were in the process of being kicked out of their hostel or they  
250 were very socially isolated or they had kind of, er they didn't have social support in their  
251 working place or those kind of things then I would be... I think those are the ones where you  
252 think "Do you know what, I'm not... I maybe don't wanna push through that avoidance at the  
253 moment because they're not stable enough in th... in o... li... in other senses.

254 I So sort of their life outside of therapy can be an indicator of what type of avoidance this is. Or  
255 sort of their level of readiness.

256 P I think the easiest thing often to do is to ask them.

257 I So sort of bring it up in the room and talk about avoidance.

53 243-253: Clinicians may push clients a bit more to do exp. work if they are avoidant but ticks several readiness points, but don't push it that much with clients who are equally avoidant but has less other readiness factors (benefit, housing, affect regulation skills)

258 P Yeah, yeah. Um, and I think it's something that we, we regularly have conversations about  
259 with people at various points through treatment is "You are gonna have to talk about this,  
260 you know, have you ever done that? How do you feel about doing that? What do you think it  
261 would be like to do that? How are you gonna manage doing that?" And I suppose how  
262 clients respond to that would... you know is... you will get some clients having signed up for  
263 treatment - I did a lady who I saw her who had obviously gone for an assessment, had signed  
264 for treatment, had sat on the waiting list, I saw her for treatment, we did three or four  
265 sessions of some kind of stabilisation stuff and then we started trying to do a timeline. It was  
266 alright for the first session; second session, completely emotional: "I just don't wanna talk  
267 about this, I don't wanna talk about it". You know, tried to get her to come back for another  
268 couple of sessions: "I don't wanna talk about it"; "OK, fine". You know, and she was  
269 someone I think was potentially stable enough to have done it. She didn't want to, actually,  
270 and I think that's a valid choice for a lot of clients that they don't... they actually don't, they  
271 don't want the type of treatment that involves exposing themselves to it so...

272 I So transparency about the nature of the treatment is important?

273 P Yeah, and I think checking in with them about if you're not certain where they're at, where  
274 they think they're at. Um, I think sometimes we can, we can maybe fall into feeling like we  
275 have to make the decisions about those kind of things when actually they know themselves  
276 really well and if you've got... if you've developed a good enough relationship with them  
277 where you can say you know "How do you feel about doing this? I'm wondering do we, do  
278 we move on or not?" You know, and even with clients where they'll kind of say "Ooh, no, not  
279 sure about that" or, or they'll kind of put other obstacles in the way then again you can  
280 check out with them: "Is that, you know..." - phrase it nicely, but - "You know, it... I'm sure  
281 that also, there is, you know, the moving house or your dog's sick or your kid's off school - all  
282 those kind of things - but do you think it also might be that it, it means that you don't have  
283 to start talking because that might be very hard?" And again generally if you ask someone  
284 directly in a nice way they'll, they'll let you know.

54 258-262: As a way of gauging what lies beneath clients' avoidance of doing exp. work, lack of willingness/motivation or their life outside therapy is too unstable - see code 5 clients are regularly asked how they feel about talking about their traumas.

55 274-275: Clinicians often feel like they alone should make the decision of when to start exp. work

56 275: Clients know themselves when they are exp. ready, so it should be a joint decision of when to start exp. work

57 277-284: Open dialogues between Client and Clinician about their avoidance, enables to evaluate their exp. readiness