DOCTORAL PORTFOLIO IN COUNSELLING PSYCHOLOGY.

by

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Thesis submitted in partial fulfilment of the requirements of the University of Wolverhampton for the post-graduate degree of:

Practitioner Doctorate in Counselling Psychology.

The following research has been conducted in line with the guidelines presented for the module: Doctoral Portfolio, PS5018.

October 2012.

Declaration.
The research dossier of any part thereof has not previously been in any form to the University or to any other body whether for the purposes of assessment, publication or for any other purpose (unless otherwise indicated). I further confirm that the intellectual content of the work is the result of my own efforts and no other person.

The right of Sarah Mills to be identified as author of this work is asserted in the accordance with ss.77 and 78 of the Copyright, Designs and Patents Act 1988. At this date copyright is owned by the author.

Signed......................................

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To my friends, thank you for your patience. I promise you will now get Sarah back! To Rachael in particular, I would not have known what to do without you in these last few months. You are truly a friend for life.
Last, but by no means least, a special thank you to the founder of Spectrum Therapy and to the participants that agreed to take part in my study. Thank you for sharing your experiences with me. I am indebted to you all.
All work throughout this portfolio has been appropriately anonymised and all identifiable information removed so no participant can be identified.

Preface to the Doctoral Portfolio.

The following portfolio aims to document a selection of work completed for the Practitioner Doctorate in Counselling Psychology course at the University of Wolverhampton. The work outlined in this portfolio aims to
demonstrate my transition from an unconfident first year trainee who relied on Cognitive Behavioural handbooks in order to “carry out” therapy to an eclectic trainee that continually seeks to mould therapeutic treatment plans to each individual client need. This process of change will be discussed in the following preface with references made to the work included in the doctoral portfolio.

The portfolio has been divided into three main sections: an Academic Dossier, a Therapeutic Dossier and a Research Dossier. The Academic Dossier contains two essays completed in year two and three of the Doctoral programme. The first essay included in this Dossier was completed for the Life Span module and the second, for the Couple Therapy module. The Therapeutic Development Dossier contains a Supervised Practice essay which explores my three years on placement as a trainee Counselling Psychologist and a Professional Issues essay which reflects on all elements of my three year training, documenting both my personal and professional development throughout the course. Finally, the Research Dossier contains a critical literature review, a qualitative research report and a critical appraisal of the research process.

As a supplement to the Doctoral Portfolio there is a Confidential Attachment, which contains a client study, a process report, raw data from the research project i.e. transcripts, annual progress reviews of the research process and feedback sheets for all work contained in the Portfolio and
Confidential Attachment. In line with the confidentiality rights of clients and participants who have volunteered to be a part of this work, all potentially identifying information has been altered to ensure anonymity.

Being a Counselling Psychologist in training has brought many challenges. The most predominant challenge that I have been faced with over the three year doctoral programme is the distinction between the “psychologist” element of the course i.e. as a scientific professional and the “counselling” element i.e. as a therapist that values meaning-making and validating a client’s subjective experiences. This distinction was initially highlighted to me when working in NHS settings that were often medically dominated and where language such as “diagnosis” and “treatment” were commonplace. Such a stance seemed to contradict my underlying philosophies as a humanistic, existential practitioner.

In my first year placement I was working in a Primary Care setting that relied heavily on the use of “diagnosis” to determine treatment plans. Clients would enter into therapy with a referral letter that outlined the client’s presenting symptoms and often there would be a recommendation made about what type of therapy should be used; more often than not, this would be Cognitive Behavioural Therapy (CBT).
After I had worked with a few clients using a Cognitive-Behavioural approach, I began to notice that the Humanistic approach I was learning in my first year university lectures, did not feature at all in the therapies offered to clients in my practical place of work. I began to get concerned that my first year client study, which aimed to document my work with a client using a Person-Centred approach, would not be possible. I spoke to my supervisor about my concerns and she told me that the main model of care offered to clients at the department was CBT because, as clinical and counselling psychologists, we should be following the “scientist-practitioner” model of care. However the department could make special allowances for my university requirements.

Having engaged in both the counselling concepts and counselling skills courses prior to enrolling onto the Doctorate in Counselling Psychology course, I was already aware of the importance of Rogers (1963) core conditions in therapy, but I was unsure how these concepts alone could produce therapeutic change in my clients. I was eager to learn this. As described in my Professional Issues essay, these were the very concepts that attracted me to the Counselling Psychology profession. Owing to this, I was disappointed to be informed that a “special allowance” would have to be made for me to be able to practice these skills with a client. I thus began a quest to find out what the “scientist-practitioner” model was and why it was apparently stopping me from practising my humanistic skills!
The scientist-practitioner model attempts to combine both the practical and research elements of the profession by advocating that the treatment methods with the highest levels of efficacy should be used in therapeutic practice (Newnham & Page, 2010). This often means that the successfulness of a treatment method is determined through outcome trials. As is the case for the most common mental health problems in the United Kingdom, i.e. depression, anxiety and post-traumatic stress disorder, to name but a few, CBT is outlined as the recommended treatment method owing to its proven efficacy from randomised control trials and meta-analyses (e.g. Butler, Chapman, Forman & Beck, 2005). It is important to note however that the research base for CBT has been challenged, mainly on the grounds of transferability of findings from research into practice (see Merrett & Easton, 2008).

My relationship with CBT has waxed and waned over the three-year doctoral training programme. Consequential to my insecurities as a first year trainee who had little experience of “live” therapy, I found CBT to be a very comfortable way of working. It provided me with the security I needed to feel confident in therapy as I could follow the recommended interventions for different symptom presentations and adhere to the predefined formulations for specific psychological difficulties. Clinician treatment manuals that provided descriptions of what to do in each session, with guidance even on how to present the concepts of CBT to my clients (e.g. Padesky & Greenberger, 1990; Padesky & Mooney, 1995) were particularly useful at this early stage in my training.
In addition, in my first year placement, the majority of my clients seemed to be responding well to CBT. For those clients who were fortunate enough to be from privileged backgrounds, who had secure attachment styles and who had been adequately educated, CBT seemed particularly beneficial. Whilst this was the case, my knowledge of other psychological therapies and theoretical concepts was growing through my university lectures. I started to recognise the usefulness of certain Gestalt concepts such as the “split self” and how the empty chair technique could be used to help marry the differing parts of a client into one complete whole (Paivio & Greenberg, 1995). In addition, I began to expand on my initial knowledge of Roger’s (1963) core conditions and how developing a strong therapeutic relationship could be therapeutic in its self. For me, these approaches seemed to be more exploratory in nature than the directive cognitive-behavioural approach I was used to and as such I felt they were more in-keeping my underlying philosophy as a Counselling Psychologist in training.

As I began to recognise the potential benefits of other ways of working with my clients, I started to become increasingly frustrated with my first year placement’s reliance on the National Institute of Clinical Excellence guidelines (NICE, 2008) for the selection of “treatment”. Whilst I could understand the importance of incorporating efficacious treatment methods in to my practice I was starting to strive for some autonomy for both my clients and me in the decision making process of therapy.
In addition to my own frustrations, I started to agree with the concerns posited by Merrett & Easton (2008) who query what happens to those clients who do not respond well, or dropout of CBT. For me, this concern was generated through recognition that CBT interventions were not suitable for all my clients. Some, for instance, found it difficult to engage in certain CBT interventions (e.g. exposure or homework tasks) even though they presented with the necessary symptoms to warrant use of such an approach. Through the Life Span module of the course I wanted to document this aforementioned dilemma in my assignment as I had previously worked with a client who felt his sense of Self had been lost through a traumatic experience he had encountered. When applying the recommended exposure based techniques to this client, which in essence are based in cognitive and behavioural paradigms (Foa & Kozak, 1986), I found he became increasingly frustrated as he felt therapy was an unnecessarily painful experience. He found the re-living aspect of treatment highly distressing and he felt the process was not addressing his true problem; his loss of identity.

I took my concerns about my client’s suitability to exposure therapy to supervision. When I was working with this client I still regarded myself to be an inexperienced therapist. I therefore held a belief that all other professionals knew better than I. This belief filtered into my first year supervision sessions and as such I took what my supervisor said to be the
absolute truth. Later on in my training I started to recognise that such a concept did not exist in psychology!

At this time, I believe I was in Level One of Stoltenberg’s (1981) developmental model of supervision where the supervisee is dependent on their supervisor for guidance. Owing to this, when in response to my concerns, she questioned my client’s motivations for change; I was reluctant to challenge her. I didn’t challenge my supervisor on this point in spite of feeling that it might be the model of treatment, not my client’s motivations, that was the problem. I believe this reluctance to challenge my supervisor was due to my belief that she was the “expert”. In addition, I was continually aware that she had the power to either pass or fail me and such, I wanted to please her. Later on in my training, through personal therapy, I realised that I, like so many of my clients, had fallen victim to cognitive distortions, as I was predicting that my supervisor would fail me, if I challenged her.

Through writing the essay for the Life Span module, where I reported on the notable absence of identity change in PTSD treatment, I began to recognise the practical dilemmas faced by Counselling Psychologists who are encouraged to routinely adopt “best” evidence-based practices into their treatment methods with clients. From this experience I found myself strongly agreeing with Garcia and colleagues (2011: p1) statement “our
most effective therapies are only as good as our clients ability to complete them”.

Through recognition of this dilemma, I started to immerse myself in the literature that discussed this notable gap between what is deemed efficacious, as determined through research trials, and what is deemed effective in everyday practice with clients. A particular commentary in the literature on this topic began to catch my attention pertaining to this recognised gap in the treatment of PTSD, particularly with veterans of war where high dropout rates and missed appointment sessions were noted as commonplace (Erbes, Curry & Leskela, 2009). I began associating the points suggested for the reduced effectiveness of exposure therapy to my previous client’s concerns of engaging in a treatment method that a) seemed to be highly distressing (e.g. Wells & Sembi, 2004) and b) seemed to conflict with his ideas of what needed to be addressed in therapy (e.g. Hemsley, 2010).

My experiences of working with a client in therapy, who was reluctant to engage in the recommended treatment method for PTSD, and my subsequent literature searches into the distinction between efficacy and effectiveness in psychological therapy, drove the premise of my current research project. I knew fairly on in the research process that I wanted to honour my previous client’s subjective experience of therapy by assessing other people’s experiences of such a therapy. This research question lent
itself to a qualitative enquiry. As I had never used or studied this methodology in depth before, I was initially reluctant to adopt a qualitative method for my doctoral research, not least because there seemed to be limited information and guidance on how to carry out such an analysis. This was markedly different from my experience of carrying out quantitative methods through my undergraduate training, where copious amounts of literature on how to conduct different statistical analyses were available (see Field, 2009).

Although I had initial reservations of adopting a qualitative method for my research, I wanted to challenge myself. Firstly, it was the method best suited to my research question. Secondly, I thought it would allow me the opportunity to start to marry the scientific and subjective elements of my profession, something that I had been struggling with in my clinical placement. Finally, I was starting to notice that I had developed a dependency on following CBT manuals in my clinical work with clients. I was doing this in spite of my growing recognition that I wanted to expand my repertoire of clinical skills. I therefore decided in both research and practice to attempt to drop these manuals in an effort to enhance my learning and grow as an autonomous Counselling Psychologist in training.

In practice, the metaphor of “dropping the manual” was represented through my choice of second and third year placements, where the use of both directive and non-directive therapies was encouraged. Initially, the thought
of applying new interventions with clients was daunting, particularly when utilising therapies that encouraged a more “here and now” way of working. Whilst I began to recognise the benefit of such interventions for some of my clients, I felt reluctant to put this learning into practice. This reluctance was due, in part, to the unpredictable nature of this style of working; I felt uneasy at the thought of dealing with issues as and when they came up in therapy. Through my Professional Issues essay, I reflect on this dilemma, attributing my reservations to the challenges these new approaches would bring to my initial ideas of what it meant to be an effective therapist; a therapist who had all the answers.

Having all the answers for my clients was a sticking point in my development. Whilst I knew I wanted to change this aspect of my work, not least because I had experienced the benefits of feeling empowered through my own personal therapy, I didn’t know how to go about this in my own clinical work with clients. Through supervision I began to realise that it was acceptable not to know the answer to my dilemma by witnessing how comfortable my supervisor was in not being able to provide me with the answer. If one were to accept the assimilation model of change (Stiles, 2001) I was internalising my supervisor’s model of coping with uncertainty.

This insight allowed me to slowly become more comfortable within therapy when I felt uncertain of the answers or what to do next. Indeed, I found that this way of being seemed to reflect positively in clients as they too began to
respond to their own life challenges in such a way. For me, this seemed to facilitate a more relaxed way of being in therapy and indeed in supervision. I felt as though the pressure of having to be right all the time had been reduced. I found this helped me move from stage one of Stoltenberg’s model of supervision (1981) into stage two as I began to feel more equal to my supervisor as we were both recognising and validating each other’s recommendations. Entering into therapy with clients in a more relaxed state encouraged me to be more flexible in my approach which in turn enabled me to incorporate other ways of working into my clinical practice. Through my supervised practice essay, I document this transition from a practitioner who used only CBT, to an aspiring eclectic practitioner who strives to select therapeutic models and concepts to suit the subjective formulations of my clients.

My journey to becoming an eclectic therapist has, by no means, been a linear one. Indeed I see my process of change throughout this transition as being in keeping with a more fluid model of change, where relapse is deemed part of the process (e.g. Prochaska & DiClemente, 1986). Through personal therapy, I began to notice that these relapses often occurred when I felt over-whelmed or confused by a client’s presentation. In such an instance I would revert back to my trusted CBT manual to give me “the answer” on what to do next. By reflecting on each lapse within supervision and personal therapy I began to understand how I could learn and grow from what I initially deemed to be a step backwards. The adoption of such learning proved useful in my third year placement in an Eating Disorders
service, where clients often put extreme pressure on themselves to change quickly and in a linear fashion.

Another challenge I faced in my transition from being a one-model therapist to an eclectic practitioner came from opponents of eclecticism who question how and why certain therapeutic tools are chosen (see Cutts, 2011). When reading this literature I started to doubt my own decision-making processes within therapy. Should I rigidly and routinely refer to the NICE guidelines of best practice when choosing interventions for example? If I don’t do this would I be working un-ethically?

I began to address these questions through my Couples Essay in my third year of training. When writing this essay I decided to compare and contrast two approaches to couple therapy: Solution Focussed Couple Therapy (SFCT) and Emotionally Focussed Couple Therapy (EFCT). In comparison to EFCT, SFCT had not received the required level of support from research trials to warrant its inclusion into treatment guidelines. This said it did have notably positive anecdotal support from both clinicians and clients in relation to its usefulness within therapy. From this essay I started to see that both therapies had strengths and drawbacks pertaining to the subjective needs of, in this case couples, regardless of whether or not they featured in treatment guidelines. In conjunction with my experiences in clinical practice where I have found the suitability of therapy to be matched to client need instead of the symptoms they present with, this learning continues to
drive my enthusiasm for working in an eclectic way with my clients. I believe therapy preferences should be considered from an evidence base but not at the neglect of valuing individual differences.

This learning connects to my underlying philosophies as a Counselling Psychologist who holds the subjective needs of my clients in high regard. This learning does not mean I advocate the abolition of treatment guidelines. Indeed as Fairfax (2008: p32) highlights “there does of course need to be evaluation, development and regulation of interventions”. What I do stand to contest however, like many other professionals (e.g. Richardson, 2006; Newnes, 2007) is that solely awarding merit to therapies that perform best in RCTs may limit our development and growth as a profession. This point is very much a feature of my research where I aim to address the notable gap between efficacy and effectiveness in the treatment of PTSD, where the most efficacious treatment is not always adhered to in real-world practice.

Through the course of the Doctoral programme I have had the opportunity to work with a range of clients presenting with a number of different problems, in a number of different clinical settings. This experience, teamed with my academic studies has seen me move from an unconfident first year trainee who relied on one therapeutic approach, to a reflective practitioner who strives to mould therapeutic plans to suit the wants and needs of my clients. Whilst I believe this forms the crux of my identity as a
Counselling Psychologist, I do recognise that certain clinical settings and professional guidelines may challenge this way of working. Through experience I have recognised that the balance between client-need and service-need are often at odds and as such the freedom to be flexible in therapy is often not possible. Whilst I foresee this as being a continued dilemma for me, I am recognising that I feel comfortable not having the answer.

References.


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Should the role of identity change be addressed in post-traumatic stress disorder (PTSD)?

Identity.

Our understanding of identity and its role in determining behaviour has come a long way since it was first given significant attention by Erikson in
Erikson (1956) first recognised the presence of what he termed an “ego identity” through his work with World War II veterans. He argued that, held at the heart of the veterans’ psychological disturbances, was a unified loss of the self in terms of behavioural predictability and self-continuity. Developmentally, Erikson (1963) contributed to lifespan theories with his eight stage life cycle scheme through which he pronounced identity as being a static concept. He argued that identity crises typically begin in adolescence and are either resolved, or not resolved by early adulthood, a process he termed “role confusion”.

Erikson’s (1956) work on identity became the building blocks for future research and debate surrounding the concept of identity. Research since has identified cultural variations in identity formation with differences between westernised and non-westernised ideas of successful identity formations addressed (Tobin, Wu & Davidson 1998) and differing ideas surrounding the origins of identity offered, with Baumeister’s (1987) socially constructed identity model and Kroger’s (1996) bio-psycho-social model of identity formation. Whilst there is ongoing debate in the area of identity, it would seem that agreement has been made surrounding the fluidity of identity development. Once seen as a static concept (Erikson, 1963), identity is now viewed as more dynamic and influenced by changing life events (McAdams, 1993).

Is it static?
The idea that identity is static has been refuted by work looking into identity change. Marcia (1966) looked at identity classification in a more qualitative way than previously done with her proposal that identity development comprises four different identity statuses namely, foreclosure, identity achievement, identity diffusion and moratorium (Anthis & LaVoie, 2006). Marcia’s model sees identity as constantly changing throughout the lifespan, giving us a feel of identity being more fluid. Although her model is able to encapsulate identity change, it has been criticised for being more descriptive than explanatory in nature as it does not suggest reasons for a change (Kroger, 2007). In order to determine any precursors to identity change we need to refer to later research into identity and trauma.

**Trauma, Identity and Treatment.**

As Erikson (1963) highlighted, a feeling of knowing who we are provides us with direction, continuity and a sense of predictability in an ever-changing world. For many, experiencing a trauma can tear apart their previous understanding of themselves and the world (Janoff-Bulman, 2006). It has therefore been suggested that psychological stability following a trauma is successfully achieved through the development of a renewed sense of self (Neimeyer, 2006). This can be seen in people navigating their way through a serious illness.
It is not uncommon for people who are suffering with, or have suffered from, a major illness to feel differently about themselves (Luyckx et al., 2008). Indeed Davidson and Roe (2007) suggest the major challenge of overcoming a serious illness, whether it be physical or mental is to overcome the “loss of valued social roles and identity, isolation, loss of sense of self and purpose in life”. It has been suggested that people who compare themselves negatively to others with regard to their situations and the situations of their peers may experience the negative effects of an illness for longer than people who do not (Carless & Douglas, 2008). A feeling of a loss of self can also bring with it a sense of grief, as the individual mourns the loss of their previous self identity (Repper & Perkins, 2003).

Not all individuals who experience a major illness report a negative shift in their sense of identity. Research has started to document Post-Traumatic Growth (PTG) in individuals who have suffered with cancer for example (Abernathy, 2008). It is thought that a positive outcome is due to an identity shift which is one of power and strength rather than of weakness or illness. In breast cancer patients the term “survivorship” has been documented as a collectively held identity status in people who have overcome the disease (Kaiser, 2008).

Work into trauma and abuse has also given us an insight into the role of identity change on psychological wellbeing. Recent research into this area is starting to move away from the traditional view that the trauma itself
causes psychological problems (Robins, 1978) as studies on the effects of early abuse and attachment styles are starting to recognise the presence of individual differences in interpretation of the abuse and later psychosocial difficulties (McCarthy & Maughan, 2010).

The National Institute for Clinical Excellence (NICE, 2008) guidelines do not specify any one recommended treatment method for client’s presenting with trauma. Therapists therefore are allowed freedom to construct the therapeutic plan in terms of what is best suited for individual clients. In therapy settings, counselling psychologists work with trauma in a number of ways. Trauma can present itself alongside other clinical disorders as seen with client’s presenting with illness or abuse as highlighted above, or it can be the central aspect of a client’s problem as seen in post-traumatic stress disorder (PTSD).

**Identity, Post-traumatic stress disorder and Treatment.**

Post-traumatic stress disorder (PTSD) was recognised as a standalone disorder in 1980 by the Diagnostic and Statistics Manual IV for Mental Health (DSM-IV). The DSM-IV classifies the disorder in terms of criteria clusters. Criterion A states that the disorder may develop following a stressful event where an individual is confronted with death, threat of death,
serious physical injury or threat to physical integrity. Criterion B highlights the symptom of re-experiencing the traumatic event, more commonly known as flashbacks. Criterion C refers to the avoidance of reminders to the trauma and Criterion D to hyper arousal including exaggerated startle responses and irritability (NICE Guidelines, 2008).

Current treatment guidelines recommend that trauma focused psychological therapy, in particular Cognitive Behavioural Therapy (CBT) or Eye Movement Desensitisation Reprocessing (EMDR), should be offered to all patients presenting with PTSD (NICE Guidelines, 2008). Exposure therapy requires clients to vividly recount the traumatic event that caused them fear, threat of death or serious physical injury. Clients are repeatedly asked to confront the memory of the event until their emotional responses decrease and they can be gradually introduced to fear evoking stimuli (Schnurr et al., 2007). Although the effectiveness of this treatment method has been proven (Elhers et al., 2010), it has faced criticism over recent years for being too ridged (Feeney, Hembree & Zoellner, 2003) and thus losing the essence of the person in the process (Hemsley, 2010). In order to explore this point, it seems preferable to refer to a case vignette from my own clinical practice:

Tom (pseudonym) is a 31 year old male who was involved in a fatal car accident of which he was later charged and convicted of manslaughter (Criterion A). In the period between the accident and the trial Tom started experiencing flashbacks of the event (Criterion B). He was unable to pass by the scene of the crime and was unable to be a passenger in a motor vehicle (Criterion C). Prior to the incident Tom considered himself to be a
respectable member of his community with many friends. He had a job, and although he was still living with his parents, he had plans to start renting his own flat. After the event Tom became introverted and was experiencing trouble sleeping (Criterion D). He believed himself to be a “murderer” and thought that others would view him as one also. He had lost all hope for the future as he felt unworthy of one.

In supervision it was decided that I would treat Tom for PTSD as he presented with all the symptoms of the disorder. The treatment plan was devised in accordance with the NICE guidelines (2008), which states that exposure therapy should be offered to all clients presenting with PTSD under the premise that the development of symptoms derives from the individual’s inability to process the experience adequately.

After a couple of sessions with Tom it became evident that his problems were not centred around the flashbacks, although these were causing him distress, but were mainly directed towards his own loss of self. He felt unable to connect with himself or others in a positive way and so was avoiding the outside world. He was confused over his reaction to the event as prior to this he saw himself as a strong person and now he felt weak and unable to cope.

Tom was sentenced before therapy could be completed. No work was carried out to address his identity shift as it was thought best to follow the instruction from NICE (2008). Therefore some brief exposure work had been carried out to try and piece together the sequence of events from the
accident. Tom reported feeling no better at the end of therapy than he did at the beginning.

When looking at the work surrounding trauma and identity one of the major considerations seem to be on the subjective nature of identity change (Mathieson & Stam, 1995). This would appear not to be the case for the treatment of PTSD. In fact, as Hemsley (2010) argues it seems to encourage the exact opposite, stating that “the structure of exposure therapy can often discourage reflection upon the individual’s meaning of the experience as we as therapists move away from a reflective form of practice into a more medical one”.

The case example above is presented in an effort to support the ideas presented by Hemsley (2010). Referring to Tom it may have been more relevant to work with him in terms of his new felt sense and to reflect upon the similarities or differences he felt since the accident in terms of his identity. This is not to undermine the usefulness of a structured Cognitive Behavioural approach in PTSD treatment. Work by Schnurr and colleagues (e.g. 2007) have highlighted the value of addressing the symptoms of PTSD in treatment, however concerns are raised around the static formulations and the recommended treatment methods presented by NICE (2008) for PTSD in terms of identity loss following trauma.

Debate surrounding the usefulness of formulations to clients in therapy is ongoing (Johnstone & Dallos, 2006). Therapists can often be directed by pre-determined formulations, especially in CBT (Herbert & Wetmore, 1999). Whilst it is argued that formulations are good for providing a
guideline to treatment (Herbert & Wetmore, 1999), do they allow for therapists to lose the essence of the client in their description? In terms of Tom, it was felt that the pre-designed formulation (Herbert & Wetmore, 1999) and the recommended treatment guidelines for PTSD as presented by NICE (2008) made the treatment plan feel rigid with no allowance for individual differences in treatment. In fact NICE (2008) have faced criticism for this by some professionals previously, as they have been asked the question “do all clients with PTSD present with the same symptoms” (Hemsley, 2010)? From the case vignette, it would appear that although the symptoms of PTSD were present in Tom’s presenting problems, the role of identity change was possibly more important to address in his treatment.

Identity is considered to be a subjective concept (Abernathy, 2008). It is the individual’s view of the self which provides direction and consistency in an ever changing world (Erikson, 1963). With the evidence of research arguing that identity change is a required component of successfully navigating through a trauma (Neimeyer, 2006), are we right to be ignoring it in our treatment methods for PTSD? It is suggested that by incorporating the concept of identity change into the treatment methods for PTSD we could help the intervention move away from what Hemsley (2010) terms the “medical model of PTSD treatment” by allowing for more idiosyncratic variances that better suit the underpinning philosophy of counselling psychology.

With regard to exposure therapy, concerns are also raised around its suitability for all clients’ suffering with PTSD. Dropout rates for this type
of treatment are seen to be high (Bradley, Greene, Russ, Dutra and Western, 2005) and it is even thought by some to be damaging to some client groups (Steenkamp et al., 2010). Specifically, research into children has documented how this type of treatment could be particularly harmful for young clients’ as it could lead to them being re-traumatised (White, 2005). Narrative therapy, as a treatment for PTSD, has proven to be particularly useful with this age group. White (2005) argues that the effectiveness of narrative therapy is down to it’s emphasis on the different identity statuses a child can poses both before, during and after the traumatic event (White, 2005). It is believed that this type of therapy is useful because it helps rebuild the individual’s shattered sense of identity following a trauma (Crossley, 2000).

From these insights into Narrative Therapy it is suggested that this type of treatment might also be useful when working with client’s in the adolescent or early adulthood phase of life. Adolescence is a time regarded by psychologists as the critical period for self and identity development (Marcia, 1966). It is known as a time of self-discovery, uncertainty and a period through which individuals are finding their way in the world (Tanti, Stukas, Halloran & Foddy, 2010). The effects of trauma in this crucial phase of identity development have been documented. Carrion and Steiner (2000) found a link between delinquent behaviours and a dissociated identity status in adolescents who had experienced trauma. Also, with the understanding that identity is not a mysterious entity but rather a cohesive result of a person’s life (Gergen & Gergen, 1988) it is plausible that a
trauma experienced at this time could have profound effects on the individual at the level of identity and thus may need to be addressed in treatment.

Critics of exposure therapy document that this type of treatment is too rigid (Feeney, Hembree & Zoellner, 2003), and not suitable for all PTSD sufferers (Bradley, Greene, Russ, Dutra & Western, 2005). From the research it would appear that different forms of treatment maybe more suited to clients of different ages as shown through work into narrative therapy (White, 2005). For children and adolescents particularly, it is suggested that treatment methods that look to work on identity change following a trauma may be particularly relevant as these individuals are navigating their way through what psychologists term “the crucial stage of identity development” (Tanti et al., 2010). It is therefore put to question whether or not we are right to have only one form of therapy documented by NICE (2008) for the treatment of PTSD for all clients.

Identity and Risk factors in Post-Traumatic Stress Disorder.

As well as having implications for treatment, the concept of identity change following a trauma could also help develop our understanding of why some people develop PTSD and others do not. Although this suggestion was rather frowned upon in earlier work into PTSD as the very question seemed to imply blame on the part of the victim (Blank, 1985), psychologists nowadays are starting to recognise the importance of identifying pre-disposing risk factors to PTSD development (McNally, 2010). Vulnerability
factors such as the severity of the trauma, a pre-psychotic diagnosis and a lack of social support have been highlighted as having an influence on PTSD development (McNally, 2010). It is argued that identity change could also be added to this list if we refer to the work carried out by Janoff-Bulman (2006) on trauma victims.

Janoff-Bulman (2006) found that victims of trauma only experienced psychological problems if they viewed the event to be traumatic. This suggests that the event itself is not traumatic but rather that “trauma” is defined by the individual’s perception of the event. Indeed, Thoits (2003) argues that psychological distress following a trauma occurs when the actions of oneself and or others do not match the individual beliefs of how one or others should act. Drawing on from this, could it be that PTSD develops when the traumatic event clashes with how one believes they or others should behave? For instance could problems occur at the level of identity whereby a rape victim who once viewed themselves as being strong, now believed they were weak and vulnerable? If we look at work into illness and identity it would suggest so.

When looking at the research surrounding cancer sufferers, psychologically positive outcomes have been found to be determined by the person’s identity shift from a status of weakness to a feeling of power or strength (Kaiser, 2008). Could it also be argued therefore that a negative identity shift in individuals presenting with PTSD could actually pre-determine the vulnerability of the individual to the disorder? It is suggested that future
empirical examinations into the effects of identity change on pre-disposing risk factors in PTSD development need to be addressed.

**Conclusion.**

The points made surrounding identity in terms of risk factors, the treatment methods for the disorder in differing age groups and static formulations pre-designed for the treatment of PTSD (Herbert & Wetmore, 1999) have obvious implications for psychologists in therapy settings. It has been argued that by incorporating the subjective concept of identity change into treatment methods for PTSD we could help it move away from what some psychologists are terming the “medical model of PTSD treatment” (Hemsley, 2010). Work into PTSD treatment with children has also offered insights into the effectiveness of other forms of treatment, namely Narrative Therapy, in reducing the symptoms of PTSD in children (White, 2005). Implications from this research have been discussed in terms of adolescents and raised concerns over the NICE guidelines (2008) suggestion that there is only one effective form of treatment in reducing the symptoms of PTSD in all sufferers.

Overall it would seem that the concept of identity change in PTSD should, at the very least, be considered in terms of treatment for PTSD in differing age groups and in determining risk factors for the disorder.

**References.**


Solution Focussed Therapy and Emotionally Focussed Therapy: Comparing and Contrasting Two Theoretical Approaches to Couple Therapy.

Introduction.

Couple therapy has evolved considerably since its inception in the early 1930’s. It has moved from being almost universally influenced by psychoanalytic theories and practices through to the more modern influences of cognitive-behavioural and emotionally-focused, attachment style theories and concepts (Gurman, 2008). This growth has mainly been
in response to the increasing demand of such a therapy as relationship
difficulties have become more widely acknowledged and help for dyadic
problems increasingly sought after (Boddington & Lavender, 1995).
Recently, and in response to this increased demand, considerable attention
has been given to the development of psychologically efficacious and
theoretically sound treatment modalities that can be integrated into a
therapists’ practice with couples (Scaturo, 2002).

The current assignment aims to explore the possible benefits and drawbacks
of two separate approaches to couple therapy: Solution-Focused Therapy
and Emotionally-Focused Therapy. These two approaches were chosen
because they both adopt a non-pathological stance (Fernando, 2007; &
Johnson, 2004), a principle which sits well with the underlying philosophy
of counselling psychology (Fairfax, 2008) and they both are relatively new
approaches to treatment, when compared to psychoanalytic or behavioural
movements. This said the two approaches differ considerably in terms of
therapeutic focus and therapeutic intervention. Both solution-focused and
emotionally focused couple therapy will be compared and contrasted with
one another through the exploration of an illustrative case vignette. This
case vignette refers to a couple, whom for the purpose of the assignment,
will be named Susan and Jonathan (pseudonyms). It is important to use
pseudonyms when presenting client work in an assignment as it helps
protect client confidentiality (BPS, 2009).
Solution-Focused Couple Therapy and Emotionally Focused Couple Therapy: An Overview.

Solution-Focused Couple Therapy (SFCT) is a relatively new, time-limited therapeutic approach to therapy, which was founded by Shazer & Berg in the early 1980’s (Gurman, 2008). SFCT is gaining momentum in both research and practice due to the positive anecdotal reports from both client and therapist in relation to its usefulness and with the increasing empirical support it is receiving (Gingerich & Eisengart, 2000). Similar to SFCT, Emotionally Focused Couples Therapy (EFCT) is a relatively new theoretical approach to treatment developed by Johnson and Greenberg in the early 1980’s (Johnson, 2004). EFCT, along with Behavioural Marital Therapy (BMT), is recognised as being an efficacious treatment method for couple therapy as determined through clinical trials (Jacobson & Addis, 1993). Such recognition is not yet applied to SFCT as it has not received the same level of empirical attention as the aforementioned therapies (Gingerich & Eisengart, 2000).

The focus of SFCT, and perhaps one of its most defining features, relates to its emphasis on the facilitative nature of therapy where couples can generate solutions rather than discuss problems and resolve relational difficulties.
Little attention is therefore placed on history taking or on explorations of emotions attached to the problem itself (Gingerich & Eisengart, 2000). In SFCT, the therapist is encouraged to use specific techniques which aim to make the couple generate solutions themselves. These techniques include the “miracle question” or “scaling questions” which are used to decipher what solutions can be generated from the problem or to search for part of the solution that may already be happening (Hoyt, 2008).

In contrast to this, EFCT sees the primary enforcer of change to be an individual’s relationship with their and their partner’s emotions (Johnson, 2004). With this in mind, one of the predominant features of EFCT is the therapist’s ability to guide the couple away from their present negative or rigid responses towards their spouse, to a more flexible, sensitive way of responding (Greenberg, 2004). The therapy therefore helps the couple redefine how they see each other in the here and now through a greater understanding of each of their emotional, internal worlds. This aspect of the therapy is notably different to SFCT techniques which focus on the present and the future solutions to a problem (Hoyt, 2008).

Whilst there are notable differences between the therapies in terms of therapeutic focus, similarities can be made at the level of their underlying philosophies as both therapies believe in the subjective nature of therapy.
and both place the therapist, not as the expert, but as a facilitator of change (Trepper, 2008., & Johnson, 2004).

**Formulating the problems presented by the case vignette.**

Considering that the focus of SFCT is on generating solutions to a problem rather than focusing on the problem itself, the SFCT assessment is often centred around who or what is important to the couple and what they would like from their relationship in the future (Zimmerman, Prest & Wetzel, 1997). Owing to this focus, therapeutic formulations are developed to provide a brief outline of the current maintenance cycles fuelling the couple’s problems but are used more as a platform from which goals can be set and client-led solutions generated (Trepper et al., 2008).

If we were to apply the concepts behind solution-focused couple therapy to the case of Susan and Jonathan, one could formulate that, for Susan, having regular contact with Jonathan has become increasingly important since their youngest son Stephen has gone to university. Owing to this, she is starting to place pressures on her Husband to find a new job closer to home. Currently this pressure to be closer to home is causing Jonathan some conflict as shown through the example given when he shouted “I can’t win” and subsequently “went to the pub”. This reaction on Jonathan’s part is in conflict with Susan’s desire to spend more time together.
In contrast to this SFCT explanation, the emphasis within an EFCT framework is on the exploration and transformation of maladaptive emotions through a process of awareness, acceptance and understanding (Greenberg, 2004). Derived from the concepts that underpin attachment theory, EFCT focuses on the attachment needs and fears of the couple in determining maladaptive patterns of interaction (Ells, 2007).

With this in mind, the difficulties faced by Susan and Jonathan, could be explained from an emotionally focused perspective in terms of their attachment needs and subsequent emotional responses to their current situations. Susan, for instance, appears to be responding anxiously to being at home alone. This emotional response suggests a dependent attachment style which is further supported by her over reliance on her youngest son Stephen before he went to university. As Stephen has now moved out of the family home, and since her mother has passed away, Susan is now seeking intimacy and attention from her Husband. Jonathan, on the other hand, appears to be detached from intimacy, preferring to be on his own. This attachment style seems to have developed from his long stays in hospital when he was younger and has since been perpetuated by his absence in the family home owing to work commitments. The now current pull of attention and intimacy from Susan is conflicting with Jonathan’s attachment style and in response he appears to be in conflict. This is making Susan feel further isolated and anxious, resulting in her issuing Jonathan with an ultimatum.
The strengths and drawbacks of both therapeutic models when applied to the case vignette.

One of the main challenges faced by a couples’ therapist is to get an overview of the couple’s difficulties from both partners perspective (Symonds & Horvath, 2004). With regard to the case above, there appears to be a lot of information from Susan’s point of view about the difficulties faced in her relationship with Jonathan. From her perspective there seems to be a very clear reason for their current difficulties: the fact that Jonathan works away from home. Conversely, there is only a small amount of information provided which allows insight into how Jonathan maybe feeling about the situation, alluding to his response to Susan’s ultimatum when he threw his hands up, saying “I can’t win”.

From an SFCT approach, the focus of generating solutions to the problem, rather than focusing on the problem itself, might be beneficial in the case of Susan and Jonathan as it could help highlight the resources and abilities the couple have in overcoming their difficulties rather than focusing on the nature and development of the problem, techniques usually deployed in the more traditional approaches to therapy (Tashiro & Frazier, 2007). This solution focused approach might be particularly beneficial for Susan as it feels as though she is currently overwhelmed by the problems faced in her relationship, so much so, that she has felt the need to issue Jonathan with an ultimatum. Such an ultimatum gives the reader the impression that Susan
may be entering into therapy with a negative view of their relationship. Owing to this, it may be important that therapy, from the outset, concentrates the couple’s attention on their desired future together rather than on their past problems or current conflicts (Trepper et al., 2008). This in turn might give Susan a different focus, shifting her attention away from the negatives of what Jonathan isn’t doing to the positive aspects of what he is doing.

Literature has supported the idea posted by SFCT that developing a positive climate between clients can influence change and thus resolve issues. Gottman, Swanson and Swanson (2002) suggest that if the therapeutic process starts by discussing a couple’s positive attributes and the adaptive ways they have previously overcome difficulties, they are more likely to use this as a directive way of responding to their current difficulties. I feel that for Susan and Jonathan, this move from a negative climate of response to a positive one maybe helpful in drawing out the reasons for why they “both want to stay together”. In order for a positive climate to be achieved, the solution-focused therapist would adopt a “language of change” (Hoyt, 2008) that focuses the couple on their combined goals of therapy and channels in on their resources as a couple to solve their own problems. In light of this, I feel that it might be important to ask Susan if there have been any times when she hasn’t found the separation from Jonathan hard, to help her generate any exceptions to the problem of Jonathan not being at home. In addition, it would be useful for the solution focused therapist to draw on any past examples where Susan and Jonathan have overcome adversity to help
highlight their ability as a couple to deal with their problems. In this example, solution focused therapy might offer some advantages to those therapies that, from the outset, aim to understand the often negative affect caused by a couple's current difficulties.

On the surface, it would seem that generating solutions to a problem, rather than focusing solely on the problem itself is an effective, practical approach to therapy. A statement which is supported by some of the positive outcome literature on the success of solution focused therapy (see Zimmerman, Prest & Wetzel, 1997). Whilst this is the case, some concerns are raised about this type of approach when applied to couple therapy as it can fail to acknowledge the role of emotion in a dyadic relationship (Kiser, Piercy & Lipchik, 1993). Indeed emotionally focused theorists have criticised solution focused perspectives on this basis as it “can discount a client’s pain and suffering by focusing on exceptions to their problems only” (Johnson, 2004). When applying this argument to the case vignette, one could surmise that for Susan, not talking about her emotions in therapy could become quite frustrating. An idea supported by the recognition that she “expresses all the feeling in the therapy sessions” and that she feels “isolated” from Jonathan. Unlike SFCT, EFCT would place high importance on the emotional expression of a couple in the hope that it would create a more secure bond between the two partners (Tashiro & Frazier, 2007).
From an EFCT standpoint, if Susan is feeling isolated and rejected by Jonathan, I feel it might be important for him to hear this as it could help reduce his negative response of frustration that he can’t seem to do anything right. Conversely, if Jonathan is feeling overly challenged by Susan as she strives for more intimacy, it might be worthy for Susan to hear this in light of Jonathan’s history where he describes himself as “always a loner”. This might help the feeling of rejection that Susan feels when Jonathan responds to her demands by “going to the pub”. In this case, it seems important to address Susan’s feelings of rejection as she is the one issuing Jonathan with an ultimatum. In this regard, it would seem that EFCT would offer some advantages over a solution-focused approach to treatment as literature on the success of couple therapy has identified the importance of making the rejected partner feel that they are still cared for by their significant other (Carr, 2009).

Whilst it is suggested that the emotional expression of a couple can help facilitate change and a hypothesis provided for how this type of approach may help the couple in the case vignette, I feel that this type of therapeutic approach might prove difficult for Jonathan. This feeling is generated by the fact that he “has to be encouraged to talk at all in therapy”. Without wanting to stereotype Jonathan into the traditional male category of not being able to talk about his feelings, he may very well find emotional expression difficult. Indeed research has looked at the consequences of the socialisation of emotional expression, in westernised males in terms of their difficulties in describing and accessing their emotional experiences (Fisher
In regard to this, similar traits have been reported in men, to those found in Alexithymic sufferers, who struggle to access their feelings because of a strong cognitive style that is concrete and reality based (Levant et al., 2003). With this in mind, a more solution focused, practical approach to therapy might be more suited to those client’s who struggle to access their emotions as they would not have to describe their negative affect, because the therapy would be based in a more concrete world of solution-based answers.

Emotionally focused theorists have recognised this dilemma in their therapy (see Johnson, 2004) and have alluded to a strong therapeutic allegiance between therapist and client as helping those individuals who find emotional expression difficult (Johnson, 2004). It is thought that if a therapist can generate a strong allegiance with both partners and, if the partners can generate a strong allegiance between themselves, therapy is more likely to be an open, safe place from which emotions can be expressed (Greenberg, 2004). This said I feel it naive to think that in real word practice this strong allegiance could be developed and maintained between every therapist with every couple. Gender disparities are noted in the literature as having a bearing on the development of an allegiance for instance as has the context of a couple’s dispute (Symonds & Horvath, 2004). Reflecting on this dilemma, I also feel that the extent to which a couple blame each other for their current difficulties could also be a barrier in developing a therapist-client, client-client allegiance, as couples’ often enter into therapy with the aim of getting the therapist on their side (Scheinkman & Dekoven-Fishbane,
2004). If the therapist connects or understands more fully with one partner’s “story” over the other, they could quite easily become entrapped in such a blame game. In this instance, it would be important for the therapist to be reflexive and to take this issue to supervision so the therapeutic relationship between themselves and the “other” partner is not jeopardised.

Blame, is noted in the literature as being a particularly significant obstacle for the couple’s therapist to overcome (Symonds & Horvath, 2004). With regard to Susan and Jonathan it could be that Susan, for instance, would want the therapist to agree with her: that the cause of their problem is Jonathan being away from home. Indeed, for me, when I initially read the case vignette I found myself being drawn towards this argument. If I was working with Susan and Jonathan therapeutically this is something I would want to be aware of especially when taking into account Jonathan’s history of “being a loner” and his current notable absence from the family home. Owing to these factors, it would seem particularly important that I would strive to avoid this pull from Susan to prevent this isolated dynamic being crossed over into the therapy.

On the one hand I can see how SFCT might be a good therapeutic approach to adopt in this instance as some research indicates that by focusing on the positives of a relationship, instead of the negatives, the “blame game” so often found in couple therapy, can be minimised (Gottman et al., 2002). Whilst, on the other hand, I can see the benefit of developing a strong
emphatic understanding of each partners circumstance in reducing blame between both therapist and client and indeed between the clients themselves. Within EFCT there is a constant attempt by the therapist to emphatically attune to each partner and to connect each partner empathically to both of their emotions (Johnson, 2004). In this regard, I believe EFCT could also help reduce the couple’s tendency to blame by helping them generate an understanding of each partner’s attachment needs and fears. Through this understanding the couple may be more inclined to respond empathically to one other and thus reduce the tendency to blame each other for their relational difficulties.

Conclusion.

In response to the increased demand for couple therapy over recent years, psychological research has sought to empirically evaluate efficacious treatment methods for this client group. Emotionally focused couple therapy, determined efficacious through clinical trials (Jacobson & Addis, 1993), and solution focused couple therapy, a treatment which is showing increasing empirical and anecdotal promise (Gingerich & Eisengart, 2000), have been compared and contrasted through an illustrative case vignette. Through this comparison, it would appear that both therapies have their
strengths. The success of an SFCT approach for example has been discussed in terms of focusing the couple’s attention away from the negatives of what their partner isn’t doing to the positives of what they are doing. Whilst EFCT has been discussed positively in relation to helping a couple reconnect emotionally and generating emphatic responses to one another, with suggestions made about how this may help reduce blame in a couple dynamic.

Through the discussions of this paper, it would seem that some of the weaknesses attached to both therapies apply to whether or not the treatment model and the techniques deployed “fit” the couple in treatment. It has been suggested for instance that an EFCT style maybe more suited to those individuals who talk easily and freely in sessions and who are aware of their emotional, internal worlds whereas an SFCT approach might be more suited to those who find practical, reality based solutions useful. This conclusion seems to highlight to me the importance of having different, psychologically sound, theoretical models available to therapeutic practitioners so that treatment packages can be modelled around client characteristics and their therapeutic needs.

References.


**Appendix 1: Case Vignette.**

Susan (aged 43) and Jonathan (aged 44) have been married for 25 years. They have two sons, Tim (aged 24) and Stephen (aged 18). Jonathan’s work as a Salesman has meant lots of house moves during their married life. The last move, 3 years ago came at a difficult time as Stephen was beginning “A” levels and Susan was nursing her sick mother, so Susan remained in the family home whilst Jonathan rented a flat near to work,
coming home at weekends. Susan has found this separation difficult and has finally issued an ultimatum to him that he either returns home and looks for another job or they split up. Her mother has recently died, and Stephen has gone to University. Jonathan has agreed to come to therapy with Susan to explore the options. Both say that they want to stay together.

**Background and History.**

Exploration during early sessions has revealed that Susan, a late addition to her family, fell in love with Jonathan whilst still at school. After becoming pregnant, they married although Jonathan had yet to complete his studies at University. Since then she supported him throughout his career in her role as the homemaker. A recent decline in her own health whilst Jonathan was working away together with the terminal illness of her mother has left her feeling drained and mildly depressed.

Jonathan is quiet, and was always a “loner” at school. A chronic leg injury meant long periods in the hospital throughout his childhood. He has seen a change in Susan since he has moved away. She has put on weight and is always discontented when he does make the effort to come home at weekends. Consequently he has been coming home less frequently.

Susan is particularly close to her youngest son, and relied on him while she was ill. She misses him now he has gone to University and feels very isolated, especially now her own mother has died. In Counselling sessions it is she who expresses all the feeling, whilst Jonathan has to be encouraged to talk at all.

Things got particularly bad a few weeks ago when Jonathan came home late. Susan told him that he didn’t care about her. She was in tears, shouted at him and gave him an ultimatum to come back home. He threw his hands up saying “I can’t win” and went out to the pub, making Susan further isolated.
Counselling Psychology Practice.

Introduction.
This assignment aims to document my 3 year experience as a trainee Counselling Psychologist working with different client groups in a number of different NHS and private settings. I will outline the challenges I have faced working within different settings and with different supervisors, reflecting on my learnings from these challenges and how they have influenced my practice as a Counselling Psychologist.

Year 1 – NHS Primary Care setting (Step 3) at North Manchester General Hospital.

Clients I worked with.

During my time at the North Manchester General Hospital I worked with a number of clients with different presentations. This ranged from clients who presented with the symptoms of social anxiety and depression through to complex grief and post-traumatic stress disorder (PTSD). I worked with both males and females aged between 17-60 years old.

Assessment Skills.

I developed a thorough understanding of assessment skills at this placement. This started with me observing my supervisor when she conducted assessments. I was able to talk to my supervisor after the session about the questions she asked and my feelings towards particular clients. From this we started to formulate client issues. As the service only used a CBT approach to treatment, I learnt how to break down a client problem into
thoughts, feelings, behaviours and physiology, using the hot-cross bun model (Padesky & Mooney, 1990). When I felt able to conduct an assessment alone, I found the assessment form that the service used particularly useful being a first year trainee as it was reassuring to have a prescriptive guide from which to follow. This form also taught me the important questions to ask when assessing client risk. It had clear sections which focused on suicidal ideation, past and present, suicidal intent, suicidal plans and preventative factors.

**My Role.**

My role at the service developed as time went on. In addition to my own client work, I became actively engaged in the weekly service meetings which involved discussions of new cases and I also became part of the assessment/screening team for new client referrals.

**Therapeutic Approaches.**

The service at North Manchester General Hospital followed the National Institute of Clinical Excellence Guidelines (NICE, 2008) for the treatment of Step 3 associated symptoms. As such the predominant treatment method offered to clients was Cognitive Behavioural Therapy (CBT).
Initially, I found this reliance on CBT to be very helpful to me as a first year trainee as it enabled me to get a solid grasp of this approach; from assessment and formulation through to therapeutic intervention. It also gave me an appreciation of the importance of subjective experience in governing psychological treatment. For instance when working with two separate clients, who were both referred for social anxiety and low mood, the type of therapeutic interventions used were different because of their subjective problems and maintenance cycles. To illustrate this point, it seems appropriate to refer to these two clinical cases to document the different factors that were in play which were influencing their problems and how this then governed the CBT treatment plan. These two clients will be referred to as Jack and Emily (pseudonyms). It is important to use pseudonyms when documenting client work as it helps maintain client confidentiality (BPS, 2009).

For Jack it became apparent that he was suffering with anxious thoughts when attempting to leave his flat alone. He expressed a fear of being judged negatively by others and his assumption that people will be critical of him and the way he lives his life. He described a belief that he was very different to his peers. Owing to these factors, Jack developed a series of avoidance strategies to help him cope with his anxiety. These included staying at home alone and being overly reliant on his mother for socialising and general daily chores such as shopping. These safety behaviours (Padesky & Greenberger, 1995) were further perpetuating Jack’s problems as they were maintaining his belief that he is different to his peers.
As the therapeutic work was governed by a CBT approach, the initial emphasis of our work was centred on Jack’s negative automatic thoughts when he was out alone and how these triggered his anxiety symptoms. Accessing a client’s negative automatic thoughts is an important feature of CBT as they are noted in the literature as being the most effective starting point for therapy (Westbrook, Kennerley & Kirk, 2009). By accessing these thoughts we were able to identify that Jack felt different because he is alone and as such was hyper-vigilant to people his own age who were either out in groups or in a couple. Owing to these negative thoughts and the assumptions he had about himself, it seemed important that we challenge these by introducing some behavioural experiments. Behavioural experiments in CBT are thought to be useful because they are a good way of disproving a client’s negative predication about themselves or the world (Wilson & Branch, 2006). For Jack, it was thought that behavioural experiments might help challenge his specific belief that he is different because walks alone.

In contrast to the work done with Jack, the focus of the therapy with Emily was on generating a formulation which documented how her alcohol dependency in social situations was maintaining her problems. Firstly we addressed her apparent under-developed sense of self as this was perpetuating her need for social approval. We introduced daily activity diaries to help her highlight what activities she enjoyed doing and which
activities gave her a sense of achievement. This is a notably important feature in CBT as it can help alleviate the symptoms of depression (Padesky & Greenberger, 1995). In Emily’s case it was felt that the activity diary could help her become aware of the amount of time she spends at home alone but also give her an insight into her likes and dislikes, an important factor in relation to developing a sense of self. In addition to this, we also looked at minimising the amount of alcohol she consumes in social settings as we identified that this safety behaviour was perpetuating her ideas about people not liking her and thus resulted in her isolating herself further.

By working with these clients I gained an appreciation of the importance of developing and utilising a formulation in therapy, not only for my own understanding of the clients issues but also for the client’s themselves to make sense of their problems. I also learnt how to adapt a therapeutic model to fit with the individual needs of my client. For Jack and Emily the CBT approach was used as the treatment modality of choice but the therapy itself had a very different focus, despite them both being referred for social anxiety and low mood.

**Context Issues.**

Although I initially found the service’s reliance on the CBT model helpful as it enabled me to develop my understanding of this approach, I began over time, to notice certain problems with fitting a client and their needs around
the only therapeutic model offered by the NHS service where I was working. This problem was highlighted to me through my continued work with Jack.

Jack had been involved with psychological services for many years in relation to his continued social anxiety and low mood. The majority of this treatment had been directed by the principles which underpin CBT, which by his own admission, had not helped him. Owing to this past experience, Jack was understandably unenthusiastic about entering into another course of CBT. I took my concerns about Jack’s suitability to the CBT model to supervision and was advised that Jack maybe reluctant to change. This however was not my impression of him. Jack expressed a willingness to lead his life differently and, although accompanied by his mother, he attended every scheduled therapy session. Under instruction from my supervisor and because of the restrictions from the department in terms of therapy, I continued to work with Jack in terms of his cognitions and safety behaviours that were thought to be fuelling the problem. I did this in spite of feeling that he would be best suited to a more systemic style of working owing to his dependence on his mother.

Owing to Jack’s subjective experience of therapy I began to notice that I faced a dilemma here as I felt that the suitability of treatment was being determined by the symptoms which Jack presented with rather than Jack himself. This in turn, led to another failed treatment attempt, which left
Jack feeling as though his problems were unchangeable and that therapy was unsuitable for him. This outcome left me feeling frustrated with the service where I was working and made me feel as though my clinical judgments as a first year trainee were not valid.

This experience taught me that the client is the expert when it comes to their own experiences as Jack knew before treatment began that CBT was not suitable for him. It also made me appreciate the importance of asking the client what therapy they have received in the past and what has has been beneficial/unbeneficial to them, questions which I now routinely ask in assessment sessions. Finally, the experience of working in a service that only offers a unitary mode of treatment has given me the drive to learn about other therapeutic approaches to therapy so that in the future I can tailor a treatment package around the needs of my clients’ rather than fitting the individual into a therapeutic approach. This experience at North Manchester General Hospital guided my second year placement decision.

**Year 2 - NHS Secondary Care setting (Step 4) Claire House, Wigan.**

**Clients I worked with.**

Throughout my yearlong placement at the secondary care facility in Wigan I worked with clients who had a long history of mental illness and as such were often diagnosed with a personality disorder. In addition, I was also
exposed to working with clients who were suffering with the symptoms of psychosis, obsessive compulsive disorder (OCD) and severe depression and anxiety. I worked with both males and females that were of working age with the exception of one client who was 80 years old.

Assessment skills.

After a few months at the service I became involved in the screening process which involved attending weekly referral meetings with the Psychology team and Gateway board. These meetings involved assessing the services suitability for new client referrals. In addition, I also conducted weekly screening sessions with a selection of clients from which information was fed back to the team about the clients’ presenting problem, vulnerability and risk. This information was then used by the team to determine the appropriate treatment package for the individuals.

This experience really helped improve my confidence in delivering assessments as I was conducting, on average, two assessments a week. I found that as my confidence grew I no longer needed the security of having an assessment form to follow. As such I was able to take brief notes on the important points raised from these sessions and allow myself the flexibility to move away from prescriptive questioning. I found that this style of assessment helped the session flow more logically from point to point. Also, by limiting the amount of time spent looking at an assessment form, I
was able to concentrate more on the individual and their presenting problems which helped me facilitate a more empathic understanding of their issues. This style is how I continue to conduct an assessment session.

**My Role.**

My role at the service developed considerably over the months I was on placement. I moved from having a clinical caseload of three when I first arrived, to eventually having ten clients. This increase in the number of clients was due to demands being put on the service. At first I found this heavy workload to be a constraint on my time, as I like to prepare thoroughly for each session and write up my notes straight after the session finishes, something which wasn't feasible with me only working two days a week and with a caseload of ten. My preparation and note-taking are things I am unwilling to sacrifice and as such I learnt, with guidance from my supervisor, to review client progress and organise my hours in terms of client need. For instance, for those clients who were progressing well, fortnightly sessions were offered instead of weekly ones. This experience gave me an appreciation of how demanding it can be working within an NHS setting, particularly in this political climate. I learnt the importance of reviewing client progress so that the needs of the service could be met without jeopardising the needs of my clients.

**Therapeutic Approaches.**
The real attraction of this placement for me was the diverse use of therapeutic approaches that were offered to clients. The main therapeutic approaches that I used with clients at this service were cognitive therapy, psychodynamic therapy and CBT. I was also exposed to formulating client issues from a schema focused approach and gained experience in integrating therapeutic models to suit the subjective formulations of clients.

With one client in particular, I found it useful to be able to draw upon different therapeutic models of treatment to help with her symptoms of psychosis. The client in question was referred to the service by her General Practitioner (GP) for auditory delusions, however after assessing her it became evident that she also presented with symptoms consistent with obsessive-compulsive disorder (OCD) and depression. For the purpose of this assignment, this client will be referred to as Louisa (pseudonym). Louisa was the first client I had worked with who presented with a number of psychological difficulties. Owing to this I found it useful to have a detailed formulation of her presenting issues from which appropriate therapeutic interventions could be applied.

In accordance with some of the treatment literature on auditory delusions which detail the importance of challenging a client’s perception that the auditory delusion is real (Chadwick & Birchwood, 1996), we took example from cognitive therapy in terms of thought challenging (Beck, Rush, Shaw & Emery, 1979) to try and loosen her once rigid cognitions that the woman...
she could hear playing the piano was real. In terms of Louisa’s low mood, we introduced an activity diary to help her see how much of her day was spent sitting and thinking about her auditory delusion. This CBT intervention was used not only to help Louisa recognise that she might want to incorporate more varied activities into her day but also to make her realise that she often listens out for the “woman playing the piano” which in turn increases the frequency of her delusion. In addition to Louisa’s auditory delusion she also suffered with negative intrusive thoughts about wanting her husband and daughter to die. These thoughts were understandably very disturbing to Louisa and as a consequence she believed she was a bad person. To work on this we introduced some mindfulness concepts (Alidina, 2010) to help Louisa recognise that a thought is just a thought in order to tackle the negative judgements she made about herself for thinking about her husband and daughter’s death.

In comparison to my first year placement where the choice of treatment modality was taken away from me, I found this eclectic way of working very refreshing. I enjoyed making informed therapeutic decisions about appropriate treatment interventions based on Louisa’s presenting issues and problems and the flexibility the service gave me in terms of treatment choice from Louisa’s perspective. As this was the first time I had worked with a client in such a way, i.e. eclectic, I found it useful to regularly review Louisa’s progress both qualitatively, using the Beck Depression Inventory (BDI-II: Beck, Steer & Brown, 1996) scale to monitor her depressive
symptoms and quantitatively to assess the frequency/severity of her delusions and intrusive thoughts.

**Year 3 – The Priory Group – Inpatient Eating Disorder Service.**

**Cheadle Royal Hospital, Manchester.**

**Clients worked with.**

In contrast to my previous NHS community mental health placements in years one and two, my third year placement at Cheadle Royal Hospital offers an In-Patient service for those individuals specifically suffering with an eating disorder. My individual caseload here consisted of women aged between 18-61 years who were suffering with anorexia nervosa, bulimia or both anorexia and bulimia. In addition to my individual work I also ran weekly group therapy sessions on the concepts of mindfulness and emotion regulation. In these groups, I worked with both males and females of working age who were suffering with an eating disorder.

**My Role.**

During my time at Cheadle Royal Hospital the psychology department went through a major re-structuring process. As I was part of the weekly psychology meetings, I was involved in the decision making process to re-
structure the team so that each unit on the Ward had its own head of psychology. The reason for wanting this change was to get more psychological input in the multi-disciplinary meetings so that client needs could be understood from a psychological perspective as well as a medical one. We also decided to appoint an over-arching head of psychology for the two units whose job would involve assessing and formulating each client referred to the Ward. After a week piloting this new structure it became apparent that the main head of psychology would not be able to conduct this process alone owing to service demand and time constraints. Because of this I, along with other members of the team, became involved in the assessment/formulation process for new referrals. This process involved individually assessing new clients so that a psychological formulation could be generated and then passed on to the wider mental health team to inform them of the appropriate treatment package for that client. The assessments involved conducting a clinical interview and administering psychometric measures, such as the Eating Disorder Inventory-3 (EDI-3: Garner, 2004). I delivered the information from these sessions and the results of the EDI-3 to the team in both written and verbal formats.

In addition to my involvement with the re-structuring process, I attended the allocation meetings which assign clients to therapists in accordance with their therapeutic need. In one of these meetings it was brought to my attention that a client on the ward had requested she see me for individual therapy. Although flattered by this request, I made the difficult decision to decline; she was already seeing another member of the psychology team and
had no clear reason to want to see me instead, as I had not had any involvement with her in the past. After looking at her assessment and formulation notes and speaking to her current therapist, it became apparent to me that the client would become avoidant of situations just as she was starting to go deeper into understanding her problems. This request, therefore, appeared to be another cycle of avoidance and as such it seemed to me that taking her onto my caseload would not be therapeutically beneficial to her as she needed to address this pattern of avoidance rather than run away from it. My decision was accepted by the team and as such she continued to see her current therapist.

**Therapeutic Approaches.**

In addition to CBT the service, and indeed my supervisor, advocated the use of Emotionally Focused Therapy (EFT) as a treatment option for clients on the Ward. This type of therapy is used in response to the research literature on eating disorders which shows Alexithymia to be a common problem for this client population (see Cochrane, Brewton, Wilson and Hodges, 1993; Fox & Power, 2009). Indeed when working with my clients I found emotional suppression to be a central function of their eating disorder. With guidance from my supervisor and in response to my formulations, I started to work therapeutically using EFT with two of my clients. Informed by this approach, I used the empty chair technique with these clients to elicit emotional expression from what they termed “two parts of themselves”; the part that wanted to eat and the part that did not. This style of work helped
both clients recognise the function of their eating disorder. This then gave
them insights into what they needed to move forward by addressing what
had been neglected in their life i.e. factors such as love and security.

This experience made me realise that in the past I have overlooked the role
of emotion in my therapeutic work with clients in favour of assessing
cognitive and behavioural difficulties. Having witnessed the benefits that
can be drawn from an approach which puts emotional expression at the
heart of therapeutic change, I feel that going forward, I will be more likely
to assess a client’s relationship with their emotions and how this may be
feeding into their difficulties.

Context Issues.

In contrast to my work within an NHS setting, where discussions of client
information between colleagues is kept vague and general (with the
exception of supervisee to supervisor contact), within my in-patient setting,
I found the confidentiality “laws” to be far less constrained. I quickly
discovered when I started working at this placement that content-specific
information was passed on from therapist to other key members of staff who
were involved in the clients care. This came as quite a surprise to me and
initially I felt very uncomfortable when colleagues would approach me for
information from my therapy sessions with clients, as I am aware of my
professional code of conduct and the guidelines covering confidentiality. I took my concerns to supervision and was informed that information was passed on to other members of staff so that an informed and consistent treatment package could be utilised by all staff members involved with each individual client.

Whilst this discussion helped me understand the different systems used in an in-patient setting compared to a CMHT setting, where different mental health disciplines are constantly involved in providing the best care for clients, I felt I should have been informed of this before starting to work with clients. As I was not made aware of this when I started the placement I felt my clients had been misinformed of my confidentiality limits. This left me feeling extremely uncomfortable as I am aware of how important confidentiality is in maintaining trust in a therapeutic relationship. I rectified this by explaining the limits of my confidentiality with my clients at the first appropriate opportunity and I made my supervisor aware of my unease at not being informed of this policy at the start of my placement. Owing to this experience, I now realise that I cannot assume that rules governing confidentiality are universal and I must be cognisant of varying working practices at different workplaces.

Supervision.
By working in three different placement settings throughout my training I have not only gained experience of working with different clients and differing presentations but I have also become exposed to different supervisory styles. Through this experience I have learnt that I thrive off supervisors who encourage me to get a detailed” feel” for the client and the lives they lead by not just concentrating on the symptoms that they present with. My second year supervisor in particular taught me how to generate an informed impression of the client by getting an in-depth view of the client’s experiences and their responses to these experiences in order to generate a more informed formulation of their difficulties. I enjoyed the encouragement my second year supervisor gave me in terms of exploring what it is like for me working with different clients and how identifying the dynamics between us in therapy can help the client overcome some of the challenges faced in their daily lives. This supervisory style has influenced the way I work with clients as I am more of an inquisitive practitioner than I was in my first year training. I now strive to understand my clients, their behaviours, life choices and emotional reactions to situations from a psychological standpoint instead of solely concentrating on the symptoms that present with.

I feel that the way I use supervision has also changed over the last three years. In my first year placement I understood supervision to be a place where I could look for direction from my supervisor to tell me what to do with my clients. Whilst I appreciate that this was probably what I needed from supervision at this time, looking back I do feel it restricted my growth
as an autonomous practitioner. This changed in my second and third year placements however as I was introduced to a more process-centred approach to supervision. I now enjoy the freedom of exploring an issue together with my supervisor to get an informed understanding of what is going on for my clients. I feel that this has given me the chance to recognise my abilities as a reflexive practitioner which in turn has given me the confidence to listen to my internal supervisor in sessions.

**Future Direction.**

Owing to my choice of placements over the last three years, I feel I have gained experience working in different settings with a variety of client problems. This experience has enabled me to make an informed decision about my future career as a practicing counselling psychologist in terms of where I would like to work and who I would like to work with. Although I enjoyed working in all three placements and feel as though each one taught me something, my role at the secondary care CMHT setting gave me the most job satisfaction. I found that I enjoyed working with the complexity and diversity of secondary care issues and relished the flexibility the service gave me in terms of therapeutic intervention. I believe these learnings will influence my future work decisions when I am qualified.

**References.**


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**Reflective Essay: Professional Issues.**

**Introduction.**

The following account is a personal reflection of my experiences throughout my three year training on the Practitioner Doctorate in Counselling
Psychology course at the University of Wolverhampton. I have drawn upon
the most predominant aspects of my life experiences before enrolling onto
the course, and my continued experiences throughout my training, to help
demonstrate how these have shaped my own personal philosophies as a
Counselling Psychologist.

My life prior to training.

I enrolled on to the Practitioner Doctorate in Counselling Psychology course
in September 2009. At the age of 25, I began to realise that what I was
doing with my life wasn’t making me happy. I felt like I was stuck in a job
that was giving me no satisfaction and I constantly felt under pressure from
my parents to “do something with my life”. The problem was I didn’t know
what I wanted from life. I had spent the majority of my childhood and early
adulthood being told what to do; complete my GCSE’s and A-levels and
then go to University. My life had followed a very nice, neat, guided path
that was already mapped out for me. It didn’t require me to think about
what I wanted to do or what the next step would be.

This path that I had been following suddenly ended after I completed my
undergraduate Psychology degree in June 2005. I felt as though there was
an expectation that I, the only person in the family who had obtained a
degree, would fall into a well paid, well respected job that my parents would
be proud of. Around this time, I felt as though I was constantly striving to
please my parents. I was searching for a way to get back onto the guided path that I had been following all my life; the path that showed me where to go to make my parents proud of me. The problem was that my reliance on my parents’ ideals of what I should be doing had left me with no real idea about what I actually wanted for myself.

In amongst my confusion at this time, my father suggested I apply for a Sales Manager position in the housing company where he worked. I accepted, although I knew my heart wasn’t in it; I hated sales. To my relief I failed the first round of interviews, but my father, being the Managing Director, “pulled some strings” and got me through to the second interview stage. I felt in turmoil. I didn’t want the job but at the same time I didn’t want to go against my father’s wishes. I remember having a powerful gut feeling which I couldn’t ignore that was telling me to turn the job down. In response to this feeling, I realised that I would have to tell my father that I wasn’t going to attend the second interview.

This was the first time in my life that I had ever listened, and responded to, my feelings. It gave me the drive I had needed to explore what I did want from life and from my future career instead of relying on this dependent-rescuer dynamic that both my parents and I were in. This was the time when I began to realise I was tired of striving for their approval. Instead, I wanted to do something for me; something that I had decided upon, something that would make me happy.
What made me decide to apply for Counselling Psychology?

Looking back I believe on some level I knew that entering onto the Counselling Psychology course would be personally beneficial to me. At the start of the course I was unable to verbalise why I had chosen Counselling Psychology as my profession, other than the fact that I wanted to help people. I had been given a taste of what counselling entailed through the counselling skills courses I had completed prior to starting the Doctorate. At the time of completing these courses I was working in a HR department of a law firm, where I felt under-valued and very beholden to my manager. Owing to the job I was in I felt pressurised to achieve results and felt that my actions always had to be justified.

I found that the evening counselling courses I had enrolled on gave me some relief from this business world environment where there always needed to be a right or wrong answer to things. I felt instantly connected to Carl Roger’s humanistic concepts of empathy, congruence and unconditional positive regard (Rogers, 1963) and I found it very therapeutic going to the classes, as often the teaching staff would demonstrate these concepts to us through a counselling session role play, where we were the clients. For me, the concepts of congruence and UPR (Rogers, 1963), really offered me an insight into what I needed from my life and what perhaps had being missing
from my development so far. I wanted myself and others to honour my feelings and decisions without feeling the need to justify them. Counselling Psychology for me was an extension of this learning. From researching the course, it became apparent that I would be given the opportunity to surround myself in the humanistic concepts that I had connected so well with during the counselling courses, whilst also allowing me to explore and learn about other treatment modalities in the hope that these too could offer me some personal insights.

Once I had enrolled onto the course I found that my experiences on placement and within my own personal therapy were the most influential contexts for my personal and professional growth.

**My First Year Placement.**

My first year placement was in a Primary Care service situated in North Manchester. The service was made up of clinical psychologists, one of which was my appointed supervisor, and other assistant psychologists. The department was focused on following the National Institute of Clinical Excellence guidelines (NICE, 2008) for the treatment of primary care symptoms and thus the main method of therapy offered to clients was Cognitive Behavioural Therapy (CBT).

Initially, the service’s reliance on CBT provided a welcome relief for me. As an unconfident first year trainee, I found it reassuring to have treatment
manuals at my disposal that had been specifically written for clinicians and
prescriptive formulations which could be followed to help generate a
psychological understanding of my clients’ problems. Where necessary,
with regard to treatment intervention, there were thought challenging
worksheets which could be followed, daily activity diaries which could be
completed and specific behavioural experiments which could be tailored to
the individual needs of my clients to help achieve therapeutic change. The
structured approach to therapy that CBT offered, in terms of agenda setting,
was also beneficial to me as it helped ease my anxiety around “what to do”
with clients in a session.

This concept of wanting to know “what to do” with my clients in therapy
was a big sticking point for me when I first started working therapeutically
with clients one to one. I remember thinking that in order to be a “good”
therapist I needed to be proactive in sessions to help show my clients how to
“get better”. In this sense CBT fitted in with my impression of what it
meant it be a “good” therapist as treatment seemed to be focused on
changing a client’s symptomatology by adopting certain cognitive or
behavioural interventions into their treatment plan. At the time, I was very
content with this style of working. It seemed to be helping my clients, it
provided me with clear guidance on how to formulate and match therapeutic
intervention to my clients presenting symptoms whilst also enabling me to
be proactive in therapy and therefore feel as though I was doing something.
Whilst this was the case, I came to realise that this approach wasn’t suitable for all my clients. For instance one of my clients in my first year placement had received two courses of CBT before coming to see me for therapy, neither of which had worked. In addition, one of my clients in my third year placement, had received a similar pattern of treatment, which again hadn’t helped because she felt as though the treatment was telling her to change, which fed into her low self worth. Alongside these client experiences I began to recognise, through my own personal therapy, that the very issues CBT seemed to be maintaining for me, in terms of wanting to be a proactive, “good” therapist, were the things I needed to explore.

How my insights from personal therapy connected to my work with clients.

I found personal therapy very hard to engage with in the beginning. I didn’t know what to say or how to be in my sessions and was therefore looking for guidance from my therapist on where to start. At this time, I remember feeling frustrated with my therapist as, it appeared to me, that she was not helping me engage in the process. After a few sessions I began to open up about my feelings of frustration.

The disclosure of how I was feeling led onto the insights mentioned above about always being rescued by my parents and therefore not having any real sense of my internal world. I began to recognise that this dynamic had filtered into the therapy room. I wanted my therapist to tell me what to do
and when she didn’t I became frustrated with her. By going through this process, I began to recognise that my therapist was staying with my struggles. She was facilitating an environment where I was the expert; I was recognising my dilemmas and I was the one who was generating my own conclusions and solutions. I was the one who was living through the experience and thus she was not the person to save me from them. Although I wasn’t given the answers by my therapist I felt understood and validated in every stage of this process and subsequently came away from the sessions feeling very empowered.

These insights from my own therapy enabled me to recognise that my initial view of a “good” therapist was in conflict with how I was experiencing my own therapist. By reflecting on my experiences I was able to connect my perceived role of a therapist to the parent-rescuer dynamic I had experienced growing up. Only this time, I was trying to be the rescuer for my clients.

Whilst I have seen first-hand the value of not being rescued by my own therapist, I feel that this maybe my Achilles Heel when I work with clients in therapy. I have started to recognise that with certain clients my default setting of wanting to fix their problems is easily triggered. In one such instance, I was working with a client who was very defensive at the start of therapy. She hardly spoke in our sessions and when she did she speak she appeared to be very angry with me; telling me that I was not the right therapist for her. My reaction to her anger was to do something in order to
rectify the way she felt about me. After all I wanted to be the “good” therapist who made things better for her. I began feeling agitated because I was taking her comments personally. I bombarded her with questions and quickly reached for my pen and paper to draw out an agenda of how we could help the situation.

By reflecting on how I had responded to this client I was able to see that CBT for me had become my default setting in my attempt to rescue the client to try and help her engage. In response to my feeling of agitation I had felt the need to do something in the therapy i.e. set an agenda, obtain her goals etc. I started to reflect on how my own therapist had responded to my initial struggles when trying to engage in therapy and realised that instead of trying to do something to help me, she had simply stayed with my feelings of frustration. I began to recognise that this way of working could start to help me alter my impressions of what it meant to be a “good” therapist. If I could stay with my client’s struggles instead of trying to change them I could start to limit the pressure I was putting on myself “to do things” in therapy and thus help the client explore what her defences were really about. This experience helped give me an insight into the type of therapist I wanted to be. I wanted to move away from this idea that I needed to rescue my clients. Instead I wanted to foster a more reflective style of working instead of trying to do something to help the client change in some way.
Supervision.

As well as recognising that I wanted to work in a more reflective way within therapy, I also started to notice that I wanted the same within supervision. In my first year placement I entered into supervision with the idea that my supervisor was somebody I had to impress, an authoritative figure that had power and was therefore somebody I should answer to. After all, this had been the way I had lived my life up until now; with others telling me what to do, and me obeying them.

Unsurprisingly I felt very much like a student in my first year supervision sessions. My supervisor would teach me about the concepts of CBT in terms of formulation and therapeutic intervention and I would go away and practice them. Initially I was relieved to have this input. I was pleased that I had someone guiding me through. After a while though, I began to recognise that I was finding the lack of autonomy in this placement setting difficult. I felt as though I was at the stage where I wanted to challenge myself. I was starting to feel that my professional growth was being constrained by the teacher-student dynamics within supervision and within the wider context of the service’s reliance on CBT. I wanted to learn more about other approaches and foster my autonomy, after all these were the things that initially attracted me to Counselling Psychology.
My Second and Third Year Placements.

I chose my second and third year placements based on the fact that neither placement was prescriptive in terms of what treatment modality could be used with clients. Whilst I knew I wanted to experience a more moment-to-moment style of therapy than I had experienced when working with a strict CBT approach, I found it scary at first to let go of my CBT treatment manuals which had become my safety net. Whilst I was feeling this way, I knew that in order for me to stay true to the type of therapist I wanted to be, I would need to stay with my struggle instead of trying to do something to change it. In doing so, I began to realise that often the difficult part of overcoming a challenge is the effort I expend when trying to change a situation to immediately make it better. I found that if I could actually just sit and accept the way I was feeling, the sense of struggle reduced and thus so did the difficulty.

Through my experiences in my second year placement, I began to connect the aforementioned learnings to the concepts which underpin Mindfulness. Through more exposure to these techniques in my third year placement and in the third year personal development group I began to feel even more connected to these principles, which fall under the umbrella term Third Wave CBT (Fletcher & Hayes, 2006). I began to notice that I wanted to adopt these principles into my everyday life as well as in my work with clients as they offered me a refreshing take on how to respond to life’s challenges.
Whilst I found that in some instances working with CBT in the traditional sense helped some of my clients change and restructure their thoughts or behaviours, I found the concepts attached to Mindfulness to be far more in-keeping with my values as a Counselling Psychologist. They seemed to focus on the relationship between my client and their thoughts and feelings and represented to me a freedom to just accept, instead of trying to change. This was a new concept for me owing to my upbringing where I was always encouraged “to do” something. I have found the adoption of these concepts particularly useful with clients who present as defensive in therapy as they have helped me recognise the importance of exploring these defences with the client instead of taking their defensives personally.

**Supervision.**

As mentioned above, throughout the training, my idea of what it meant to be a “good” therapist was starting to waver. Owing to this, in my second and third years, my expectations of how I should be in supervision also changed. Once I stopped trying to impress my supervisors I began to recognise that I was able to learn more and become more reflective in supervision. In my third year, I began to discuss the power dynamic between my supervisor and I in terms of student-professional which was something I had never done before with my past supervisors. This to me symbolised a major turning point in my development as I was starting to recognise and share my own personal experiences within supervision. My supervisor was able to accept
and validate my concerns over this dynamic and together we were able to reflect on this when appropriate in our supervision sessions.

This experience has really made me appreciate the profession I am in. Comparing it to my previous job in HR, where I always felt under pressure to do the right thing, it felt liberating to have another professional encourage the disclosure of my perceived “negative aspects”. This has shown me that one of my most important roles as a Counselling Psychologist is to recognise and explore my struggles with clients within supervision instead of trying to impress. I believe this recognition is helping me to grow professionally as I am now more open to exploring things that I have difficulty with within supervision.

How my experiences have shaped my philosophies as a Counselling Psychologist.

My experiences of working in different placements, with different treatment modalities and supervisors, and my experiences within personal therapy have really helped shape my philosophies as a Counselling Psychologist. In particular I have recognised the importance of validating an individual’s experience as true and therefore not trying to change them or their situation in some way to “make it better”. As previously mentioned, this view conflicted with my initial impression that the therapist was the expert and so
should provide clients with the answers to their problems. Seeing first-hand the importance of not being rescued in therapy, I strive to empower my clients by exploring their difficulties instead of trying to rescue them by doing something to make their situation better.

Whilst I feel strongly about this concept I do recognise that it might not be easy to uphold. Firstly I recognise that being the rescuer for my clients is something I need to be constantly aware of owing to my experiences growing up. Secondly I recognise, through my own process of change throughout the course, that certain professional contexts can feed into this dynamic for me by reducing my feeling of autonomy as a practitioner. I believe that my experiences within my first year placement for instance where I felt very guided, not only by my supervisor, but also by the wider placement setting in terms of being told what treatment modality to use, sought to limit my professional growth, in much the same way as my personal growth had been limited by following my parents’ guidance.

Looking back now, I can see that one of my original drivers in choosing Counselling Psychology as my profession was to help foster my independence. I believe this is why I felt so connected to the humanistic values that I was exposed to in my counselling courses prior to enrolling onto the Doctorate. The ideas of acceptance and autonomy I feel have been linked in my personal journey throughout the Doctorate course. I have not only become more aware of my own internal world, which has fostered my
autonomy, but I have also become more accepting of it. I have recognised through my training that autonomy is something that I need in order to feel connected with myself. I have found that autonomy for me is very much represented by a freedom to choose which treatment modality to use in therapy and that this diversity drives my professional enthusiasm. This also seems to be a core component of what it means to be a Counselling Psychologist as we can offer a diverse range of therapeutic styles to clients instead of having a “one model fits all” approach to treatment. I feel that these learnings are very much guiding my current views of therapy and the type of therapist that I want to be.

How I intend to maintain my philosophy.

Firstly, owing to the fact that personal therapy has been so beneficial to me, I am reluctant to give it up. I am planning, once in paid employment, to attend regular therapy sessions with my current therapist who is a Counselling Psychologist. For me it has been so important to have this contact with a therapist from my own discipline, particularly when working in the National Health Service (NHS) which can so often be medically informed. Particularly in my first year of training, when I was in a setting where there was so much emphasis on diagnosis and treatment outcome, I found it really useful to draw example from her style of working as it confirmed the importance of my humanistic roots as a Counselling Psychologist that the client is the expert.
Secondly I came to realise, particularly through my second and third year placements that working eclectically with clients in therapy is something I enjoy. I found I relished making informed therapeutic decisions about appropriate treatment interventions based on my clients presenting issues and problems and the flexibility the services gave me in terms of treatment choice from my clients’ perspectives. I feel this flexibility helped develop my confidence as an autonomous practitioner as I was able to suggest different ways of working with my clients. This insight has given me the motivation to continue studying different treatment modalities that I haven’t been exposed to on the course. In addition it has made me realise that in the future I would like to work in a setting which encourages the use of different therapeutic styles.

Finally, my experiences throughout my training have taught me the importance of exploring and accepting the subjective experiences of my clients. I feel this concept is central to the Counselling Psychology profession and is something that I am trying to promote through my research. As part of my thesis I have recently completed a review paper which explores the importance of adopting a qualitative mode of enquiry in the treatment of post-traumatic stress disorder (PTSD). This idea came to me when I worked therapeutically with a client who presented with the symptoms of PTSD using the recommended exposure based interventions (NICE, 2008). Through this process, I not only found that my client was struggling to engage in the treatment but that I was also finding the process of exposure work to be very demanding. In response I found myself
wanting to explore other treatment methods for PTSD at the level of client experience to ascertain what components of a treatment method make it effective in real world practice. I feel that by adopting an epistemological stance that honours the exploration of client experiences in my research I can help generate a fuller picture of what is useful to my clients in therapy. I feel this approach to research values not only the subjective nature of Counselling Psychology but also the “practice-led” element which is used to define our profession (BPS, 2005). This is something that I intend to adhere to more fully in my future research.

Conclusion.

I have gained so much from completing the Practitioner Doctorate in Counselling Psychology course. Through this process I feel I have moved from being a person who strived to intellectualise all of my experiences to a person who strives to listen to, and accept, my emotional world. The insights generated from my own personal therapy have helped me connect my childhood experiences to my initial views of what it meant to be a “good” therapist. I began to recognise how this ideal was impacting on my client work, dictating my adherence to particular treatment models and influencing my experiences within supervision. These insights have not only helped me identify the importance of accepting my own and my clients internal worlds but that also exploring and reflecting on a situation/feeling/behaviour can often be more beneficial than trying to change it. I intend to honour my learnings going forward by engaging in...
the study of different treatment modalities and through my involvement in promoting the profession through more practice-led research.

References.


**Search Strategy.**

Science Direct, PsychInfo and Swets Wise databases were used to identify literature and research from peer-reviewed journals relevant to the current thesis. In addition, Google Scholar and Google Books were used as preliminary search engines. Combinations of the following terms were used to identify relevant articles: PTSD, Exposure Therapy, EMDR, Combat, Veterans, limitations, treatment failure, dropout, client satisfaction, clinician adherence, shame, anger, guilt, engagement. The papers selected by the search engines were examined for compatibility to the current research and extra literature was obtained from the articles reference lists.
Preface to the Research Dossier.

Post-traumatic Stress Disorder (PTSD) has been regarded as a standalone disorder since its categorisation in the Diagnostic and Statistical Manual 3rd edition (DSM III) in 1980. Recognition that mental health problems can derive from particularly disturbing, life threatening events came after World War One when soldiers returned from combat with psychological problems that could not readily be explained by psychiatrists (Jones & Wessely, 2005). At the time, the terms “shell shock” and “war neurosis” (Tanielian & Jaycox, 2008) were used to describe the acute effects of battle that encompassed an array of psychological symptoms which we would now refer to as PTSD.
The recent wars in Iraq and Afghanistan have resulted in a new wave of military personnel being deployed for combat. The mental consequences of combat are more readily recognised in recent times, by both mental health professionals and society in general. Alcoholism is recognised as the main problem in returning veterans in the UK with prevalence rates of approximately 30% in males aged between 16-24 years (King’s Centre for Military Health Research, 2010). Current epidemiological studies suggest that 4% of combat troops returning from the wars in Iraq and Afghanistan suffer with posttraumatic symptoms in the United Kingdom (King’s Centre for Military Health Research, 2010) with higher rates of 15-20% recorded for veterans from the United States (Hoge, Castro, Messer, McGurk, Cotting & Koffman, 2004).

PTSD is accepted as being accompanied by various co-morbid problems. For example psychological and psychosocial co-morbidities such as depression, dissociation, social avoidance (Bremner, Southwick, Brett, Fontana, Rosenheck & Charney, 1992) and anger (Forbes, Parslow, Creamer, Allen, McHugh & Hopwood, 2008) are recognised as common, particularly in those individuals presenting with PTSD in the aftermath of war (see Frueh, Turner, Beidel, Mirabella, Walter & Jones, 1996). Identifying appropriate psychological therapies that can be useful in helping reduce the symptoms of combat-related PTSD and the associated co-morbidities is therefore of considerable interest.
The current ways in which appropriate therapies are identified for psychological problems are a pertinent issue (Hemsley, 2010). In the UK, the National Institute of Clinical Excellence guidelines (NICE) have produced a framework for evaluating therapies which currently emphasise the importance of outcome measures in determining “best practice” (Newnes, 2007). This method of evaluation deems therapies efficacious if they consistently show their usefulness in reducing the symptoms of a particular psychological complaint through randomised control trial conditions (RCTs).

Whilst the Counselling Psychology profession recognises the importance of therapeutic regulation (see Nowill, 2010) the current method of evaluation (Fairfax, 2008) and the limitations of utilising only those therapies that have performed well in RCTs in actual clinical practice has been strongly questioned (see Newnes, 2007). It is argued by some that the success of cognitive behavioural therapies (of which exposure therapy is akin) stays solely within the clinical trial from which the results were generated. Individual differences found in both client and therapist for instance can stand to limit the transferability of findings from research into clinical practice (Onwuegbuzie & Leech, 2005). For Counselling psychologists who recognise that each individual client may experience a situation, a psychological problem or a therapeutic model differently (Corrie, 2010), this current way of therapy evaluation can be seen to be particularly limiting.
For the treatment of PTSD and its corresponding subgroups which include combat-related PTSD, these concerns are not uncommon. Exposure therapy is shown to be an efficacious therapy for reducing the symptoms of PTSD (Foa et al., 2005; Schnurr et al., 2007), and yet there is a disconcerting mismatch between the efficacy of exposure therapy in reducing the symptoms of PTSD as determined through clinical research trials and its effectiveness when applied to real world clinical practices, particularly for veterans of war (Erbes, Curry & Leskela, 2009; Garcia, Kelley, Rentz & Lee, 2011). In psychological therapies where both efficacy and effectiveness are of considerable importance for any psychological change to occur, this distinction needs to be addressed.

It is argued in Paper One of the Research Dossier (full publication reference supplied in Appendix 1), that the most popular way of exploring the usefulness of therapeutic interventions in PTSD i.e. through objective outcome studies, may sometimes overlook, or fail to pay sufficient attention to, factors of great importance to therapists in real-world practice. In a therapeutic field where there is a notable distinction between treatment efficacy and treatment effectiveness, the current review aims to compare and contrast two PTSD treatments which fall either side of this research-practice distinction: exposure therapy and Eye-Movement Desensitisation and Reprocessing (EMDR). In comparison to exposure therapy, EMDR is regarded as a less theoretically grounded therapy with weaker evidence of
efficacy. Yet it appears to be more accepted by clinicians and clients in practical settings. Intrinsic factors which could contribute to this anomaly are discussed throughout the paper. These factors suggest that therapies which differ from normal evidence-based practice convention still warrant exploration as they can help develop our understanding of what makes a therapeutic model practically effective.

The aim of Paper Two (prepared in line with author guidance for the Journal of Clinical Psychology, see Appendix 2), is to empirically explore the practical effectiveness of another therapeutic model, specifically designed for combat-related PTSD: Spectrum therapy (for a full description of the clinical protocols involved in Spectrum Therapy, please refer to Appendix 3). Much like EMDR, Spectrum therapy seems to highlight the efficacy-effectiveness distinction in the treatment of PTSD. Spectrum therapy is not as theoretically grounded as exposure therapy nor does it have any current evidence of efficacy. It does however seem to be gaining momentum in charitable organisations in the UK and is well received by veterans who have previously dropped out of exposure therapy. Exploring veterans’ reasons for their engagement in Spectrum therapy and their disengagement from exposure therapy could help increase our understanding of the factors related to both therapies which either help or hinder practical engagement. The qualitative study presents a number of important themes which can be used to inform professionals on how to start closing the gap between efficacy and effectiveness in PTSD treatment.
1.0 PAPER ONE: CRITICAL LITERATURE REVIEW.

Distinguishing between treatment efficacy and effectiveness in Post-traumatic Stress Disorder (PTSD): Implications for contentious therapies

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Paper One.

Critical Literature Review.
Distinguishing between treatment efficacy and effectiveness in Post-traumatic Stress Disorder (PTSD): Implications for contentious therapies.

1.1 Abstract.

Research psychologists often complain that practitioners disregard research evidence whilst practitioners sometimes accuse researchers of failing to produce evidence with sufficient ecological validity. The tension that thus arises is highlighted, using the specific illustrative examples of two treatment methods for post-traumatic disorder (PTSD): Eye-Movement Desensitisation and Reprocessing (EMDR) and exposure based interventions. Contextual reasons for the success or failure of particular treatment models that are often only tangentially related to the theoretical underpinnings of the models are discussed. Suggestions regarding what
might be learnt from these debates are put forward and implications for future research are discussed.

**KEYWORDS**: Eye-Movement Desensitisation and Re-processing (EMDR), Post-Traumatic Stress Disorder (PTSD), Treatment Efficacy, Treatment Effectiveness, Qualitative.

### 1.2 Introduction.

In general terms, the term theory is defined as “a set of principles on which the practice of an activity is based” (Oxford English Dictionary, 2011). For Counselling Psychologists, who value inter-subjectivity, psychological theories are used to inform a practitioner’s therapeutic practice and provide “tools” that can be utilised in therapy (Moller & Hanley, 2011). Although the importance of theory in our profession is plain to see—it dominates our language, informs therapeutic practice, and is a core component of any psychological training programme—it is not the only element that influences psychological therapy. Therapist factors such as competence have been highlighted as having an impact on therapeutic variance (Wampold, 2004) as have client factors such as personality and motivation (Onwuegbuzie & Leech, 2005). Other psychologists such as Rosenzweig (1936) and later Luborsky et al (2002), with the idea of the “Dodo Bird Effect”, have also sought to highlight the importance of commonalities in therapies such as a therapeutic alliance and allegiance. If one were to accept the “Dodo Bird Effect” as a valid description of the relative merits of
different treatment models, one would have to conclude that other general factors such as a strong therapeutic alliance and allegiance are just as important as specific psychological models in determining treatment success (Wampold, 2004).

Despite the regular resurgence of this idea, and regular repetition of Rosenzweig’s (1936) phrase, “All have won so all must have prizes”, applied psychology has accepted, to a great extent, the notion of evidence based practice (EBP; Newnham & Page, 2010). Derived from the medical model (Hemsley, 2010), EBP emphasises the need to find the most successful treatment method for a particular disorder as determined by the highest forms of evidence, the randomised control trial (RCT) and the meta-analysis. Such acceptance leads the National Institute of Clinical Excellence to expend effort in ensuring practitioners have up-to-date evidence on which to base their practice (Hemsley, 2010).

Despite a great deal of rhetoric in applied psychology regarding the importance of evidence-based practice models, in real-world therapy settings not all practitioners rely on such evidence when choosing and delivering treatments (Newnham & Page, 2010). The current trend for the adoption of EMDR as a treatment for PTSD is illustrative and will be taken up in this paper as an example used to demonstrate a set of more general points.
1.3 **Post-traumatic Stress Disorder.**

Within the treatment arena of Post-Traumatic Stress Disorder (PTSD), there is a wealth of evidence that supports the use of exposure-based CBT for reducing the symptoms of PTSD and its sub-groups which include combat-related PTSD (Power et al., 2002). Such work remains topical today not least because of the recent wars in Iraq and Afghanistan. Exposure based interventions enjoy a sound theoretical grounding, having developed initially from behavioural movements with the more traditional techniques of flooding and implosion (Groves & Thompson, 1970), and later having developed alongside both cognitive and behavioural paradigms with the treatment protocol involving exposure to the feared stimuli combined with cognitive restructuring (e.g. Foa & Kozak, 1986). As well as general support for the broad theoretical orientation, which is at root an application of basic behavioural psychological principles, exposure based interventions for the treatment of PTSD also enjoy sound evidence of efficacy in the form of trial data (Foa, Dancu, Hembree, Jaycox, Meadows & Street, 1999; Foa et al 2005; Schnurr et al., 2007). In fact the research base which supports the use of exposure based interventions in the treatment of PTSD is so vast that some professionals are now terming it the zeitgeist of the disorder (Russell, 2008).

1.4 **Exposure based CBT: The zeitgeist of the disorder.**
Studies examining the efficacy of this form of treatment go back to the early 1980s and include Frank and Stewart’s (1984) investigation into the desensitisation of female rape victims. More up to date research has reported on the success of exposure therapy when compared to other independent methods of treatment such as stress inoculation training (see Foa et al., 2005). For combat-related PTSD specifically, a number of studies report a similar trend. Research conducted by Cooper and Clum (1989) examined the effectiveness of imaginal flooding, a form of exposure therapy, over standard psychotherapeutic and pharmacologic approaches in the treatment of combat-related PTSD. The evidence from this study supported imaginal flooding in the reduction of symptoms relating to the traumatic event, including traumatic stimuli-related anxiety ($F=5.58, p<.05$), sleep disturbance ($F=11.1, p<.01$) and self-monitored nightmares ($F=6.08, p<.05$). Exposure therapy has also been reported as more successful in eradicating PTSD symptoms in female war veterans specifically when compared to person centred therapy. Schnurr et al. (2007) studied 277 female veterans and 7 active duty personnel with combat-related PTSD. Participants were randomly assigned to either a prolonged exposure or person-centred condition. Women who received prolonged exposure experienced a greater reduction in their symptoms than those assigned to the person-centred condition directly after treatment ($d=0.29, p<.01$) and this difference was maintained at 3 month follow up ($d=0.24, p<.047$).

Despite the ascent of CBT and exposure-based therapies, and the solid evidence base they enjoy, a range of other treatment methods for PTSD
have become popular during recent years. Several of these therapies have been grouped together under the title of “Power Therapies”. The Power Therapies, of which Eye Movement Desensitisation and Reprocessing (EMDR) is an example, share one thing in common: they claim to work more efficiently than the existing interventions for anxiety disorders (Herbert et al., 2000). These therapies have been derided for a lack of adequate trial data, and for lacking theoretical substance (Devilly, 2005).

1.5 EMDR: Theoretical substance.

In 1989, EMDR was introduced into the therapeutic arena as a new treatment method for psychological trauma (Shapiro, 1989). Shapiro’s account of its discovery describes a happy accident, and a flash of insight. It was not based on pre-existing psychological theory (Muris & Merckelbach, 1999), and in this respect differs considerably from exposure therapy and CBT.

The theoretical basis of EMDR has been challenged by component breakdown studies which look to identify those mechanisms within a treatment protocol that are necessary and sufficient to achieve the established aims (Rogers & Silver, 2002). It would appear that where EMDR starts to become unstuck is in its suggestion that the dual stimulation e.g. eye movements, or finger tapping, are what makes the treatment unique and efficacious (see Herbert et al., 2000). Most studies, when testing this claim,
have found that outcome is not dependent on the presence of this unique aspect of the treatment protocol though these findings are not universal (Rogers & Silver, 2002). For example, Wilson, Silver, Covi and Foster (1996) conducted a study which sought to identify the contribution of eye movements in the EMDR protocol. They compared EMDR to two identical procedures which omitted the eye movement component. The results of which indicated that the dual attention aspect of EMDR does contribute to treatment outcome as desensitisation rates were higher in the full EMDR treatment condition than the other two conditions which omitted the use of dual stimulation.

1.6  **EMDR: Weaker evidence of efficacy.**

When comparing EMDR to the front-runner in PTSD treatment, that of exposure intervention, only a few studies have compared the efficacy of these two treatments directly. For reasons of space, it is not possible to document the results from all these comparison studies however a few will be discussed. Ironson, Freund, Strauss and Williams (2002) compared EMDR to prolonged exposure therapy in a sample of 22 traumatised outpatients. Both treatments appeared successful in reducing the symptoms of PTSD, with a larger pre-post effect size for prolonged exposure (d = 2.18, t = 5.27, p = .002) than for EMDR (d = 1.53, t = 3.36, p = .008, ds calculated
by the current author). Ironson et al. (2002) compared the treatments by way of a multifactorial ANOVA which showed neither treatment to be statistically superior to the other (F=0.6, p<.82). Lee, Gavriel, Drummond, Richards and Greenwald (2002) found similar results. In their study of 24 participants, the EMDR group improved slightly more (d = 1.87) than the stress inoculation plus prolonged exposure group (d= 1.73), but the difference between the two active treatment groups did not reach statistical significance cut-offs (F =1.37, p=.29). Devilly and Spence (1999), in their comparison study, found exposure techniques when delivered through a CBT package, were superior to EMDR in reducing PTSD symptomatology, and in this case the difference reached statistical significance criteria [Λ(6,16)=.37, p < .007].

1.7 The Effectiveness—Efficacy Distinction Applied to EMDR.

Whilst there is some promise in terms of EMDR’s efficacy from the research noted above, even a charitable interpretation would have to acknowledge that the evidence base for EMDR is weaker than that for exposure therapy, with respect to PTSD. Some psychologists go much further and describe EMDR as “pseudoscience” (Herbert et al., 2000) and urge the abandonment of research on EMDR and similar therapies categorised as such. We feel that such a position fails to take into account an important distinction between treatment efficacy and treatment effectiveness in psychological therapy.
Taking physical medicine, where the terms efficacy and effectiveness are derived, as an accessible example: Drugs and procedures can often be efficacious, bringing about desired outcomes due to the nature of their chemical or mechanical properties, and yet lack effectiveness because they are not well adopted by doctors and patients. The classic example is poor treatment adherence due, for instance, to undesirable side effects. In medical research, it is widely accepted that an intervention might be highly efficacious, and yet have poor effectiveness in practice, whilst treatments of lesser efficacy might produce moderately successful outcomes in terms of practical efficacy (Marchand, Stice, Rohde & Becker, 2010).

EMDR enjoys high client satisfaction with regard to dropout figures and treatment side effects (Marcus, Marquis & Sakal, 1997; Wilson, Becker & Tinker, 1995) and has seen a meteoric rise in the number of therapists trained to deliver EMDR. With this in mind, it could be suggested that EMDR might offer some advantages over exposure based therapies in regard of various contextual factors. A number of these contextual factors could be hypothesised to be associated with the high acceptability of, and considerable therapist loyalty to, EMDR in light of the erstwhile acceptance of exposure-based treatments.

1.7.1 The client experience.

It is not a new suggestion that prolonged exposure is thought to be distressing and so is poorly tolerated by many clients (Scott & Stradling,
Exposure therapies, particularly the more traditional methods of flooding, involve the client repeatedly re-visiting the memory that they find traumatic in an attempt to desensitise them to the feared stimulus. Pitman and colleagues (1991) in their study which examined six case vignettes found re-occurring complications which they believe to be “under-recognised” in flooding therapy for PTSD. For instance they document how this type of therapy can produce adverse consequences such as an exacerbation of feelings relating to guilt, self-blame and failure.

Whilst some researchers such as Feeny and colleagues (2003) disagree, arguing instead that most clients can tolerate and do benefit from exposure based interventions, there is a good deal of commentary in the literature on how exposure therapy is not suitable for all PTSD sufferers (e.g. Litz et al., 2010). Client factors have been discussed in terms of treatment success for exposure based interventions. It has been suggested that clients presenting with anger (Jaycox & Foa, 1996), alcohol abuse (Pitman et al., 1991), suicidal ideation and avoidance, as measured through session attendance, (Tarrier, Liversidge & Gregg, 2006) may affect treatment outcome. Worryingly, Axis I disorders such as depression are often associated with PTSD (Strachan, Gros, Ruggiero, Lejuez & Acierno, 2011) and dysfunctional readjustment traits such as alcohol abuse are notably high in veterans returning from war in both the US and UK (Rona, Jones, Fear, Hull, Hotopf & Wessely, 2010; King’s Centre for Military Health Research, 2010).
Comparatively, within the United States at least, EMDR has been recognised by The Department of Veterans’ Affairs and Department of Defence (2004) as being less distressing than exposure therapy and suitable for those PTSD sufferers who might not benefit from exposure therapy (Russell, 2008). EMDR is considered more associative in nature compared to the directive aspects of exposure therapy and it focuses on brief rather than prolonged exposure to the traumatic memory (Rogers & Silver, 2002). Evidence supplied by Wilson et al (1996) found that the dual attention component of EMDR treatment is associated with relaxation in clients and as such is useful in regulating the level of distress caused by the exposure component of the EMDR protocol. The current evidence does not permit a strong conclusion, but it appears that EMDR may be less distressing than prolonged exposure, either because of the nature of the treatment or because a specific element of the treatment has a relaxing effect.

1.7.2 The therapist experience.

By most measures, the evidence base for exposure-based therapies, especially exposure-based CBT is stronger, but data suggest that only about twenty percent of practitioners who specialise in the treatment of anxiety disorders use this type of therapy to treat PTSD (Tarrier et al., 2006). For combat-related PTSD specifically, Fontana, Rosenheck and Spencer (1993) in their study of 4000 Veterans with PTSD, found that exposure therapy was used to treat fewer than 20% of this population and was the primary treatment in only 1% of cases. Therapist fears of addressing the trauma directly, a concern that the treatment will exacerbate the symptoms in sufferers, and the distressing nature of the treatment are highlighted as the
main reasons for therapist reluctance in utilizing this type of treatment (Becker, Zayfret & Anderson, 2004).

Whilst there appear to be notable difficulties in matching the acceptance of exposure therapy from research into practice, it has been shown that when exposure therapy is used in real-world therapy settings it is successful in reducing PTSD symptomatology. A recent study by Tuerk et al. (2011) recruited 65 veterans of the recent Afghanistan and Iraq wars receiving care in a Veterans Administered (VA) Healthcare context to examine this point. Whilst they did not use a control group, Tuerk and colleagues did successfully manage to demonstrate that exposure therapy can be applied to real-world therapy settings by showing that prolonged exposure was as successful in reducing the symptoms of combat-related PTSD in this type of setting as in Randomised Control Trails (RCTs). Whilst this is the case, the aforementioned utilisation rates for exposure based interventions are concerning.

Comparatively, it would appear that EMDR is warmly received by a substantial proportion of therapists. There is currently an international association, conference and journal devoted to EMDR for example (Becker, Darius & Schaumberg, 2007). For combat–related PTSD specifically, EMDR is now being recommended as a treatment option for combat-related PTSD in the US (EMDR Institute; Department of Veterans’ Affairs and Department of Defence, 2004) and is frequently offered in local Military
Community Mental Health departments in the UK (Wesson & Gould, 2009).

Numerous studies have compared the dropout rates in exposure based conditions with the dropout rates in other therapy conditions. Some of these studies have found increased dropout rates in exposure therapy when compared to supportive therapies for PTSD (Schnurr et al., 2007), with others finding no association between treatment method and dropout rates (Feeny, Hembree and Zoellner, 2003). Factors affecting dropout have also been researched. Demographic factors (Tarrier, Sommerfield, Pilgrim & Faragher, 2000), pre-treatment symptom severity (Minnen, Arntz & Keijsers, 2002) and feelings of shame, anger and guilt (Jaycox & Foa, 1996) are just some of the variables thought to influence dropout rates in PTSD treatment.

For EMDR, dropout rates have not been studied as extensively as they have for exposure therapy. A cursory cross-study comparison suggests 10% dropout rates can be expected from EMDR (Marcus et al., 1997; Wilson et al., 1995), compared to rates above 25% for exposure therapy (e.g. Foa, Rothbaum, Riggs and Murdoch, 1991). On the one occasion where dropout rates for these two therapies were compared within the same study, tentative evidence of higher dropout rates in exposure therapy is reported (Ironson et al., 2002).

1.7.3 The EMDR Movement.
Shapiro (2002) has claimed that approximately 25,000 therapists are now fully trained in delivering EMDR as a treatment method to clients. Anecdotal evidence and a cursory perusal of any psychological training bulletin board would support such a number. It has been accepted into the National Institute of Clinical Excellence guidelines (NICE, 2012) as a recommended treatment method for PTSD alongside exposure therapy and is quickly gaining recognition in US and UK military settings (Russell, 2008). Alongside its recommendations for PTSD and combat-related PTSD, it is also being more widely used in the treatment of other common psychological disorders such as Phobias (Muris & Merckelbach, 1997) and Panic (Feske & Goldstein, 1997), although it has not yet gained acceptance by NICE for these disorders (Nowill, 2010). With these points in mind, few psychologists would argue the point made by McInally (1999) that EMDR “has grown quicker than the psychoanalytic and behavioural movements”.

Despite the contentious issues which surround EMDR in terms of theoretical grounding and efficacy, there is evidence to show that the therapy is gaining quick momentum, as highlighted above. In addition to the aforementioned intrinsic factors relating to the therapy’s processes, some professionals have also posited a sociological explanation for its rapid growth. In his article entitled “Power Therapies and possible threats to the science of psychology and psychiatry”, Devilly (2005) refers to some common social factors deployed by certain pseudoscientific therapies, of which he includes EMDR, to explain the adherence of clients and therapists to these therapies. With reference to these factors, Devilly (2005) refers to
the hard hitting article made by Pratkanis (1995) that puts forward nine necessary qualities that a pseudoscience must possess so that people can “buy into the concept”. The factors highlighted by Pratkanis (1995) include such terms as “creating a phantom”, by which he describes developing a concept that brings hope to something that appears hopeless. In the context of EMDR Devilly (2004) connects this to Shapiro’s claim that the therapy was 100% successful after one session. Something which gave other professionals hope in the otherwise hopeless domain of treatment for such a complex disorder.

Whilst the likely existence of contextual and social factors such as those identified by Pratkanis (1995) and their relevance to the adoption of EMDR as described by Devilly (2005) should be acknowledged, labelling EMDR mere ‘pseudoscience’ may in fact exacerbate the in-group out-group thinking of therapists trained in this tradition and further alienate them from a discourse on the evidence for and against the EMDR model. For applied psychologists who place high value on the scientist–practitioner model of research and therapy (Moller & Hanley, 2011), these strong social concepts cannot be ignored if we want to retain our professional standing. The question of whether a therapy is adopted for purely pseudoscientific reasons, for contextual reasons to do with the distinction between efficacy and effectiveness, or because of experimental evidence, goes to the very heart of whether psychologists can truly describe themselves as scientist-practitioners. It is crucial that EMDR and other power therapies be studied for what they are, for what they might offer, and for how they have achieved
such popularity in such a short time, though this is no reason to dispense with inquiry.

Other researchers too (e.g. Sikes and Sikes, 2003) have contrasted exposure based interventions and EMDR in terms of efficacy, theoretical grounding and effectiveness, suggesting that this relative mismatch needs to be explained. The “wagging finger” need not be pointed at new and innovative ideas but instead be pointed at the way in which psychological research is conducted in general. With this in mind, it has been suggested that therapies such as EMDR, might be better suited to a practice-based evidence (PBE) mode of enquiry rather than from the traditional evidence based practice (EBP) perspective (Nowill, 2010). The transition from EBP to PBE is thought to be a worthy one as ever increasingly EBP is being criticised for being compatible with certain modes of treatment akin to the medical model such as CBT, and not with others (Newnes, 2007; Hemsley, 2010).

Alongside the suggestions made for a change in how psychological research is conducted with respect to PBE, it is also argued here that there is a need for client-centred research to be more widely adopted in the PTSD treatment arena.

1.8 Client-Centred Research.

For some time, a number of practitioners have been calling for an enhanced place for the client perspective in the science of psychological intervention (Stewart and Chambless, 2010). Such research would help us answer the
question we have posed: why are theoretically sound and efficacious treatment methods in PTSD sometimes not terribly effective in practice?

To date, very little is known about the client experience of trauma therapy. Becker et al. (2007) examined client preferences for exposure versus alternative treatments for PTSD, including EMDR, in individuals with varying degrees of trauma history. Their participants were asked to imagine undergoing a trauma, developing PTSD and seeking treatment. Participants showed a preference for exposure therapy over EMDR, though Becker and colleagues acknowledge the lack of ecological validity of their findings since their sample did not include participants suffering from PTSD, and relied instead on participants imagining themselves in the situation.

Qualitative psychological methods, especially phenomenological ones, offer tools to examine the client experience and generate insights into the efficacy-effectiveness question in an inductive manner (see Hanson, 2004). Whilst this is the case, qualitative methods are underutilised in research. This is demonstrated by a lack of available qualitative research published (Rennie, Watson & Monteiro, 2002). It is suggested that this bias is due to the traditional views that “good” research is based on falsifiable theories and outcome measures that can be generalised to the wider population, all of which sit comfortably within an EBP framework (Fairfax, 2008).

For the treatment of PTSD, it would appear that the research base has followed this trend. Whilst there is a wealth of quantitative research
documenting the efficacy of treatment protocols, there is little evidence aimed at un-picking the reasons for the efficacy/effectiveness anomalies presented in this article. By drawing upon other research which has documented the usefulness of qualitative enquiry by allowing a more intricate understanding of the ingredients and processes within therapy (see Berry & Hayward, 2004), it is suggested that this might be a worthy transition in the field of PTSD research. This seems even more relevant when looking at the growing appreciation, within psychology at least, that generalised findings from RCTs are inhibited because of individual differences found in both therapist and client (Fairfax, 2008).

1.9 Conclusion.

The importance of finding appropriate treatment methods that can be used to help clients presenting with the symptoms of PTSD is considerable. The evidence base is currently dominated by RCTs where client satisfaction, therapist burden, dropout rate and other similar factors are far from the primary outcome measures, and are often considered extraneous. In these studies, exposure based interventions have proven to be the gold standard, not only because of their proven efficacy but also because of their strong theoretical underpinnings. It has been proposed that the poorer uptake of
these treatments, as compared with EMDR in the current example, reflects a research base which does not adequately take account of the distinction between efficacy in research settings and effectiveness in real-world therapeutic settings. Throughout the current paper it has been suggested that PTSD research would benefit considerably from an increased attention to practical effectiveness. This will require the adoption of a client-centred research model where the client experience is central.

Paper Two.

Research Report.
How do veterans make sense of their disengagement from traditional exposure therapy and their subsequent engagement in a non-exposure based intervention for Post-traumatic Stress Disorder (PTSD)? An Interpretative Phenomenological Analysis.

2.1 Abstract.

Exposure therapy is a proven efficacious treatment for PTSD; however its effectiveness in real world practice is limited by high rates of premature dropout, particularly for veterans of war. The current study aimed to explore this anomaly by qualitatively examining how veterans make sense of their engagement in or disengagement from PTSD treatments. Semi-structured interviews were conducted with seven veterans who had dropped out of exposure therapy and the transcripts were analysed using Interpretative Phenomenological Analysis (IPA). A number of
corresponding themes were grouped together into four super-ordinate themes: The Importance of Control, The Importance of Positive Change, The Problem with Emotion and The Importance of Relationships. From these findings the importance of explaining the rationales behind the treatment protocols and the importance of teaching techniques to manage, rather than avoid, emotions generated through therapy are discussed. The findings may help therapists to further explore the difficult matter of improving therapy for this client group so that dropout rates can be reduced and engagement increased.

KEYWORDS: Post-traumatic Stress Disorder (PTSD), Combat, dropout, engagement, efficacy, effectiveness, Interpretative Phenomenological Analysis (IPA).

2.2 Introduction.

2.2.1 Combat-related PTSD.

With advances in military equipment and medicine more soldiers are surviving injuries sustained through combat in the recent wars in Iraq and Afghanistan than ever before (Beder, 2011). Recent research suggests that 20% of serving military personnel experience psychological difficulties relating to their deployment in war zones, with 4% reported as suffering with the symptoms of post-traumatic stress disorder in the United Kingdom and higher rates of between 15-20% reported for US veterans (King’s
Centre for Military Health Research, 2010; Hoge, Castro, McGurk, Cotting & Koffman, 2004). Providing support for returning veterans and continuing to expend effort in evaluating therapeutic methods for this PTSD cohort is extremely topical and necessary.

2.2.2 Exposure Therapy might not be the whole answer.

It remains evident that, as a profession, we have at our disposal a highly successful treatment method for reducing the symptoms of PTSD: exposure therapy. Traditional exposure therapy is based on an emotional processing model which requires clients to vividly recount the traumatic event that caused them fear, threat of death or serious physical injury (e.g. Foa & Kozak, 1986; Ehlers & Clark, 2000). Clients are repeatedly asked to confront the memory of the event until their emotional responses decrease and they can be gradually introduced to fear evoking stimuli (e.g. Foa & Kozak, 1986). This mode of treatment has its origins in classical and operant conditioning paradigms and is deemed most successful when teamed with cognitive restructuring which serves to invalidate the negative appraisals generated by the individual from the traumatic event (e.g. Ehlers & Clark, 2000).

Research trials which have sought to identify the most efficacious treatments for PTSD have repeatedly reported on the positive effects of exposure therapy in reducing PTSD symptoms (e.g. Bradley, Green, Russ,
Dutra & Westen, 2005; Bisson & Andrew, 2005; Bisson, Ehlers, Matthews, Pilling, Richards & Turner, 2007) such as trauma re-experiencing, avoidance, hyper-arousal and irritability (see DSM-IV-TR, 2000). In addition, this treatment method has proven more efficacious, as determined by randomised control trails (RCTs), when compared against waitlist controls and other active treatments (Bisson et al., 2007).

In the domain of combat-related PTSD specifically there have been a number of studies and meta-analyses which have reported on the usefulness of exposure-based interventions for this population (see Bradley et al., 2005; Schnurr et al., 2007). Exposure based interventions have proven useful for soldiers presenting with the symptoms of PTSD in the aftermath of the Gulf war (Yoder et al., 2012). In relation to veterans returning from the wars in Iraq and Afghanistan, Rauch et al. (2009) found traditional exposure therapy to be successful in reducing the symptoms of PTSD in a naturalistic setting, albeit through a modest sample size ($N=10$). Owing to the trial data and meta-analyses of such data, exposure therapy has been accepted by the National Institute of Clinical Excellence guidelines (NICE, 2012), as an evidence-based treatment for all clients presenting with posttraumatic symptoms.

### 2.2.3 The researcher-clinician divide when applied to the treatment of PTSD.
Despite the supportive trial data regarding the efficacy of exposure techniques in reducing PTSD symptoms, there is some evidence that this type of therapy is not as successful when applied to real world clinical populations (see Cook, Schnurr & Foa, 2004). Such a possibility ought to be viewed in a broader context of the putative gap between science and practice in mental health psychology. For years researchers have been arguing that mental health clinicians do not incorporate empirical findings into their practice. Conversely clinicians have argued that research findings are limited because they cannot easily be integrated into everyday practice as experimental trials do not consistently represent routine conditions (Newnham & Page, 2010).

In the treatment of PTSD these debates seem ever-present when examining the literature on the low utilisation rates of exposure therapy in practice (see for an example, Becker, Zayfret & Anderson, 2004). For combat-related PTSD specifically it has been shown that despite the recommendations from clinical guidelines that advocate the use of exposure based interventions for combat-related PTSD, therapists are reluctant to utilise this therapy in military settings (Fontana, Rosenheck & Spencer, 1993).

Exposure therapy suffers from high dropout rates, where clients have disengaged from treatment before completing the recommended number of sessions (Schottenbauer, Glass, Arnkoff, Tendrick & Gray, 2008; Zayfret, DeViva, Becker, Pike, Gillcock & Hayes, 2005). There is some evidence
that this is due to the nature of therapy and not merely a confound due to the nature of the psychological problems for which exposure therapy is most often used (e.g. PTSD and phobia). For example, exposure based interventions have been shown to have higher dropout rates than other treatment modalities used for the same range of psychological problems, such as Eye-Movement Desensitisation and Re-processing (EMDR: Power et al., 2002; Ironson et al., 2002). In studies where participants are suffering from combat-related PTSD, dropout rates from exposure therapy have been reported as higher than those from supportive therapy in female war veterans (Schnurr et al., 2007).

Whilst the research on dropout figures from Randomised Control Trials (RCTs) are concerning in themselves, Zayfret et al. (2005) suggest that dropout figures from RCTs should be doubled when applied to real-world practice. Zayfret and colleagues (2005) make this suggestion on the basis that many participants drop out of research studies prior to randomisation and thus propose that a significant proportion of clinical dropout is not accounted for in RCTs. Owing to this, they studied dropout figures for exposure-based CBT in a clinical setting and found that 72% of clients receiving this type of treatment drop out before the end of therapy. Within
this figure many of the dropouts were reported prior to the start of therapy but, of those that did commence exposure work, 40% dropped out during treatment. These figures led Zayfret and colleagues (2005) to conclude that more research needs to be conducted on factors which influence dropout, in particular those that influence client engagement to this type of treatment.

2.2.4 What are the reasons for the reduced effectiveness of exposure therapy in clinical practice?

There are two factors specified in the literature as having an impact on client and clinician adherence to exposure therapy in routine settings. First, Becker and colleagues (2004) report on clinicians’ fears of utilising this type of therapy with traumatised clients. They identified that clinicians felt uncomfortable using exposure therapy because of concerns that the treatment would increase symptomatology and cause distress as the individual goes through the process of re-living.

Second, in terms of client adherence to exposure therapy, most research has reported on client variables to ascertain reasons for exposure therapy disengagement, i.e. what it is about the client that makes them dropout of treatment. For example, Bryant et al. (2003) conducted a study which compared the outcome measures of exposure therapy, exposure therapy combined with cognitive restructuring, and supportive counselling. Treatment dropouts were shown to have higher scores than treatment
completers on measures of depression, severe avoidance and catastrophic thinking. In addition many studies show that substance misuse affects attendance of sessions. For example, Sparr, Moffitt and Ward (1993) found that clients presenting with PTSD and substance misuse were significantly more likely to miss appointments than those clients who presented with post-traumatic symptoms that were not self-medicating.

That co-morbidities might increase dropout is of particular concern considering that alcoholism is the main psychological problem reported for returning veterans in the UK (King’s Centre for Military Health Research, 2010). In addition there is evidence of high co-morbidity rates of depression and anxiety with PTSD in UK populations (King’s Centre for Military Health Research, 2010). Moreover, increased levels of anger (Forbes, Parslow, Creamer, Allen, McHugh & Hopwood, 2008) and masculine tendencies are attributed to this client group when discussing the influencing factors associated with treatment engagement in US veterans (Hoge et al., 2004). With the recognition of such a diverse array of associated symptoms and factors which can contribute to client dropout from exposure therapy, some researchers are calling for a more detailed study of the intrinsic therapeutic factors which can give rise to client satisfaction with exposure therapy (Zayfret et al., 2005).

2.2.5 How can future research help address the efficacy-effectiveness distinction in the treatment of PTSD?
There appears to be a clear disconnect between what is accepted in clinical practice in the treatment of PTSD by both clinician and client, and what is supported through research trials. The author has so far discussed a treatment modality with excellent efficacy data from controlled trials but reduced effectiveness in real-world practice: exposure therapy. On the other side of this debate are those therapies that have been shown to be less scientifically efficacious than exposure therapy but are more widely accepted by both clinician and client in the treatment of PTSD. Eye Movement Desensitisation and Reprocessing (EMDR) has recently been used as an exemplar of this type of efficacy-effectiveness distinction in the treatment of PTSD (Paper One of current Research Dossier).

EMDR is acknowledged as having a less solid evidence base than exposure therapy (see Devilly & Spence, 1999). In addition, the explanation given by its proponents for its mode of action i.e. the dual stimulation aspect of therapy, has been put to question through some component breakdown studies that have shown client outcomes to be no poorer when this therapeutic protocol is omitted from therapy than when it is included (see Herbert et al., 2000). Regardless of these scientific problems EMDR enjoys higher client satisfaction as determined by dropout rates and rapid therapist adherence in real-world practice (Marcus, Marquis & Sakal, 1997; Wilson, Becker & Tinker, 1999). Other therapeutic approaches which can be compared to EMDR on the grounds of this efficacy-effectiveness distinction are also enjoying great success at present, not least in UK charity organisations for the treatment of PTSD. A cursory perusal of the available
treatment methods for PTSD through internet search engines would support such a claim. One such therapeutic method that currently has no evidence of efficacy but has high anecdotal client satisfaction is Spectrum therapy.

Spectrum therapy is a therapeutic package specifically designed for war-related PTSD that is currently being used in UK charity organisations. Spectrum Therapy is marketed as a non-exposure based therapy for veterans with PTSD\(^1\) because the client is not asked to move repeatedly through their traumatic memories with the therapist. Instead the principles behind Spectrum therapy are based on an emotional-focussed model of treatment,\(^2\) where clients are encouraged to associate with all emotions attached to the traumatic event, including anger, sadness, guilt, shame and fear, rather than the details of the event itself. This distinction between Spectrum therapy and traditional exposure therapy seems important, not least because of the recognised role of not only fear, but other negative emotions in PTSD such as shame, anger, guilt and sadness (Lee, Scragg & Turner, 2001; Beck, McNiff, Clapp, Olsen, Avery & Hagewood, 2011).

A further distinction between Spectrum therapy and traditional exposure based therapy is that Spectrum Therapy is delivered by practitioners trained

\(^1\) For the purpose of the current study, Spectrum Therapy is referred to in later sections either by name or by “a non-exposure based treatment”.

\(^2\) This description is based on the researcher's own observations; it is not used in reference to Greenberg & Johnson's Emotionally-Focussed Therapy (EFT).
in Neuro-Linguistic Processing (NLP), who once served in the military, rather than psychologists. Whilst the fact that the therapy is run by non-psychologists might be frowned upon by psychologists, it is interesting to explore this innovation since researchers have often described this client cohort as being mistrusting of civilians (e.g., Coll et al., 2012). It is also recognised that NLP, like EMDR, has been labelled by some in the literature as a pseudoscientific “Power Therapy”. A term used to describe a therapy with no theoretical or scientific substance (see Devilly, 2005). Whilst these points are not refuted by the current author, it is argued that therapies which appear to enjoy high client satisfaction in the absence of any efficacy trials could help develop our understanding of what makes a PTSD treatment method effective in real-world practice.

2.2.6 How can research explore client satisfaction of therapies?

Research into client experiences of therapy has, to date, mainly been conducted through quantitative hypothesis-testing designs whereby pre-defined categories have been used by the researcher to identify client satisfaction of therapy (McLeod, 2001). Whilst this research is deemed important, not least because of the expectations placed on practitioners in the National Health Service to report on outcome measures and client satisfaction, it is argued that qualitative methods are better suited to gather
data rich enough to allow for a more detailed understanding of the client’s subjective experience (see Berry & Hayward, 2004). This is particularly relevant for Counselling Psychologists who are guided by professional practice guidelines which advocate the importance of client subjectivity within therapy (BPS, 2009).

Very little work has been done to date to explore experiences of exposure therapy. Of the one study known to the current author that qualitatively explored client experiences of exposure therapy, Shearing, Lee and Clohessy (2011) report the experiences of clients who have stayed engaged with exposure therapy to be positive once they had overcome their scepticism of, and fears about, engaging in the re-living process. Investigating the experiences of those who do not drop out of exposure therapy in this way, may help allay the fears therapists have about using this treatment with PTSD sufferers in practice (Becker et al., 2004). Such work however is not likely to help gain the trust and engagement of clients unless it results in changes to the treatment model and how it is delivered (see Becker & Zayfret, 2001).

By exploring client reasons for dropout from a particular psychological treatment method, we can start to gain an understanding of how these therapies can be moulded, and better presented, to increase client satisfaction. This could go some way in helping to bridge the gap between what is efficacious in research trials and what is effective in therapy. This
seems particularly important in the treatment of PTSD as both client and clinician have at their disposal, a highly successful treatment method which is being underutilised and in some cases, not adhered to in therapy. In the case of combat-related PTSD specifically, where high dropout rates from exposure therapy are recorded (Erbes et al., 2009; Schnurr et al., 2007) it seems essential that research not only look at enhancing treatment methods that reduce the symptoms of PTSD, but also focus attention on helping make efficacious therapies more attractive to this client cohort.

2.2.7 The aim of the current study.

The aim of the current study is to examine what therapeutic factors have led to veterans’ disengagement from traditional exposure therapy and their subsequent engagement in a non-exposure based treatment for PTSD. Given that Starks and Brown-Trinidad (2007) laud the usefulness of qualitative methodologies for this type of exploration, and with the notable lack of this type of inquiry in the field of PTSD in the aftermath of war (see Shearing et al., 2011), the current research base would gain value from a qualitative exploration into how veterans make sense of their engagement or disengagement from specific therapies.

As the concern of the current study is not with what is efficacious in the treatment of PTSD, but more with what factors influence engagement of
PTSD treatment, it will be interesting to look at the distinction between efficacy and effectiveness by comparing how clients make sense of their disengagement from a highly efficacious treatment method in PTSD, that of exposure therapy, and their subsequent engagement in a treatment package for PTSD which has no current evidence base: Spectrum therapy.

In the absence of any efficacy trials it will be interesting to examine what it is about Spectrum therapy that has kept veterans, who previously dropped out of exposure therapy, engaged in this treatment method. It is hoped that this qualitative exploration of client experiences will add to our knowledge of client engagement in combat-related PTSD which will aid future theory development, and eventually lead to improvements in our existing efficacious therapeutic methods for PTSD, such as exposure. With this in mind, the current study is guided by the research question: How do veterans make sense of their disengagement from traditional exposure and their subsequent engagement in a non-exposure based treatment for PTSD? It is believed that such an inquiry will help bridge the gap between efficacy and effectiveness in the arena of combat-related PTSD treatment, which is currently a widely held concern for practitioners and researchers alike (Becker et al., 2004; Garcia et al., 2011; Shearing et al., 2011).

2.3 Method.

2.3.1 Design.
The critical literature review for the current study has identified a gap in existing knowledge between efficacy and effectiveness in the treatment of PTSD. Furthermore, this gap has been explored in the introduction section of the study in relation to veterans of war receiving exposure therapy. Concerned with these debates, the current study used qualitative methodology to address the research question which focuses on participants’ subjective experiences of both traditional exposure therapy and a non-exposure based treatment package for PTSD: Spectrum Therapy. As qualitative approaches adopt an exploratory stance (Lyons & Coyle, 2007) and can help discover the success or failures of particular interventions (Starks & Brown-Trinidad, 2007), it was felt that this would provide valuable insight into clients’ experiences of therapy that have not previously been acknowledged, particularly from the experience of veterans who have disengaged from exposure therapy.

2.3.2 Interpretative Phenomenological Analysis (IPA).

This research was guided by the principles of Interpretative Phenomenological Analysis (IPA). This research method was chosen because of IPA’s theoretical position as an inductive approach to analysis which allows a detailed exploration of how participants make sense of their lived experiences (Smith, 2004). In this instance, the information gathered concerned participants’ experience of PTSD treatment methods in order to assess what factors either helped or hindered therapeutic engagement from
exposure therapy and a non-exposure based intervention. In addition, IPA was the methodology most consistent with the research aims when compared to other qualitative enquiries.

Grounded theory was considered during the developmental stage of the current research; however it was deemed inappropriate due to the focus on social processes rather than individual experience (Lyons & Coyle, 2007), the aim here is to take the client’s perspective. In addition, considering the focus of the current study is on individual participant experiences of treatment and not a desire to build up a new theory for PTSD treatment, grounded theory was discounted from the design selection. Other qualitative methods were considered, such as thematic analysis and content analysis, however it was felt the interpretative aspect of IPA would help develop a deeper meaning of participant narratives which could be used to ascertain a richer psychological understanding of the factors which affect client engagement in PTSD treatment. As this interpretative element of IPA is not promoted in either thematic or content analyses, they too were discounted from the design selection.

A central feature of the IPA design is that the researcher analyse the data produced from the interviews in order to make meaning of the clients’ experiences. As this can only be done from one’s own interpretations and conceptions, it seems appropriate that the author be transparent and honest about “one’s own perspective” (Smith, 2008).
2.3.3 Reflexivity.

The author of the current study is a 28 year old, White-British female, who developed an interest in the research topic through her own clinical practice as a trainee Counselling Psychologist. The author became interested in the treatment of PTSD when working with a client presenting with the symptoms of PTSD using exposure based interventions. The author found it difficult to apply these techniques to a very vulnerable client who was finding the work distressing. In response to this experience the current author started to search out research papers which supported the difficulties applying exposure based techniques to clinical practice with regard to dropout (Zayfret et al., 2005) and barriers to clinician utilisation of exposure techniques (Becker et al., 2004), looking for ways to improve her own practice.

2.3.4 Epistemological Position.

Willig (2008) suggests that a psychologist’s philosophical stance be utilised not only in practice but also in research. The value system attached to the Counselling Psychology profession which heralds the importance of subjectivity and understanding the lived experience of people has been incorporated into the development of the current research question. For this reason the epistemological stance adopted for the research is one that views the construction of reality as being based on subjective and social factors.
This constructivist framework differs from the traditional views of positivism and empiricism which strive to find an objective reality (Lyons & Coyle, 2007). As IPA places high importance on meaning-making from the perspective of an individual’s personal and social contexts, it sits well within the current researcher’s epistemological position. Furthermore Stewart and Chambless (2010) document the importance of case study reports in gaining clinical interest towards research findings and thus provide an insight into how to address the recognised gap between research and practice in the field of psychology. This seems a particularly important consideration for the current study as there has been a proven mismatch between evidence and practice in the arena of PTSD treatment (Becker et al., 2004; Garcia et al., 2011).

### 2.3.5 Recruitment

Participants were recruited through the founder of Spectrum therapy who operates privately in Manchester and in UK charitable organisations across the country who have adopted this approach to PTSD treatment (for a copy of the consent form provided to the founder of Spectrum therapy, please refer to Appendix 4). Initially, the founder of Spectrum therapy informed potential participants about the nature of the current study. From this, only those individuals who had expressed an interest in taking part in the current research and who had given permission for their details to be passed on were deemed contactable by the researcher. These participants were initially contacted by telephone where a full description of the study and their role...
within it was provided. At this stage, if participants agreed to take part, an
e-mail containing the study’s information pack and consent form was sent to
them (for a copy of the participant consent form, please refer to Appendix
5).

Participants were eligible for the current study if they had been diagnosed
with PTSD, had disengaged from a course of exposure therapy in the past
and had subsequently engaged in a full course of Spectrum therapy. In
addition, as the focus of this study was to examine war veterans’
experiences of PTSD treatment, all participants needed to have served in a
military setting for at least 2 years and experienced a traumatic event within
this setting that triggered the symptoms of PTSD for which they were
seeking treatment.

2.3.6 Participants.

A total of seven participants were recruited for the purpose of the current
study. This sample size was decided upon because of the recommendations
made by Smith and Osborn (2008) that between five and seven participants
is suitable for an IPA design. Smith, Flowers and Larkin (2009) describe
the main feature of IPA as gaining a thorough understanding of individuals’
experiences through a case by case analysis which can be restricted in larger
samples.
Through purposive sampling, IPA aims to find participants with similar experiences or characteristics (Smith et al., 2009). The inclusion criteria, described above, were adhered to strictly not least to ensure the homogeneity of the sample. In addition to the outlined criterion, all participants reported strong avoidant tendencies and problems regulating anger before receiving any therapeutic intervention. Four of the seven participants were self-medicating, either through use of alcohol or taking non-prescription drugs, as a means of regulating their symptoms. No attempt was made to restrict the gender of participants, however due to the nature of the client group, all participants were male.

Table 1 Details of participant demographics.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age (years)</th>
<th>Ethnic Origin</th>
<th>Length of time in the service (years)</th>
<th>Involved in active combat</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>25</td>
<td>White British</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Male</td>
<td>29</td>
<td>Black African</td>
<td>9</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Male</td>
<td>34</td>
<td>White British</td>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Male</td>
<td>32</td>
<td>White British</td>
<td>5</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>42</td>
<td>White</td>
<td>22</td>
<td>Yes</td>
</tr>
</tbody>
</table>
2.3.7 *Ethical Approval and Considerations.*

An initial research proposal was submitted to the University of Wolverhampton Research committee in November 2010 (please refer to Appendix 6 for a copy of the Res20 form). On completion of minor amendments, ethical approval was granted by the Ethics Committee of the University of Wolverhampton, School of Applied Sciences in June 2011, (please refer to Appendix 7).

A two-part process was adopted for consent. Potential participants were sent an information pack (see Appendix 8) by email upon expressing an interest to take part. The participants who responded to this email were telephoned some days later to confirm their involvement. Once participants had agreed to take part, a suitable time and date for the interview was arranged with the participant. At the start of each interview, the researcher asked the participants whether they had fully read and understood the information pack which had been sent to them via e-mail before verbally outlining the nature and purpose of the study. The researcher then directed participants through the consent form, highlighting in particular, the sections pertaining to participant confidentiality, anonymity and their right to withdraw. Participants were made aware that original transcripts would be...
read by the research supervisors only after all potentially identifiable information had been omitted. In line with the Data Protection Act (1998), participants were made aware that transcripts would be kept for up to five years in a secure electronic format that was password protected. Time was allowed for participants to ask questions about the research before the recordings started.

One of the ethical concerns raised at the planning stage of the study was the vulnerability of this client group to potential distress. In line with this consideration, participants were made aware at the point of consent that they would not need to talk about their specific traumatic experiences, but more their experiences of treatment and how this impacted on their symptoms. In addition, throughout the recordings the researcher remained sensitive to the needs of participants, and where necessary, informed them of their right to withdraw from questions if they so wished. Debriefing sheets were prepared for use with any participant who showed signs of distress, with details of alternative treatment options and support organisations (please refer to Appendix 9).

2.3.8 Development of the Interview Schedule.

It is important when using an IPA design that the interviewees have optimal opportunity to detail their own experience and be viewed as the expert of their own “story” (Lyons & Coyle, 2007). For the purpose of the current
research question, the participant-centred feature of IPA was deemed most attractive, as it allows participants to explore and describe their experiences, something which cannot be achieved through questionnaires alone. A semi-structured questionnaire was developed for use in the interview which would allow the researcher to adapt the interviews for each participant according to their accounts and thereby draw out their most relevant and meaningful experiences.

Open-ended questions are considered the exemplary method for an IPA design as they offer a “focused yet flexible method of data collection” (Smith & Osborn, 2008). In order to allow for flexibility within the interviews, semi-structured, broad ranging questions were developed by the researcher to give participants the opportunity to reflect upon their own personal experiences of therapy. In order to remain focused on the research question the interviewer designed an interview schedule to address three main areas of participant experience (see Table 2). For a copy of the full interview schedule please refer to Appendix 10.

Table 2 A snapshot of the Interview Schedule

<table>
<thead>
<tr>
<th>Areas of Interest</th>
<th>Example of the Semi-structured Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Their experiences of life with PTSD</td>
<td>What was life like for you with PTSD?</td>
</tr>
<tr>
<td>Symptomatology</td>
<td>Effect on family and work life.</td>
</tr>
<tr>
<td>Exposure Therapy</td>
<td>What influenced their decision to disengage from the therapy?</td>
</tr>
</tbody>
</table>

153
How did they feel about the therapeutic protocols/what they were asked to do in therapy?
How comfortable did they feel in the sessions?
How did they feel after the therapy sessions?

Their experiences of Spectrum Therapy
What was it about the therapeutic method that influenced their decisions to stay engaged in the treatment?
How did they feel about the therapeutic protocols/what they were being asked to do in therapy?
How comfortable did they feel in the sessions?
How did they feel after the therapy sessions?

At the start of all recordings participants were given an opportunity to discuss their experiences of life with PTSD. This was thought important because in IPA there is an appreciation of adding “context” to participant experiences so that a richer data set can be assembled. This not only relates to the research question, but also to the participant themselves (Smith et al., 2009). Indeed Shenton (2004) refers to this context as a “thick description” whereby a detailed overview of the participant is provided so that findings may later be contextualised. For this reason it seemed important to get an impression of client experiences before entering into therapy as it was thought this could add some rich data pertaining to participant context whilst also adding value to the research question.
With regard to the questions pertaining to participant experiences of therapy direction was taken from the results of Shearing, Lee & Clohessy’s (2011) qualitative study into client experiences of reliving in trauma focused cognitive behavioural therapy. Whilst Shearing et al. (2011) found participants experience of exposure therapy to be generally positive, they allude to several factors within the discussion of their findings which relate to participants unease with both the process of therapy and the impact of engaging in the re-living protocol once therapy had finished. For this reason it was thought important that non-directive questions relating to these factors be incorporated into the current interviews.

As the current researcher was inexperienced in conducting semi-structured interviews, it was decided by both the researcher and the researcher’s supervisor that some initial training and role playing be incorporated into supervision prior to any interviews being conducted. Amendments to the style of questioning were deduced from this supervisory input before the researcher carried out the first of the interviews with participants. After the first two interviews were conducted both the researcher and the researcher’s supervisor analysed the transcripts in terms of the questioning style and comparisons were made between the questions that could have been asked and what participants were actually asked. This sought not only to develop the researcher’s interview style but also to enhance the credibility of the research study.
After analysing these initial transcripts, the original decision to include five participants in the current study, was extended to include seven participants to allow for a richer data set to emerge. The transcripts of all seven interviews are included in the data set.

2.3.9 Interview Process.

A total of seven participants were interviewed in total for the purpose of the current study. All interviews took place over Skype in order to reduce any unnecessary anxiety for participants travelling to unfamiliar locations.

Each recorded interview lasted approximately 30-60 minutes. Participant demographics were taken before the interview commenced. At the end of each interview, the researcher again confirmed participant participation and each were given the lead researcher’s contact details in case of any future questions. Directly after the interviews, the researcher commented on the interview process and the initial impressions of content that emerged from the recordings in a reflective diary aimed at increasing researcher reflexivity throughout the data collection and analysis phases. Each interview was followed by a debriefing session and participants were directed to the debriefing form contained in their information pack.
2.4 Results

2.4.1 Data Analysis

All transcripts were transcribed by the researcher in a bid to familiarise the researcher with the emergent data. Unfortunately, due to time constraints, participants were not able to read their transcripts to check for accuracy. Owing to this, after each transcription, the researcher listened to the recordings several times whilst simultaneously cross-checking the transcripts.

The data were analysed and coded in accordance with the principles of IPA outlined by Lyons and Coyle (2007) and Smith et al. (2009). The first phase of analysis involved the researcher becoming “immersed in the data set” (Smith et al., 2009). As the researcher was involved in all aspects of transcription and accuracy checks, familiarity was readily obtained. This said the process of active engagement in the data is notably important in the IPA literature as it helps the researcher stay connected to the original recordings (Shenton, 2004). With this in mind the researcher re-read each transcript twice more before any interpretation took place.

In terms of interpreting the data, direction was taken from Smith et al. (2009) who define three distinct categories of data coding in an IPA study: the exploration of descriptive comments, outlined in the current transcripts
in normal font, linguistic comments, noted in italics and conceptual concepts denoted in bold font. An example of this initial interpretation phase can be found in Table 3.

Table 3 Example of the initial interpretation phase.

<table>
<thead>
<tr>
<th>Original Quotations</th>
<th>Interpretations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>P: Well this way, the major thing was revisiting things that, places that I didn’t want to go then</td>
<td>Wanting to avoid his memories. “major” – highlighting the extent of the conflict. Therapy conflicted with his desire to stay disconnected.</td>
</tr>
</tbody>
</table>

Once the initial interpretations had been completed, the researcher re-read the data once more to draw out the main emergent themes within the data (see Table 4.)

Table 4 Example of how emerging themes were generated.

<table>
<thead>
<tr>
<th>Emergent Themes</th>
<th>Original Quotations</th>
<th>Interpretations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict between avoidance and the re-living process.</td>
<td>P: Well this way, the major thing was revisiting things that, places that I didn’t want to go then</td>
<td>Wanting to avoid his memories. “major” – highlighting the extent of the conflict. Therapy conflicted with his desire to stay disconnected.</td>
</tr>
</tbody>
</table>
The emergent data for all of the transcripts were then re-analysed so that patterns from the transcripts could be outlined (see Table 5). These patterns were subsequently entitled “sub-ordinate themes” (Smith et al., 2009). For an example of a participant’s table of themes, please refer to Appendix 11.

Table 5 Generating the sub-ordinate themes.

<table>
<thead>
<tr>
<th>Sub-ordinate Theme</th>
<th>Emergent Themes</th>
<th>Original Quotations</th>
<th>Interpretations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whose agenda is it anyway?</td>
<td>Conflict between avoidance and the re-living process.</td>
<td>P: Well this way, the major thing was revisiting things that, places that I didn’t want to go then</td>
<td>Wanting to avoid his memories. “<em>major</em>” – <em>highlighting the extent of the conflict. Therapy conflicted with his desire to stay disconnected.</em></td>
</tr>
</tbody>
</table>

The final stage of coding involved the researcher making connections across the sub-ordinate themes through the process of abstraction (Smith et al., 2009). This involved generating clusters of themes based on similarity from which larger super-ordinate themes were generated. These larger, super-ordinate themes were then titled to capture the nature of the sub-ordinate
themes associated with this larger grouping. Owing to the nature of the study, where participants were asked to comment on factors that both helped or hindered engagement in PTSD treatment, polarisation (Smith et al., 2009) was often adopted, as the factors related to each sub-ordinate theme were sometimes discussed on the grounds of opposition. Please refer to Appendix 12 for a copy of the grand master table where all super-ordinate themes, sub-ordinate themes and corresponding quotations can be found.

Throughout all stages of data analysis, the researcher and research supervisor met to discuss the emergent themes and to reflect upon the lead researcher’s interpretations of data to ensure that the researcher interpretation was as credible and un-biased as possible.

A total of four super-ordinate themes were identified across the majority of the interviews, capturing within them a total of eight sub-ordinate themes (a thematic diagram is presented in Table 6).

As the research is concerned with exploring how clients make sense of their experiences within the respective therapies which have either helped or hindered engagement, the themes described are all concerned with the following research question: How do veterans make sense of their disengagement from traditional exposure and their subsequent engagement in a non-exposure based treatment for PTSD? This said it seems
impossible to fully contextualise the findings without summarising and interpreting what participants chose to say about their experience of PTSD.

To this end, some of this contextual material will be presented in the hope that it will provide a richer understanding of their experiences within treatment.

In order to ensure anonymity throughout the research, and so direct examples from the transcripts can be used to illustrate the points made, all participants will be referred to using pseudonyms.

Table 6 Thematic diagram of themes.

<table>
<thead>
<tr>
<th>Super-ordinate Themes</th>
<th>Sub-ordinate Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Importance of Control</td>
<td>Whose Agenda is it Anyway?</td>
</tr>
<tr>
<td></td>
<td>The Importance of Understanding</td>
</tr>
<tr>
<td>The Importance of Positive Change</td>
<td>Concerned for recovery.</td>
</tr>
<tr>
<td></td>
<td>A Bright Future.</td>
</tr>
<tr>
<td>The Problem with Emotion</td>
<td>Feeling unable to cope with feeling.</td>
</tr>
<tr>
<td></td>
<td>Not wanting to Share.</td>
</tr>
<tr>
<td>The Importance of Relationships</td>
<td>Military/Civilian Divide.</td>
</tr>
<tr>
<td></td>
<td>Feeling supported in recovery.</td>
</tr>
</tbody>
</table>

2.4.2 **Theme: The Importance of Control.**

All participants described the importance of control when describing either their engagement in, or disengagement from, the therapeutic process. This sense of control is concerned with the choice they felt they had in the
respective therapies and gaining an understanding of the rationales behind the treatment protocols that they were being asked to engage in.

2.4.2.1 Whose Agenda is it Anyway?

Many participants report on the conflict between the therapeutic protocols being asked of them in exposure work and what they wanted to do in therapy. The majority of participants report feeling reluctant to engage in the re-living aspect of the treatment plan. This conflict is represented through narratives of feeling forced to engage in the re-living process of exposure work.

Matt: Yeah, well it was like I wasn’t in control, they were asking me to do something that I really didn’t want to do, but I was there for a reason so I thought well you know let’s try it. I didn’t want to do it but then again I had to do it. It was a control thing, I had no control it was a frightening experience (line 72)

Luke: This way, the major thing was revisiting things that, places that I didn’t want to go then (line,115)

Ben: But when you are explaining it to a therapist kind of thing or someone in a working environment it’s more a case of I’ve got to do this...erm...and it becomes like a battle if you will (line 124)
These experiences in therapy seem particularly important for this group of participants as all of them describe using avoidance as a coping mechanism when dealing with the symptoms of PTSD. The following examples from two of the narratives are used to illustrate this avoidant style coping mechanism which is described by all participants, and highlights a belief that in order to carry on with life, they need to stay disconnected from their traumatic memories.

Matt: I think that’s what I was doing to be fair I was just numbing myself to come back, coz I have got to block myself I’ve got to get on with my life I’ve got to block it all somehow (line 122)

Frank: I was running marathons and stuff, I was punishing myself to try and convince myself that I was fine (line 32)

For Matt and Frank in particular, the belief that they must stay disconnected from their experiences in order to carry on with life entered into the therapy room and made them actively decide to work against the process. This experience in therapy seemed to generate a conscious decision to disrupt the re-living process in an attempt to re-gain control over the therapeutic environment.

Matt: Yes I thought you know I don’t want to go here I don’t want to go there, so I disrupted the flow (line 102)
Frank: I would stay that way until I could put a lid on it again and then by that time I was back in speaking to her, I was thinking I really don’t want to take the lid off this so I would tell her a different story, I just didn’t want to visit there, I would tell her something else it doesn’t matter what it is it could be about anything, it wouldn’t be about military it would be about my personal life or it would be about this, it would be anything other than that, so I avoided as best I could what really hurt me (line 88)

For other participants feeling as though they were working to somebody else’s agenda was reported in a different way. For one participant in particular, the structured nature of exposure therapy left him feeling as though the treatment was very restricted and impersonal.

Frank: it was very restricted, I felt it was restricted, this is what we do in CBT, this is what we are trained in, this is how we take you, there was no flexibility on how to address... or never showed itself.... the system was too structured (line 130)

When describing how they felt in Spectrum therapy, a very different set of narratives emerges, which relates to participants’ positive experiences in therapy owing to a sense of choice they felt they had in the sessions.
Matt: Whereas they are not telling you.... not saying to you, you must do this or go back into this or go back into that, it’s your choice (line 238)

Luke: like the process you know, you’re pretty much, doing all the work yourself they are just directing you (line, 254)

Frank: They are using your language pattern...so... you’ll come up with answers erm...no one’s telling or advising you or suggesting to you (line 164)

For Frank and Matt, a sense of control was generated through Spectrum therapy because they felt they were not working to somebody else’s agenda and timescales.

Frank: By being given the space to reflect and connect with myself at my own pace instead of being bombarded with questions about what exactly had happened to me in the army (line 192)

Matt: I mean you’re not being told to do it, if errr...if you want to talk, you can talk you know..... there’s no time scale on it, you know everybody’s sort of like you know... yes go and have a cup of tea and we’ll talk about something different, we’ll do this, we’ll do that you know it’s like yes it’s like a great big....freedom (line 248)
For Sam in particular, Spectrum therapy was reported as feeling more “gentle” as therapy seemed to go at a pace he felt comfortable with.

Sam: Well the colour is like it keeps you safe it makes you feel safe and if things do get uncomfortable you can use the colour to disassociate yourself from whatever it is that’s being found uncomfortable (line 141)

This sense of choice and flexibility that participants felt they had in therapy seemed to make the therapy feel individualised as all participants describe their wants and needs being incorporated into the therapeutic process.

Frank: Yes, I guess that the amazing thing is errr the therapy is about you treating you, not someone else forcing you to be treated their way, does that make sense?(line 166)

Sam: Yes that was something I chose to do, but yes that was something I suggested that I would like to do and they put it into intervention to make that happen (line 127)

Thomas: But with Spectrum therapy you don’t go through that you don’t have to talk about the event you can talk about a moment in time or the fear or where the position of … where you feel the emotion you don’t…..erm from my experience of it….it is a very gentle process which doesn’t dig into any sort of err….. it allows you… going through a process without going
into minute detail that could be very uncomfortable it certainly was in my
case anyway, I didn’t need to go into minute detail (line 222)

Matt: Yeah, yes, they worked on a lot of things you know, but they worked
on what you wanted to work on (line 302)

In addition, feeling in control of the therapeutic process in Spectrum therapy
seemed to generate positive feelings about the therapist and the therapeutic
relationship, where an equalizing of power was described between client
and practitioner.

Matt: It was basically comradeship everybody seemed to be on the same
level you know because they were trained therapists it didn’t mean that they
were above you...they were on the same level as you (line 224)

Researcher: And what affect does that have on you do you think feeling on
the same level? (line 227)

Matt: Well its great isn’t it, you’ve got the control (line 228)

Researcher: Right, ok....so it makes you feel in control does it?(line 229)

Matt: Yes, they have the control and you have the control. (line 230)
Sam: It was like the approach he used I felt very much equal to the person who was treating me (line 99)

2.4.2.2 The Importance of Understanding the Rationale.

For some participants it would appear that developing a thorough understanding of the usefulness of the therapeutic protocols involved in exposure therapy was an important factor that was missing from this therapy as they discuss feeling ambivalent towards the value of the therapeutic protocols in their recovery. Throughout these narratives there is a strong sense that the participants did not understand why re-visiting their traumatic memories was necessary.

Ben: it was like putting me back in there you know ...so close your eyes get back in there.... and why would I want to do that you know?(line 40)

Matt: Erm...basically to discuss obviously your army career, sort of like traumas that you have (line 60)

Researcher: Right, how did you experience that process?(line 61)

Matt: I mean to me it was like opening up old wounds that I , I wouldn’t say I had pushed to the back of me mind because they’re always there but it’s like I wanted to block them out. I don’t....I wish I could wake up one morning and somebody’s drilled a hole in my head and took these things out (line 62)
For another participant, ambivalence is presented through a sense of frustration aimed at the therapist for “repeatedly” asking him to talk about his experiences. This participant describes his mental model of how therapy should work being at odds with that of the therapist. Through this description the participant portrays a belief that avoidance is a necessity in his recovery. Owing to this, the reader is left with the impression that not only is he confused about the benefits of the re-living process, but that he also believes engaging in such process will hinder his recovery.

Gary: Yes I mean just asking what I had been through, all the time asking about what I had experienced....and erm.... I just thought it was all totally irrelevant to what...... I was trying to get well, in myself like......I become resentful of counselling for years I just thought what a waste of time you know (line 62)

For Ben, being informed of the therapeutic protocols involved in exposure therapy seems particularly important as he felt that the therapist was asking him to disclose his traumatic experiences for their value instead of his own. This is described when he talks about how he experienced the internal nature of Spectrum Therapy. An illustrative example of this point is documented below; however there are many examples in Ben’s narrative where he refers to feeling as though he was engaging in the re-living process
for the benefit of the therapist rather than for himself. This is strongly conveyed in the following narrative where he connects being asked to re-live his experiences with a morbid curiosity in his therapist.

*Ben:* what (name of Spectrum therapist) seemed to do was like... so like ask me to pick a certain memory, when you felt this... ok then.... now he didn’t want you to openly discuss this....see that’s privately for you with the feelings and that, so which was a great thing, I thought to myself wow these aren’t asking me to go into details as if they are not just after a gory story kind of thing you know (line 102)

In congruence with this point, two other participants described the importance of being informed of the rationale behind the therapeutic protocols in Spectrum therapy in helping them engage and feel more comfortable with what they were being asked to do. This seems to give participants a sense of control over the process which subsequently gives them confidence to engage in therapy.

*Thomas:* Well it wasn’t difficult...erm I mean I understood why I was doing these things that I was being asked to do so I felt ok in doing them you know (line 216)

*Matt:* why are they asking me to think of something nice (line 194)
Researcher: Yeah (line 195)

Matt: I don’t think I’ve had anything nice happen to me in a long time, but they explain to you why you are doing it which was important...well it was for me anyway to erm...have somebody explain to me why this was important (line 196)

2.4.3 Theme: The Importance of Positive change.

The next super-ordinate theme that was identified relates to the importance of seeing positive change in therapy. When discussing the factors that influenced their engagement within therapy, all participants either spoke of a concern for their recovery or seeing a bright future as factors which affected their engagement.

2.4.3.1 Concerned for recovery.

For some feeling unable to cope with the re-living process of exposure therapy was connected to a fear that they would be unable to cope with the after effects of engaging in this therapeutic protocol once out of the session and thus their recovery would be impeded.

Matt: You are trying to get your head together on your own and if I had all that messing around with my head again it was just like here we go again (line 188)
For the majority of participants they reported being concerned about engaging with the actual re-living process itself because it felt too overwhelming for them. For these participants this was represented through a feeling that the re-living process was all consuming.

*Sam:* Well it was like you were still there, I just remember every time I had to talk about it I used to get the intensity of being there again (line 62)

*Thomas:* For very short periods she had me in the moment of being...in...and erm....even now I have to just have to you know......(line 176)

The researcher observed that some participants spoke about how the reliving process impacted on their ongoing lives by bringing the trauma to the forefront of their minds.

*Luke:* it just revisited everything and brought it all back to the surface so then when I was coming away it may have made it worse (line, 113)

*Ben:* Erm...more or less...because it was putting it right at the front of your mind, I mean it’s always there like I say these intrusive thoughts are always there (line 40)
Many participants explained how, when they had engaged in the re-living process, they saw no positive change in their symptoms which contributed to their decision to leave therapy. The following example is illustrative of many a narrative.

*Sam: that’s why I eventually stopped going to the therapy it wasn’t making things better* (line 89)

Some participants report frustration in exposure therapy as they became concerned for their recovery after the sessions. This was identified in the narratives through descriptions of feeling worse after the re-living process.

*Luke: Were all based on that , so I keep reliving what my dreams are about, what you know, what other things are effecting, what flashbacks are happening etc* (line, 94)

*Researcher: Huh, yeah ok* (line (95)

*Luke: I’d come out of there 10 times worse you know* (line 96)

*Sam: I would be more upset sometimes I could go there and I would end up being in a worst state afterwards sometimes* (line 68)
For others a sense of desperation was felt as they began to lose faith in their recovery after engaging in a session of exposure therapy.

Frank: Like I would go and feel worse after the treatment and it was like I’m not getting better at what stage do I tell her that this is not working for me what else can I have... this is not working (line 114)

Earlier on in Frank’s narrative he talks about why he felt his recovery was impeded in exposure therapy.

Frank: I felt great trust with the lady treating me and we had a good rapport going, the only thing was as I have said before it’s trauma focused and again it was re-visiting a story I have told that many times it has become completely impersonal and a void of me (line 102)

Researcher: Right so why do you think it had become a void of you? (line 103)

Frank:...because if I felt or...if I was to be associated with what I was saying I would become very ill again and I just didn’t want to be there, so it was...it was... so what, and I wasn’t resolving anything we were just going over old ground of 20 years (line 104)
This shows that in therapy, Frank made a conscious decision to stay disconnected from his memories in exposure work because of a fear that connecting with the memories would impede his recovery. This fear of an impeded recovery seems so strong that it overrode the strong therapeutic relationship he had developed between himself and his therapist.

2.4.3.2 A Bright Future.

Conversely, many participants reported seeing positive change after Spectrum therapy which encouraged them to continue with the process. For many, the importance of seeing quick change in therapy seemed to prove as motivation to actively engage in the treatment protocols.

Ben: *then once you notice that it is working you can’t wait to go on and do some more and see what else you can dispel kind of thing* (line 162)

For Thomas, shifting the focus from his past experiences to his future seemed to generate positive change and encouraged him to stay engaged in Spectrum therapy.

Thomas: *Well it erm....it changed me from being in a position where I was helpless to actually being in a position that made me realise that actually*
there is a future there’s a way forward so that obviously...erm...the... the positive change was there so it helped (line 226)

This is something that seemed particularly important for Thomas when examining how bleak his future appeared to be when he was suffering with PTSD.

_Thomas: Oh yes massively you have to remember that PTSD it destroys....errr.. it makes your life miserable, anything that can take you from a place where you are wanting to take your own life to a place where you can see a future and actually you have got something to work with is incredible in my eyes that is something you have got to take note of (line 228)_

Interestingly, this sense of a lost future pervades the majority of narratives when participants talk about their experiences of life with PTSD. It remains to be seen whether this is an important factor in contributing to client engagement in Spectrum therapy, given the hope participants describe after engaging in these therapeutic protocols.

In addition, when discussing the positive effects of Spectrum therapy, a feeling of empowerment was related to the brighter future participants felt
was now possible. Some participants spoke about this feeling of empowerment after Spectrum therapy when talking about how confident they felt in their abilities to get better autonomously without the help of a therapist.

*Sam:* I was always willing to submit to the treatment... always went into every session wanting to find whatever I was looking for to enable me to get better. I didn’t find that until I learned Spectrum, it wasn’t something that was told to me or it wasn’t something that was suggested to me, it was something I figured it out on my own (line 123)

*Frank:* It’s helping you because you know that actually you can put in place what you were taught when you were away (line 168)

As many participants described feeling like a failure when suffering with the symptoms of PTSD, this theme appeared central to their experience of Spectrum Therapy.

*Matt:* Oh yes, yes I mean I tried to commit suicide (line 12)

*Matt:* I tried that a couple of times and bloody failed at that as well (line 14)

*Thomas:* I thought I was showing massive signs of weakness (line 108)
Gary: We had heard about the Americans in the Vietnam War and that
erm.. but we just pushed it aside and thought aah just typical Yanks you
know and PTSD if you like was deemed as being weak (line 18)

2.4.4 Theme: The Problem with Emotion.

The third super-ordinate theme relates to a strong narrative that features in
all the transcripts which documents participants’ desires to stay
disconnected from their emotions in exposure therapy. This super-ordinate
theme is broken down into two sub-ordinate themes. The first sub-ordinate
theme is concerned with fearing the consequences of connecting with their
emotions in therapy. The second sub-ordinate theme under this category is
more akin with a fear of sharing their emotions with another.

2.4.4.1 Feeling unable to cope with feeling.

The first factor under this super-ordinate theme which seemed to effect
participation in exposure therapy relates to a feeling that they could not cope
with the negative emotions generated from exposure therapy. In several of
the narratives, there is an underlying sense that participants view their
emotions as debilitating and therefore they want to avoid connecting with
them. The following narratives once again depict an avoidant style coping
mechanism that the majority of participants report as affecting their
engagement in exposure therapy. For the majority of participants they not
only report wanting to avoid the memories of the trauma as described in the
earlier theme of “whose agenda is it anyway?”, but also a desire to avoid connecting with the emotions attached to the traumatic memories.

Thomas: I actually find I can talk about it now whereas before it would have triggered the same emotions and issues I had when I was thinking about the incident itself (line 170)

Ben: Well not good coz I don’t think they were addressing it, it was a case of you had to talk about it. I think they were doing it with the idea that if you talked about it, it shouldn’t bother you, and I thought hang on a minute I can’t talk to you about it, coz I know that, that them feelings are still there with the memories (line 54)

Matt: I could feel myself shaking you know and..... I’d cry I would cry for want of a better word and I couldn’t understand why I was crying. I just didn’t want to be there to be honest (line 70)

Frank: ….it felt… it was easy to talk about if I stayed disconnected, you know without opening myself up to how I was feeling (line 126).

When discussing his experiences of life with PTSD, Frank reports how his emotions took him away from the professional person that he once was. As he did not want to lose this sense of Self, he felt he had to disassociate from his emotional world.
Frank: I was able to become two people I felt these emotions and these things inside, I put them to one side and tried to stay professional in what I did (line 16)

Interestingly, when talking about their positive experiences of Spectrum therapy, many participants describe how the therapeutic protocols involved in this therapy changed the fearful relationship they once felt they had with their emotions. It would seem that identifying and connecting with their emotions in this therapy was encouraged which in turn allowed them to change their preconceived conceptions that their emotions should be avoided.

Frank: This was my own piece of learning that Spectrum Therapy helped me to uncover....that my emotional world was not something to be afraid of (line 190)

Frank: Yes...I managed to get an understanding of what had happened and I found that I didn’t need to be fearful anymore...I didn’t need to separate myself in two...I found I could connect with my emotions around what happened without being afraid (line 188)

For Gary his recovery was concerned with changing his relationship with his emotions which in turn seemed to change his relationship with the trauma.
Gary: *for me you know I guess it was a bit like shifting something spiritually you know what I mean it was like, it was ok just to feel that way. It’s changed my outlook on i....t it’s changed my thinking on it, it’s like what I went through, erm.. that I don’t have to be fearful of it any more I don’t have to be angry about it anymore erm....*(line 76)

For Gary, it would appear that he took comfort in the Spectrum therapist’s ability to be able to contain his anger which in turn gave him encouragement to express his anger instead of avoid it.

Gary: *I mean they would tell me that it was ok to feel it as erm...as it was all about feeling my emotions so I felt it was ok to express my anger *(line 84)

Creating an environment where Gary felt able to express his anger without a fear that any negative social consequences would ensue seems particularly important when examining the impact anger had on his Social Self before entering into treatment.
Gary: I would start to get angry you know and may be smash the house up and get .......... you know that..... and then that’s who you resemble to them, then I realised that there was no point talking about it (line 36)

Generating an understanding of one’s emotions and the ability to manage the Self were noted by several participants as the most useful part of staying engaged in Spectrum therapy. This emotional awareness for many of the participants seems to be one of the most influential factors in their recovery as they report feeling in control of their emotions instead of their emotions being in control of them.

Ben: Now what the erm...Spectrum therapy did was make sure you are in control of your emotions, they teach you to deal with the emotions (line 178)

Matt: Yeah, I think the emotions will always be there but...they... they are more controllable now (line 261)

Researcher: OK so you have control over them now? (line 262)

Mat: I have yes, I’ve feel as though I’ve got control over me (line 263)

Sam: It’s like you can read your emotions....it’s a fresh start for you (line 137)
Another significant factor identified in the majority of the narratives associated with the sub-ordinate theme of *feeling unable to cope with feeling* relates to how the re-living element of exposure therapy generated specific un-wanted emotions for participants. For these participants shame, anger and guilt were highlighted as hindering their engagement in exposure work.

*Ben:* Erm...no I wouldn’t say it was easy as I said it was emotional you have to go through it but there was a lot of guilt inside me (line 48)

It would appear that for two participants, this feeling of guilt relates to their military experiences which seem to be all consuming after engaging in exposure therapy. For these participants it feels as though exposure therapy left them feeling all consumed with their war-related behaviours.

*Ben:* Yeah because a lot of your actions and a lot of the way...erm...personally myself after treatment I would sit wallowing on what....what have you done and the anger, and think that was horrible (line 146)

*Matt:* Well it like you feel bad because you’re faced with all the bad things that have gone on and it makes you not want to erm....open yourself up anymore do you know what I mean? (line 146)
For others, the presence of anger was believed to be generated from the re-living process. For those that reported anger as consequential to the re-living process of exposure therapy, this was described as influencing their decision to disengage from the therapy. Owing to the way these participants describe their anger, the reader is left with the impression that this emotion is viewed by the participants as unacceptable and is subsequently something that needs to be avoided.

Luke: they had quite a few no shows as well coz I was getting so badly worked up after it (line, 100)

Sam: Well not for me, no, I just used to feel uncomfortable and a lot of the time I’d get angry (line 87)

Gary: It wasn’t long because, like I say I got slightly angry with her and the fact is I thought this is a load of rubbish and I stopped going (line 46)

The negative consequences of getting angry in the therapy sessions seems particularly important to participants as the majority discussed the impact of anger when suffering with PTSD in terms of it taking away their sense of identity. For Sam, Thomas and Ben this is highlighted through their descriptions of how they felt anger changed the relationship they had with themselves.
Sam: I was so angry I was taking it out on my family, I mean, sometimes I would get up and I wouldn’t be able to feel comfortable where I was in my own skin (line 32)

Thomas: I would be..... very unreliable, I would be very volatile, and.....trying to exist in...well normality didn’t really seem to exist in any, in any, spectrum, I have tried to,.... I remember..... sort of trying to make sense of anything was very difficult at the time, being very aggressive very angry (line 6)

Ben: Well, it’s like you’re...you’re having like an out of body experience, you can see yourself erm..... you can see yourself doing things and losing your temper, losing your anger, and everything and it’s as if you are standing at the side and watching it happen and you are powerless to do anything you know (line 2)

In addition to guilt and anger, five out of the seven participants reported how the presence of shame made it difficult for them to engage in the re-living process of exposure therapy. For some, shame seems to be generated by the re-living process itself. For Sam, this was true because he felt he was acting strangely in therapy as a result of fear. For Sam this fear seemed to be generated by the realism of the re-living process.
Sam: It’s all fear driven a lot of things, is from fear, its fear...I mean... anyone would do strange things when they are scared it does sort of induce erratic behaviour if you’re scared (line 62)

Sam: See every time you tell it you get the same burst of emotions that you had when you were there, the main thing is you’re not there so the shouting and the erratic behaviour is now making you look quite like there’s something wrong with you (line 70)

For three participants shame was generated through exposure therapy because their suffering was brought to the forefront. For these participants there seems to be reluctance in engaging with this suffering because they attribute this to a sign of failure.

Frank: after normal therapies that I have known in the past I have felt dirty and hateful and horrible and didn’t like myself because how I have allowed all this to happen to me, how have I allowed myself to be so ill (line 172)

Ben: Erm....I had a horrible sense of loss because errr I was proud when I was doing the job itself and I didn’t think it had affected me until afterwards, when they obviously were putting me back in there and having to go through.... you got all those horrible feelings again, you know the shaky inside the total uncomfortableness, and total restlessness (line 44)
For Thomas in particular this theme is particularly poignant as he describes a significant sense of failure when he was suffering with the symptoms of PTSD as he placed high expectations on the Self to be able to cope. Thomas clearly wanted to stay disconnected from his suffering as he attributes this to a defected Self. This defected Self seems to be highlighted in exposure therapy and subsequently contributes to his disengagement from treatment.

*Thomas:* What a waste of time you know and I remember thinking as well, I remember thinking was this real.... was my mind playing tricks, I was actually quite lost. I remember thinking was this making me ill by doing this and then convincing myself that there was nothing wrong with me (line 160)

*Researcher:* Right and did that make it difficult for you when you were in the therapy?(line 161)

*Thomas:* Well yeah like I only went to 4 or 5 of those sessions, because in my own mind at the time I remember thinking I am stronger than this and that (line 162)

For one participant, shame seemed to feature more as a pre-existing self-judgement that his military experiences were bad and therefore could not be shared. This is distinct from the other narratives where shame was experienced as a consequence of the re-living process itself. For Gary, it would seem that pre-existing shame attached to his military experiences
inhibited his ability to talk to the therapist in the re-living process of exposure therapy.

Gary: Yes it was I mean you have got to look at.....like all the stuff I have done and seen to tell someone about it it’s pretty difficult you know what I mean?(line 92)

For Gary it would appear that sharing his experiences means he will need to share what he sees as a horrible secret relating to his actions in the military. For this reason he found the internal nature of Spectrum therapy particularly useful as he was able to keep his experiences hidden from the therapist which then seemed to encourage engagement in the therapeutic protocols.

Gary: before, when I was asked to talk about my experiences I felt ashamed....like what I had done, was bad...but in Spectrum I didn’t have to talk about my problems (line 107)

2.4.4.2 Not wanting to share.

The importance of not having to share their military experiences with the therapist in Spectrum therapy is not only featured in Gary’s narrative, but in the majority of the other narratives also. Participants reported how the internal nature of Spectrum therapy helped them connect with their
emotions. The narratives associated with this point state the importance of an internal process in Spectrum therapy, where participants were not asked to share their experiences with the therapist, as helping them feel able to cope with emotion. In not having to verbalise their emotions participants felt more able to cope with the therapy as it would seem that for the majority, keeping their emotions in their heads had been a long standing coping mechanism. In Spectrum therapy participants report being able to keep this coping mechanism intact as they do not have to verbally express their emotions. This feels safer and more manageable to the majority of participants.

**Sam:** you are not verbalising it you can cope with it you can’t take away the emotions or you know, change anything that’s ever happened, but you can cope with it because you are not verbalising it, the emotions are not being shown so you are able to go through it without the intensity, without any emotion being present really (line 111)

**Frank:** ... I again... I could never express what was going on inside me, but with Spectrum it’s all about emotion, it all about what you see what you hear, what you feel and it’s all held in your head. Because it’s about that you can give yourself the permission to go there and erm...be involved with what happened (line 186)

**Luke:** So that you’re ok...you might be going through the situation when you felt, you know, different emotions or whatever but you, you don’t as such have to speak out about it you know (line, 177)
These accounts suggest that participants felt unable to cope with their emotions in exposure therapy because of an over concern of how the therapist would view the emotion and subsequently the Self. This concern seems to be eliminated in Spectrum therapy because the participants were not required to share their emotions with the therapist. This seems to provide an element of safety in treatment as the participants do not feel they are exposing themselves to judgement.

2.4.5  **Theme: The Importance of relationships.**

Participants described two main factors associated with Spectrum therapy that enhanced their therapeutic relationship and subsequently encouraged them to engage with the therapeutic process. This super-ordinate theme has therefore been broken down into two sub-ordinate themes which relate to *Military/Civilian Divide* and *Feeling Supported in Recovery*.

In the majority of narratives, participants describe a difference between how they view their relationships with civilians and people who are ex-military. This difference seems to be generated from the strong bond formed between serving members when in combat. This camaraderie is reflected in participants’ descriptions of an unparalleled level of trust and understanding experienced between themselves and other veterans of war. This level of trust and understanding, for the majority of participants, is absent from their relationships with civilians.
In addition, many participants describe feeling supported by their Spectrum Therapist as positively affecting their therapeutic relationship. This subordinate theme will be discussed in relation to participant experiences of the continuing availability of Spectrum therapists and a clearly expressed normalisation process where participants felt connected to their therapist on the level of military experience and PTSD symptom comparison.

2.4.5.1 Military/Civilian Divide.

Many participants described the importance of the therapist being a veteran in Spectrum therapy in helping them feel connected to the practitioner. This connection seems to be generated by a shared understanding of military experiences between the participants and the Spectrum practitioner.

Luke: Yeah because it was ex-forces erm, who were delivering the treatment so obviously the understanding was there, it helped then you know (line 167)

Gary: When I got there I met this team and some of them were ex-soldiers which made me feel a bit more comfortable (line 64)

Researcher: Why did that make you feel comfortable do you think? (line 65)

Gary: Well...immediately I knew that they would understand me and what I had been through (line 66)
For some, feeling understood also seemed to generate trust in the therapeutic relationship.

_Matt:_ They understand what I am going through I understand what they are going through and I trust them to be honest (line 38)

_Sam:_ Yes that massively helped I’ve got to say that straight away you know you are talking to a mucker you’re talking to someone who knows the terminology and I think that’s the basis of the... the trust (line 107)

Other participants went further with this point by placing trust and understanding as the main reason for their engagement in therapy. This is summed up in Matt’s narrative when he talks about how he would feel if his therapist didn’t understand him.

_Matt:_ Frustrated, despondent, uncomfortable, you name it, angry....... it’s everything (line 222)

Thomas also believes trust to be a central part of treatment engagement, particularly in trauma work as he felt he was exposing himself to his therapist in this type of therapy.
Thomas: they are asking you to re-live and going through processes which are very personal to you, I know for a fact that if I haven’t engaged with someone on a level I am comfortable with and I trust that individual I would go no further, you know my own defence mechanisms would kick in (line 144)

The importance of building a trusting relationship where the participants felt understood seems to be particularly important as the majority of participants described feeling unsafe to discuss their experiences with civilians for fear that they will judge them.

Ben: And as well when I feel...errr...if you’re trying to talk to a civilian, somebody who has not been through it they might feel you are being farfetched kind of thing, like you are exaggerating the story or something like that so you clam up and just tell them the basics erm....but you can tell a soldier the full story because he is getting right in there he is with you, you know that’s how I feel (line 78)

Matt: but it’s just something there you know straight away that your thoughts are safe with that veteran (line 284)
This “them and us” mentality seemed to enter in to the therapy room for Gary and impacted on his relationship with his therapist.

*Gary: because she was a civilian and the fact is when you’re trying to tell someone about what you have been through its like....you know.... you get the impression do they believe me* (line 32)

This description by Gary offers an insight into his thought process about the severity of this military/civilian divide as he feels his military experiences are so far removed from everyday life that his therapist might not believe what he is saying. Interestingly, other participants allude to this point when talking about their difficulties re-integrating back into society when they left the military, with the majority reporting feeling a being a breed apart from civilians.

*Matt: I always distanced myself from people....I don’t know, whether I couldn’t trust them, whether.....I always felt as though people were like looking at me staring at me, talking about me.... paranoia basically* (line 24)

*Sam: It’s finding your way back into society, I didn’t see how I was going to do it* (line 46)

*Gary: You’ve got to remember when you are soldier you are trained to kill aren’t you so....but your mind says that you can’t think that way because it goes against the grain in human nature unless you’ve got psychotic
problems or whatever in you, schizophrenic you want to go out or you’re a serial killer that’s something totally different. But like when you have been trained to be aggressive and kill someone and then go back into Civi Street and try to re-adapt to normal life...I guess a lot of ex-soldiers would struggle with that you know (line 98)

This divide between ex-military officers and civilians seems to be strengthened by the necessary camaraderie developed between themselves and other military officers for survival whilst serving.

Ben: It was like a code, an unwritten code amongst all the forces that, you know when you are serving you know, whether it be a ships company, whether it be in barracks or whether it be out at war, you know that you have got your mates and you trust them like you do your brothers, not like anybody else (line 86)

It would seem for some of the participants that being in the military and having such a level of trust with other military personnel made it difficult to trust people who have not been in the forces. This seems to impede the therapeutic relationship as participants feel it is more difficult to trust a civilian than an ex-military officer.
Luke: Coz like when you are going through stuff as close to the wall that’s causing you problems you want to kind of trust the person that you have to revisit that stuff with, but I didn’t trust him you know (line, 125)

Researcher: Oh right, why do you think that was?(line, 126)

Luke: Well, I mean basically, he hadn’t experienced what I had, had he? (line, 127)

Matt: If you got a civi doing that I wouldn’t open up like I did, I wouldn’t have done what I did you know, but because it was ex-squaddies I trusted them, it’s just one of those things if I met an ex-squaddie walking down the street today within 5 minutes I would be talking to him and I would trust him (line 210)

2.4.5.2 Feeling supported in recovery.

The second factor identified in the majority of participant narratives which connects to the super-ordinate theme, The Importance of Relationships, relates to feeling supported in their recovery. For some participants this seemed to be represented by the fact that they did not feel alone in their recovery. This was mainly generated through the structure of Spectrum therapy and the availability of Spectrum therapists.

Luke: Yeah, so its erm, it’s as though if, if something’s brought up then you know that the following day it can be talked through and helped with and
that you don’t have to wait 6 days or however long to, to revisit the problem (line 295)

Gary: but the process of being there continually for 4 days helped me connect (line 113)

Researcher: Right in what ways do you think it helped you connect?(line 114)

Gary: Well I knew it was ok to speak about my anger because I wouldn’t be left dangling with it for days on end....it could get resolved (line 115)

These narratives give the impression that some of the participants felt alone in their recovery in exposure work and that often this would prevent them from engaging in the process because they felt unsupported. This seems to be an important feature for Ben that he felt was missing in exposure work.

Ben: they brought them all to the top and you talked about them and then that’s it, they say ok then thanks very much I’ll see you in a week’s time and so I say ok I’ll see you later (line 154)

For one participant in particular the weekly structure of exposure work actually felt quite damaging as he describes going through unhelpful processes in between therapy sessions.
Frank: don’t leave the person hanging on. Don’t leave them hanging on because by the time... like I said if someone’s been made to visit a trauma they have then got to wait another week to re-visit that trauma then that’s another week of self-blaming and then trying to disassociate yourself from what has happened ermm.. You know what I mean?(line 178)

Researcher: Yeah, did that experience in between sessions, affect how you viewed therapy Frank?(line 179)

Frank: Yeah definitely, I mean after the hour, that’s it your time is up but the problems don’t stop there you know (line 182)

There is also a sense that some participants felt supported because of the consistency of the Spectrum therapists. Such descriptions pervaded both Ben’s and Luke’s narratives when they talk about the positive effects of the therapists’ persistence and availability in their recovery.

Ben: They don’t give up on you... you know what I mean?(line 138)

Luke: Well... you’ve always got in your head you can go back if you wanna you know, if you need a little bit more, but, which at the minute I haven’t so, and it’s been a while so (line 326)

The second way some participants documented feeling supported was through being given hope in their own recovery. For Ben and Matt this
hope seemed to be generated through the comparisons between their own and their Spectrum therapist’s experiences of PTSD and the military.

Ben: So I thought right all these people here have been that angry ex-soldier that I have been for twenty years so I thought you’ve got to give this a bash (line 96)

Matt: But anyway after like the second day it was sort of like …obviously talking to a couple of the lads that were doing the therapy they were ex-squaddies and I saw how they were and obviously talking at night after the therapy had finished you know staying in the place just talking to them in general about what they had been through and it was like how come you are like that now? And it started to all make sense (line 166)

Comparisons between the clients themselves also seemed to encourage engagement in the process as their experiences of the therapy could be normalised. This seemed to encourage engagement as they felt connected in the uncertainty of the therapeutic experience. There is a sense through these narratives that participants felt able to cope with the effects of treatment when their experiences were normalised by others who were also engaged in the therapeutic process.

Matt: I had a little chat with another guy on the course one night and said what do you think of this, he said I really don’t know what it is, but
2.5 Discussion.

2.5.1 Overview of results.

The current study had one aim: to explore how veterans make sense of their disengagement from traditional exposure therapy and their subsequent engagement in a non-exposure based intervention for PTSD. The findings from the current study indicate that there are a number of similarities in the experiences of the participants as represented through the shared themes. In addition, there seems to be shared themes across opposing aspects of treatment experience which were noted as either helping or hindering participant engagement in therapy. For example, under the super-ordinate theme *The Importance of Control*, participants reported a lack of control in exposure therapy as hindering their engagement, whilst a higher degree of control was reported in Spectrum therapy as helping them feel safe engaging in therapy. These themes and the corresponding oppositions will be discussed in relation to the current literature with implications for therapeutic practice and future research highlighted.

2.5.2 The Importance of Control.

One of the main reasons why participants in the current study decided to disengage from exposure therapy was because they report experiencing a
conflict in therapy as their avoidant style coping mechanisms were being challenged. This is recognised as being a particularly difficult balancing act in therapy for the trauma therapist. Whilst it is important for therapists to facilitate an environment where the client feels in control of the processes being asked of them in order to develop a feeling of safety, the therapist also needs to stay mindful that adhering to a client’s avoidant behaviours or cognitions could maintain their symptoms (Lindy, Wilson & Friedman, 2004).

For participants in the current study re-visiting memories that they wanted to forget seemed anathema to them and in some cases impacted on the therapeutic relationship, as participants felt the therapist had control over their treatment plan. This subsequently seemed to generate feelings of frustration or left participants questioning the therapist’s intentions for asking them to engage in the re-living process. Whilst a perceived lack of control has been highlighted as affecting dropout from exposure therapy in clients suffering with PTSD after a motor vehicle accident (Taylor, Fedoroff & Koch, 1999), until now this finding has not been supported by research on PTSD resulting from other event types, such as combat.

In Spectrum therapy participants reported a more client-driven experience where their wants and needs of therapy felt accepted and validated. This is mainly discussed in relation to a sense of freedom participants felt they had as they were not asked to repeatedly revisit their traumatic memories with
the Spectrum practitioner. This finding agrees with Murphy, Rosen, Thompson, Murray & Rainey’s (2004) suggestion that clients with PTSD are often ambivalent about changing the coping strategies that maintain their symptoms. For combat-related PTSD in particular, addressing ambivalence about changing a veteran’s coping mechanisms is recognised as being an important first step in the treatment plan of this client cohort, as they often present with strong beliefs that their coping mechanisms are functional rather than dysfunctional (Murray et al., 2004). The current findings would extend this point further by suggesting that dropout can occur if this ambivalence is not addressed. This seems particularly true for those veterans who strongly believe that avoidance is imperative to their survival.

Participants in the current study report feeling unaware of the benefits of the therapeutic processes involved in exposure work and how this impeded their engagement. This lack of understanding seemed to contribute to their frustrations in exposure therapy as they were being asked to engage in a process which went against their internal model of coping. For this reason it seems that gaining an understanding of the rationales behind the protocols in exposure work was an important aspect of therapy that was missing for participants. This finding was surprising given that one of the outlined components of exposure therapy is the presentation of the overall treatment model, including rationales and goals (Foa & Rothbaum, 1998). This said, with increasing pressures for treatment methods to be delivered in a timely and cost-effective format, this whole process is advised to take no longer than one session (see Cook et al., 2004). For the client cohort in the current
study, it would seem that a continuing narrative on the usefulness of the re-living protocols was vital to their engagement in such a fear-evoking process. This point is further supported by the majority of participants explicitly mentioning the importance of continually and repeatedly being informed of the benefits of the therapeutic processes involved in Spectrum therapy.

2.5.3 The Importance of seeing Positive Change.

Participants spoke of their concern that if they were to engage in the re-living process of exposure therapy their recovery would be impeded. This seems to be related to a fear that negative consequences would ensue if they were to engage in the re-living aspect of exposure therapy. Participants report a fear of their symptoms getting worse or feeling overwhelmed by the re-living process as reasons for their disengagement from exposure therapy. Such fears have been noted in the literature as being “common appraisals” made by PTSD sufferers (Ehlers & Clark, 2000). Contrary to cognitive theories of PTSD, which postulate that a client’s fears of facing their trauma memory will be worse than the reality of doing so (e.g. Ehlers & Clark, 2000), participants in the current study report their fears being actualised in therapy. These findings, whilst contrary to the standard cognitive model, are not entirely unpredicted. Indeed caution regarding the use of exposure therapy appears in the literature on the grounds that the re-living process can be an overwhelming experience for clients (see Hembree et al., 2003).
Some participants reported experiencing a worsening of PTSD symptoms during re-living, a finding which confirms the fears expressed by clinicians as a reason for not adopting this type of therapy in real world practice (see Becker et al., 2004). Conversely, seeing quick change in their symptomatology in Spectrum therapy contributed to participants’ continued commitment to this therapy. Seeing change in Spectrum therapy gave participants a feeling of empowerment and hope for the future as they started to realise that their suffering could be altered. This finding is important to consider in line with not only the current participants’ feelings of a lost future when describing their experiences of life with PTSD, but with this being present in PTSD sufferers in general (Rauch & Foa, 2006). With some research showing that PTSD symptoms worsen before reducing after exposure therapy (e.g. Shearing et al., 2011), and with findings which document a gradual decrease in PTSD symptomatology from exposure therapy (e.g. Speckens, Ehlers, Hackman, & Clark, 2006) it would seem important for the exposure therapist to be transparent and discuss this potential outcome with the client throughout therapy before potential dropout occurs.

2.5.4 The Problem with Emotion.

All participants discussed having a maladaptive relationship with their emotions and how this impeded their engagement in exposure therapy. Participants report not only wanting to avoid the traumatic memories themselves but also the emotions generated through therapy. In the PTSD
literature, emotions such as shame, anger, guilt and sadness are frequently identified as impacting on PTSD sufferers (Lee Scragg & Turner, 2001). Researchers who have supported the presence of emotions, that extend past the predominant emotion of fear in PTSD (Foa & Kozak, 1986), have criticised the exposure model on the grounds that moving through the traumatic memory can heighten emotions such as shame, guilt and anger as the client becomes more exposed to the event and the associated feelings attached to the trauma (Pitman et al., 1991). This seemed to be a feature for participants in the current study as they report on the presence of these specific emotions when discussing the influencing factors associated with dropout from exposure therapy.

For participants in the study there seemed to be a fear of feeling as they felt unable to cope with the negative emotions generated through exposure therapy. This sits comfortably with the findings by Price, Monson, Callahan and Rodriguez (2006) that a “bi-directional relationship” between emotional functioning and PTSD is evident in this client group. Price and colleagues (2006) discuss how a fear about experiencing strong emotions and a concern about controlling one’s reactions in response to emotions in therapy, may impact on the client’s successful completion of PTSD treatment.

In relation to the findings from the current study, participants report being overly concerned with their reactions in therapy. This was identified in participants as a feeling of shame in response to viewing their fear reactions
as strange and erratic. In addition, participants also report feeling ashamed to admit they were suffering with the symptoms of PTSD in therapy. Participants describe difficulties associating themselves with their suffering because they attribute this to a sense of a failure. Indeed this finding is not restricted to the current study with many papers reporting on the effects of shame, and “the fear of retaliation”, as affecting veterans’ decisions to seek help for their post-war symptoms (Hoge et al., 2004). What is interesting from the current study however, is how this sense of failure affected engagement in therapy. For one participant in particular, his reactions in therapy seemed to disrupt his internal model of the Self as someone who is strong and who can cope with adversity. Unable to associate the Self with weakness, the participant decided to disengage from the therapeutic process which was highlighting this perceived sign of weakness. Whilst the role of shame is reported in the literature as being present in the initial stages of PTSD treatment (Jakupcak & Varra, 2011) to the current author’s knowledge this has not, until now, been extended to dropout in combat veterans receiving exposure therapy.

The presence of anger was identified in the current study as having an impact on participant engagement in exposure therapy. In the majority of cases, the presence of anger after sessions was considered the main reason for dropout. Whilst it is not a new suggestion that veterans’ seeking therapy for PTSD also present with high levels of anger (e.g. Forbes et al., 2008), it is suggested here that high levels of anger may result in premature dropout from exposure therapy. This seems to be consequential to participants
viewing the emotion as unacceptable. For participants in the current study who discuss the negative impacts of anger on their Social Self when leaving the army, one can start to understand why getting angrier after exposure sessions contributed to their decision to disengage from therapy.

In addition, participants in the current study report feeling worse after exposure therapy. They attribute this to feeling consumed with their harmful actions in the military as they moved through their trauma memories. In the current study the description of “feeling worse” was interpreted as guilt. Guilt is recognised in the literature as being associated with PTSD, although to a lesser degree than fear which is referred to in the “formation and maintenance of the disorder” (Lee, Scragg & Turner, 2001).

Guilt has been shown to increase during exposure therapy (Pitman et al., 1991). For combat-related PTSD it has been argued that this construct has a more significant impact on treatment outcome than in other PTSD client groups. It has been suggested by Litz et al (2009) that guilt be more heavily recognised in war related PTSD therapies owing to the nature of combat where veterans often experience, or are actively engaged in, situations which go against their moral compass of what is humane. Indeed participants in the current study report the presence of guilt throughout the re-living aspect of exposure therapy and how this then contributed to an increase in depressive style cognitions once therapy had finished. With reference to the current findings where participants report an increase of
guilt as influencing their decision to drop out of exposure therapy, it would seem crucial that future research take note of the presence of guilt, not only in impeding outcome of treatment but also when examining the effect it has on client adherence to treatment in this PTSD cohort.

It has been shown through the foregoing discussion that participants were reluctant to engage in exposure therapy because it highlighted negative unwanted emotions which they wanted to avoid. Interestingly, participants felt more able to engage in Spectrum therapy which, as a therapeutic method, explicitly encourages the recognition of emotions attached to the traumatic event. Not only did participants stay engaged in this treatment method, they report gaining recognition and understanding of their emotions to be the most useful aspect of Spectrum therapy.

What seemed to aid participants’ willingness to connect with their emotions was a faith that the Spectrum practitioners would be able to contain their emotions within therapy. In addition some participants report on the importance of being explicitly informed that experiencing negative emotions was acceptable within therapy. In conjunction with the literature, this finding is congruent with a “staged approach to PTSD treatment” (Cloitre, Koenen, Cohen & Hyemee, 2002). Such an approach suggests that exposure techniques should be offered alongside other therapeutic concepts from different therapeutic packages to help improve client engagement.
Becker and Zayfret (2001) advocate the use of Dialectical Behavioural Therapy (DBT) to help retain client engagement in exposure for instance.

DBT utilises concepts such as validation, mindfulness and the dialectic of acceptance and change in relation to a client’s relationship with their emotions (Linehan, 1993). If the findings of the current study are found to generalise, such an approach could help clients presenting with similar difficulties stay engaged in exposure therapy by equipping them with the relevant skills needed to stay with their emotions instead of avoid them. The findings of the current study could therefore be used to expand on the recognised importance of acceptance in general psychological wellness (Hayes, Strosahl & Wilson 2012), by tentatively suggesting that increasing a veteran’s acceptance of emotions might encourage adherence to exposure therapy.

Alongside this recognition is the importance of the internal nature of Spectrum Therapy in encouraging participants to connect with their emotions. Participants in the current study identified the benefits of not having to disclose their emotions to their Spectrum practitioner as helping them connect with their emotions. This finding adds weight to the presence of external shame associated with emotional expression in males (see Cusack, Deane, Wilson & Ciarrochi, 2006) as participants seemed more willing to acknowledge their emotions when they were not required to disclose their emotionally laden experiences with their practitioner.
2.5.5 The Importance of Relationships.

The importance of developing a strong therapeutic relationship between client and therapist is noted in the literature as being a central feature of client engagement in exposure therapy (Cloitre et al., 2002). For participants in the current study, the development of a trusting, emphatic relationship seems to be developed through a shared understanding of military life between themselves and the Spectrum therapy practitioners. Conversely, when describing their experiences in exposure therapy, participants describe a concern that civilian therapists will not understand their military experiences and may in fact judge them for these experiences.

In the literature this military/civilian divide is recognised as a consequence of the severity of military experiences, where serving officers are often exposed to situations that are so far removed from everyday civilian experiences that they feel disconnected from society once leaving the military (Litz et al., 2009). This seems to be the case for participants in the current study as they describe how the military environment felt like a family unit with unparalleled levels of trust formed between themselves and the other veterans. In their relationships with civilians they describe this camaraderie as being absent and report struggles fitting into civilian life.
For some participants in the current study a perceived lack of understanding from their civilian therapist seemed to impede the formation of trust in the therapeutic relationship which subsequently impacted on their willingness to talk about their experiences in therapy. Given the recognition by participants that they felt misunderstood by civilians and with the acknowledgement by some that they feared judgement from their civilian therapist and were already ashamed of their military experiences or indeed their reactions within therapy, this divide might provide an explanation for why participants were reluctant to talk about their experiences in therapy: for fear of being shamed further. This finding has implications for the role of shame in the development of a trusting therapeutic relationship particularly for clients who view themselves to be a breed apart from their therapist as they fear this lack of understanding will lead to negative judgement. With the recognition that shame can affect expression of symptoms, a willingness to reveal painful emotions and help-seeking behaviours (Gilbert & Proctor, 2006) and with the recognised role of shame, particularly in combat-related PTSD (Litz et al., 2009; Bruner & Woll, 2011), it seems important that this military/civilian divide be explored further in relation to shame and the effect this has on therapeutic engagement of veterans receiving exposure therapy.

Feeling connected to the therapist, and indeed the other clients engaged in Spectrum therapy at the level of military experience, seemed to provide participants with hope in their own recovery as their experiences of therapy could be normalised. This normalisation process subsequently motivated
participants to engage with the therapeutic protocols involved in the therapy. This finding supports other research which highlights the positive influence of a group programme in helping increase veterans’ motivation to engage in therapy (see Erbes et al., 2009).

In relation to the set-up of Spectrum therapy, participants highlight the ongoing availability of their Spectrum therapy practitioners over the four day treatment programme as encouraging disclosure of their problems. This structure, which differs from the weekly sessions offered to participants in exposure therapy, seemed to generate a feeling of safety as participants described feeling reassured that if they were to disclose their problems, they would get resolved.

2.5.6 Implications for Practice.

Counselling and Clinical Psychologists are able to work with clients presenting with the symptoms of PTSD in accordance with NICE (2012) guidance on the treatment of PTSD in adults and children. The difficult nature of engagement for veterans throughout exposure therapy (see Erbes et al., 2009; Garcia et al., 2011) warrants consideration by both Counselling and Clinical Psychologists on how clients can be supported through this efficacious treatment for PTSD. It has been highlighted that the most favoured mode of scientific enquiry (e.g. objective, quantifiable research) has proven useful in identifying an efficacious therapy for reducing PTSD.
symptoms. This said there is still a gap in our knowledge. This gap relates to the *effectiveness* of PTSD treatments in clinical practice as researchers try to explain the high dropout figures reported for exposure therapy.

Clinical practice guidelines for Counselling Psychology specifically describe the profession as being concerned with the subjective nature of a client’s symptoms or experiences and distinguish between Clinical Psychology professions on these grounds (BPS, 2009). Following Berry and Hayward (2011) who report on the usefulness of qualitative modes of enquiry to explore such an anomaly, the current study aimed to explore the subjective reasons for veterans’ disengagement from exposure therapy and their subsequent engagement in a non-exposure based treatment for PTSD.

As the findings of the current study are based on the salient themes of seven veterans, it is not possible to demonstrate that the results are applicable to other populations. This said it has been recognised by Stewart and Chambless (2010) that practitioners are inclined to relate the findings of the single case study to their own clinical work if they see similar characteristics between their clients and those represented in the research. From the standpoint of a Counselling Psychologist, having awareness and understanding of these unique experiences could therefore prove useful when working with veterans presenting with similar characteristics and symptoms in their clinical practice. Owing to this some important though as yet tentative considerations for clinical practice emerged from this study.
From the findings of the current study, it is evident that participants enjoyed, and found it easier to engage in, a process which seemed to be more in-keeping with their avoidant style coping mechanisms. In the face of considerable and growing evidence of the psychologically salutary effects of acceptance and the damaging effects of avoidance (e.g. Foa & Kozak, 1986; Hayes, Wilson, Gifford, Follette & Strosahl, 1996), as a profession we cannot advocate avoidance in the treatment of PTSD. Instead what seems to be an important aspect of treatment, particularly from the experiences of participants in the current study, is the importance of facilitating an environment where the client feels in control of the therapeutic protocols being asked of them and equipping them with the tools to manage the emotions generated by therapy.

It is suggested by Foa and Rothbaum (1998) that clinicians delivering exposure therapy remember the importance of facilitating a collaborative relationship where both client and therapist mutually agree on when, where and how to apply exposure techniques. The findings from the current study would support such advice. Participants seemed to engage more readily in a process which they felt was flexible and where they felt in control of the therapeutic process. Flexible approaches to exposure work are available for therapists (e.g. talking, writing or listening to a recording of the traumatic event) and could be used as a means to help increase client control over the
therapeutic process and reduce resistance to exposure techniques particularly with veterans who present as highly avoidant.

The findings of the current study suggest that therapeutic engagement in exposure therapy could be increased through a continual narrative on the importance of the therapeutic protocols and their usefulness in reducing symptoms. Whilst informing our clients of the rationales behind exposure therapy is documented as an initial stage in the treatment plan (Foa & Rothbaum, 1998), it may be that this is not emphasised enough, particularly for clients who present with strong avoidant styles of coping. In this instance it could prove useful for exposure therapy to take a lead from other psychological treatments such as EMDR and Acceptance and Commitment Therapy (ACT) where detailing the model of treatment and the benefits of such a model for specific symptoms, is recommended in the first few sessions of treatment (Shapiro, 1995; Hayes et al., 2012).

It has been suggested by Becker and Zayfret (2001) that prefacing exposure treatment with emotion regulation skills for clients with PTSD might improve client engagement. The findings from the current study would add weight to this previously un-supported statement, particularly for clients presenting with PTSD symptoms in the aftermath of war. Where emotionally laden experiences are accessed and often expressed in exposure therapy, having skills to manage these emotions so veterans do not feel overwhelmed and are therefore less likely to avoid their emotions may
prove vital in treatment adherence. This is seen as important for the participants in the current study as anger, guilt and shame seemed to affect their engagement in the re-living process.

 Adopting emotionally-focussed treatment packages within exposure therapy, for example, anger management skills (Jakupcak et al., 2007) or compassionate mind training for shame (Gilbert & Proctor, 2006) could provide clients with the necessary skills to help change their avoidant reactions to such affective states. It is suggested, for participants in the current study at least, that this modification could have increased their tolerance of exposure techniques. This finding seems particularly important for combat-related PTSD specifically as often this client group is recognised as viewing emotional expression as a sign of weakness (Litz et al., 2009).

Finally, it is evident from the findings in the current study that participants feel there is a clear cut divide between people who have served in the military and civilians. This divide is connected to a belief that civilians, including their civilian therapist, would not understand their military experiences because they themselves had not witnessed such devastating events. In the current study this had an effect on the development of trust in the therapeutic relationship and in some cases led to participants fearing judgement from their therapist for having such experiences.
With this point in mind, it might prove fruitful to examine the role of self-disclosure in the therapeutic context. Whilst there is disagreement in the literature on the usefulness and indeed the relevance of a therapist’s self-disclosure in therapy (Forrest, 2010), it is suggested that this could have a positive impact on the development of a trusting relationship between veterans and their therapists. For those therapists who have broadly traumatic experiences or who have previously worked with veterans therapeutically, such disclosures could help challenge the belief that their civilian therapist will not be able to comprehend their experiences. Alternatively, when veterans feel that their experiences of war are so far removed from the everyday experiences of their therapist, not explicitly having to recount their traumatic memory seems to be beneficial. Internal investigations as featured in Spectrum therapy or focusing on brief segments of the trauma network as featured in EMDR (Shapiro, 1995) may therefore prove a worthy addition to exposure therapy to help improve its practical effectiveness.

2.5.7 Limitations and suggestions for future research.

One of the main criticisms surrounding the usefulness of qualitative studies, particularly those such as IPA which utilise relatively small sample sizes, is that the results cannot be generalised to the wider population (Smith et al., 2009). However this is not to say that the results from idiographic studies are not useful to both researchers and practitioners. It is suggested by Shenton (2004) that the data from idiographic methods, such as IPA, are
best understood within the boundaries of client characteristics and their
situations to enhance the transferability of findings from research into
practice. This therefore allows the reader to decide whether their client’s
characteristics in practice match those of the participants in the study and
therefore whether the results can justifiably be transferred to their work with
that client. In order to enhance the transferability of findings from the
current study the researcher incorporated questions into the interview
schedule pertaining to the participants experiences of life with PTSD before
moving onto questions about therapy.

In addition, qualitative methodologies can be useful when studying an
under-researched area of psychological enquiry, where generating
hypotheses may be particularly difficult (Smith et al., 2009). The
explorations from idiographic methods can give direction to future research
by providing areas of interest which can be further explored either in
different environments or from different methodological orientations
(Shenton, 2004). For instance the findings of the current study could be
built upon by either quantitatively analysing the effects of the current
themes on client engagement to PTSD treatment or by recruiting a different
PTSD cohort such as those affected by rape or road traffic accidents to
assess if similar qualitative themes arise.

Three out of the seven participants had gone on to train as Spectrum
practitioners after completing Spectrum therapy. It could therefore be
argued that these participants were motivated to enhance the desirability of this therapy. Whilst this possibility cannot be discounted, the researcher was not able to detect any distinction in the narratives between those who had, and those who had not decided to give back to the therapy from which they had benefited. One way of minimising this limitation would be to compare the experiences of veterans who have dropped out of exposure therapy but who have subsequently engaged in another treatment delivered through the National Health Service, such as EMDR. With comparisons of EMDR and Spectrum therapy being identified on the grounds of a less solid efficacy base and reduced theoretical substance when compared to exposure therapy (as discussed in Paper One), it would be interesting to see if similar qualitative themes depicted in the current study also emerged from this comparison.

One of the criteria for inclusion in the study was that participants had a diagnosis of Post-traumatic Stress Disorder at the time of receiving treatment. The researcher did not receive any confirming information of their diagnosis, but instead relied on self-reports and participants’ referral for exposure therapy, as confirmation of their diagnosis. In light of this, the current researcher aimed to qualitatively examine the participants’ symptoms and experiences of PTSD symptoms before focussing on their experiences of therapy. All participants described having symptoms consistent with PTSD criteria as outlined by the DSM-IV-TR (2000), which include flashbacks of the trauma, avoidance and irritability. A full clinical
assessment for the purposes of the current study would have been neither feasible nor appropriate.

The current study relied on participants giving recalled experiences of both therapies. For two participants, who had received exposure therapy a few years ago, this recall was often described as “difficult”. With this in mind, it is possible that for these participants in particular, their experiences of exposure therapy may have been affected due to the passing of time. In addition, Worthen and McNeil (1996) identify a possible bias in retrospective evaluations in psychological enquiries, as recall of past experiences may be evaluated negatively based on evaluations of participants’ current needs instead of their needs at the time of receiving help. With these points in mind it would be useful for future explorations of treatment experience to be conducted with participants who have recently dropped out of exposure therapy but are subsequently engaged in another therapy for PTSD to help limit the potential distortions that may occur over time.

Finally, it has been suggested by Becker and Zayfret (2001) that exposure based interventions would be better adhered to by clients if therapy was prefaced by emotion regulation skills. The findings from the current study would support such a claim as all participants found it difficult to accept and stay with emotions such as anger, guilt and shame when engaged in exposure therapy. The current study therefore suggests that future research
may want to examine whether an integrated form of treatment (i.e. exposure teamed with emotion regulation skills) for combat-related PTSD is useful in increasing client engagement to exposure therapy.

2.6 Conclusion.

The aim of the current research dossier was to respond to the gap in the current literature which documents a clear distinction between efficacy and effectiveness in the treatment of PTSD and combat-related PTSD. This distinction between what is deemed useful from research trials, and what is deemed useful in actual clinical settings, is a common problem in more general areas of psychology (Fairfax, 2008). For Counselling and Clinical psychologists in particular, whose professions adopt the scientist-practitioner model of care, this is a particularly significant problem as routinely and consistently the use of evidence based practices in clinical settings is encouraged (Newnham & Page, 2010).

The distinction between research efficacy and practical effectiveness has been demonstrated in the current literature review through a comparison of two popular PTSD therapies: exposure therapy and EMDR. Whilst both therapies are deemed to be popular they are so for different reasons. Exposure therapy dominates on the grounds of theory (e.g. cognitive and
behavioural paradigms) and is favoured through clinical outcome trials, whereas EMDR appears more popular with clients and therapists in practice.

The review suggests that certain therapeutic factors pertaining to both exposure therapy and EMDR may have an impact on client engagement and therapist utilisation which have not yet been adequately explored through the conventional mode of evaluation e.g. the randomised control trial. Support for a more exploratory mode of enquiry using qualitative research methods to further our understanding of the client experience of therapy has been previously supported in the treatment of psychosis (Berry & Hayward, 2011). In the arena of PTSD treatment, where there is a recognised distinction between treatment efficacy and effectiveness, the current review has called for a more client-centred exploration to help explain such an anomaly (see Paper One of the current Research Dossier). It is suggested that this type of research enquiry could help uncover strategies to improve client tolerance of exposure therapy and thus reduce the fears highlighted by clinicians for not using this treatment method in practice (see Becker, Zayfret & Anderson, 2004).

Such a suggestion has been adopted by the current research project which set out to explore how veterans make sense of their disengagement from exposure therapy and their subsequent engagement in a non-exposure based intervention for PTSD: Spectrum therapy. Spectrum therapy was deemed to be a useful therapeutic approach to study because like EMDR, it too differs
from exposure therapy on the grounds of efficacy and effectiveness.
Moreover, anecdotally, a high proportion of clients receiving Spectrum therapy had previously dropped out of exposure interventions delivered through the National Health Service (NHS).

One of the more significant contributions to our understanding of PTSD therapies made by the current research has been to increase our knowledge of why veterans themselves believe they disengaged from exposure therapy. Up until now, the research base has mainly centred on a quantitative exploration of dropout which usually attributes client variables and co-morbidities as the reason for dropout from PTSD treatment (Zayfret et al., 2005). Whilst useful, such analyses can distract from proactively examining how therapies can be moulded to suit client need (Murphy et al., 2004). No work has previously been conducted on client reasons for dropout from exposure therapy, neither generally, or with veterans of war.

The current research has suggested that less efficacious approaches to treatment may in fact be able to help develop those therapies which are highly efficacious but are not particularly effective in practice. By recruiting participants that have disengaged from exposure therapy but who have also engaged in another, more novel therapeutic intervention for combat-related PTSD, the current study has been able to identify therapeutic factors which participants themselves ascribe a causal role in relation to their engagement in, or disengagement from PTSD therapies. Such factors
may be able to help further our understanding of what makes a therapeutic approach to PTSD treatment *effective* in practice.

Based on the findings from this research the following preliminary suggestions for increasing veterans’ adherence to exposure therapy could be useful for Counselling Psychologists and other mental health professionals working with this client group in clinical practice:

- Facilitating a collaborative environment where the client feels in control of the therapeutic processes being asked of them.
- Giving a repetitious account of the usefulness of techniques (e.g. re-living) throughout the therapeutic protocols.
- Prefacing exposure techniques with emotion regulation skills.
- Being mindful of the military/civilian divide and the potential effect this may have on the development of a therapeutic relationship.
- Normalising therapeutic and military experiences throughout the re-living process.

Whilst the outcomes from this research are tentative as they are based on limited samples, they pave the way for confirmation in future research. Such explorations are needed if the gap between efficacy and effectiveness in the treatment of PTSD is to be bridged.
Paper Three


3.1 Developing the research proposal.

Discovering that a requirement of the doctoral portfolio was to devise an original research project that contributed to the existing psychological literature was, at first, quite overwhelming. There had been several years between the completion of my undergraduate degree and the start of the Counselling Psychology Doctorate and, given the speed with which research progresses in this field, I was not confident that any idea I had would be original. This meant that when I first contemplated my research project, I reverted back to my default setting and looked to be told what to do. I started, in a haphazard fashion and with no clear sense of what I wanted to do, by looking at the limitations of other studies. The process left me frustrated. Although academically I understood the potential for further study in some of the areas I looked at, the topics gave me neither the drive nor the passion that would be required to undertake such a significant piece of research.

It was the dual element nature of professional Counselling Psychology that led to the breakthrough and to the conception of my research proposal. At the same time that I was looking for answers and ideas in the limitations of other people’s research, so too was I experiencing challenges in my clinical placement. A client that I was working with therapeutically was finding it
difficult to engage with the recommended treatment method for PTSD.
From this practical experience I began to witness the limitations of routinely applying therapies with the highest level of efficacy into my clinical work. This began my fascination with the efficacy/effectiveness debate in psychological therapy which subsequently featured in many of my academic assignments. Through exploration of the existing literature on this debate, I was beginning to notice that other researchers were documenting this distinction, particularly in the arena of PTSD, and combat-related PTSD treatment (e.g. Zayfret et al., 2004; Erbes et al., 2009). After a discussion with my research supervisor on this topic I began to search for therapies within the field that might help explain this divide, i.e. therapies that were not as efficacious as exposure therapy, but that were showing promise in clinical practice.

Whilst looking for alternative therapies for PTSD, I became aware of Spectrum therapy, which is marketed as a non-exposure-based intervention for combat-related PTSD. This therapy appeared to suitably relate to the efficacy/effectiveness distinction. It had not previously been researched but was, at least anecdotally, proving to be successful in keeping clients engaged with therapy up to completion. From my experiences in practice, my subsequent literature searches on the research/practice divide in PTSD therapies, and through recognition that other, more novel therapies such as Spectrum were proving popular with clients, my original research idea was conceived. This proposal included interviewing clients to determine why they had disengaged from exposure therapy but had remained engaged with
Spectrum therapy. I decided to focus my research on client experiences of therapy as the available research explained client dropout rates from exposure therapy by focusing on client factors (Sparr et al., 2003; Van Minnen et al., 2002; Bryant et al., 2003). Through my own clinical practice, and whilst writing my critical review paper, I became more aware that this explanation may be somewhat limited and that other variables, pertaining to therapeutic experience could also influence dropout (see for support Berry & Hayward, 2011).

Although the potential to undertake this research excited me and I was confident of its value, I had reservations about how experienced academics would view a thesis on a subject that had little previous academic scrutiny. In addition, I was becoming aware, through more regular contact with Spectrum therapy that a high number of veterans were actively seeking out this treatment method. Owing to my aforementioned reservations and my increasing awareness of client demand for this therapy, I decided to include another aim for my research: to study quantitatively, the success of Spectrum therapy in reducing the symptoms of PTSD. On reflection this idea was a goal too far. Certain factors throughout the development of my research rendered this additional goal neither desirable nor achievable.

As I became more immersed in the literature which outlined the efficacy/effectiveness distinction in PTSD treatment (please refer to my critical literature review), I began to notice the valuable contribution my qualitative study would make in this field. I became more excited by the
prospect of starting to help bridge the gap between what is deemed effective in practice and what is efficacious from research trials. In addition, the cohesive nature of the portfolio, with the recommendation that all individual parts must make up a complete whole, led me to re-evaluate the decision to include the quantitative section of my research. I wanted to honour my original idea of conducting a piece of research which would aim to help improve existing therapies (i.e. exposure) on the grounds of practical effectiveness, and thought the addition of a quantitative section which aimed to test the outcome measures of a new therapy would threaten the fluidity of my research as a whole. It was on these grounds that I decided to omit the quantitative section of my research. I do, however, intend to honour this analysis in future research, not least because I feel it important that novel therapies be deemed suitable for scientific enquiry more readily than is currently the convention. It is thought that such a move would add worthwhile growth and development to mental health professions (Russell, 2008).

3.2 Methodological Challenges.

Having never attempted to do an IPA study before, some of the main challenges I faced when conducting this research came when interviewing the participants. First, because I had prior experience of exposure therapy working unsuccessfully with a client in my own clinical practice, I wanted to ensure that this did not influence the accounts of my participants. I was therefore cautious of this when designing and delivering my interview.
questions. I attempted to adopt an open, semi-structured style of questioning, as suggested by Smith, Flowers and Larkin (2009) to shape the interview to participants’ honest experiences of therapy. In addition I frequently informed participants that I was interested in their positive and negative experiences of exposure and Spectrum therapy.

Secondly, although I recognised the importance of recording participants’ experiences of PTSD symptoms, so that their narratives on therapy could be put into context (see Shenton, 2004), I did not expect that some participants would speak about their experiences of PTSD symptoms at such length. Following the first few interviews, I began to have some concerns that the data I was collecting was not sufficiently rich in relation to my research question. I raised these concerns at a supervision session and as a result amended my interview schedule to include fewer questions on participants’ experiences of PTSD symptoms.

As a final consideration I was aware during the interview process of the conflicting pressures I was under with regards to completing good quality interviews whilst also working to tight deadlines. At the start of the planning phase I hoped to transcribe each interview before completing the next in order to help me reflect on the narratives and become immersed in the data at an early stage. Unfortunately this goal was not attainable owing to the time it took for ethical approval to be granted and my other university commitments. This said I feel the quality of the data was not greatly
affected by this omission as, I did allow myself some time to reflect on the questions asked and the information obtained.

Upon reaching the analysis phase of my research, I began to agree with my supervisor’s warning that conducting qualitative research would be challenging. Not only are there various ways of conducting such a piece of research (see Smith et al., 2009: p80), but also the explorations and analyses involve detailed and time consuming processes. Alongside this, I initially struggled with IPAs defining feature: the double hermeneutic aspect of interpretation where “the researcher is seen to be making sense of the participants making sense of their world” (Smith, 2004).

My first challenge with this concept came in the initial analysis phase, when generating my interpretations of the data set. I was not confident in my ability to generate meaning from the narratives of participants, to fulfil the “interpretative aspect”, yet keep the analysis as a true representative of the original data. Confounding my fears was the recognition that a proportion of my interpretations centred on participant emotions. This was a concern for me as, at the time of conducting my analysis, I was in a placement that encouraged, and saw great value in, Emotionally-Focussed Therapy (EFT). In addition, whilst on this placement, I was starting to recognise the value of Dialectical Behaviour Therapy (DBT), in helping my clients recognise and tolerate their emotions. With these contextual factors in mind I was aware of the importance of having my supervisor continually check through my
interpretations in order to limit researcher bias and fulfil the primary aim of IPA: to detail the lived experience of the participant (Smith et al., 2009).

3.3 Conclusion.

Undertaking such a large piece of qualitative research can be a detailed and complicated process and I feel extremely proud that I have been able to complete this work. There are many different ways to undertake an IPA study and as such it often requires one to use one’s own judgement, something that I was not particularly confident doing in the past, preferring to seek academic guidance from tutors, and personal guidance from my parents.

The research has helped me to develop skills that I can transfer to my clinical practice. I am more confident in making clinical judgements and at expressing my clinical opinion in departmental meetings. With clients themselves, I am more confident to apply a here and now style of working and of making in the moment decisions. With regard to my findings specifically, I feel these will influence the way I work with future clients under an exposure therapy framework, not least in terms of detailing the model, and the importance of the techniques, to my clients. I hope to expand on the suggestions outlined for future research from this study when I am a qualified Counselling Psychologist.
4.0 References.


Berry, C. & Hayward, M. (2011). What can Qualitative Research tell us about service user perspectives of CBT for Psychosis? A synthesis of


King’s Centre for Military Health Research. (2010). *What has been achieved by fifteen years of Research into the Health of the UK Armed Forces?* Available [Online:]  


5.0 APPENDICIES.

Appendix 1: Reference for the current Critical Literature Review (Paper One)
Appendix 2: Journal of Clinical Psychology Notes to Authors

Appendix 3: Description of Spectrum Therapy.

Appendix 4: Example of Spectrum Therapy Consent Form

Appendix 5: Example Participant Consent Form

Appendix 6: A copy of the research Res20 form

Appendix 7: A copy of Ethical Approval

Appendix 8: Participant Information Pack

Appendix 9: Debrief Sheet

Appendix 10: Interview Schedule

Appendix 11: Participant Tables of Themes

Appendix 12: Grand Table of Qualitative Themes
Mills, S., & Hulbert-Williams, L. (2012). Distinguishing between treatment efficacy and effectiveness in Post-traumatic Stress

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Disorder (PTSD): Implications for contentious therapies.

*Counselling Psychology Quarterly, 25 (3), 319-330.*

APPENDIX 2: JOURNAL OF CLINICAL PSYCHOLOGY NOTES TO AUTHORS.


Manuscript Preparation
Format. Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure Legends 9) Permissions. Start each element on a new page. Because the Journal of Clinical Psychology utilizes an anonymous peer-review process, authors’ names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.


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- **Review Articles.** Review articles should focus on the clinical implications of theoretical perspectives, diagnostic approaches, or innovative strategies for assessment or treatment. Articles should provide a critical review and interpretation of the literature. Although subdivisions (e.g., introduction, methods, results) are not required, the text should flow smoothly, and be divided logically by topical headings.

- **Brief Reports.** Abbreviated reports will be considered, and are especially encouraged if they involve: 1) replications; 2) replication failures; 3) well-designed clinical trials and other studies with negative findings; 4) potentially interesting serendipitous findings or results obtained by post-hoc hypotheses; or 5) Dissertations in Brief (DIB). DIB is intended to encourage students to submit innovative research conducted during the student’s graduate studies. It is expected that DIB manuscripts would be submitted by the student, who would be the first author. All Brief Reports should contain an abstract and provide a concise synopsis (12 manuscript pages or less) of the major findings presented in the study. The format of manuscripts submitted for Brief Reports
may adhere to the Research Report or Review Article format as appropriate. Authors of Brief Reports should make available a full description of method and statistical analyses with a report of all data and information needed for meta analyses. Brief Reports should include explicit statements of limitation, and power analyses may be necessary.

- **Commentaries.** Occasionally, the editor will invite one or more individuals to write a commentary on a research report.

- **Editorials.** Unsolicited editorials are also considered for publication.

- **Notes From the Field.** Notes From the Field offers a forum for brief descriptions of advances in clinical training; innovative treatment methods or community based initiatives; developments in service delivery; or the presentation of data from research projects which have progressed to a point where preliminary observations should be disseminated (e.g., pilot studies, significant findings in need of replication). Articles submitted for this section should be limited to a maximum of 10 manuscript pages, and contain logical topical subheadings.

- **News and Notes.** This section offers a vehicle for readers to stay abreast of major awards, grants, training initiatives; research projects; and conferences in clinical psychology. Items for this section should be summarized in 200 words or less. The Editors reserve the right to determine which News and Notes submissions are appropriate for inclusion in the journal.

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informed consent was obtained from the research participants after the nature of the experimental procedures was explained.

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**APPENDIX 3: DESCRIPTION OF SPECTRUM THERAPY.**

Spectrum Therapy is an emotion focused therapy for Posttraumatic Stress Disorder that utilises cognitive restructuring techniques to help reframe past
problematic memories into positive resourceful strategies that the clients can use in the present day.

The first step in the therapeutic protocol involves some relaxation techniques. This usually involves muscle relaxation and encourages clients to identify a “safe place” within their minds that they can go to if they are finding the protocols distressing. Clients are asked to hold in mind the memory that they found traumatic before identifying the associated emotions attached to the memory. Once an emotion has been identified clients are asked to describe the emotion in terms of a colour or a sensation and to follow that sensation or colour back to the first time they experienced the emotion (this usually takes the client back to childhood). Once the client has identified this memory they are asked to notice what cognitive associations they made in relation to the target emotion. Throughout this process, clients are reminded that they can “go” to their safe place if they are finding anything too distressing. Clients are required to tell the therapist the colour/sensation and the cognitive associations related to the emotion but not the details of the traumatic event itself. Whilst clients are still holding the past memory in mind, they are asked to identify any learning that they could take from the event that perhaps they didn’t see before when they were a child. Once a positive learning has been identified, clients are encouraged to attach a colour or sensation to this new learning and to mentally replace this with the old colour/sensation attached to the emotion originally identified. This whole process is repeated with each individual emotion that a client relates to the traumatic event.
APPENDIX 4: EXAMPLE OF SPECTRUM THERAPY CONSENT FORM.

RESEARCHER:  Sarah Mills  
sarah.mills@wlv.ac.uk  
University of Wolverhampton  
Millennium City Building
STUDY TITLE: How do veterans make sense of their disengagement from traditional exposure therapy and their subsequent engagement in a non-exposure based intervention for PTSD?

The founder of Spectrum Therapy hereby gives consent for the named researcher to carry out a study investigating client experiences of our post-traumatic stress disorder intervention.

I understand the nature of the study and am willing to volunteer participants for the purpose of this research investigation.

I give consent for Spectrum Therapy and it’s interventions to be documented in this research project.

I am aware of participant’s confidentiality rights and their right to withdraw from the study at any time.

Signed………………………………… Date…………………… 

Name (in print)…………………………………

Position in the charity………………………………………………

REF: CONSENT FORM: ST

APPENDIX 5: EXAMPLE PARTICIPANT CONSENT FORM.
[Consent Form – Section 2]

STUDY TITLE: How do veterans make sense of their disengagement from traditional exposure therapy and their subsequent engagement in a non-exposure based intervention for PTSD?

I have read and understood the attached information sheet regarding the doctoral study which is looking to investigate client preferences for combat-related PTSD treatments.

I am aware that the study will require me to answer questions regarding PTSD and the subsequent treatment methods I have had to eradicate my symptoms of the disorder.

I have been informed of my confidentiality rights and my right to withdraw from the study at any time.

I am aware that if I have any queries regarding the current study that I should contact the researcher or supervisor on the details provided above.

I hereby consent to taking part in the study.

Signed…………………………………. Date……………………

[Condensed box]
I would like to receive a summary of the research findings
by ☐ email
　　　　　　…………………………………………………………………………………………………
or by ☐ by post
　　　　　　…………………………………………………………………………………………………

APPENDIX 6: A COPY OF THE RESEARCH RES20 FORM.

UNIVERSITY OF WOLVERHAMPTON

RES 20B

School of Applied Sciences
Behavioural Sciences Ethics Committee:
submission of project for approval

To be completed by SEC:

Date Received:

Project No:
This form must be word processed – no handwritten forms can be considered
ALL sections of this form must be completed
No project may commence without authorisation from the School Ethics Committee

**CATEGORY B PROJECTS:**

There is identifiable risk to the participant’s wellbeing, such as:

- significant physical intervention or physical stress.
- use of research materials which may bring about a degree of psychological stress or upset.
- use of instruments or tests involving sensitive issues.
- participants are recruited from vulnerable populations, such as those with a recognised clinical or psychological or similar condition. Vulnerability is partly determined in relation to the methods and content of the research project as well as an *a priori* assessment.

All Category B projects are assessed first at subcommittee level and once approved are forwarded to the School Ethics Committee for individual consideration. Undergraduates are not permitted to carry out Category B projects.

<table>
<thead>
<tr>
<th>Title of Project:</th>
<th>How do veterans make sense of their disengagement from traditional exposure therapy and their engagement in a non-exposure based intervention for PTSD?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Supervisor:</td>
<td>Dr Lee Hulbert-Williams</td>
</tr>
<tr>
<td>(for all student projects)</td>
<td></td>
</tr>
<tr>
<td>Name of Investigator(s):</td>
<td>Miss Sarah Mills</td>
</tr>
<tr>
<td>Level of Research:</td>
<td>Practitioner Doctorate in Counselling Psychology.</td>
</tr>
<tr>
<td>(Module code, MPhil/PhD, Staff)</td>
<td></td>
</tr>
<tr>
<td>Qualifications/Expertise of the investigator relevant to the submission:</td>
<td>Bsc Honours Degree in Psychology. Practitioner Doctorate in Counselling Psychology: relevant modules covered: Cognitive-Behavioural Therapy for PTSD, Research methods and Advanced Research method modules.</td>
</tr>
<tr>
<td>Participants: <strong>Please indicate the population and number of participants, the nature of the</strong></td>
<td>Approximately 5 participants will be recruited for the study. All participants will have been treated for post-traumatic stress disorder through both exposure therapy and the non-exposure</td>
</tr>
</tbody>
</table>
participant group and how they will be recruited.

intervention; Spectrum Therapy. All participants will be combat veterans varying in age from 18-60 years old.

Continued overleaf

Please attach the following and tick the box provided to confirm that each has been included:

| Rationale for and expected outcomes of the study | ✓ |
| Details of method: materials, design and procedure | ✓ |
| Information sheet* and informed consent form for participants | ✓ |
| *to include appropriate safeguards for confidentiality and anonymity | |
| Details of how information will be held and disposed of | ✓ |
| Details of if/how results will be fed back to participants | ✓ |
| Letters requesting, or granting, consent from any collaborating institutions | ✓ |
| Letters requesting, or granting, consent from head teacher or parents or equivalent, if participants are under the age of 16 | |

Is ethical approval required from any external body? YES/NO (delete as appropriate)

If yes, which Committee?

NB. Where another ethics committee is involved, the research cannot be carried out until approval has been granted by both the School committee and the external committee.

Signed: _______________________________ Date: _______________________________

(INVESTIGATOR)

Signed: _______________________________ Date: _______________________________

(SUPERVISOR)
Rationale for the study.

Post-traumatic stress disorder (PTSD) was recognised by the Diagnostic and Statistics Manual (DSM-IV) as a standalone disorder in 1980 (Power, 2002). The life time prevalence of the disorder is thought to be between 1-14%, with even higher rates recorded for specific populations such as war veterans or rape victims (Zayfert & Becker, 2007).

Combat is among the list of life experiences associated with symptoms of PTSD. Accurate diagnosis of combat-related PTSD can often be complicated by the existence of concurrent disorders including depression, anxiety and substance abuse (Frueh, Turner and Beidel, 1995). War related
nightmares, paranoia, flashbacks and persistent hyper arousal states are common symptoms associated with combat, decades after military service (Richard & Lauterbach, 2006). Alongside this, researchers are starting to highlight symptoms specific to this trauma group such as shame, guilt and moral injury (Litz et al., 2009). Life time prevalence of the disorder has been estimated to be between 15-20% for those exposed to combat (Frueh and Hamner, 2000) and as such it is important that researchers aim to find an effective treatment method for the disorder in this population.

It is clear from the literature reviewed that a good deal of research work has been done in exploring the efficacy of exposure therapy in the treatment of PTSD since its introduction into the DSM-IV. Most of the research in this area supports the use of exposure therapy in treating this disorder however it has been highlighted that this form of therapy may not be suitable for all sufferers (Bradley et al., 2005). Recent work aims to explore non-exposure therapies amidst concerns that exposure therapy is less suitable for combat veterans with PTSD on the grounds of dropout (Erbes, Curry & Leskela, 2009). It is also suggested that research may benefit from the exploration of client preferences for treatment (Frueh et al., 2002). It is argued that this mode of exploration could help us mould current methods of treatments around their usefulness to clients and help us move away from what some researchers’ term “the rigid boundaries of exposure based techniques” (Feeney, Hembree & Zoellner, 2003).
The current study aims to address this gap in the PTSD literature by qualitatively examining client preferences for a non-exposure based treatment method called Spectrum Therapy which is currently offered to combat veterans through UK charities and through web advertising. The majority of clients who receive this treatment have experienced some form of exposure therapy in the past which hasn’t worked for them. It is therefore important that the study looks to investigate client experiences of past exposure therapy and their current experiences of the alternative non-exposure based treatment method. This will help research move into the domain of process outcome, something which Freuh et al (2002) highlights as an area which needs more attention in PTSD research.

**Expected outcomes of the study.**

The current study is of particular relevance to counselling psychology research as it aims to assess a non-exposure based treatment method for PTSD through the subjective experiences of clients exposed to this treatment intervention. More generally, it is hoped that the outcomes of this study will help further our understanding of effective, non-exposure based treatment interventions for PTSD.

**Method.**
Frueh et al (2002) have highlighted a need for researchers to evaluate process outcomes in PTSD treatment. They suggest that studies may need to look at patient satisfaction in the treatment of PTSD to help guide future research.

Participants will be recruited for the study through their involvement with Spectrum Therapy. The participants will have already completed the therapy carried out by the charity and will also have had prior experience of an exposure based intervention. They will be asked a series of specialist questions designed by the researcher which ask them about their experiences of treatment. This information will be qualitatively analysed to help identify what the participants feel either helped or hindered their engagement in treatment. This client led information could then help guide future research which looks to find the most effective forms of treatment for combat-related PTSD.

In order to gauge the usefulness of this alternative type of therapy, participants will be asked to answer a series of questions to determine their preference of treatment. It will be interesting to explore what worked or didn’t work for them in this type of treatment. What was different between this type of treatment and the treatment they have received in the past? What their preference is for treatment and which treatment method was most effective and why?
**Data Analysis.**

All questions will be designed by the researcher in a semi-structured format to allow for flexibility.

The questions will be delivered by the researcher in a face to face interview. It is proposed that the qualitative data will be analysed using Interpretive Phenomenological Analysis (IPA). This form of analysis will enable recurrent themes to be identified from the specific data set and be discussed in terms of the usefulness of therapy and participant preferences of combat-related PTSD treatment.

**Data Management.**

All data will be anonymous. At the top of each interview schedule, participants will be asked to write a sequence of letters or numbers that is individual and memorable to them. This will help maintain participant confidentiality whilst allowing for their answers to be pulled from the study if required.

The data collected for the current study will be stored securely for five years after publication after which it will be destroyed.
All participants will be given an information pack. This will contain information on the nature of the study, the confidentiality policy, their right to withdraw and their consent form. Participants will be asked to read all documents before filling in their consent forms.

Due to the fact that the interviews may require participants to revisit events relating to their PTSD, it is important that clients feel comfortable in not consenting to take part in the study if they so wish. These forms will therefore be administered by the charity two weeks before the interview date. Client’s who do consent to the study will be reminded of their right to withdraw both during the interview and after the interview if they decided they do not want their answers to be documented.

Participants who wish to receive a summary of the findings, on completion of the study, will be asked to provide the appropriate mailing details on the consent form.

The founder of Spectrum Therapy is fully aware of the nature of this study and is supportive in volunteering all participants for its purpose. He is aware that his therapeutic intervention will be documented in the study. A
written and signed consent form will be obtained from the charity after the proposal has been ethically approved.

The proposal for the current study will be assessed by the University’s ethics committee. Prior to the recruitment of participants, permission from the ethics board will have been granted. No NHS approval is needed for this study.

APPENDIX 7: A COPY OF THE ETHICAL APPROVAL.

School Ethics Committee

Minutes of the School Ethics Committee held at 10.00am on Wednesday 22nd June 2011 in MC123.

Present

Dr N Morris Chair
Prof K Manktelow
Dr Ken Scott (New Cross)
Dr. Iain Coleman
Dr Yvette Primrose
1. Apologies

Apologies were received from Prof R Morgan

2. Minutes of previous meeting

The minutes were accepted as an accurate record.

3. Matters arising from previous minutes

IPLC

5. Chairs Action

4. Sarah Mills

This form has been passed.

APPENDIX 8: INFORMATION PACK FOR PARTICIPANTS.

[Information Sheet – Section 2]
Aim: To investigate client experiences of PTSD treatment. Experiences from Spectrum Therapy and past exposure treatments will be discussed in terms of their effectiveness and likeability.

STUDY TITLE: How do veterans make sense of their disengagement from traditional exposure therapy and their subsequent engagement in a non-exposure based intervention for PTSD?: An Interpretative Phenomenological Analysis.

Dear ………………

I am currently undertaking my doctoral training in Counselling Psychology, and as part of my research project I am carrying out a study to investigate effective treatment methods for combat-related PTSD. For this, I am going to be investigating a non-exposure based intervention in treating PTSD symptoms called Spectrum Therapy.

The aim of the study is to investigate client preferences for combat-related PTSD treatment. In order to do this, I am inviting people who have had both previous experiences of Spectrum Therapy and experiences of the more commonly used exposure therapy delivered through the NHS or Combat Stress.

The aim is to have a 30-60 minute interview with the individuals willing to partake in the study to determine their preferences for, and experiences of, past interventions used to help treat their combat-related PTSD symptoms. All questions will be designed by the researcher and delivered through an interview.

Your rights as a participant.

Provision will be made to protect the rights and well-being of the participants by adhering to the relevant ethical guidelines and code of conduct (BPS, 2006; Division of CP, 2001; HPC, 2008); and Data Protection Act (1998).

Confidentiality: All data collected for the purpose of the study will be kept confidential. Your name will not be added to any material used in the interviews. Instead we would ask you to note down a unique sequence of letters or numbers that only you know on the top of your interview schedule at the end of the session. This will enable recognition of your answers if you decide you want to withdraw from the study.
The data provided will be stored in a secure unit and destroyed 5 years after the research has been examined by the University Board at Wolverhampton.

The right to withdraw: As a participant you are free to withdraw at any time during the study without giving any reason and without prejudice. If you wish to withdraw from the study, all information and data collected from you (interview transcript and consent form) will be destroyed, or it can be returned to you if requested. However, once the analysis has been completed, it will be difficult to remove the information from the report, which remains anonymous as explained above.

Thank you for taking the time to read this. If you wish to take part in this study please can you sign and date the consent form attached.

If you require any further information or clarification on any of the points listed above please feel free to e-mail the researcher on the e-mail address detailed above.

Yours sincerely

Researcher: Sarah Mills

Supervisor: Dr Lee Hulbert-Williams

APPENDIX 9: DEBRIEFING FORM.

Debriefing Document

Many thanks for participating in the interview; your views are greatly appreciated.

This research project is designed to explore client preferences for combat-related PTSD treatment. The study looks at client reasons for their
disengagement from traditional exposure therapy; as delivered through the National Health Service, and their subsequent engagement in Spectrum Therapy

Please remember that although some of the information from this research may be published, your confidentiality will be secured and you will not be identifiable. The tape from the interview will be kept in a locked cabinet and given a number which is known only to the researcher. Following transcription the tapes will be destroyed. Any identifiable information or names will be removed from the transcripts to protect your identity.

You also have the right to withdraw from the research at any point and with no consequences.

A general summary of the findings of the study can be obtained by sending an email to the researcher on the below email address from autumn 2011. Unfortunately no individual feedback can be given.

Following the debriefing, if you require any more help please find below the numbers and web addresses of some organisations in your area which may be able to help with any issues that may arise.

**Samaritans: 08457 90 90 90 (24hrs).**

**Veterans UK**
tel: 0800 1692277
web: [www.veterans-uk.info/](http://www.veterans-uk.info/)
Provides free help and advice to both military personnel and the veterans community

**ASSIST (Assistance Support and Self Help in Surviving Trauma)**
helpline: 01788 560 800
web: [www.assisttraumacare.org.uk](http://www.assisttraumacare.org.uk)
Support, understanding and therapy for people experiencing PTSD, and families and carers

**The Human Givens Institute**
web: [www.hgi.org.uk](http://www.hgi.org.uk)
Provides a list of therapists who use guided imagery and the ‘rewind’ technique

Thank you once again for your participation.

Sarah Mills. sarah.mills@wlv.ac.uk
APPENDIX 10: A COPY OF THE INTERVIEW SCHEDULE.

The proposed topics for discussion are as follows:

- **Pre – treatment questions.**
  1. What was life like for you with PTSD?
  2. Symptomatology
  3. Effect on families and work life.
- **Their experience of exposure therapy.**
  1. What type of therapy have they received in the past to help with their PTSD?
  2. How long were they in therapy for?
  3. What influenced their decision to disengage from the therapy?
4. What specifically did they find difficult or un-helpful, if anything?
5. How did they feel about the therapeutic protocols/what they were asked to do in therapy?
6. How comfortable did they feel in the sessions?
7. Did they find anything about the therapy helpful?
8. The overall experience.
9. Would you consider this mode of therapy in the future if you needed it?
10. If not, why not?

- **Their experience of Spectrum Therapy**
  1. What made you decide to look for an alternative treatment method?
  2. Why Spectrum Therapy?
  3. What was it about this type of therapy that appealed to you?
  4. How long were they in therapy for?
  5. What was it about the therapeutic method that influenced their decisions to stay engaged in the treatment?
  6. What specifically did they find difficult or un-helpful, if anything?
  7. How did they feel about the therapeutic protocols/what they were being asked to do in therapy?
  8. How comfortable did they feel in the sessions?
  9. Did they find anything about the therapy helpful?
  10. The overall experience.
  11. Would you consider this mode of therapy in the future if you needed it?